

**Erie St. Clair End-of-Life Care Network
Sarnia Lambton
Palliative Care Consultation Team (PCCT)**

Final Evaluation Report
Sarnia Lambton PCCT

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**For:
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Glossary of Terms

Average (+/-)	Average is calculated as the mean score; +/- = standard deviation, which is the average distance between individual scores from the overall average score.
CAPCE	Comprehensive Palliative Care Education Program
CCAC	Community Care Access Centre
ED/ ER	Emergency Department/ Emergency Room
EOL	End of Life
ESC EOLCN	Erie St. Clair End-of-Life Care Network
HPC	Hospice Palliative Care
LEAP	Learning Essential Approaches to Palliative and End-of-Life Care
NP	Nurse Practitioner
OT	Occupational Therapist
PCCT	Palliative Care Consultation Team
PPSMC	Palliative Pain and Symptom Management Consultant
PT	Physiotherapist

INTRODUCTION

In January 2009 a Palliative Care Consultation Team (PCCT) was established in Sarnia Lambton as one of several initiatives aimed at creating and supporting an integrated Hospice Palliative Care (HPC) system in this region. The PCCT is a multidisciplinary resource team for palliative and end-of-life care. The core team (Internal CCAC providers) consists of an expert Nurse Practitioner, Social Worker, Spiritual care provider, administrative assistant, Rehabilitation Professional (OT or PT), as well as a palliative care physician, and is supported by secondary level experts (experienced palliative care nurses) from nursing service provider agencies (referred to as Resource Nurses, who have additional training in palliative care). The team provides access to specialist level HPC expertise. The local Palliative Pain and Symptom Management Consultant provides consultation support to the team. The team aims to provide integrated and coordinated end-of-life care and to provide enhanced palliative and end-of-life care in this region. An evaluation of the initial development and implementation of the Sarnia Lambton PCCT was conducted in early 2009. The results of the evaluation indicated that the team was making significant headway in meeting its goals; the team was well received by clients and caregivers and early impacts on the use of health system resources were identified.

This report describes the methods and results of the second year evaluation of the Sarnia Lambton PCCT. The evaluation of the Chatham Kent PCCT is presented in a separate report.

EVALUATION METHODS

Evaluation Focusing: An evaluation advisory committee was established to support this evaluation; members acted as advisors, providing advice and feedback on the development and implementation of evaluation tools, facilitating identification of participants and data collection, and providing feedback on the final evaluation report.

Evaluation Objectives: The identified objectives of the evaluation were to:

- i) describe the services provided by the PCCT and the population served
- ii) identify impacts associated with the PCCT to date
- iii) describe the ongoing process of developing and implementing the PCCT.

Sources of Information: A combination of qualitative and quantitative methods were used to assess both process issues and outcomes:

- **Referral and Service Tracking** data were collected from April 1, 2009 to September 30, 2010.
- **Caregiver Satisfaction Interviews** were conducted with 3 family caregivers of individuals receiving care from the PCCT.
- **Key Stakeholder Survey** completed by 19 individuals representing the provider agencies, CCAC, hospice and hospital.
- **Key Stakeholders Interviews** were conducted with 8 individuals to obtain in-depth information about the effectiveness and impacts of the PCCT.

- **Focus Group and Individual Interviews with representatives of the PCCT** were conducted with a 15 individuals to obtain in-depth information about the development and implementation of the team.

This evaluation study was approved by the Research Ethics Board, University of Western Ontario.

RESULTS: Key Findings

Objective 1: Describe the services provided by the PCCT and the population served

Referrals: A total of 341 clients were referred to the PCCT between April 1, 2009 and September 30, 2010; 81 clients remained on the team's active caseload; 260 had been discharged from service, 79% of whom had died. The average length of stay on service was 71 days, with a range of 0 – 345 days. The number of referrals to the team per month ranged from 12 to 27, with an average of 19 (+/-3.9) referrals per month. The average age of clients was 70 years; there was an equal distribution of women and men referred to the team. Half of the clients lived with their spouse or life partner. Cancer was the most common diagnosis (83%).

Service Provision: As would be expected, end-of-life care was the primary service category (80%) for clients at the time of referral to the team, followed by long-term support (11%). From February 1, 2010 – September 23, 2010 there were 985 client interactions with core team members, with 134 different clients; the average number of interactions per client was 7 (range = 1 – 63). There was an even distribution of face-to-face visits (48%) and telephone contacts (51%). The highest percentage of interactions involved the Occupational Therapist (37%) and the Nurse Practitioner (35%). Thirty percent of interactions with a team member prevented an Emergency Department visit, that is, if the team had not been involved the client would have gone to the Emergency Department to access medical attention; this involved 13% (N = 43) of clients, with an average of four (+/- 4.6) Emergency Department diversion interactions per client.

Objective 2: Identify impacts associated with the PCCT to date

Across all of the sources of information for this evaluation, the following impacts associated with the PCCT were identified:

Client and Caregiver-Related Impacts

- Client and caregiver satisfaction (timeliness, care coordination, the amount of information with which to make treatment or care decisions, and preparation for what will happen next).
- Increased ability to remain at home to die or for as long as possible due to:
 - In-depth assessment and good management of symptoms
 - Improved pain and symptom management
 - Increased access to palliative care expertise
- Increased ability to die in location of preference
- Increased access to palliative care within the home:
 - Access to expertise
 - Access to care 24/7
 - Access to holistic care
- Improved access to emotional and spiritual support
- Improved home safety

- Timely access to care
- Increased access to laboratory services at home
- Improved access to consistent care (continuity of care across providers and sectors)
- Increased satisfaction with care
- Increased client and caregiver support
- Increased caregiver confidence in managing loved one at home

Health Professional-Related Impacts

- Improved communication between care providers
- Increased access to expertise (MD, NP) for primary nurses
- Increased capacity for palliative care among community-based nurses
- Increased opportunities for education for community nurses
- Reduced workload for team physician with availability of the Nurse Practitioner
- Increased job satisfaction among community nurses
- Improved self-care for community nurses

Health System-Related Impacts

- More timely access to care
- Increased care provider capacity to assess, prevent, and manage symptoms within the home setting
- Enhanced quality of palliative and end-of-life care
- ED avoidance
- Planned hospitalizations delayed
- Shorter lengths of hospital stay
- Increased deaths in the community (home, residential hospice)
- Improved care coordination
- Improved collaboration among care providers
- Standardized assessment/ care
- More efficient use of existing resources

Objective 3: Describe the process of developing and implementing the PCCT

A number of factors were identified as ***facilitating*** the development and implementation of the PCCT:

- Availability of team physician and Nurse Practitioner
- Management and peer support within nursing agencies
- Ongoing and open communication between all partners (CCAC management, nursing agencies, team members)
- Collaborative relationships among partners
- Regularly scheduled rounds
- Ongoing identification and resolution of issues/ problems
- Team members as palliative care champions
- Capacity building opportunities for Resource and primary nurses
- Increasingly improving communication across sectors
- Support from the Palliative Pain and Symptom Management Consultant

Challenges to the development and implementation of the PCCT included:

Resource Nurse related issues:

- Recruitment and Retention of Resource Nurses
- Inequity between agencies regarding visit reimbursement
- Maintaining on-call responsibility
- Unclear understanding of the Resource Nurse role

Implementation/ service delivery issues:

- Limited support from some family physicians
- Limited family physician capacity for palliative care
- Variability in palliative care knowledge and skills among primary nurses
- Limited availability to NP off hours
- Limited access to interprofessional care

Logistical issues

- Lack of timely communication of clients to be discussed at rounds
- Limited communication between Resource Nurses and palliative care physician
- Travel time (time commitment and lack of reimbursement)

Resolution of challenges identified in the initial evaluation: The initial evaluation of the PCCT identified a number of challenges related to service delivery issues related to limited use of resource nurses, facilitating trust among provider agencies, and timely access to nursing support and the logistics of implementing the team. There was general consensus among the key stakeholders and PCCT representatives that were interviewed that for the most part these challenges have been resolved. Challenges related to limited support from some family physicians, adequate Resource Nurse reimbursement across service provider agencies and adequate lead time to prepare for case review at rounds continues to be an ongoing challenge for Resource Nurses in some instances.

Suggestions for improvements, sustainability and further development

- Provide ongoing opportunities for advanced palliative care education
- Recruit more Resource Nurses
- Succession planning for team member roles
- Expand and sustain the NP role
- Increase education opportunities for family physicians
- Resolve Resource Nurse visit reimbursement issues
- Create opportunities for team building
- Market/ promote the Resource Nurse Role
- Promote the team more widely outside of the region
- Increase time allotted for social work and chaplaincy services
- Explore opportunities for using Occupational Therapists to the full scope of their practice
- Recognize Case Managers as formal members of the PCCT
- Improve communication between team physician and Resource Nurses
- Create clear criteria for Resource Nurse activities
- Ensure wise accountability and allocation of funding
- Provide Resource Nurses enough lead time to prepare for rounds

General suggestions for improvements to palliative care

- Increase opportunities for palliative care education for hospital staff
- Increase availability of shift nursing hours at end of life
- Improve financial support for clients
- Identification of patients presenting in the Emergency Department with palliative issues who are not currently connected with palliative services
- Increase availability of respite to support caregivers

CONCLUSIONS

Based on the findings of this evaluation, the following conclusions can be made about the Sarnia Lambton Palliative Care Consultation Team:

- The PCCT continues to provide a vital palliative and end-of-life care service in Sarnia Lambton. There is much support for team; it has been well received by caregivers, health professionals across disciplines and key stakeholders across sectors. The team has had significant impact on increasing timely client and caregiver access to expert support. This support has improved patient care, has prevented unnecessary visits to the Emergency Department and has contributed to reduced lengths of hospital stay for clients involved with the team. The introduction of a Nurse Practitioner, social worker and chaplain to the team has increased the team's capacity to respond to crises and to provide a more holistic approach to end-of-life care. This client-centred approach to care is further supported by the availability of in-home laboratory services and extended equipment rental.
- The team continues to achieve its objectives related to improved client care as well as health system improvements related to improved care coordination, efficient use of existing resources and reduced use of acute care resources (i.e., reduced ED visits and admissions). Although there are positive impacts associated with being a member of the team, such as increased job satisfaction and increased opportunity for capacity building in palliative care, challenges identified in this evaluation related to the Resource Nurse role places them at high risk for burnout and threatens their sustainability on the team. Attention to and resolution of these challenges will go far to supporting and sustaining their role on the team. Suggestions for improvements identified by key informants for this evaluation can also further support the efforts of the team, such as opportunities for team building (e.g., team retreat), improving communication, and building capacity for interprofessional care. Commitment to team building has been identified as a key characteristic of effective health care teams.¹
- Despite some implementation and logistical challenges, team members are very satisfied with their accomplishments as are key stakeholders. The team has in its favor inherent characteristics of effective health care teams: good collaboration and communication and attention to conflict resolution.² Continued attention to the identification and resolution of challenges will work to further support the sustainability of the team. A significant challenge to the work of the team is the limited capacity for palliative care among some family

¹ Mickan, S.M., & Rodger, S.A. (2005). Effective health care teams: A model of six characteristics developed from shared perceptions. *Journal of Interprofessional Care*, 19(4), 358-70.

² Lemieux-Charles, L., & McGuire, W.L. (2006). What do we know about health care team effectiveness: A review of the literature. *Medical Care Research Review*, 63(3), 263-300.

physicians in the region. This challenge was also identified in the initial evaluation of the team and is well documented in the literature.³ Although beyond the scope of the team to resolve, suggestions for increased access to LEAP training and opportunities to learn about the expertise of the team may help to ameliorate this issue.

- A significant theme arising from this evaluation is improved coordination of palliative care across sectors. A number of factors contribute to this improvement: the efforts of the PCCT and its strong partnership with St. Joseph's Hospice, the increased use of standardized assessment tools such as the PPS and ESAS, which work to create a common language to facilitate continuity of care across sectors, as well as increased educational opportunities as provided through the ESC Education Blueprint. Ongoing capacity building through opportunities for palliative and end-of-life care education across sectors and disciplines will work to further facilitate an integrated palliative care system in this region.
- There is much support in the literature for the establishment of palliative care teams as an opportunity to improve quality and coordination of palliative care and to reduce costs associated with acute care use.⁴ However, despite the research evidence to support the use of palliative care teams, very few exist in community settings across the province. The continued success of the Sarnia Lambton PCCT makes it a potential model for other regions of the province with lessons learned in the development and implementation of the team informing expansion in other areas. To this end, the work of the team should be promoted. Attendance and presentations at regional, provincial, and national conferences would allow the team to celebrate its successes and also to network with other palliative care experts to learn about new best practices and opportunities for on-going performance improvement. Capacity building opportunities for team members were supported by key informants in this evaluation as an opportunity to retention membership and sustain the team.

Limitations: There are several limitations to this evaluation. Data related to impacts of the team on the health care system is largely anecdotal. Empirical evidence based on hospital data (e.g., ED readmission rates, reduced hospital admissions, reduced length of hospital stay) among PCCT clients and a comparison group (of clients not seen by PCCT) would provide stronger evidence of the PCCT's ability to manage care effectively within the community. It is acknowledged that availability of this data related specifically to palliative care is limited. Some of the data that was initially to be included as part of the description of the client population served by the team and the services provided by the team were not available either because they are not tracked and/ or not easily accessible. Although the perspective of consumers is highly valued and the evaluation plan included interviews with the caregivers of PCCT clients, it was extremely difficult to access these individuals for inclusion. At the time that team members were providing information to caregivers about the evaluation study, many of the clients were either in crisis or in transition between sectors so that it was an inappropriate time to recruit them for the evaluation.

