Pallium Project & Canadian Hospice Palliative Care Association (CHPCA)
Putting Progress Into Action (PPIA)
Provincial Hospice Palliative Care (HPC) Service Development Introduction Workshop
Nova Scotia, September 14, 2005

Record of Small Group Exercise Report Back

(source – small group flip chart/oral report back)

Background/Context

The baseline process The Pallium Project uses to support local/regional hospice palliative care service development is a one-day provincial workshop entitled Putting Progress into Action (PPIA).It is based on the Canadian Hospice Palliative Care Association (CHPCA)'s, *Model to Guide Hospice Palliative Care Based on National Principles and Norms* (i.e., CHPCA Model).

PPIA is designed as a starting point to protect time, focus attention/energy and facilitate dialogue at the local health authority-level, so local system leaders and hospice palliative care champions can move forward together to strengthen, streamline and improve the quality and sustainability of hospice palliative care services as part of a commitment to primary health care renewal.

In addition to briefings for local communication of hospice palliative care policy and quality/best practice directions and developments at the national-level (e.g., accreditation changes), time is protected for local health service leaders within the province to commence a dialogue about potential opportunities to advance HPC locally/regionally.

This document is a record of the Small Group Work report backs to the plenary for the small group work conducted during the Putting Progress into Action workshop on September 14, 2005, as outlined in the day agenda presented in Appendix A. The information presented in this document is intended as a participant reminder of the report for the day. The reader who was not present during the workshop is urged to use this document with caution due to the exclusion of specific context around the report back comments. Participants during the day represented a cross-section of district health system leaders (as defined by the District Health Authority map in Appendix B) and hospice palliative care champions from Nova Scotia.

Errors, omissions and clarifying comments can be sent by registered participants to Michael Aherne at michael.aherne@pallium.ca.

Small Group Work Exercise #1 – Characteristics of Integration/Challenges in Hospice Palliative Care Delivery

Facilitator note: Small groups opted to address this question one of two ways. They either addressed the question about what would characteristics of integration for HPC within Nova Scotia's health delivery system look like. Others opted to address it as challenges because of integration barriers/gaps.

Group A (This group answered in the form of challenges)

- Currently no single point of entrance – 24hrs
- Movement towards, but currently no minimum standards from provincial health department or/a funded program wherever you receive care (but hopefully movement by end of 2005)
- Lack of appropriately trained and educated palliative care primary providers
- Care is not delivered where you want it to be
- Lack of designated hospice space
- Inconsistent quality assurance for HPC from providers

Group B

Facilitator note: Group B did not submit written flip chart notes for this exercise, but rather opted to provide an oral report back during the large-group exercise debriefing portion of the workshop.

Group C *(Facilitator note: This group answered in the form of what might integration of HPC look like):*

- All providers would have a common vision of what HPC is trying to do
- All would be clearly outcome focused/client focused with sustainable elements that addressed required human resources and funding
- Service jurisdictions would be invisible to clients and families within the province.
- There would be minimal duplication; efforts at role clarification
- There would be good working relationships across settings and jurisdictions
- There would be comprehensive care by a team of those working in the areas of their gifts/training/expertise
- The system would be coordinated and supported and there would be complementarity
- Easy access
- Timely access by an appropriate team member
- Movement towards a common definition of palliative care
- Case management as the base for coordination of care
- Regular and effective communication
- Ongoing education and professional development

Group D *(Facilitator note: This group opted to answer the characteristics of integration option)*

- Formalize a total team approach
- Case management for coordination
- Responsive – some type of 24 hour coverage, especially for those at home
- Basic resources
- Availability of supplemental resources (could be alternative treatments)
- Volunteers
- Weekly rounds/communications regarding those involved with clients receiving HPC services
- Accessibility <u>regardless of setting</u> *(note: group underlined original for emphasis)*
- Identify and reduce barriers in the system
- Ongoing education of a team who has HPC responsibilities
- A provincial champion to further growth of HPC programming
- Community support
- Partnerships and collaboration
- Health District to Health District cooperation

Small Group Work Exercise #2 – Part A - Key Actions in 3 Months (if province announced a provincial palliative care office and initial designated funding)

Group A

- Put someone in charge of hospice palliative care (HPC) – a "captain" with power – one for Nova Scotia (e.g., provincial coordinator) and one for each district
- The actions for HPC "have" and "have not" communities/service catchments will be different
- HPC "Have Nots" need to do a gap analysis
- Focus on increased public and political awareness to show individuals the gaps in palliative care

