

# **Practice Support Program: End of Life Module & CHaRD**

December 1, 2011

**2011 Annual Cancer Conference**



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Executive Director  
Society of General Practitioners of BC

# Conflict Disclosure Information

- **Catherine A. Clelland, MD, CCFP, FCFP**
- **FINANCIAL DISCLOSURE**
  - **Grants/Research Support:** *N/A*
  - **Consulting Fees:** *N/A*
  - **Other:** *Executive Director, Society of General Practitioners of BC*

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  - Substitute Decision Makers (SDM)
- Practice Support Program: End-of-Life Module
- Community Healthcare and Resource Directory (CHaRD)
- Questions



# **Consent Legislation Changes September 1, 2011**

# Consent Legislation Changes

- September 1, 2011 – changes to Health Care (Consent) and Care Facility (Admission) Act come into effect.
- Written Advance Directives become a legally binding document.
- New options for Advance Care Planning and who decides for an incapable adult.
- Health organizations, physicians, NPs, nurses and other regulated health care providers & Emergency Medical Assistants/First Responders must comply with consent refusals.

# Advance Directives (AD)

- Written consent to (or refusal of) health care to a health care provider in advance of a decision being required about that care.
- Must be signed by a capable adult and be witnessed by two witnesses – cannot be a person who provides personal or health care or financial services (including family/relative) to the adult – or by a lawyer or notary public.
- Must be relevant for the specific decision required.
- May not instruct providers to give treatment that is not medically appropriate, or to withhold something required in law.
- Only acted upon when adult is incapable.
- AD made outside BC are not likely fully compliant with requirements of AD in HCCCFAA but can be useful to inform the decisions of a substitute decision maker.

# When Should an AD not be followed?

- If it does not meet requirements to be valid;
- If it deals with health care on the prescribed exclusion list;
- If it does not deal with the health care decision at issue;
- If it is so unclear that it cannot be determined if the adult has given or refused consent;
- If it is in conflict with the patient's known wishes, values or beliefs; or
- If there is concern the AD was induced due to fraud, undue pressure or other form of abuse/neglect.

# Advance Care Plan (ACP)

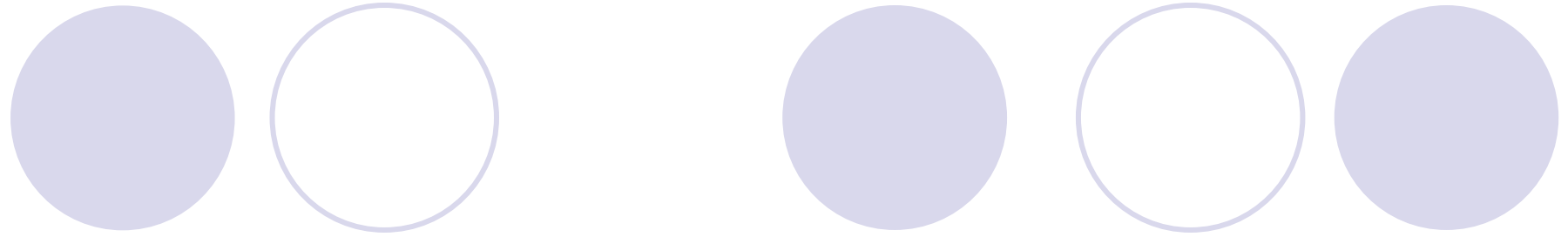
- An ACP is a written summary of a capable adult's beliefs, values, wishes and/or instructions for future health care based on ***conversations*** with trusted family/friend and health care provider.
- ACP to be used by a Substitute Decision Maker (ADM) to make health care decisions for the adult when incapable; and may include consent or refusal.
- Decisions based on health care provider's offer of ***medically appropriate care***.
- ***Health care providers and SDM must respect adult's beliefs, values and wishes.***
- ***See BCMA/Dr. Doris Barwich video***

# Substitute Decision Makers (SDM)

Advance Directive – Not a form of SDM- Is patient's written consent or refusal given in advance;

Hierarchy of SDMs:

- Personal Guardians (Committee of the Person) – highest ranking substitute decision maker – can give or refuse or withdraw consent to any health care. The AD is not binding on the decisions of a Personal Guardian;
- Representative – named by the adult under a legal Representation Agreement – changes to who can be named as Representative. Must treat the instructions of any AD as the adult's wishes expressed while capable;
- Temporary Substitute Decision Maker (TSDM) – if no AD and no appointed Personal Guardian or Representative, healthcare providers can appoint a TSDM.