³ Grande, G.E., Barclay, S.I., Todd, C.J., (1997). Difficulty of symptom control and general practitioners' knowledge of patients' symptom. *Palliative Medicine*, 11(5), 399-406.

⁴ Hearn, J. & Higginson, I.J. (1998). Do specialist palliative care teams improve outcomes for cancer patients? A review of the literature. *Palliative Medicine*, 12, 317-332.

Speck, P. (2006). *Teamwork in palliative care*. London: Oxford University Press.

1.0 Introduction

In February 2008, the Erie St. Clair End-of-Life Care Network (ESC EOLCN)⁵ submitted an application for funding from the Erie St. Clair (ESC) Local Health Integration Network (LHIN) through the Aging at Home Strategy to develop and implement a Palliative Care Consultation Team (PCCT). Notification of funding for year one (\$572,000) was received in July 2008. Year one funding was flowed through the North Lambton Community Health Centre; operationalization of the team was through the Community Care Access Centre (CCAC). The ESC EOLCN was to serve in an advisory role. Year one funding was for a team in one county – Sarnia Lambton. In November 2009 the ESC LHIN approved the Consolidated Chatham-Kent/Sarnia Lambton Palliative Care Consultation Team project and provided annualized base funding of \$1,298,295.

This team was one of several initiatives aimed at creating and supporting an integrated Hospice Palliative Care system in this region. An integrated Hospice Palliative Care system would serve to connect sectors, use common language tools, coordinate education across sectors and among disciplines, provide accountability and reporting infrastructures and encourage each health sector to be part of the integrated system of care. This would serve to ensure that Ontarians have access to consistent, high quality end-of-life care that can relieve suffering and improve quality of life.

The PCCT is a multidisciplinary resource team for palliative and end-of-life care. The core team (Internal CCAC providers) consists of an expert Nurse Practitioner, Social Workers, Spiritual care providers, administrative assistant, rehabilitation professional (OT or PT), as well as a palliative care physician, and is supported by secondary level experts (experienced palliative care nurses) from nursing service provider agencies (referred to as Resource Nurses, who have additional training in palliative care). The local Palliative Pain and Symptom Management Consultant provides consultation support to the team. The team provides timely access to consultation support for primary care providers with the expectation that a shared care model of care will be developed. The PCCT comprehensive assessment and care planning, consultation reports to Primary Care providers, capacity building through mentoring, patient and family education and counselling (e.g., Advance Care Planning, processes involved in home deaths), follow-up and direct care provision, as needed across sectors (clients are seen in their home, a clinic setting or health care settings as relevant). Additional services not currently provided by the home care system, such as in-home laboratory services, are provided by the team as needed. Other services, such as extra social work visits, and extended equipment rental augment service delivery currently provided by the home care system. Coordinated care planning and on-going education (capacity building) is facilitated by regular clinical rounds (bi-monthly). On-call access to the team is available 24/7, by accessing the Resource Nurses.

⁵ The EOLCN serves in an advisory capacity and is not responsible for the day-to-day operations of the team; the ESC CCAC has operational responsibility for the team.

Clients referred to the team, are those who require specialist level expertise.⁶ Priority is given to clients in crisis, at risk of accessing acute system resources (e.g., hospital admission, emergency department visit), or needing more services than currently available.

The main objectives (goals) of the PCCT are to:

- increase access to specialized palliative care for clients in the community, including expertise in symptom management, disease progression/ prognosis, and all domains of issues associated with illnesses and bereavement.
- make it possible for clients to die with dignity at home, if that is their location of choice.
- decrease dependence on hospital through: emergency department avoidance, admission avoidance, reduced Alternative Level of Care (ALC) days, and reduced hospital length of stay.
- improve patient flow/ coordination/ integration across the care continuum.

An overview of the program and anticipated outcomes are summarized in the program logic model presented in Appendix A.

An evaluation of the initial development and implementation of the Sarnia Lambton PCCT was conducted in early 2009.⁷ The results of the evaluation indicated that the team was making significant headway in meeting its goals; the team was well received by clients and caregivers and early impacts on the use of health system resources were identified. Although the team built on existing capacity for palliative care within the community, it was suggested that additional supports and resources (continuing education, team building, promotion) could further support the efforts of the PCCT.

Building on the evaluation conducted in 2009, an evaluation framework was finalized in June 2010 for the second year evaluation of the PCCT in Sarnia Lambton. For this evaluation there is particular interest in demonstrating the role of the PCCT in building system capacity for palliative and EOL care within the community (e.g., reducing use of acute care system resources, PCCT support to primary care and/or palliative care physicians to improve efficiency).

This report describes the methods and results of the second year evaluation of the Sarnia Lambton PCCT. The evaluation of the Chatham Kent PCCT is presented in a separate report.

⁶ Three questions guide eligibility: Would you be surprised if this client died in the next six months? Does this client have symptoms and/or support needs? Do these symptoms and/or support needs require specialist level interventions?

⁷ Hillier, L.M. (April 30, 2009). Erie St. Clair End-of-Life Care Network Palliative Consultation Team. Final Evaluation Report. London, ON: Author.

2.0 Evaluation Methods

2.1 Evaluation Focusing

The evaluation objectives and methods were initially discussed in a meeting on April 7, 2010, with a number of key stakeholders: Beth Lambie, Director, ESC EOLCN; Andrew Ward, Senior Manager⁸, Client Services, ESC CCAC; Cindy Stokes, Client Services Manager, ESC CCAC; Jennifer Allison, Client Services Manager, ESC CCAC; Vivianne DeWitt, Coordinator of Oncology, Palliative & Supportive Care, Chatham-Kent Health Alliance; Julie Johnston, Coordinator, Palliative Pain and Symptom Management Consultation Program; Lynn Chappel, Regional Vice President (Interim), Windsor Regional Cancer Centre; Paul Brown, Account Manager, ESC LHIN, Pete Crvenkovski, Manager, Quality and Utilization , ESC LHIN, and Jamie Lesparence, ESC LHIN.

To develop and implement the evaluation framework, an advisory committee was established consisting of the following members:

- Ann Brignell, Palliative Pain and Symptom Management Consultant, Kent and Lambton Counties
- Dr. Colin Bryan, Physician, Chatham Kent Palliative Care Consultation Team
- Vivianne DeWitte, Coordinator of Oncology, Palliative & Supportive Care, Chatham-Kent Health Alliance
- Barb Frayne, Registered Nurse, St. Joseph's Hospice, Sarnia
- Julie Johnston, Coordinator, Palliative Pain and Symptom Management Consultation Program
- Beth Lambie, Director, ESC EOLCN
- Dr. Glen Maddison, Physician, Sarnia Lambton Palliative Care Consultation Team
- Cindy Stokes, Client Services Manager, ESC Community Care Access Centre

Members of this advisory committee acted as advisors to this evaluation, providing advice and feedback on the development and implementation of evaluation tools, facilitating identification of participants and data collection, and providing feedback on the final evaluation report.

Key Stakeholders for this evaluation include: PCCT members, consumers (clients, caregivers), Community Support Services (CSS) agencies, CCAC and Community Service Provider Agencies, Community Health Centres, (CHC), primary care providers, hospitals, cancer centers members of the ESC EOLCN and the ESC LHIN.

2.2 Evaluation Objectives

The identified objectives of the evaluation were to:

- iv) describe the services provided by the PCCT and the population served:**
- Who made up the PCCT (numbers/ disciplines)?
 - How many clients were referred to the PCCT?
 - How many initial visits were conducted?

⁸ Andrew Ward resigned from this position in October 2010 and did not review the final evaluation report.

- How many clients have been assessed?
- Who were the clients being assessed? (age, gender, place of residence, diagnosis, Palliative Performance Score, location/sector at time of assessment)
- What was the response time to referrals?
- What were the activities of the team (assessment, follow-up, direct care, other activities)?
- Where were clients served (home/ clinic/ other locations)?
- How many clients received follow-up?
- How many clients received direct care from team members?
- How much time did each visit take (time per visit, time per client)?
- How many members of the team were involved with each client?
- Which team members were involved with each client?
- How many visits did each professional (Nurse Practitioner, Social Worker, Chaplain, Occupational Therapist, Physicians and any other professionals) have with clients?
- How many individual clients are on each professionals' (Nurse Practitioner, Social Worker, Chaplain, Occupational Therapist, Physicians and any other professionals) case load? How long did clients remain on service?
- How many clinical rounds were held?
- How many referrals (calls) were received 'off hours'?
- What was the model of care employed with each client (shared care with primary care, consultation only, consultation and follow-up)?
- Who received the consultation report (primary care, client, Community Service Provider agency, CCAC, acute care)?
- Where did clients die (home/ hospital/ long-term care home/ residential hospice)?

v) identify impacts associated with the PCCT to date:

Health System impacts:

- What impact does the PCCT have on EOLC service within the community: number of nursing visits, shift nursing hours, Personal Support Workers hours for EOLC, number of EOLC clients served in the home, number of visits to out-patient clinics (palliative care clinics)?
- What impact does the team have on increasing access to EOL health care services?
- What impact does the PCCT have on the number of deaths that occur at home? In hospital? In hospice?
- What impact does the PCCT have on acute care length of stay (LOS) and number of admissions for clients requiring palliative care?
- What impact did the team have on Emergency Department visits and hospital admissions by clients requiring palliative care?
- What impact did the team have on admission through the Emergency Department vs. direct admissions (for clients requiring admission to hospital)?

Client/ Caregiver-related impacts:

- What impact does the PCCT have on patient/ caregiver satisfaction with:
 - access to assessment, care, and support services?
 - pain and symptom management?

- Psychological/ social/ spiritual support?
- timeliness of access to assessment, care, and support services?
- coordination of care across providers and sectors?
- communication with formal providers (response to their questions and concerns)?
- communication among formal providers (degree to which each provider involved is informed and aware of that client's status and treatment plans?
- Informed decision-making process (i.e., do they feel they have enough information with which to make treatment/care decisions?)?
- preparation for death (EOL care, death management, post-death process)?
- What impact does the PCCT have on client/ caregiver satisfaction with assessment, follow-up, and care provided by the team (e.g., time spent with team members, explanations, results, overall perceptions of the assessment/ follow-up/ direct care provision)?
- What impact does the PCCT have on meeting patient/ caregiver preference for place of death (concordance between preference and actual place of death)?

Provider-related impacts:

- What impact does the PCCT have on provider satisfaction with:
 - care integration?
 - communication across providers and sectors?
 - care coordination and care planning for those requiring palliative care?
- What impact does the PCCT have on formal care provider's capacity to manage palliative care/ EOL issues within the community?
- What impact does the PCCT have on the increased use of standardized clinical assessment tools (ESAS, PPS) within the community?
- What impact does the PCCT have on response to assessment scores within targeted ranges?
- What impact does the PCCT have on care planning processes that appropriately respond to PPS and ESAS finding?

vi) describe the ongoing process of developing and implementing the PCCT:

- What factors facilitate the ongoing development and implementation of the PCCT?
- What were the challenges associated with implementation and what are the potential strategies to overcome these?
- To what extent have challenges associated with the initial development and implementation of the Sarnia Lambton PCCT been resolved?
- What factors facilitate and challenge the role of the resource nurses (secondary expert team)?
- What resources are needed to support the work of the team? Are resource needs for capacity building being met?
- What service delivery issues have arisen?
- What are some of the key lessons learned in the ongoing development and implementation of the PCCT that can serve to inform the development and implementation of other PCCT teams?
- What are suggestions for improvement? For sustainability? For expansion to other counties?

- What are potential next steps/ goals for the PCCT?

2.3 Sources of Information

A comprehensive evaluation framework for the Sarnia Lambton PCCT was developed based on the program logic model for this initiative. This evaluation framework is presented in Appendix B. A combination of qualitative and quantitative methods were used to assess both process issues and outcomes. The following sources of information were used to achieve the objectives of this evaluation.

Referral and Service Tracking

Information describing the referrals received, services provided, and clients serviced by the PCCT were gathered from the CCAC Client Health and Related Information System (CHRIS), which provides information on client demographics, and service notes. A list of information tracked is presented in Appendix C.

Caregiver Satisfaction Interview

Caregivers of clients served by the PCCT were invited to participate in a brief telephone interview. (Although the perspectives of clients are valued, it was anticipated that as many of the clients would be at end of life they would not be able to participate in the interviews; caregivers were the next best representative/proxy for clients). The purpose of this interview was to obtain information related to:

- satisfaction with services received from the team (access, timeliness, care coordination, communication, informed decision making, preparation for death).
- for clients who have died – satisfaction with the management of death and location of death.
- suggestions for improvements to EOLC services provided by the PCCT.

The guide for this interview is presented in Appendix D.

Caregivers eligible to participate in this interview were those on the current team caseload during the evaluation time period (August – October 2010) and who had been involved with (seen by) the team on more than one occasion (caregivers whose loved one was waiting to be seen or who had only seen the team on one occasion were not eligible to participate). To participate in an interview, caregivers had to be the primary caregiver of someone who was served by the PCCT and needed to be able to read and speak English.