Group C

- Hire and educate a provincial consultation team
- Integrate – negotiate with cancer care, VON (Victorian Order of Nurses), LTC (long term care), etc
- Research and fact-finding to assure role clarification of new office/program within existing structures, services and programs that intersect with hospice palliative care
- Start policy process towards catastrophic drug coverage and oxygen through public funding

Group D

- Develop mission/vision/values and a plan with a provincial working group
- Need an interagency working group that meets regularly. This working group would need to establish the staffing priorities ($$ needed), mission/vision/values/structure/policies/indicators/standards and quality improvement framework.
- Formulate a plan for a provincial HPC program/structure

Small Group Work Exercise #2 – Part B - Key Actions in 6 Months (if province announced a provincial palliative care office and initial designated funding)

Group A

- *Facilitator note: No documented report back for 6 month exercise*

Group B

- *Facilitator note: See consolidated response from Group B which appears below*

Group C

- Activate/make active HPC consult team and work on role clarification
- Enable VON with respect to after hours care
- Ensure 24 hr availability (i.e., palliative unit)

Group D

- Begin to implement the plan (by hiring staff in order of priority). This is comprehensive implementation that includes staffing up in the provincial program/agencies are required.
- Education/public relations of staff/public about how new provincial HPC plan works

Small Group Work Exercise #2 – Part C - Key Actions in 2 years (if province announced a provincial palliative care office and initial designated funding)

Group A

- Separate the acute care model from the palliative care model (model of reproducible program funded like Veteran's program).
- Separate the providers of care
- Call the program "End-of-Life" program

Group B

- *Facilitator note: See consolidated response from Group B which appears below*

Group C

- Establish hospice services
- Ensure consistent 24hr RN supports available for what appears to be the last days and hours (i.e., last 3 days).
- Increase the capacity of local primary care teams and cancer care entitlements
- Further work on definitions/role clarification to ensure good working between primary care teams versus consult team (i.e., consult teams supports primary care/does not necessarily have primary care "turn over" patients for HPC)
- Staffing in place to properly support hospice services and 24 hr RN care at end-of-life

Group D

- Evaluation report to update and amend original plan
- Make changes (continuous quality improvement) based on evaluation and make staffing adjustments as required.

Consolidated Response

Group B – *Facilitator's Editorial Note: Group B opted to do their "own thing" in terms of a consolidated response to Small Group Work Exercise #2. The responses to the questions about moving ahead as reported on their flip chart are:*

- Seek the establishment of a body accountable for hospice palliative care provincially.
    - "steers the ship"
    - Rolls out and implements the standards/CHPCA Norms/education
    - Links to national initiatives in palliative and end-of-life care
    - Takes leadership for establishing benchmarks/indicators in Nova Scotia
    - Might look similar to mental health portfolio

Appendix A – Agenda for Nova Scotia Putting Progress Into Action Workshop

AGENDA, SEPTEMBER 14, 2005, HALIFAX

Time	Activity	Facilitator / Speaker
0830	Welcome & Introduction to Pallium Atlantic	Gael Page, President, CHPCA
	Nova Scotia Context and Developments	Dr. David Henderson, Physician Leader, Hospice Palliative Care
	Primary Health Care & Hospice Palliative Care	Michael Aherne, Director, Initiative Development, Pallium Project, Phase II
	Accreditation & Other Quality Initiatives	Laurie Anne O'Brien, Co-Chair, National Working Group on Quality Care & Best Practices, Canadian Strategy on Palliative & End-of-Life Care
	Cross Canada Check-up (National Developments)	Sharon Baxter, Executive Director, Canadian Hospice Palliative Care Assn.
	Morning Break	
	CHPCA Square of Care & Organization	Sharon Baxter
1200-1240	Networking Lunch	
	Challenges in HPC Services	Working Groups (Michael Aherne and Provincial Co-chairs)
	Building on District / Provincial Strengths	Working Groups
	Afternoon Break	
	Moving Ahead – 3 month, 6 month and 2 year action planning exercise	Working Groups
	Action planning discussion of "Doing the Doable"	Working Groups
1545 hrs	Concluding Comments	Michael Aherne

Appendix B – Map of Nova Scotia District Health Authorities (September 2005)