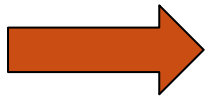
# Practice Support Program: End-of-Life Module

# Module Aim

- Improve the care of patients and families living with, suffering and dying from life-limiting and chronic illnesses by:
  - › Early Identification (Registry Building)
  - › Enhance and Improve physician confidence related to End of Life care (e.g. care planning, forms, communication, resources)
  - › Improve Collaboration (clarity of roles, appropriate resource referrals, network of community resources, etc)
  - › Improve the experience of the patient, family, physician, MOA and healthcare providers in End of Life care.

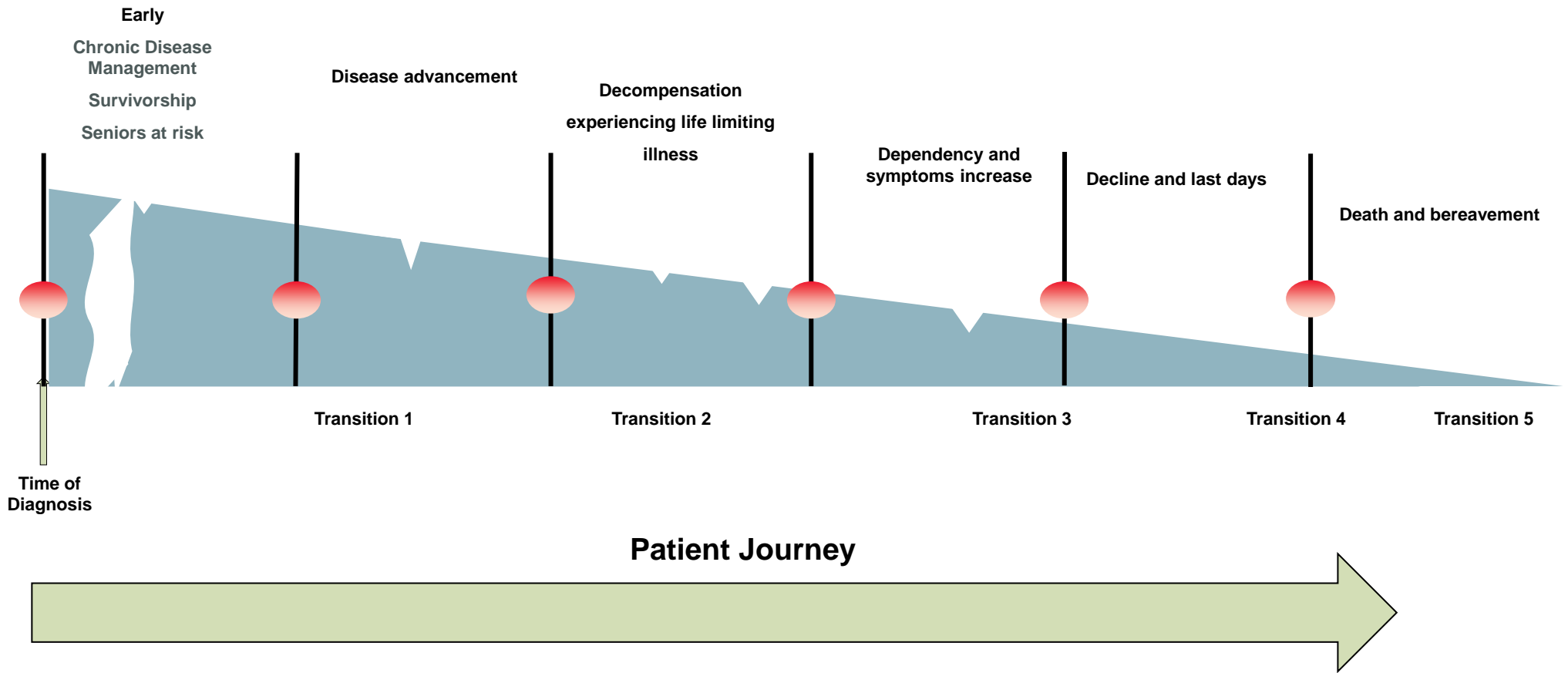
# Module Aims (continued)

- To improve the care of patients and families living with, suffering and dying from life-limiting and chronic illnesses by:
- Improving collaboration:
  - Identifying and referring appropriate patients to specialty palliative care and others for consultation and services.
  - Understanding provider needs, clarifying roles, tools and resources for practice support and collaboration.
  - Improving collaborative care planning, coordination and communication with patients/caregivers and physicians and other local health care and community providers.