Caregivers were recruited to participate in the interviews over an 8-week period (mid-August to mid-October). It was anticipated that 20 caregivers would agree to participate in an evaluation interview.

Key Stakeholder Survey

Key stakeholders including representatives from local community service provider agencies (supervisors, frontline nursing staff), CCAC (Case Managers, frontline nursing staff with community service provider agencies), and other relevant key informants were invited to complete a brief survey asking them about their level of satisfaction with:

- the work of the team (capacity building, consultation support, timeliness of access to assessment, care),
- the assessment and resulting treatment recommendations,
- overall perceptions of the effectiveness of the team,
- impacts (outcomes) of the team,
- suggestions for improving/ sustaining EOL services as provided by the PCCT.

Outcomes were assessed using a post-pre methodology,⁹ in which respondents were asked to rate current (i.e., post-PCCT involvement) outcomes (e.g., changes to care) and were then asked to rate the current outcome in comparison to prior to the inception of this initiative. This survey is presented in Appendix E.

To maximize response rate and ease burden of completion, this survey was administered on-line via Survey Monkey (www.surveymonkey.com). Consistent with the method of survey distribution described by Dillman,¹⁰ respondents were invited to complete the survey via e-mail and received follow-up reminders via e-mail to complete the survey. The survey was available for completion for a 2-week period from October 2 to 14, 2010.

Individual Interviews with Key Stakeholders

Individual telephone interviews were conducted with a purposeful sample of key stakeholders including representatives from three community service provider agencies, CCAC, and other relevant key informants. The purpose of these interviews is to obtain in-depth information about the PCCT, specifically:

- effectiveness in meeting objectives for clients/caregivers and care providers
- potential health system, provider, and client/ caregiver-related impacts
- identification of factors (enablers, barriers, challenges) impacting implementation/ use of the team
- identification of strategies to overcome barriers and challenges
- suggestions/ recommendations for enhancing EOL service delivery.

The guide for this interview is presented in Appendix F.

These individual telephone interviews were conducted between September 20 and October 18, 2010. Participants were given the interview questions in advance.

Focus Group and Individual Interviews with the PCCT and Team Leaders

A focus group interview was conducted with members of the PCCT; individual interviews were proposed with team leadership (representatives from CCAC management, EOLCN). The purpose of these interviews was to obtain in-depth information about the team, specifically:

- factors facilitating the ongoing development and implementation of the PCCT
- challenges/ barriers to implementation and strategies to overcome these
- lessons learned
- suggestions for improvement, sustainability, further development and implementation of the team in this setting and as expanded to other counties, and,
- potential impacts (patient, care provider, and system related).

⁹Rockwell, S.K., & Kohn, H. (1989). Post-Then-Pre Evaluation. *Journal of Extension*, 27(2), 1-7.

¹⁰Dillman, D.A. (2000) *Main and internet surveys. The Tailored Design Method 2nd Ed.* New York: John Wiley and Sons.

The guide for this interview is presented in Appendix G.

The focus group interview with the team was conducted on September 28, 2010 in conjunction with a regularly scheduled team meeting. Individual interviews were conducted via telephone.

2.4 Data Collection and Analysis

Referral and service tracking data was compiled by the PCCT/ CCAC CHRIS. Survey data was analyzed using SPSS15.0.¹¹ Descriptive statistics (frequencies, means, standard deviations) were generated for numeric variables. Content analyses were conducted on open-ended responses using an inductive analysis approach, in which common themes are identified and categorized.¹² All interviews were conducted by the evaluation consultant and were digitally-recorded and transcribed. Interview analysis was consistent with recommended practices for qualitative data.¹³

2.5 Ethics Review Board Approval

This evaluation study was approved by the Research Ethics Board, University of Western Ontario.

3.0 Evaluation Results

The following is a summary of the highlights and main themes that emerged from the evaluation. Detailed presentations of the results of the referral and service tracking, caregiver satisfaction survey and key stakeholder survey are located in Appendices H - J, respectively.

3.1 Evaluation Response Rates

Table 1 presents the response rates for various components of the evaluation, which ranged from 43% – 100%.

Table 1: Response rates for evaluation components

Evaluation Component	Number completed/ Number invited (Response Rate)
Caregiver Satisfaction Interview	3/7 (42.9%)
Key Stakeholder Survey	19*/24 (79.2%)
Key Stakeholder Interviews	8/9 (88.9%)

¹¹ SPSS 15.0. Chicago, IL: SPSS Inc., 2007.

¹² Cavanagh, S. (1997). Content analysis: Concepts, methods, and applications. *Nurse Researcher*, 4, 5-16.

¹³ Patton, M.Q. (2002). *Qualitative Evaluation and Research*. Thousand Oaks, CA: Sage.

Evaluation Component	Number completed/ Number invited (Response Rate)
Interviews with:	
PCCT members	11/13 (84.6%)**
Leadership	2/2 (100%)

*As the same survey was being completed by key stakeholders associated with the Chatham Kent team, survey respondents were asked to indicate which team they were associated with (Sarnia Lambton, Chatham Kent, or both teams). Six individuals reported that they were involved with both team, and four individuals did not respond to this question. The data from these 10 individuals is included here.

** In total 14 individuals attended the focus group interview: 10/ 13 members of the PCCT (core team members and Resource Nurses) and 4 CCAC Case Managers. One team member was interviewed individually via telephone

3.1.1 Caregiver Satisfaction Interviews

A total of 2 caregivers expressed an interest in participating in the interviews during the evaluation data collection time period; 5 additional caregivers expressed an interest in participating in an interview after the data collection period, however only 2 of these caregivers could be reached to complete interview. In total 3 interviews were completed (43% response rate). The interviews ranged in length from 17 to 26 minutes.

Two of the caregivers were spouses of care receivers; one was the child of a care receivers. At the time of the interview two of the care receivers were at home, one had recently died.

3.1.2 Key Stakeholder Survey

A total of 24 invitations to complete the on-line survey were distributed via e-mail; all invitations were deliverable. Nineteen surveys were completed (72% response rate), including six individuals who indicated that they were involved with both the Sarnia Lambton and Chatham Kent PCCTs and four individuals that did not indicate with which team they were associated.

The highest proportion of survey respondents were registered nurses (26%) and CCAC Case Managers (21%), otherwise there were a variety of disciplines represented (See Table 2). There was much variability in the amount of time that respondents have been employed in their current profession (range = 1 - 45 years), with the average being 19 years. The majority of survey respondents (69%) have practices in which greater than 51% of their clients require palliative/ end-of-life care and the majority (58%) have worked with the PCCT in regards to more than 21 clients in the past three months.

Table 2: Description of Key Stakeholder Survey Respondents (N=19)

Demographic Variable	Percentage (#)
<i>Discipline:</i>	
Registered Nurse	26.3% (5)
Registered Practical Nurse	5.3% (1)
CCAC Case Manager	21.1% (4)
Pastoral/spiritual care	5.3% (1)
Occupational Therapist	5.3% (1)
Social Worker	5.3% (1)
Other*	10.5% (2)
<i>Practice Setting:</i>	
Community based agency/ organization	63.2% (12)
Hospital	5.3% (1)
Private Practice	5.3% (1)
Long-Term Care	0
Other**	5.3% (1)
<i>Number of years working in their field (N =14)</i>	
Average (+/-)	19.2 years (13.2)
Range	1 - 45years
<i>Percentage of clients in practice requiring palliative/ end-of-life care</i>	
Not applicable	0
None	0
Less than 25%	0
26% - 50%	10.5% (2)
51% - 75%	21.1% (4)
Over 75%	47.4% (9)
<i>Contact with PCCT in the past three months</i>	
In regards to more than 21 clients	57.9% (11)
11-20 clients	5.3% (1)
6 -10 clients	26.3% (5)
1-5 clients	5.3% (1)
Not at all	5.3% (1)

Note: Percentages may not sum to 100% due to missing values

* Other: Administration, Music Therapist

** Other: Across all sectors

3.1.3 Interviews with Key Stakeholders

Key stakeholders were identified by the evaluation Advisory Committee. A total of 9 key stakeholders were invited to participate in an interview; 7 interviews were completed (two key stakeholders declined an interview). Interviews were conducted with one nursing supervisor/manager from each of the three community provider agencies, two CCAC Case Managers, representatives from St. Joseph's Hospice, and one representative from the palliative care unit, Bluewater Health. The interviews ranged in length from 15 to 40 minutes (average = 28 minutes).

3.1.4 Interviews with PCCT Members and Leaders

Fourteen individuals participated in this focus group interview; one individual participated in an individual telephone interview. Participants included: Nurse Practitioner (N = 1), Physician (N = 1), Occupational Therapist (N = 1), Social Worker (N = 1), Resource Nurses (N = 6), CCAC Oncology Case Managers (N = 4), and representative from St. Joseph's Hospice (N = 1). Two individuals representing team leadership participated in individual telephone interviews. The focus group interview was 53 minutes in length; the individual interviews ranged from 20 – 84 minutes (average = 41 minutes).

3.2 Objective 1: Describe the services provided by the PCCT and the population served

Data on referrals to the PCCT and services provided were collected from April 1, 2009 to September 30, 2010. Data for the time period January 1 – March 31, 2009 are presented in the evaluation report for the initial evaluation of the team.¹⁴

3.2.1 Team Membership

During the evaluation time period, the team consisted of 15 members: 5 CCAC internal providers: Nurse Practitioner, Social Worker, Occupational Therapist and Chaplain supported by an Administrative Assistant, Team Leader, 8 Resource Nurses (3 each from 2 provider agencies and 2 from 1 provider agency; an additional Resource Nurse will be in place in January 2011) and one palliative care physician. In addition, a Music Therapist is available.

3.2.2 Referrals to the Palliative Consultation Team

A total of 341 clients were referred to the PCCT between April 1, 2009 and September 30, 2010 (See Table 3). As of September 30, 2010, 81 clients remained on the team's active caseload; 260 had been discharged from service, 79% of whom had died (N = 205/ 260). The average length of stay on service was 71 days, with a range of 0 – 345 days¹⁵. The highest percentage of clients were discharged from service due to death (205/260; 79%); more clients died at home (150/205; 73%) than in hospital (55/205; 27%).

¹⁴ Hillier, L.M. (April 30, 2009). Erie St. Clair End-of-Life Care Network Palliative Consultation Team. Final Evaluation Report. London, ON: Author.

¹⁵ Zero length of stay on service refers to clients who were only seen on one occasion by the team.

Table 3: Number of Clients Referred to the PCCT between April 1, 2009 and September 30, 2010

	Number of Clients
Number of clients of referred (April 1 2009- September 30, 2010)	341
Number of clients on active caseload*	81 (23.8%)
Number of clients discharged	260 (76.2%)
Length of stay on service (N = 260)	
Average (+/-) days	70.7 (79.7)
Range	0** – 345
Discharge Disposition (N = 260)	
Hospitalized (>14days)	12.7% (33)
Died at home	57.7% (150)
Died in hospital	21.2% (55)
Admitted to Long-Term care	2.3% (6)
Client preference***	1.2% (3)
Treatment complete	1.9% (5)
Service incomplete – change in service specialty	0.4% (1)
Other	2.3% (6)

* As of September 30, 2010.

** 0 length of stay = same day service and discharge

***Client has chosen to no longer receive service.

The number of referrals to the team per month ranged from 12 to 27, with an average of 19 (+/- 3.9) referrals per month (See Figure 1). Referrals to the team were highest in June 2010 (N = 27) and lowest in July 2009 and January 2010 (N = 12, respectively).

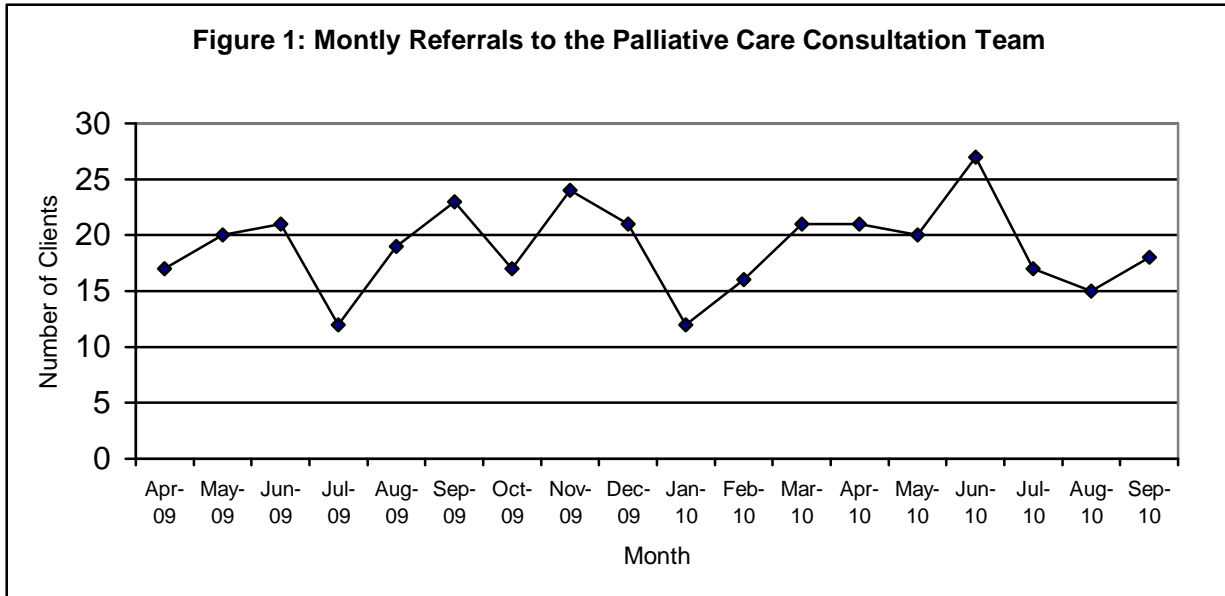


Table 4 presents demographic information on the clients referred to the PCCT. The average age of clients was 70 years; there was an equal distribution of women and men referred to the team. Half of the clients lived with their spouse or life partner. Cancer was the most common diagnosis (83%).