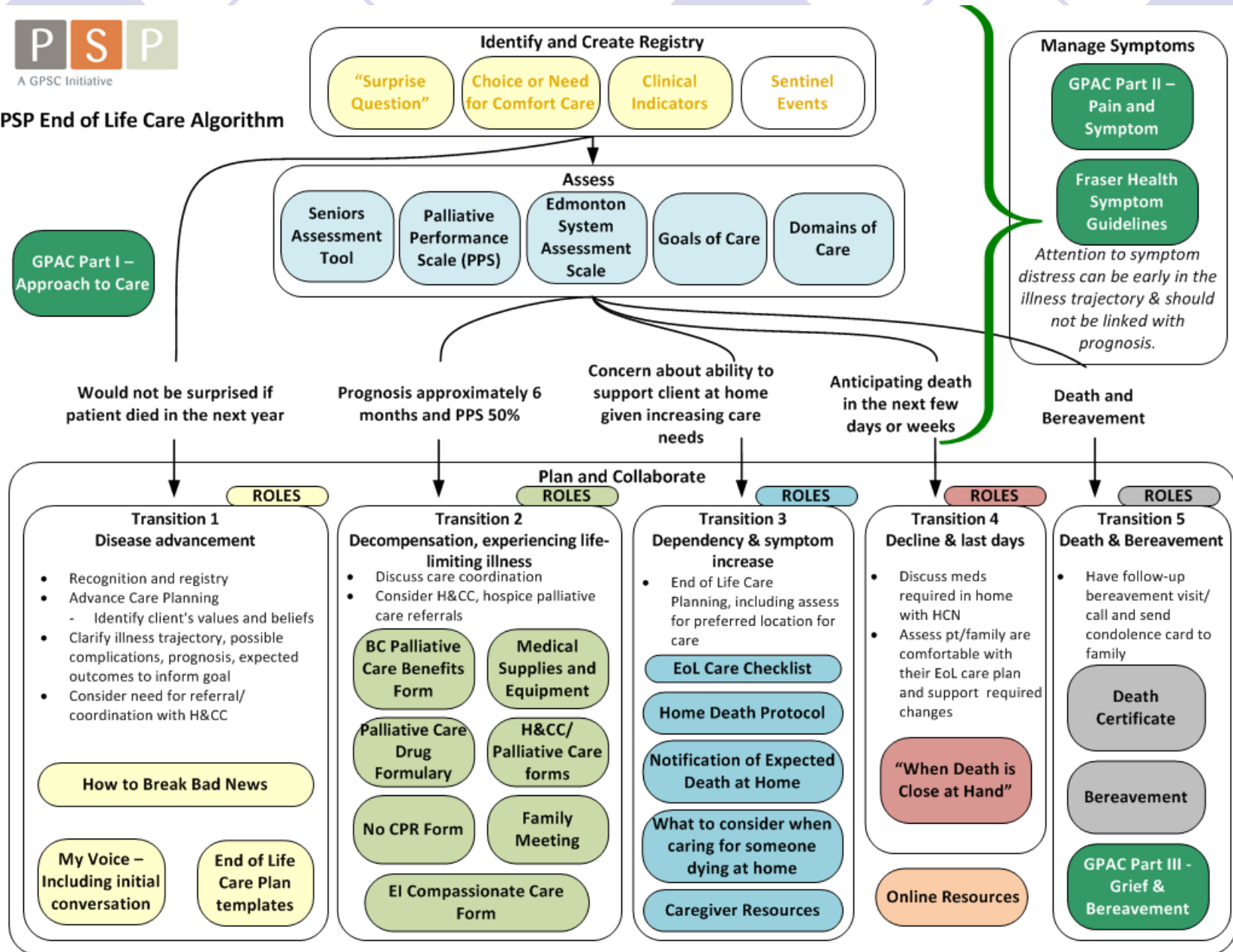
**“Integration  
in Action”**

# Palliative Approach: Care through all the transitions



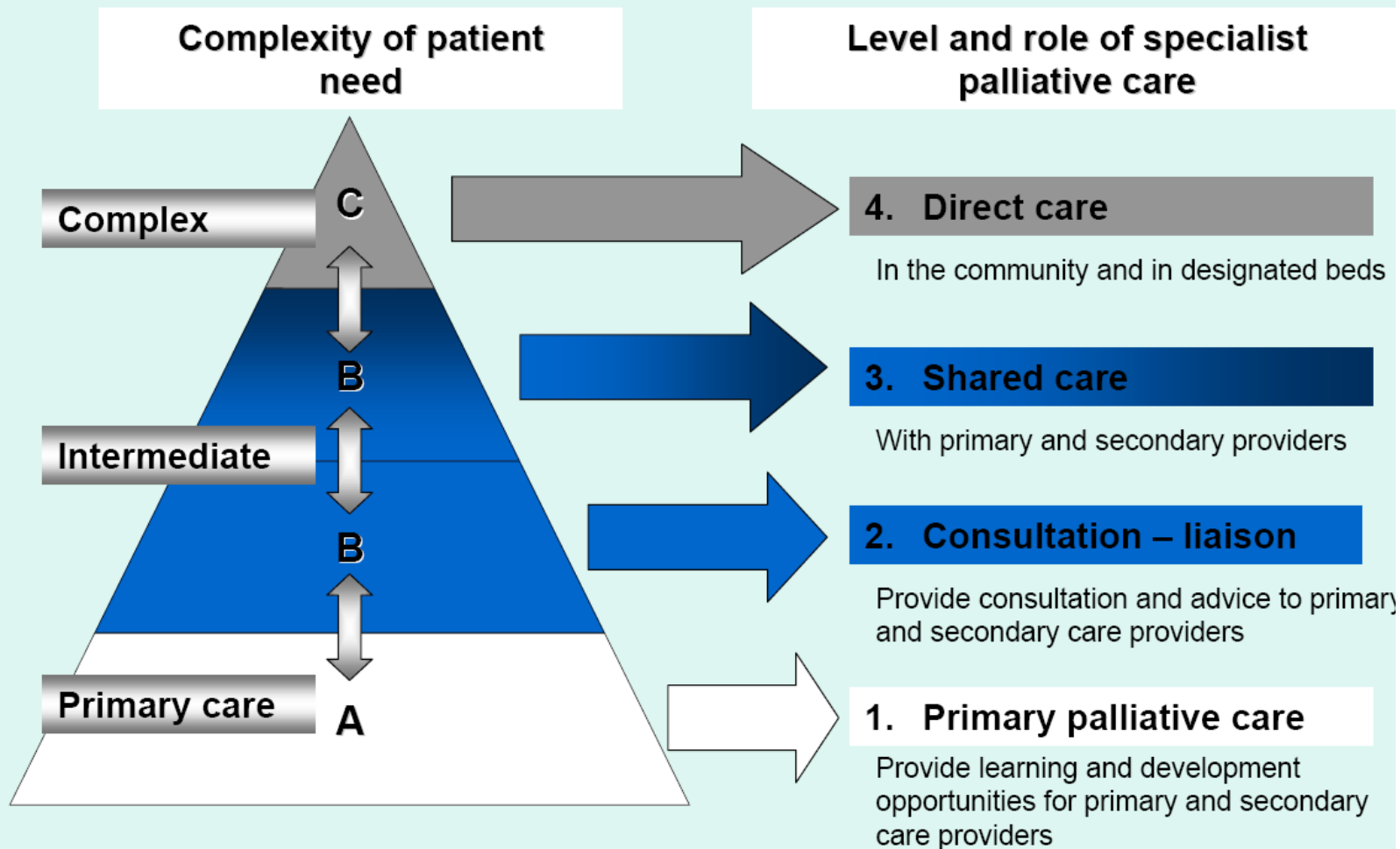
McGregor and Porterfield 2011

**PSP End of Life Care Algorithm**



# Best practice: Collaborative and Interdisciplinary

Specialist palliative care service delivery based on a population based approach with four delineated levels of care



# Expected outcomes of an early palliative care approach

- “Good death” in the most appropriate location.
- Better pain and symptom management.
- Better long term outcomes for bereaved relatives.
- Improved experience of care.
- Better quality of care.
- Lower health care costs.

Zhang et al. Arch Intern Med Vol 169(5) Mar 9 2009:480-488

# Who would benefit from a palliative approach?

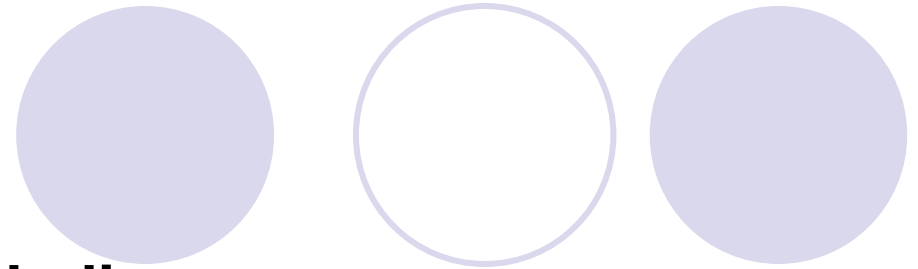


# Identify patients: Gold Standard Framework Triggers Plus One

## Four triggers for supportive/palliative care:

1. The surprise question: **“Would you be surprised if this patient were to die in the next 6 – 12 months?”**
2. Choice/need: patient makes a choice for comfort care only, or is in special need of supportive/palliative care.
3. Specific indicators: clinical indicators for each of 3 main EOL groups (cancer, organ failure, frail elderly /dementia).
4. Sentinel events

# Target Population



- **Include patients with advanced disease:**
  - › Cancer
  - › AIDS
  - › COPD and other chronic respiratory conditions
  - › Chronic heart disease
  - › Renal failure
  - › Neurological conditions, including dementia
  - › Frailty or multiple co-morbidities
- **Consider patients in residential care as a target population**

# Working together GP and Home and Community Care?



# Who is the patient's care team?



- Patient, family and informal network
- Family physician
- Specialist Physician (Oncology, IM)
- Community pharmacist
- Home Health / Community Care –
  - Nurses/rehab/home support
- Nurse practitioners, community RT
- Disease specific consultants / services
- Hospice palliative care consult teams

# Collaboration with Home and Community Care/Palliative Care

- Participation of Home and Community Care at Learning Sessions and Train the Trainer Sessions
- Creation of regionally-specific Integration material where applicable
- Development of learning objectives and action period activities for Home and Community Care staff
- Evaluation includes the input from Home and Community Care /Palliative Care staff



# Who is involved in PSP EOL module roll out?

- ~500 GPs with MOAs
- ~100 H&CC/palliative care staff ~  
1H&CC/PC: 5 GPs
- ~30 - 50 specialist physicians
- ~40-50 PSP Coordinators

# Specialist-GP shared care

- Communicate:
  - relevant patient-specific information
  - family issues if relevant.
- Clarify early in Specialist-GP relationship:
  - roles in care of patient through transitions of Chronic Disease Management
  - needs, expectations and outcomes from the consultation
- Indicate lines of communication/availability for access to advice throughout transition to support GP in the care of patient at end of life.