Table 4: Demographic Information for Referred Clients (N = 341)

Demographic Information		Results
Age (years)	Average (+/-) Range	70.0 (13.5) 12* - 95
Gender	Female Male	50.4% (172) 49.6% (169)
Living Arrangements:	Alone Spouse/ Life partner With Spouse and family With family Non-private residence Other arrangement	17.0% (58) 49.6% (169) 8.2% (28) 7.6% (26) 0.9% (3) 1.8% (6)
Diagnosis (at time of assessment):	Cancer** Other conditions	83.3% (284) 16.7% (57)

* Only one client was <19 years of age; the majority (78%) were over 61 years of age (See Appendix H).

** Lung cancer: N = 82; 24.0%; GI (esophagus, bowel, intestines, colon): N = 51; 15.0%; Breast: N = 28, 8.2%; Prostrate: N = 14; 4.1%; Leukemia/ Lymphoma (Hodgkin's & Non-Hodgkins): N = 7; 2.1%; All other types (cervix, ovary, endometrium, brain, gall bladder, liver, kidney, pancreas, occur in less than 7, 2.1%, clients each): N = 102, 29.9%.

3.2.2 Service Provision

As would be expected, end-of-life care was the primary service category (80%; See Table 5) for clients at the time of referral to the team, followed by long-term support (11%).

Table 5: Service Recipient Category* for Clients of the Palliative Care Consultation Team

Diagnosis and Service Category	Percentage (#)
<i>Service Recipient Categories at Time of Referral:</i>	
Acute	1.2% (4)
End of Life	79.8% (272)
Long Term Support	10.6% (36)
Maintenance	7.9% (27)
Rehabilitation	0.6% (2)

* Clients' overall service goals at the time of admission. *Acute*: to address the client's need for short term education, care or support as a result of illness, disability or injury; *End of Life*: to alleviate distressing symptoms to achieve the best quality of life by providing complex support in the last stages of their illness; *Long term support*: to delay institutionalization by providing supportive care, and relief of symptoms to preserve the client's level of function and autonomy, OR the client is in a Residential hospice setting. *Maintenance*: to maintain the client's independence by preventing/ minimizing the premature decline in health and/or functional status; *Rehabilitation*: to optimize the client's functional status within limits of their disability and to facilitate social integration and independence.

In February 2010, data collection regarding the work of PCCT care providers internal to CCAC was initiated. Type of client interactions and the service providers involved are presented in Table 6. From February 1, 2010 – September 23, 2010 there were 985 client interactions with 134 different clients; the average number of interactions per client was 7 (range = 1 – 63). There was an even distribution of face-to-face visits (48%) and telephone contacts (51%). The highest percentage of interactions involved the Occupational Therapist (37%) and the Nurse Practitioner (35%). The number of services involved with each client ranged from 1 – 4, with an average of 1.5 (+/- .73) services involved per client. The majority of clients (58%) had interactions with just one service; 32% had interactions with 2 services and 10% were involved with 3 or more services. CCAC internal providers were consulted 224 times regarding 76 different clients; the average number of consults was 3 (+/- 3.1) per client.

Table 6: Percentage (Number) and Type of Client Interactions and CCAC Internal Providers Involved (February 1 – September 30, 2010)

	Percentage (#)
<i>Number of Interactions:</i>	985
<i>Number of interactions per client:</i>	
Average (+/-)	7.4 (9.1)
Range	1 – 63
Number of clients	134

	Percentage (#)
Type of Interactions (N = 985)	
Case Conference	0.5% (5)
Face-to-face visit	48.2% (475)
Telephone call	51.3% (505)
Client Interactions with Core Team Members* (N = 985)	
Nurse Practitioner	34.9% (344)
Occupational Therapist	36.9% (363)
Chaplain	8.5% (84)
Respiratory Therapist	2.9% (29)
Social Worker	16.8% (165)
Number of Core Team Members Involved per Client (N = 134):	
Average (+/-)	1.5 (.73)
Range	1 – 4
Number of Consultations with Core Team Members*:	224
Number of consultations per client:	
Average (+/-)	3.0 (3.1)
Range	1 – 18
Number of clients	76

* CCAC Internal Providers only (Core team members)

Thirty percent of interactions with a team member prevented an Emergency Department visit, that is, if the team had not been involved the client would have gone to the Emergency Department to access medical attention; this involved 13% (N = 43) of clients, with an average of four (+/- 4.6) Emergency Department diversion interactions per client (See Table 7). Home Laboratory Services were ordered for five clients since the service was made available in May 2010. There were 86 'on-call' interactions with clients. Two of the community service provider agencies responded to 81% of these calls. One agency responded to a small proportion of calls (17%); this was due to staffing shortages. The majority of these calls (N = 69) were managed with telephone contact. Few of these on-call interactions necessitated the involvement of a physician (22%) or nurse practitioner (1%).

Table 7: Emergency Department Diversions, Home Laboratory Services and On-Call Interactions with Clients

	Percentage (#)
Number of client interactions considered hospital avoidance/ diversion (N = 985)	30.3% (298)
Number of clients with an interaction considered hospital avoidance/ diversion (N = 341)	12.6% (43)
Average number of interactions per client considered hospital avoidance/ diversion (N = 43) Average (+/-) Range	4.42 (4.6) 1 – 18
Home Laboratory Services (May 1 – October 29, 2010)	5
Number of ‘On-Call’ interactions	86
Number of ‘On-Call’ interactions per provider agency (N = 86)	
Provider A	48.8% (42)
Provider B	32.6% (29)
Provider C	17.4% (15)
Type of On-Call interaction (N = 86)	
Telephone consults	68.6% (59)
Face-to-face visits	31.4% (27)

3.3 Objective 2: Identify impacts associated with the PCCT to date

3.3.1 Client and Caregiver-Related Impacts

Impacts as Identified by Clients and Caregivers

Caregiver Satisfaction: All of the caregivers reported that they were ‘extremely’ satisfied with their first visit with PCCT, and all were either ‘very’ (N = 2) or ‘extremely’ (N = 1) with the timeliness of care, care coordination, the amount of information with which to make treatment or care decisions, preparation for what will happen, with the way the team responded to their questions and concerns and the level of communication among all of the different care providers or services involved in their loved one’s care.

Caregivers were asked to identify at least one thing that they really liked about the team and the service or care provided; caregivers indicated that they liked team members’ honesty and

enthusiasm, change in care receiver's mood, and the client-focused care that was provided, as reflected in the following comments:

"I really liked their honesty. They look you straight in the eye and tell you like it is. They don't treat [care receiver] like she's fragile. I like their enthusiasm. They really seem to care and want to do a good job."

"We can tell the difference in his mood when the chaplain comes in or when the music person comes to play guitar. [Care receiver] really likes it. It's like having a friend come to visit."

"The personal service. They were just like friends. They came in and cheer us and helped us when we needed it. They were a life line for us and I don't know what we would have done without them."

When asked if there was anything about the team or the service/care they received that they did not like, all 3 caregivers indicated that they had no complaints to make about the care they have received from team members.

Caregiver Support: All 3 caregivers reported that the team gave them information or suggestions that helped them to better care for their loved one at home. In particular, one caregiver commented that the team reviewed with him all of the medications his wife was taking, what they were for and when and how to give them to her. As well, they gave him "tips" on how to make her more comfortable when she is not feeling well.

Emotional/ Spiritual Support: All 3 caregivers reported that they were offered emotional or spiritual support; 2 accepted a visit from the team Chaplain or Social Worker and they were both extremely satisfied with the way the PCCT met their emotional/ spiritual needs, as reflected in the following comments:

"It has been really helpful to have the chaplain visit. His mood has been uplifted. [Care receiver] was so depressed before [chaplain] started coming, but that has made a big difference."

Provision of Special Equipment: All 3 caregivers reported that the team suggested or recommended special equipment for their home (e.g., walker or bathroom equipment such as shower grab bars, raised toilet seat, or shower bench); all 3 accepted the recommendation for special equipment and were 'very' (N = 1) or 'extremely' (N = 3) with the way their needs for special equipment were met by the team.

Additional interview comments made by caregivers reflected their satisfaction with the team and gratitude for the care they have received, as illustrated by the following comments:

"It's an excellent program. [Care receiver] wants to die at home and they'll help him and us to do this."

"It can't tell you enough how super they are. The nurse practitioner and the social worker especially. The social worker always makes her [care receiver] feel better. I think it's really

good that she has someone other than family to talk to about things. This is all really more than I expected.... The team is superb. I think they need to keep it up.”

“Everyone who is dying and who wants to die at home should have this. If they really want people to die at home and to stay out of the hospital, this is the way to do it. It should be mandatory to have this.”

Client and Caregiver Impacts as Identified by Key Stakeholders and PCCT Representatives

Interviewed key stakeholders and PCCT representatives identified a number of impacts for clients and caregivers associated with the PCCT; these are summarized in Table 8.

Table 8: Summary of Client/ Caregiver-Related Impacts as Identified by Key Stakeholders and PCCT Representatives

Client/ Caregiver Impacts

- Increased ability to remain at home to die or for as long as possible due to:
 - In-depth assessment and good management of symptoms
 - Improved pain and symptom management
 - Increased access to palliative care expertise
 - Increased ability to die in location of preference
 - Increased access to palliative care within the home:
 - Access to expertise
 - Access to care 24/7
 - Access to holistic care
 - Improved access to emotional and spiritual support
 - Improved home safety
 - Timely access to care
 - Increased access to laboratory services at home
 - Improved access to consistent care (continuity of care across providers and sectors)
 - Increased satisfaction with care
 - Increased client and caregiver support
 - Increased caregiver confidence in managing loved one at home
-

- **Increased ability to remain at home to die or for as long as possible due:** The PCCT was credited with increasing the ability of clients to remain in their own homes to die or for as long as possible due to: the in-depth assessment that is conducted and resulting management of symptoms, improved pain and symptom management, and increased access to palliative care expertise.

“That they get expertise available to them to help keep them at home and to problem solve their pain and symptom management issues.” [Key Stakeholder ID1]

- **Increased ability to die in location of preference:** With the increased capacity for end-of-life care within the community, clients are better able to remain at home to die, if that is their preference. For those preferring to die in residential hospice or in hospital, the team is able to facilitate the discussion about place of death and facilitate their transfer to these care settings.

“I think the group here has more confidence to talk to patients about that topic, where maybe someone, a primary nurse would find it very awkward... You’ve got to talk about the options and how it may pan out and what it might look like and so that’s helpful for the client.” [PCCT ID1]

“They’re foundation builders too for [Hospice]. So they’re working out there, assessing and just even talking about where do people want to die. They’re dropping bread crumbs all along the way, giving them a little bit at a time, so when the time comes it’s not so over whelming. [Key Stakeholder ID5]

- **Increased access to palliative care within the home:** The team increases client access to specialized medical care (palliative care physician), to this expertise 24 hours a day, 7 days a week, and to holistic care.

“The holistic approach is really good. We’ve got a social worker now, an OT and the nursing and just bringing that whole holistic approach.” [PCCT Team ID1]

- **Improved access to emotional and spiritual support:** The introduction of social work and chaplaincy services has increased clients’ access to emotional and spiritual support. Similarly, the introduction of music therapy has had a positive impact on clients.

“As you know, spirituality is one of the domains of care. We didn’t have that before so it was a huge gap. The case managers would touch on this but really would mostly recommend or refer to churches. So now we have a chaplain who can address clients’ spiritual needs fully.” [PCCT ID9]

“I mean there are team dollars that have been used for music therapy, that has had a huge impact here. I mean it improves quality of life for [clients]. We have some that have been here for longer periods of time and they certainly look forward to it. Music therapy really is a therapy. A lot of people don’t know a lot about it, myself included, but it really does have a positive effect on people.” [Key Stakeholder ID8]

- **Improved home safety:** Education and support to caregivers within the home, as provided by team members, has improved the safety within home environments. It was noted that safety related to medication (opioid) use, equipment use (CADD pumps, hospital beds), and mobility (falls prevention) has improved with the inception of the team.
- **Timely access to care:** With the PCCT, clients are able to access specialized care quicker than when they are not associated with the team, and quicker than prior to the inception of the team. It was noted that when a primary nurse visits a client that requires immediate attention, consultation support can be accessed within minutes.