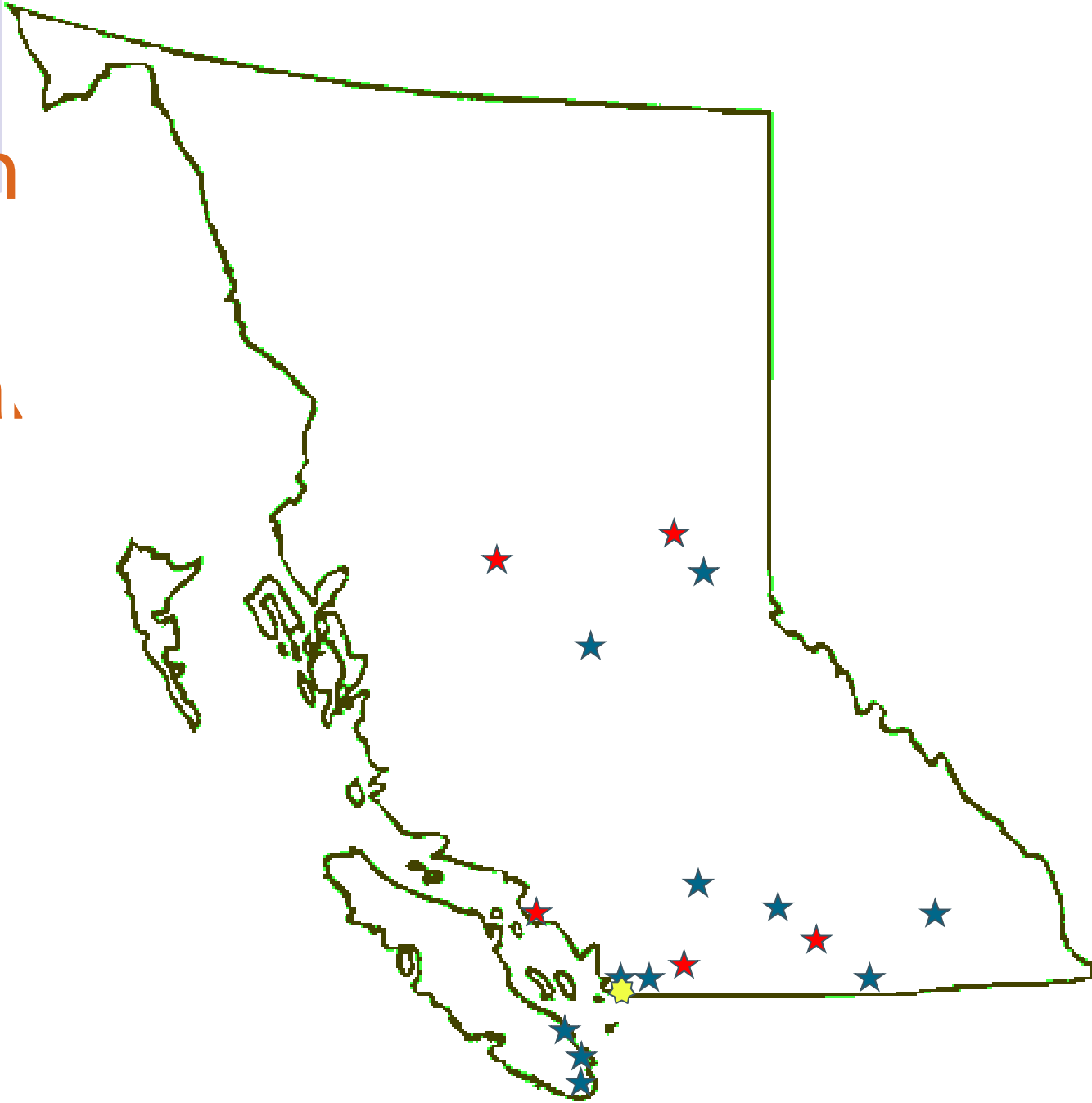
# Specialty practice and EOL

- If specialist determines palliative approach appropriate:
  - reflect in treatment recommendations
  - give GP advice/permission about stopping medications.
- Inform patient/family
  - All options including palliative care with no active treatment
  - **Realistic outcomes of treatment options**
- Give patient ACP planning documents:
  - follow up with all care providers – include in communications to GP
- Shared care through end of life
- Include recommendations for disease specific symptom management as patient approaches end of life.

# Feedback from the Train the Trainer Phase

- GPs were more confident in:
  - › identifying patients (96.9%)
  - › initiating a conversation about eol care with a patient (83.9%)
  - › guiding the patient with regards to his/her goals (81.3%)
  - › communicating the patient's needs and wishes to other care providers (84.4%)
  - › supporting a patient during the terminal phase of his/her illness (90.6%) and patient's family during grief and bereavement (90.6%)
  - › participating in collaborative care with H&CC nurses (90.6%)

Through  
the  
past year.



# Residential Care



- Initial focus on care in the community
- Potential for PSP to expand to residential care

# ACP info

- <https://www.bcma.org/news/advance-directives#video>
- [What is the role of the physician in advance care planning?  
http://www.youtube.com/watch?v=Agf3HT2lwPc](http://www.youtube.com/watch?v=Agf3HT2lwPc)
- BCMA – “Health care consent laws are changing – What you need to know”
- Healthcare Providers Guide to Consent – Ministry of Health

# A new referral resource



## CHARD

Community Healthcare and Resource Directory

A GPSC initiative

Helping you find referral information for...

Home and Community Care



Hospice Services



Medical Supplies



Mental Health Practitioners



Pain Management



Support Groups



General Practice Services Committee



# CHARD improves the referral process

- ◆ Aimed at reducing the time, effort and frustration required to identify the most appropriate and available referral resource for the patient





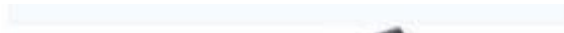
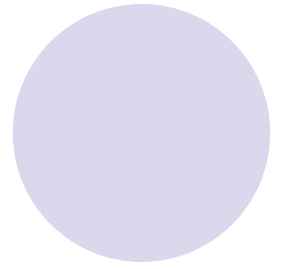
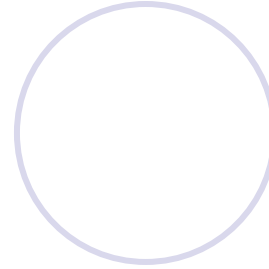
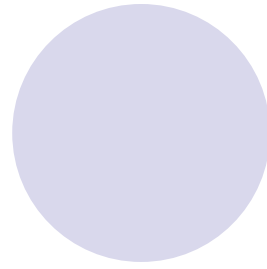
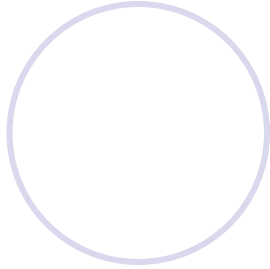
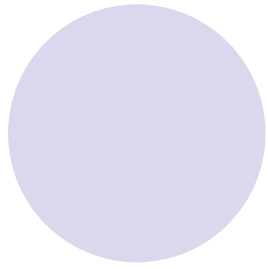
## The Community Healthcare and Resource Directory:

- Offered at no cost to BC physicians and their delegates
- Secure web-based directory of referral resources
- Detailed information on:
  - Over 5,000 specialist physicians
  - Approximately 5,000 programs and services
  - Nearly 18,000 allied health professionals



# Use CHARD to find resources:

- **Local**
  - › Close to you and your patients
- **Detailed**
  - › Complete information to find the right resource the first time
- **Providing Choice**
  - › A wider range options for you and your patient



**Video**



## Favourites: Quick access to frequently viewed resources

See the help section or call us at 1-877-330-7322 for assistance in getting your favourites setup



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Login to CHARD >

It's this easy to get started:

- 1 Create Your Account
- 2 Activate Your Account
- 3 Search CHARD



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Need more options? Use [Advanced Search](#)

### Find who / what:

START

Enter name or type of practice

### Medical topic area: (Optional)

All

### Where: (Optional)

V0N 2R0

or

Choose a city

Show results within:

20km

GO

### Search for:

Everything >

Physicians >

Health Authority Services >

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### Home Hospice Palliative Care - Richmond @ Richmond Hospital

✓ Accepts new patients

More Info

Phone (604) 278-3361

**Location**

7000 Westminster Highway  
Richmond, BC  
V6X 1A2  
Canada

**Distance** 0.00 km

**Specializations:**

Provides hospice palliative care services to persons living with and dying from life limiting conditions in th...

♥ [Add to Resources](#)



### Integrated Hospice Palliative Care Program - Richmond @ Salvation Army Rotary Hospice House

✓ Accepts new patients

More Info

Phone (604) 278-3361

**Location**

6460 No. 4 Road  
Richmond, BC  
V6Y 2S9  
CANADA

**Distance** 2.30 km

**Specializations:**

Provides a specialized residential care setting at the Rotary Hospice House, for people diagnosed with termina...

♥ [Add to Resources](#)



### Salvation Army Rotary Hospice House @ Salvation Army Rotary Hospice House

✓ Accepts new patients

More Info

Phone (604) 207-1212

**Location**

6460 No. 4 Road  
Richmond, BC  
V6Y 2S9  
CANADA

**Distance** 2.30 km

**Specializations:**

Provides a specialized residential care setting for people diagnosed with terminal illness for end of life car...

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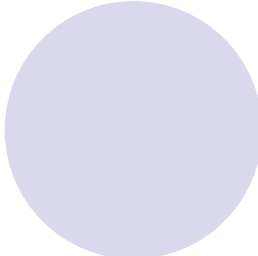
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Advanced Search



Provide Feedback



## Home Hospice Palliative Care - Richmond @ Richmond Hospital

✓ Accepts new patients **MSP**

### Service Details

#### Description

Provides hospice palliative care services to persons living with and dying from life limiting conditions in their home. Services include care coordination and support, pain and symptom management, grooming and bathing, rehab, and specialist consultation services and are provided by an interdisciplinary team. Richmond Continuing Health Services are located on the 5th Floor of the North Tower.