“Help is just a phone call away. I think people find great comfort in that... So much is done by phone. Things are done so much more timely and efficiently.” [Key Stakeholder ID5]

“ It doesn’t even require a medical referral so it’s really the person in the home is basically a phone call away to intake that gets you on the team and gets you all this help. So it’s not like you have to sit at home and wait for a referral process to go through, which can take months sometimes. “ [PCCT ID1]

- **Increased access to laboratory services at home:** The availability of having in-home blood test is a great convenience for clients who are too ill to travel to a lab or who do not have access to transportation.
- **Improved access to consistent care (continuity of care across providers and sectors):** As care providers across the continuum of care (hospice, community, hospital) are more aligned in the language used related to palliative care, use of end-of-life care strategies, and philosophy of care, clients have improved access to care that consistent across the providers and sectors.
- **Increased satisfaction with care:** It was noted that the work of the team with clients and caregivers has increased their satisfaction with the care provided in the community. This is evidenced by the number of clients who initially plan to die in residential hospice or hospital but who decide to die at home based on their positive experience with the PCCT. In particular, it was noted that clients are satisfied with the care they receive at home that prevents visits to the Emergency Department, which can be long and physically and emotionally draining and allows them to remain at home as long as possible prior to admission to hospice or hospital.

“I get a lot of positive feedback from families about deaths at home and the support they get up to that point, or even if they go in hospital the support they get prior. They get to stay in their home where they’re more comfortable for a lot longer with the team.” [Key Stakeholder ID6]

- **Increased client and caregiver support:** Access to a Social Worker through the PCCT has increased the emotional support and grief and bereavement counseling available to clients and caregivers. Moreover, it was noted that caregivers and family members are better prepared for hospital admissions and that clients and caregivers are less stressed with the emotional and educational support provided by the team.

“First of all what I hear when the patients are admitted to hospital is that the education component or the teaching component to the family, is great. They get some basic understanding of why they’re coming in to hospital, the ongoing education as to what to expect.” [Key Stakeholder ID4]

“Reduced stress, care giver and patient stress because they’re aware of what’s happening and what their choices are and how they’d be supported... I think the greatest impact is the support provided to each individual and patient because of the amount of suffering, and not just physical but emotional, and spiritual suffering at end

of life when, when people are left to negotiate the system alone without supports, just that alone is a major thing.” [PCCT ID3]

- Increased caregiver capacity and confidence in managing loved one at home:**
 Education and counseling support provided to caregivers has increased their ability and confidence to manage their loved one’s care at home.

“I think people are being educated more, they’re understanding the situation and our team is able to guide them through it and take away a lot of the fear. People have huge fears that they’re going to die in misery and pain.” [PCCT ID3]

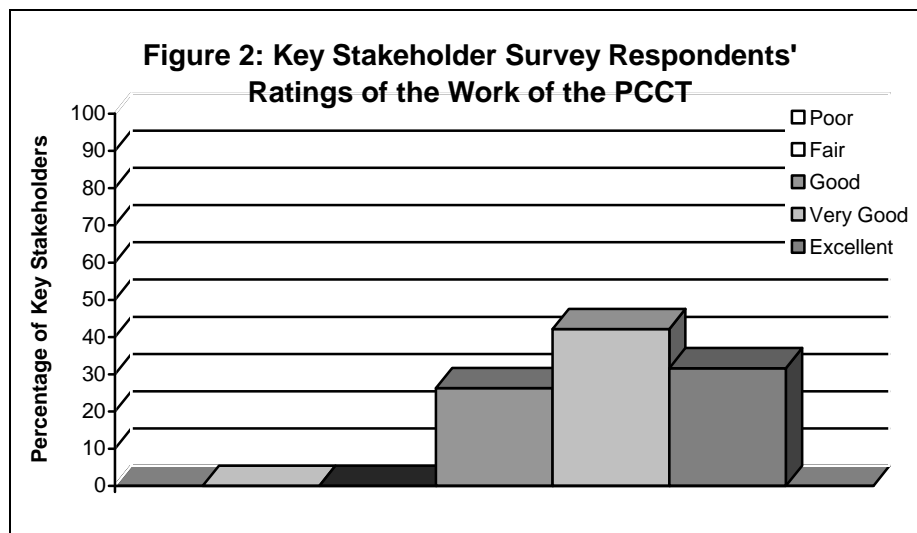
It was noted that client caregiver distress can contribute to Emergency Department visits despite the work of the team to prevent these visits.

“Sometimes we had some patients and families and no matter how good of a nurse you’ve got in there, if they’re panicked, they’re going to go emerge, because that’s just who they are, and then others will just call on the nurse all the time and really totally put all their trust in them.” [Key Stakeholder ID2]

3.3.2 Health Professional-Related Impacts

Care Provider Impacts as Identified by Key Stakeholder Survey Respondents

Key Stakeholder Satisfaction: The majority (74%) of the key stakeholders survey respondents rated the work of the PCCT as “good” (42%) or “very good” (32%); See Figure 2. Consistent with expected targets (as outlined in the evaluation framework), over 90% of key stakeholders were satisfied with the work of the PCCT.



Using a 5- point scale (1 = not at all; 5 = extremely satisfied), survey respondents were asked to rate their level of satisfaction with a number of aspects of team functioning. Table 9 presents the

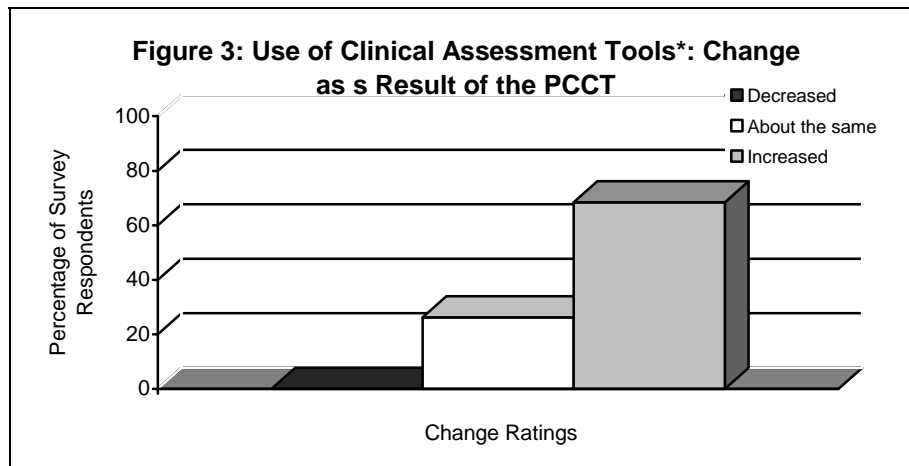
rank ordering of their satisfaction with these aspects of team functioning based on average ratings. Generally, ratings ranged from moderately high (3.7) to high (4.6) levels of satisfaction. Survey respondents were most satisfied with the ability of the team to support clients to die in their preferred location, the direct provision of care and the quality of the assessment conducted. Key stakeholders were least, but still moderately satisfied with integration of care across health sectors and care providers. Consistent with expected targets (as outlined in the evaluation framework), over 90% of key stakeholders were satisfied with the various aspects of the PCCT.

Table 9: Rank Ordering of Key Stakeholders Satisfaction with Various Aspects of Team Functioning (N = 19)

Ranking	Aspects of Team Functioning	Average (+/-)*	Range
1	Ability to support clients to die in their preferred location(N = 18)	4.56 (.71)	3 – 5
2	Direct provision of care (N = 19)	4.37 (.68)	3 – 5
3	Quality of assessment (N = 19)	4.32 (.75)	3 – 5
4	Treatment recommendations/ planning (N = 19)	4.26 (.87)	3 – 5
5	Patient/ family readiness for death (N = 19)	4.21 (.92)	2 - 5
6	Capacity building for end-of-life care (education/ resources) for team members (N = 19)	4.16 (.90)	2 - 5
7	Follow-up (N = 19)	4.11 (.81)	2 – 5
8	Timeliness of access to assessment (N = 18)	4.06 (1.0)	2 – 5
9	Availability of team members for informal consultation (questions, follow-up) (N = 19)	4.05 (1.0)	2 – 5
10	Care coordination (N = 19)	4.00 (1.0)	2 – 5
11	Integration of care across health sectors (community – hospital) (N = 19)	3.84 (1.2)	1 – 5
12	Communication between the team and other care providers (N = 19)	3.79 (1.1)	1 – 5
13	Integration of care across care providers (N = 19)	3.72 (1.3)	1 – 5

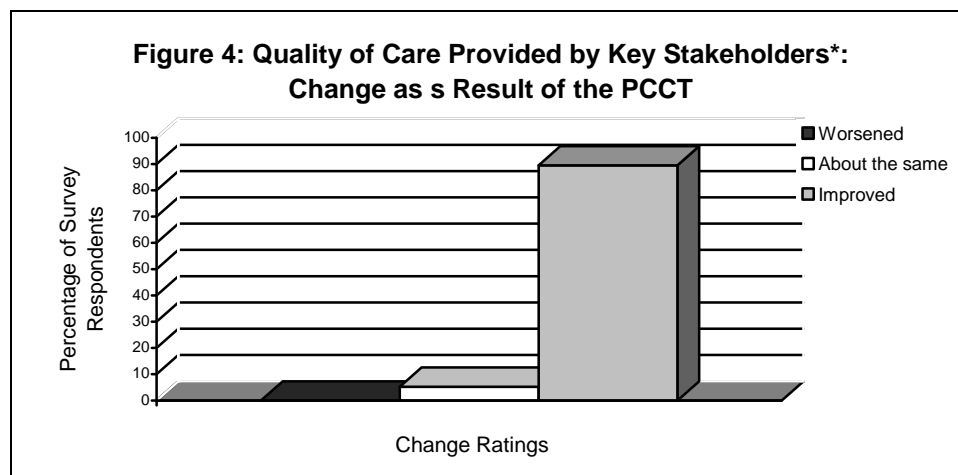
* As rated on a 5 point rating scale: 1 = not at all satisfied; 5 = extremely satisfied.

Capacity Building: The majority of key stakeholder survey respondents (68%) reported that their use of assessment tools (ESAS, PPS) has increased as a result of the PCCT (See Figure 3).



*5 point rating scale: Much increased, increased, neither increased nor decreased, decreased, much decreased. Increased use = sum of much increased/ increased ratings; Decreased use = sum of much decreased/ decreased ratings. Note: Percentages do not sum to 100% due to missing values.

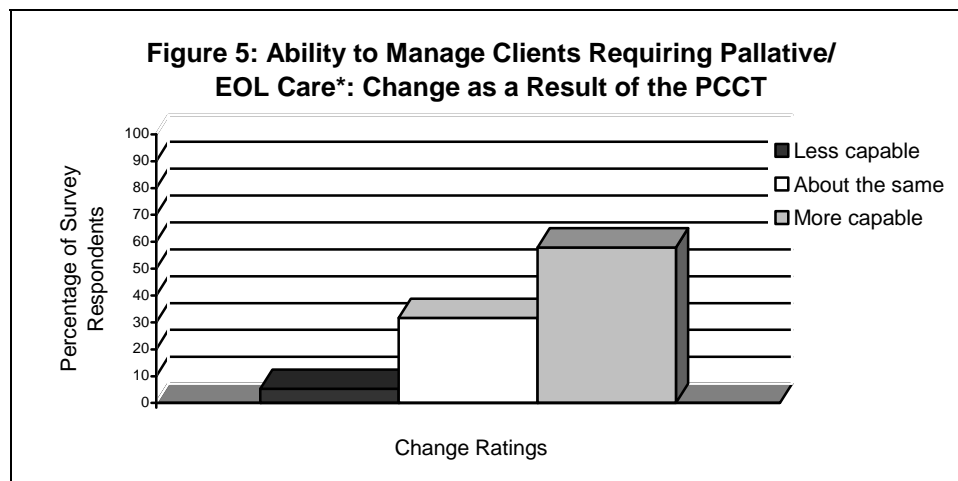
Similarly, the majority of key stakeholder survey respondents (90%) reported that the quality of care they provide to clients requiring palliative/ end-of-life care has improved as a result of their involvement with the PCCT (See Figure 4).



*5 point rating scale: Much improved, improved, neither improved nor worsened, worsened, much worsened. Improved = sum of much improved/ improved ratings; Worsened = sum of much worsened/ worsened ratings. Note: Percentages do not sum to 100% due to missing values.

The majority of key stakeholder survey respondents (58%) reported that as a result of the PCCT they were now more capable of managing clients requiring palliative/ end-of -life care in their own practice; 32% indicated that their ability to do so had not changed as result of the team (See Figure 5). These results are less than expected targets (as outlined in the evaluation framework; expected target – 90% of providers reporting increased capacity). Average ratings of

current ability to manage clients requiring palliative care were quite high (4.7; +/- .49, as rated on a 5-point scale).



*5 point rating scale: 1 (less capable now), 2, 3 (about the same), 4, 5 (more capable now); Less capable now = sum of ratings of 1 and 2; More capable now = sum of ratings of 4 and 5.

Health Care Provider Impacts as Identified by Key Stakeholders and PCCT Representatives

Interviewed key stakeholders and PCCT representatives identified a number of impacts for health care providers associated with the PCCT; these are summarized in Table 10.