#### Topics

Cancer Services , Cardiac Services , Neuro-degenerative Diseases , Other , Palliative & Hospice Services , Renal Services , Respiriology Services

#### Subject Areas

Death and Dying Issues , Home Health Care , Hospice Care , Pain Management , Palliative Care , Terminal Illness

#### Service Type

Public

#### Accepting Direct Referrals?

Yes

#### Accepting new patients?

Yes

#### Transportation Note

Paid parking is available.

#### Street Address

Richmond Hospital  
7000 Westminster Highway  
Richmond, BC  
V6X 1A2  
Canada

#### Mailing Address

5th floor- 7000 Westminster Highway  
Richmond, BC  
V6X 1A2  
Canada



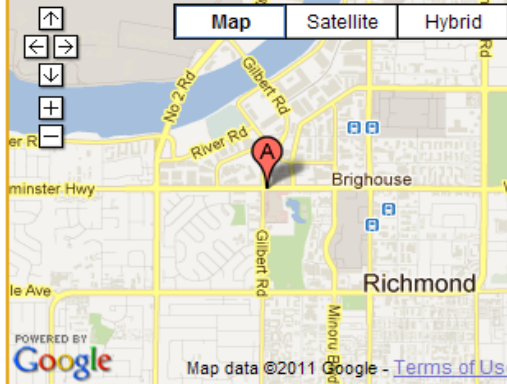
#### Wheelchair Accessibility

Yes.

#### Languages

English

Reference# **SL066962**



[Get directions to this address](#)

### Browse Categories

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- [Tens Units](#)

### Contact Details

*Last Confirmed on Nov 03, 2011*

**Home Hospice Palliative Care -  
Richmond @ Richmond Hospital**

## Contact Details

Last Confirmed on Nov 03, 2011

### Home Hospice Palliative Care - Richmond @ Richmond Hospital

Office Tel: (604) 278-3361  
Office Fax: (604) 278-4713

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## Referral Details

### Age

Accepts patients 19 and up.

### Gender

All

### Inclusion Criteria

Patients who require palliative and end-of-life care.

### Geographic Restrictions

Richmond.

### Costs to the patient

No Fee

### Referral Procedure

Please fax the completed referral form. Please contact Continuing Health Services Intake to learn about accessing these services. A health care professional will discuss needs, eligibility and the referral process.

[SV058184\\_Richmond Integrated Hospice Palliative Care Program Form \(pdf\)](#)

### Instructions to Patients

Patient must be assessed for eligibility before receiving this service. Please contact Continuing Health Services Intake to learn more. If one has already received service and needs additional help, they can contact their Continuing Health Services case manager directly.

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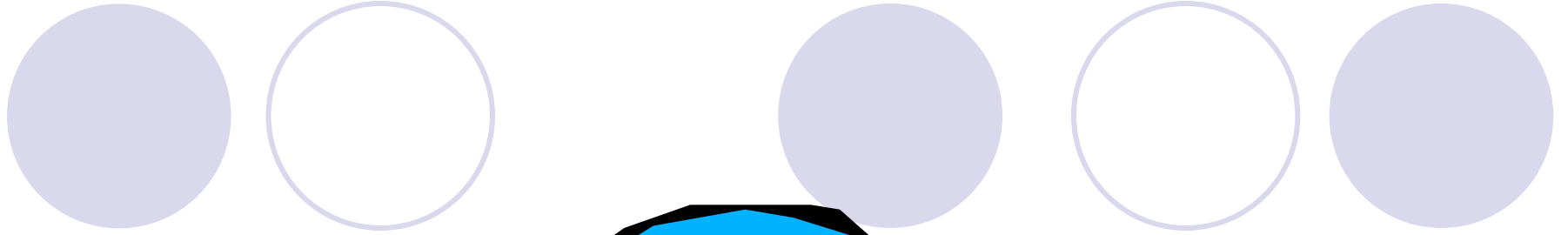
Or contact us:



**1-877-330-7322**



[chard.support@gov.bc.ca](mailto:chard.support@gov.bc.ca)



**Thank You**

Dr. Cathy Clelland