Table 10: Summary of Health Care Provider-Related Impacts as Identified by Key Stakeholders and PCCT Representatives

Health Care Provider Impacts

- Improved communication between care providers
 - Increased access to expertise (MD, NP) for primary nurses
 - Increased capacity for palliative care among community-based nurses
 - Increased opportunities for education for community nurses
 - Reduced workload for team physician with availability of the Nurse Practitioner
 - Increased job satisfaction among community nurses
 - Improved self-care for community nurses
-
- **Improved communication between care providers:** Quick access to care and greater collaboration between partners (e.g., community nurses across agencies, community nurses and CCAC Case Managers) has resulted in improved communication between care providers/ agencies.
 - **Increased access to expertise (MD, NP) for primary nurses:** With the inception of the team, primary nurses providing palliative care have greater access to expert resources thus making it easier for them to provide effective care.

“It’s easier for them [primary nurses] to care for palliative patients knowing that they have that expertise available.” [Key Stakeholder ID6]

- **Increased capacity for palliative care among community-based nurses:** It was noted that community based nurses, particularly the Resource Nurses, have enhanced their ability to provide palliative and end-of-life care due to the education and mentoring they have received from the team.

“I think it’s because of the education that the nurses are receiving and they are doing better home assessments so there’s a better trust level between most of the resource nurses and then getting the orders from the physician, you know, rather than having to go to emerge and be admitted to hospital. [Key Stakeholder ID2]

- **Increased opportunities for education for community nurses:** All community nurses have greater opportunities for formal and informal (“in the moment”) education as a result of the team; primary nurses learn from and are mentored by Resource Nurses, who in turn are mentored by the core members of the PCCT. It was also noted that access to palliative care education has been enhanced by the ESCEOLN palliative care education strategy (education blueprint).

“I think there’s more opportunities for education. I think they certainly appreciated that, the people that have participated on the grand rounds. I think there’s improved education all the way around and I think part of it is not only the team, but the whole palliative care [education] strategy. [Key Stakeholder ID1]

“It is the ability for the resource nurses to go out with a visiting nurse and provide teaching to the situation and the hands on teaching that makes it, I feel it makes for better care.” [Key Stakeholder ID7]

- **Reduced workload for the team physician with the availability of the Nurse Practitioner:** The introduction of the Nurse Practitioner on the team has reduced the team physician’s workload as she is, within the scope of practice, able to order certain diagnostic tests and medications. Working in collaboration with the team physician, she is able to consult with him on the majority of cases thereby reducing the need for him to do home visits and reserving his time for more complex issues/ cases.

“As far as supporting the team, nurse practitioners have been able to certify death, if the nurse practitioner has seen the client and the physician, the primary physician is not available. So that’s a real support to our physicians who are very busy. But also to be those eyes and ears and collect information and as the team’s expertise is developing and they are being recognized by the physicians as having that expertise.” [PCCT ID9]

“It’s reduced [Team physician] workload. So he’s not always running out to a home visit. He’s hardly done any home visits [with introduction of the NP], when he used to do quite a few, so I think because it’s the simpler ones that the Nurse Practitioner deals with. He comes in for the complex issues that are harder to manage, or when medication needs to be ordered that [NP] isn’t able to order.” [Key Stakeholder ID2]

- **Increased job satisfaction among community nurses:** As working as a community can be very isolating, involvement with the team has increased community nurses job satisfaction as they have resources to access that help them to do their jobs better. Similarly, affiliation with the team and additional capacity building opportunities for the Resource Nurses has increased their satisfaction with their work.

“Oh I think you know certainly any time you’re able to help somebody through the journey and relieve stressors, relieve the hurting, certainly the rewards of that. You really get to know people and you have the ability to get to know people because unlike in the acute care setting or in the community, the goal isn’t to teach and reduce. It’s to see them throughout the journey, and so they can really meet some very tough goals with therapeutic relationships that take time to build.” [Key Stakeholder ID5]

“Resource nurses I know that for the most part most have a real sense of accomplishment around changing the illness journey for patients and their families.” [PCCT ID3]

- **Improved self-care for community nurses:** The team Social Worker has provided support to team members to enhance their self-care (to reduce burn-out). The introduction of a memorial service to commemorate clients have died (to be held in December 2010 as organized by the team chaplain) is anticipated to improve closure and self-care for care providers.

“The social worker is actually at rounds, she is able to provide to the resource nurses little sessions on caring for self, so that has been implemented on a regular basis, so that directly impacts the resource nurses.” [Key Stakeholder ID9]

3.3.3 Health System-Related Impacts

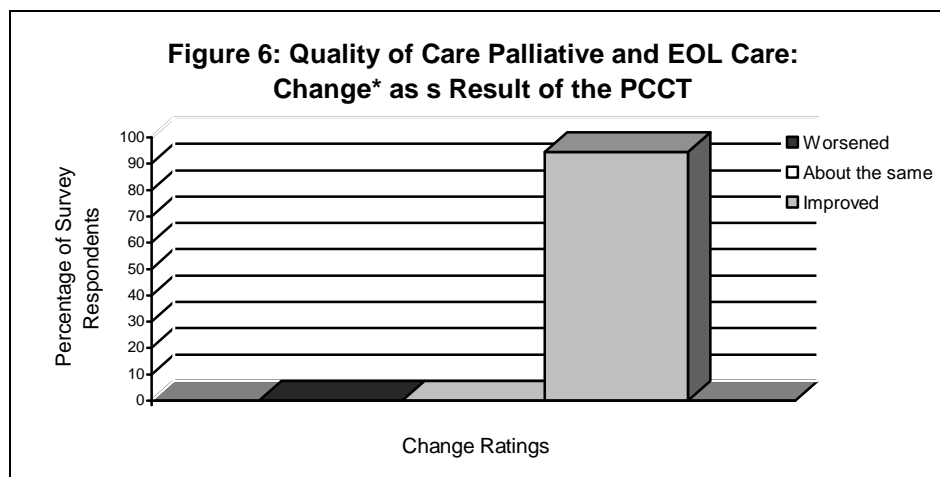
Health System-Related Impacts as Identified Caregivers

Use of Health System Resources: As part of the caregiver interviews, caregivers were asked to indicate whether the help that they received from the PCCT helped to keep their loved one out of the hospital or from visiting the Emergency Department. All 3 of caregivers that were interviewed reported that team was able to prevent Emergency Department visits, primarily due to access to the Nurse Practitioner and team Physician so that medications orders could be changed, as reflected in the following comment:

“We ran into some problems one day and the nurse that was here called the Nurse Practitioner. She noticed that there were problems with one of the medications and she was able to change that right away. That made a huge difference. Otherwise we might have had to go into the hospital because she was always tired and dehydrated and had the runs. Once we changed the dose of the medication she was better and we were both pleased.”

Health System-Related Impacts as Identified by Key Stakeholder Survey Respondents

Improved Quality of Palliative Care: Key stakeholder survey respondents were asked to rate the extent to which the overall quality of palliative and end-of-life care provided to clients has improved as a result of the PCCT (See Figure 6). All of the respondents (95%) that answered this question reported that quality of care has improved, with the majority of respondents (63%) indicating that care has “much improved”.



*5 point rating scale: Much improved, improved, neither improved nor worsened, worsened, much worsened. Improved = sum of much improved/ improved ratings; Worsened = sum of much worsened/ worsened ratings. Note: Percentages do not sum to 100% due to missing values.

Key stakeholder survey respondents identified a number of impacts/ outcomes associated with the PCCT, many of which reflected improved quality of care as evidenced by:

- Emergency Department avoidance through access to a Physician or Nurse Practitioner, increased nursing capacity to manage complex issues at home, and direct admissions to the Palliative Care Unit.
- Access to improved care within the community has resulted in more appropriate use of the Emergency Department and Palliative Care Unit.
- Access to spiritual support for clients.
- Use of music therapy to reduce anxiety.
- More timely access to care.
- Increased care provider capacity to assess, prevent, and manage symptoms within the home setting.
- Collaboration among community partners and those within the clients' circle of care to assist clients to achieve end-of-life goals, such as their preferred location of death.
- Improved communication between hospital and community-based care providers.

These impacts are reflected in the following comments:

"I am finding that we have been able to keep more patients at home (by their choice) when they have very complex issues/concerns. As opposed to before the team, these patients would have been sent to hospital."

“The ability to speak directly with the NP or GP in charge of the situation and make changes to the service plan as appropriate in a short period of time has helped to keep the client in their home and create hospital avoidance.”

“The availability of spiritual/consultative care has helped the clients feel more connected to the care pathways provided by the entire team.”

“Increase communication from hospital to community to hospice. All speak the same “language.”

Similarly, key stakeholder survey respondents were also asked to indicate whether they thought the work of the PCCT has helped to keep clients out of the hospital or from visiting the Emergency Department. The majority of key stakeholders (68%) reported that the team has kept clients out of hospital (See Table 11). Comments associated with this were related to the team’s ability to do this due to increased capacity for assessment, prevention and management of palliative issues (pain control, bowel and medication management), access to physicians, on-call expert advice, education to families and clients, and access to emotional and spiritual care, as reflected in the following comments:

“Prevention/ anticipation of problems 2. Extensive teaching with families and patients 3. Access to NP and physician to deal with problems at home”

“Averting hospital/ER admissions/visits by managing the Client in their home, through the professional expertise and compassion of all Team members to create a comfortable and safe home environment, enabling the Client to best achieve their end of life goals.”

“Through home assessments, trouble shooting at home, access to palliative physician 24/7 and anticipation of complications that may occur, better education to families and clients.”

“Nurse Practitioner & resource nurse home visits often instrumental in avoiding unnecessary ER visits. Nurses can consult with palliative physician from the home and adjust meds/address medical issues.”

“Allowed a broader scope of options available at home so they could avoid a visit to ER.”

Table 11: Key Stakeholder Survey Respondents Reports of Hospital Avoidance As a Result of the Team

Do you think that the work of the Team has helped to keep clients out of the hospital or from visiting the Emergency Department?	
Not sure	0
No	10.5% (2)
Yes	68.4% (13)

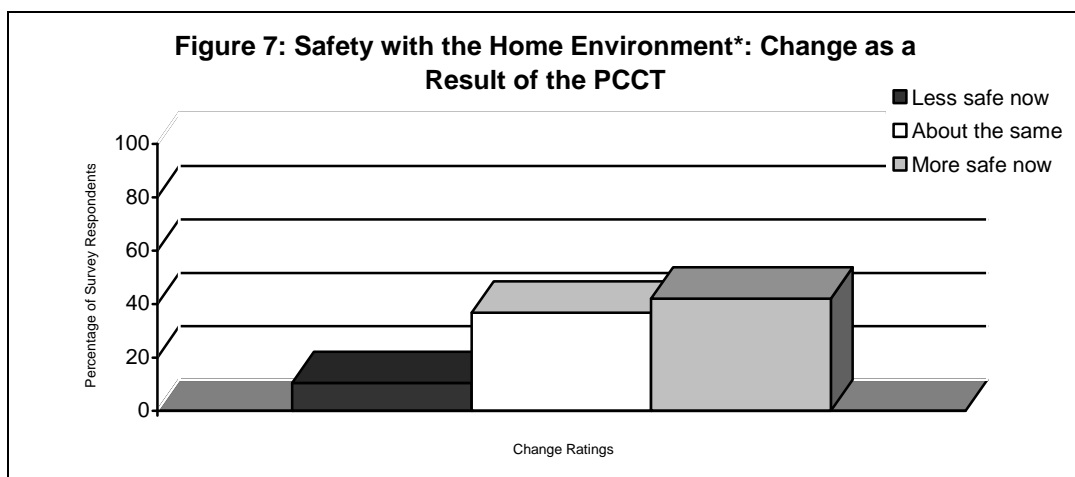
Note: Percentages do not sum to 100% due to missing data.

As a result of the PCCT, the majority of key stakeholders reported that client’s length of hospital stay (58%) and the number of clients dying in hospital (63%) has decreased, and that access to vital health care services at home has increased (68%, See Table 12). Less than 21% of respondents indicated that there were no changes to these indicators.

Table 12: Health System Impacts as a Result of the PCCT

As a result of the work of the Team has...	Increased	Stayed the Same	Decreased
client’s length of hospital stay...	0	21.1% (4)	57.9% (11)
the number of clients dying in hospital....	0	15.8% (3)	63.2% (12)
access to vital health care services at home....	68.4% (13)	10.5% (2)	0

Safety within Home Environments: Key stakeholder survey respondents were asked to rate the current level of safety within home environments for palliative/ end-of-life care in comparison to prior to the inception of the PCCT. Forty-two percent of respondents reported that the level of safety within home environments has improved since the inception of the team; 37% indicated that safety within the home had not changed as a result of the team (See Figure 7). These results are less than expected targets (as outlined in the evaluation framework; expected target – 90% of providers reporting safer home environments as a result of the team). However, when compared with the results of the initial evaluation of the team, the percentage of respondents indicating improved in home safety rose by 11% (from 30.8%) and the percentage of respondents indicating no changes in home safety reduced by almost 25% (from 61.5%).



*5 point rating scale: 1 (less safe now), 2, 3 (about the same), 4, 5 (more safe now);
 Less safe now = sum of ratings of 1 and 2; More safe now = sum of ratings of 4 and 5.
 Note: Percentages do not sum to 100% due to missing responses.

Health System-Related Impacts as Identified by Key Stakeholders and PCCT Representatives

Interviewed key stakeholders and PCCT representatives identified a number of health system impacts associated with the PCCT; these are summarized in Table 13.

Table 13: Summary of Health System-Related Impacts as Identified by Key Stakeholders and PCCT Representatives

Health System Impacts

- Enhanced quality of palliative and end-of-life care
 - ED avoidance
 - Delayed hospitalizations at time of death
 - Shorter lengths of hospital stay
 - Increased deaths in the community (home, residential hospice)
 - Improved care coordination
 - Standardized assessment/ care
 - More efficient use of existing resources
-

- **Enhanced quality of palliative and end-of-life care:** With the expertise of the team, client-centred holistic care, increased capacity for palliative care among community nurses, and improved communication between care providers, it was perceived that palliative and end-of-life care in this region has improved.

“I just think it’s all going well and we give better care and people are supported better.” [Key Stakeholder ID6]

“I think that quality of life at end of life has improved considerably for patients and their families who are on the team. Not only is there a system better managed when they’re at home, but also all the domains of issues are being addressed as much as possible, and are willing to address those things, such as issues around relationships and talking about end of life and the plan and talking about do not resuscitating, and making choices around those things, so all of those things.” [PCCT ID4]

- **ED avoidance:** It was noted the visits to the Emergency Department for palliative care issues have reduced because:
 - Primary nurses can access the team to resolve issues
 - Caregivers are better supported to manage crises at home
 - Clients and caregivers have increased confidence in care provided in community
 - Increased access to Symptom Response Kits

“[The team] has greatly reduced the ER visits for the clients at home. In fact, usually before they require the ER visit one of the PCCT nurses will go out and assess the situation and then talk to the physician so they have reduced ER visits.” [Key Stakeholder ID4; hospital representative]

“A lot of times the same nurse, or the same couple of nurses over time they develop this relationship, which is really unique, and people have such confidence in that one

nurse, and the resource nurse from that agency that they're willing to stay at home and not go on to emerge and we certainly encouraged that.” [PCCT ID3]

It was noted however, that ED visits for those at end of life living in rest and retirement homes and in long-term care homes has not been impacted, as they continue to lack the capacity to manage end-of-life care in-house.

- **Planned hospitalizations delayed:** The availability of the team and increased capacity for end-of-life care in the community provides those who die in residential hospice or hospital an opportunity to remain at home as long as possible prior to their planned admission to residential hospice or hospital.
- **Shorter lengths of hospital stay:** With the availability of palliative care expertise within the community, hospital based care providers are confident in discharging clients home sooner than they did prior to the inception of the team.

“Without the team involved I would say that the length of stay would be longer. We're able to send them home for end of life care, and to die at home, and it is directly related to the team being in place and the expertise of that team.... I'm going to say 75% of the patients that we see in the unit that usually have a PCCT team involvement and to further that when they go home, if they don't and when they go home, we would like to connect them with a PCCT.” [Key Stakeholder ID4; hospital representative]

- **Increased deaths within the community:** It was noted that with the availability of residential hospice more people are dying in the community (at home and in hospice) than in the hospital.
- **Improved care coordination:** It was noted that care coordination across sectors is improved with the use of common language and assessment tools. Similarly there is improved care coordination with increased collaboration between providers, organizations, and across sectors due to reduced territoriality regarding clients and services.

“At the hospital, with the team member going out, we speak the same language and we understand the same components. If the patient is complaining to the nurse about a certain symptom, we can relate, we can understand so I'm going to say the common thread there is understanding the basic language. We speak the same language.” [Key Stakeholder ID4]

- **Standardized assessment/ care:** The Palliative Care Report used by the team, was credited with supporting a common language and approach to care. The report is used as an admission form by Hospice and is used at team rounds as a guide for case discussions. This tool was described as improving communication across sectors, thereby enhancing care coordination and integration.
- **More efficient use of existing resources:** The introduction of the NP has resulted in less reliance on the team physician. This was viewed as a more economical and efficient use of health system resources. Similarly, it was noted that the availability of the St.

Joseph's Hospice provides an alternative to hospital admission; the team assists in decision-making regarding hospice. The availability of direct admission to the palliative care unit, bypassing the Emergency Department was also viewed as efficient (both economically and for clients). Moreover, it was noted that as a volunteer coordinator is a team partner, there has been improved use of palliative care volunteers.

"The other thing, the other perspective, or the other way in which the team is utilized through hospice is that they do our assessment, so they will go out and to the assessment for eligibility for hospice and to identify, is it the right time for this person to come in so that's certainly a big help too." [Key Stakeholder ID8]

"I think the team really works to provide the right care to the right person at the right time." [PCCT ID9]

Additional comments made by key stakeholder survey respondents reflected their support for this service and their perceptions that the quality of palliative care in this region has been enhanced:

"The Team is composed of individuals who have a passion for palliative and end-of-life care. The individuals I have had the opportunity to work with have consistently demonstrated Client centered practice and their commitment to providing the best service(s) to end of life Client's in Lambton and Chatham County."

"I think we have a great system working here in this region. We are very lucky and blessed to have great care providers that other communities do not have available yet. We are inspiring other communities to provide the same quality of care we have and we are definitely leading the way for quality patient care in this province."

"I believe from a chaplaincy perspective that society is learning how to die with dignity and in the presence of family familiar surroundings."

"Team has been a great asset in this region and hope to continue providing a team effort and build up on the expertise between each professional."

Case Illustrations¹⁶: The following case studies describe actual clinical interactions between PCCT members and their clients. These cases illustrate the impacts associated with timely access to expert care, supported deaths in the clients' preferred location, caregiver and family member support, coordinated care, and ED and hospital avoidance.

Case #1:

The team became involved with an 88-year-old woman who lived alone in a rural area. She was experiencing the symptoms of impending death that had progressed quite quickly and much to the surprise of her daughter and physician, who was not clear on why the client was deteriorating so quickly. Her daughter was quite distressed and received minimal assistance from her family physician. The team NP assessed the client at home and consulted with the family physician. She provided support to the daughter who was not coping well with the situation and it was decided that the client's care could not be managed at home. The NP

¹⁶ Some of the details have been modified in order to protect the confidentiality of the client.

consulted with the palliative care unit and the client was transferred to hospital the next day. The client died peacefully in hospital several days later.

In this instance, the PCCT:

- ★ provided timely access to medical care
- ★ mobilized care that was the “right care, in the right place, at the right time”
- ★ initiated end-of-life care in preparation for continued care within the hospital
- ★ provided information and support to a distressed family member
- ★ collaborated with the family physician to make care decisions

Case #2:

A client in the advanced stages of lung cancer had been followed by a Resource Nurse for several visits. On one occasion the primary nurse contacted the Resource Nurse because the patient’s pain and other physical symptoms had rapidly escalated and earlier recommendations were no longer effective. Family members had wanted to take the client to the Emergency Department. The Resource Nurse visited the client while the primary nurse was present, assessed the patient and consulted with the team physician who revised the medication order. The Resource Nurse arranged with the pharmacy for delivery of the new medication, which was delivered within the hour. The Resource Nurse also provided some suggestions for making the client more comfortable. Within several hours the clients’ pain and symptoms had subsided. The patient did not visit the Emergency Department.

In this instance, the PCCT:

- ★ provided timely access to assessment and intervention
- ★ consulted with team physician to initiate effective pain and symptom control
- ★ provided consultation support to the primary nurse
- ★ provided in the moment (bedside) mentoring
- ★ prevented an Emergency Department

Case #3

An older woman was cared for by the PCCT in the community. She developed a complication that required a hospital admission; the family was unable to cope with the complication at home. The family was concerned that the client would not return home as it was the client’s and families wish that she die at home. The client’s condition was stabilized in hospital after a few days. In consultation with the team, she was discharged home to die in her preferred location; the team provided support (emotional, education, equipment) to the family. Without the support of the team in place, the client would have remained in hospital longer, and may even have died there.

In this instance, the PCCT:

- ★ worked collaboratively across sectors to provide continuity of care
- ★ supported the client and family’s wishes to die at home
- ★ shortened the hospital length of stay

Case #4

A PCCT client dying in hospital had a 93-year-old father who was living in long-term care in a rural area and who did not have access to transportation to visit his dying daughter. The Resource Nurse who was in the area for another client visit, took the opportunity to use her off work-time to drive the gentleman to the hospital so that he could say goodbye to his daughter. It was the last time the client saw her father before she died.

In this instance, a PCCT member:

- ★ showed compassion and commitment to supporting quality of life and death
- ★ went beyond job expectations to support a client
- ★ supported a grieving parent and dying client

Case #5

A senior living alone in the community had refused all community home care support offered by the CCAC. She was in denial of her diagnosis, despite her worsening condition. She refused service from the PCCT. She did not answer telephone calls. The team Physician was able to conduct a home visit, which facilitated team involvement as she was otherwise not wanting to allow team members into her home. As her condition was deteriorating rapidly, the team members conducted the assessment as the group and quickly developed and implemented a care plan to facilitate the client's wishes to die at home, despite living alone. The client passed away three days later, in her home and not alone.

In this instance, the PCCT:

- ★ overcame the clients' resistance to care
- ★ worked collaboratively to develop and implement an effective care plan in a timely manner
- ★ supported the client's wishes to die at home
- ★ improved the client's quality of life and death
- ★ ensured that the client did not die alone

Case #6:

A client living at home was experiencing increased pain and symptoms on a Saturday evening. The client had wished to die in a residential hospice as the caregiver was unable to manage end-of-life care at home. The Resource Nurse conducted a home visit at the request of the primary care. As the client was deteriorating quickly, the Resource Nurse contacted the NP, who in consultation with Hospice staff was able to facilitate admission that same day. The client died in Hospice shortly thereafter. Without access to the Resource Nurse and NP, and subsequently Hospice, the client would have gone to hospital and quite possibly could have died there.

In this instance, the PCCT:

- ★ provided timely access to care during "off hours"
- ★ facilitated a seamless transfer to hospice and coordinated care across settings
- ★ supported a clients' preference for location of death
- ★ improved the quality of the client's life and death
- ★ avoided an Emergency Department visit and hospital admission

3.4 Objective 3: Describe the process of developing and implementing the PCCT

3.4.1 Facilitating Factors

Key stakeholders and PCCT representatives identified a number of factors that have facilitated the development and implementation of the PCCT; these factors are summarized in Table 14.

Table 14: Summary of the Factors Facilitating the Development and Implementation of the PCCT

Facilitating Factors:

- Availability of team Physician and Nurse Practitioner
 - Management and peer support within nursing agencies
 - Ongoing and open communication between all partners (CCAC management, nursing agencies, team members)
 - Collaborative relationships among partners
 - Regularly scheduled rounds
 - Ongoing identification and resolution of issues/ problems
 - Team members as palliative care champions
 - Capacity building opportunities for Resource and primary nurses
 - Increasingly improving communication across sectors
 - Support from the Palliative Pain and Symptom Consultant
-

- **Availability of team physician and Nurse Practitioner:** Access to a palliative care physician and NP was identified as critical to the success of the team both in terms of provision of care but also capacity building within the team; it was noted that without these roles the team would not be sustainable. Availability of NP has increased team member access to consultation support.

“Well I have to say one thing that I think works extremely well is [palliative care physician’s] involvement with the team, with hospice and with the hospital. He’s a very integral link, and I think that there’s a lot of continuity there because he’s involved with the team because he’s involved with hospice; he does a lot of educating. Everybody’s been getting that same education. It’s a real benefit to have him as part of the team.” [Key Stakeholder ID8]

“I think what’s working well is the nurse practitioner. She responds appropriately to [Resource Nurse] care needs and requests. I really find I communicate with her almost on a daily basis. The nurse practitioner is a huge benefit.” [Key Stakeholder ID7]

- **Management and peer support within nursing agencies:** Ongoing support from management and primary nurses was credited with providing Resources Nurses the encouragement and support needed to maintain their role.

“Management support. From our perspective you have to support the nurses that are participating on the team, their time, the expectations, and monetary wise.” [Key Stakeholder ID1]

- **Ongoing and open communication between all partners (CCAC management, nursing agencies, team members) and across sectors:** It was noted that there is good communication between all of the partners involved in this initiative including CCAC management, CCAC Case Managers, the community service provider agencies (management and nursing staff) and team members. This communication allows for the prompt and effective resolution of challenges that arise, ensures that all critical information is distributed in a timely manner, and that all partners contribute to problem-solving efforts. It was noted that this open communication contributed to the identification of gaps services and lead to the introduction of the social worker and chaplain to the team.

“Communication between the agencies and the CCAC and also the team members, feeling an openness to be able to, to say what they think.” [Key Stakeholder ID1]

“Good lines of communication that are only going to potentially get better as people get to know each other and I think that definitely is a way that you’ll have that ongoing improvement and its going to transfer to the care that the client receives.” [Key Stakeholder ID3]

Although it was noted that there is room for improvement, the work of the team has gone a long way to improving communication across sectors so that clients have timely and smooth transitions and effective care coordination between sectors.

“Excellent communication with [the team], absolutely. They key common thread is speaking the same language, knowing where the patient best fits for the problems that they’re experiencing at home, whether it be a hospice admission or the hospital, so it’s the right place for the patient.” [Key Stakeholder ID4]

- **Collaborative relationships among partners:** The willingness of partners from across sectors to work collaboratively to improve palliative care in this region was identified as important to the development of the team.

“I think the fact that in both communities the CCAC who took the lead in implementation was very careful about including all the partners, and then of course I think the second part of that is that the partners were willing to come to the table, and there could have been some staking out of: ‘This is our area’, and there wasn’t. People were very willing to look at a new project and see how that would fit and enhance it from what we’ve had over the years, so I think that has worked well.” [PCCT ID4]

- **Regularly scheduled rounds:** The opportunity for team members and other relevant partners/ stakeholders to meet on a regular basis was perceived as a critical mechanism for capacity building as all participants learn from the case reviews and in particular from problem solving complex cases and for communication of critical information.

“Consistently meeting as a team, like twice a month, without gathering as a group I think things would not move as well. It’s the face to face, the human touch to it. To know that there’s other people and you’re not alone, you can ask questions, you can get support, ideas if you don’t know where to go next. There’s people you can relate to, along with all the different disciplines that are available.” [PCCT ID1]

- **Ongoing identification and resolution of issues/problems:** Consistent with good communication and regular opportunities for interactions among team members, is the perceived importance of ongoing identification and resolution of issues that arise. Team members and key stakeholders reported that they perceived that their feedback was valued and efforts to resolve problems were genuine. In particular, it was noted that feedback gathered from the initial evaluation of the team was used to improve team processes.

“That the feedback they received [from the evaluation] has been listened to and things have changed as a result and I think that’s been beneficial because I think that was sort of critical for the team to continue to succeed today.” [Key Stakeholder ID1]

- **Team members as palliative care champions:** CCAC internal providers and agency Resource Nurses, as well as Case Managers were described as champions for palliative care; their passion for palliative care is evidenced in the quality of care they provide and their advocacy for optimal care for their clients.

“Members of the team, they’re very passionate and I think it’s the buy in from all of the team members, and that’s including the oncology case managers.” [PCCT ID9]

- **Capacity building opportunities for Resource and primary nurses:** Ongoing opportunities for mentoring and education for both resource and primary nurses was viewed as critical to ensuring quality care and sustainability of the team.
- **Improving communication across sectors:** Although it was noted that there is room for improvement, the work of the team has gone a long way to improving communication across sectors so that clients have timely and smooth transitions and effective care coordination between sectors.
- **Ongoing CCAC support for Hospice:** It was noted that the CCAC has been very supportive of St. Joseph’s Hospice and has provided resources to support services (e.g., Music Therapy, palliative care clinic) for clients served in the community. This support has served to strengthen the partnership between these two organizations and improve access to and quality of care provided.

“The CCAC’s been pretty supportive of [Hospice], with the team dollars being used for other supports at hospice as well, and music therapy is one of them. The palliative care clinic is another one where the administrative support for the palliative care clinic comes from some of those dollars and it’s had a huge impact, I mean we’ve had people that call us Friday with a referral and they’ll be in to see Dr. Madison early the following week. The wait time for people is really short. They’ve been extremely supportive of hospice and we’re certainly working together so I feel like we have a good relationship.” [Key Stakeholder ID8]

- **Support from the Palliative Pain and Symptom Management Consultant:** The local PPSMC was perceived as a valued resource, champion, and advocate for the PCCT.

“[PPSMC]’s one of the partners that is present at rounds, education, the palliative medical rounds, she’s part of that. She’s a support to the nurse practitioners as far as when they were first starting out as a resource for them, and again developing that expertise, their professional knowledge and its really tertiary support.” [PCCT ID9]

3.4.2 Challenges

A number of challenges were identified by key stakeholders and PCCT representatives related to the Resource Nurse role as well as the implementation of the PCCT and service delivery issues. These challenges are summarized in Table 15.

Table 15: Summary of the Factors Challenging the Implementation of the PCCT

<p><i>Resource Nurse related issues:</i></p> <ul style="list-style-type: none"> • Recruitment and retention of Resource Nurses • Reimbursement issues • Maintaining on-call responsibility • Unclear understanding of the Resource Nurse role <p><i>Implementation/ service delivery issues:</i></p> <ul style="list-style-type: none"> • Limited support from some family physicians • Limited family physician capacity for palliative care • Variability in palliative care knowledge and skills among primary nurses • Limited availability to NP off hours • Limited access to interprofessional care <p><i>Logistical issues</i></p> <ul style="list-style-type: none"> • Lack of timely communication of clients to be discussed at rounds • Limited communication between Resource Nurses and palliative care physician • Travel time
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Resource Nurse related issues:

- **Recruitment and Retention of Resource Nurses:** Ongoing recruitment and retention of Resource Nurses was identified as a significant challenge to on the ongoing implementation and sustainability of the team. There are currently a limited number of Resources Nurses; one community service provider agency had difficulty recruiting a third Resource (each agency is to have three resource nurses; an additional Resource Nurse has recently been recruited and will commence in the role in January 2011). Recruitment has been challenged by the lack of incentives for the role. Despite expectations for on-call responsibilities and maintenance of a regular caseload, there are no financial incentives to take on the added work responsibilities. Without reducing their current caseload few nurses are interested in taking on a new role. It was noted that

nurses currently in the position are at high risk for burn out due to increased work load. Sustaining Resource Nurse positions may be an issue in the future as some nurses have indicated that they are unable to continue the role beyond one year.

“We need more resource nurses. As well as their own cases, they need time to teach within their own agency, which pretty well is non-existent, so they’d be doing their own case loads, plus taking on-call because even suggestions to meet with or to mentor different nurses, it’s the craziness I guess of their work day. There’s been a few that have talked recently again that they just can’t carry on doing this... As much as what we can say the team’s there, it’s the Resource Nurses that work longer hours. But the team doesn’t work weekends, except for the resource nurses. So the resource nurses being the one 24/7 who are trying to keep up this team.” [Key Stakeholder ID2]

“Not enough resource nurses... There’s just not enough regular nurses, not enough hours. You need them and their days are filled already.... Your day just goes longer, I mean sometimes you just feel like your day never ends, so that’s why we need some more other nurses getting trained and willing to do it.” [PCCT ID1]

A representative from one service provider agency commented that given on-call expectations within their agency, nurses are not interested in assuming higher on-call responsibilities associated with the team because of the disruption to their personal life.

“From an agency perspective the biggest challenge is to get people to go on the team. We have nurses with expertise but they don’t want to participate on the team, because of some of the expectations. Our nurses are already on call 24 hours a day, 7 days a week, and then it’s that 24 hour a day being on call for the agency and there’s really no benefit to them. So it’s a life style issue, that is actually a deterrent to being on the team.” [Key Stakeholder ID1]

- ***Inequity between agencies regarding visit reimbursement:*** Although some advancement had been made in addressing reimbursement issues related to how visits were paid so that the Resource Nurses were reimbursed fairly for their time,¹⁷ there continues to be reimbursement issues related to the lack of remuneration for extended travel time and inequitable reimbursement for time spent conducting visits across agencies (per visit vs. per hours, e.g., so that a 15 minute visit when paid per visit could be reimbursed similar to a 1.5 hour visit when paid by the hour; those being paid by visit are paid more for their time); there is a perception that nurses are being penalized when a visit is long; salaried positions were identified as a potential solution to this issues.
- ***Maintaining On-call responsibilities:*** Changes to on-call expectations (no daytime on-call; daytime requests managed by primary agencies) have reduced challenges associated with managing palliative clients with Resource Nurses’ regular nursing caseload. However, on occasion, Resource Nurses will be asked to see a client on an urgent basis (“STAT”), however this is disruptive to their regular caseload and can put them 3 – 4 hours behind in visiting clients. It was suggested that dedicated Resource

¹⁷ Reimbursement was changed so that each Resource Nurse visit was considered the equivalent of two home visits.

Nurses may relieve this pressure, however as the caseload may not be able to sustain a full-time dedicated position, it might be difficult to fill this kind of position.

“Occasionally they’ll get a call from CCAC wanting [Resource Nurses] to go and see somebody as soon as possible, and everyone’s aware that they’re not an emergency kind of response team, but they are expected to go in as soon as they can sometimes, and that presents a challenge because if they’ve got a pretty full day already planned with their clients, then if they have to go and see somebody as soon as they can then all those people that they had booked for the day are going to be late, so its trying to handle all that, and tell people that you could be 2 or 3 hours late.” [Key Stakeholder ID6]

“Well because of changes in staffing not all of the agencies have a full 3 people on the resource team, so I feel that we’re burning them out because we are relying on them on almost an emergency or priority basis and they have full case loads to deal with on their own, plus the list. And then we ask them to put all that on hold to go out and see someone you know, immediately so they can get care, and then they are still expected to fulfill their case loads and it’s hard when there’s only you know 2 that we can rely on from some of the agencies.” [Key Stakeholder ID7]

- **Unclear understanding of the Resource Nurse role:** It was noted that on a few occasions primary nurses, family physicians, and clients were not clear on the role on the Resource Nurse and expected the nurse to provide direct patient care. There is a need to ensure that it is clear that the Resource Nurse role is a consultation service and not a direct care service, which is the role of the primary community nurse.

Implementation/ service delivery issues:

- **Limited support from some family physicians:** It was noted that while support from family physicians for the work of the team has increased significantly since the inception of the team, there continues to be some physicians who not fully acknowledge the expertise of the team, including the NP, and are not willing to accept recommendations for patient care. It was noted that there have been situations in which a family physician would not support the referral to the team so that clients felt that they needed to give up their physician in order to be involved with the team.
- **Limited family physician capacity for palliative care:** It was noted that limited family physician knowledge about palliative and end-of-life care has challenged nurses to provide optimal care.

“Well some of [the family physicians] don’t realize things like if somebody is having problems with pain they don’t know all the education that we’ve got. The doctor may say: ‘Well start them on a patch.’ We’ve learned that you don’t just start someone on the patch who’s not been on opiates before. And they don’t all know that. And its happened before where they’ve started somebody on a patch in between the nurses visits.” [Key Stakeholder ID6]

“Family doctors are really hard to get a hold of, there’s only a few that you can really get, even during the day, let alone after hours. Some of these family doctors, their

patients have advanced cancer and when they have increased pain or they have symptoms, they should be seen urgently because it can be something dangerous. But they don't kind of prioritize them any different from somebody who has a cough, and who's given an appointment in two weeks, well that clearly isn't right. [PCCT 3]

- **Variability in palliative care knowledge and skills among primary nurses:** It was noted that variability in the palliative care knowledge and skills among primary nurses can pose a challenge when those with limited palliative care experience are challenged to implement recommendations made by the team.

"[Provider agencies] are continually changing personnel and some of the front line workers just don't get it, I mean they don't have the experience and the confidence and we've had some problems there. Unfortunately it goes all the way up the line and some of the people who are supposed to be teaching them aren't probably as sharp as they should be, so that's an issue." [PCCT ID3]

Related to this, it was noted that some primary care nurses are not recognizing the need to contact Resource Nurses. Ongoing education for primary nurses was suggested as a strategy to overcome this challenge.

"There's a big gap around the primary nurses not calling the resource nurses, I'm pretty sure that the agencies are encouraging and talking about this, at the agencies and team meetings, but part of the issue I think is the ability of the primary nurse to recognize that there is an issue, and recognize that she's not managing it and it's about their education too." [PCCT ID4]

It was noted the some primary nurses would not assume the Resource Nurse position because of their lack of understanding of what palliative care entails; their misunderstanding of the field creates unfounded fears of nursing in palliative care.

"They're like: 'I don't do dying. ...I can do a good IV but I don't want to do palliative.' They're terrified, absolutely terrified. We try and get that message out that palliative doesn't mean you're dying, for sure it means you have a life threatening illness, we're going to keep you comfortable and it could take your life, but that doesn't mean they're end stage as soon as they're told they're palliative." [PCCT ID1]

- **Limited availability to Nurse Practitioner off hours:** As the team NP currently works a compressed work week, she is not always available to consultation and home visits. It was suggested that this role is critical to the team, there should be additional NPs to provide 24/7 coverage.

"[The NP] works 12 hour days and takes 1, 2 days off during the week and she's also doing on call for [palliative care physician] for her own education. So if she's doing the clinic then that takes her away from our patients in the community...it would just be nice to have her another couple days. It would be nice to have somebody 24/7 I guess, because things don't usually happen Monday to Friday." [Key Stakeholder ID2]

- **Limited access to interprofessional care:** With the initial success of the team Social Worker, Occupational Therapist, and Chaplain, it was noted these services are in greater demand but are currently limited in the amount of time that they are available to work on the team. It was suggested that access to these services be increased.

Logistical issues

- **Lack of timely communication of clients to be discussed at rounds:** It was noted that Resource Nurses sometimes are not notified about which clients will be discussed at rounds until the day before the meeting, so that they do not have adequate time to update themselves on the client's progress. Attempts to get primary nurses to provide regular updates on PCCT clients has been difficult given their workload, vacations, and staff turnover. This challenge was also identified in the initial evaluation of the team.
- **Limited communication between Resource Nurses and palliative care physician:** It was noted that there is sometimes limited two-way communication between the Resource Nurses and the palliative care physician. They may send a note the physicians outlining recommendations but do not received feedback on what decisions have been made; Nurses have noted discomfort on relying on clients to report on changes made to the care plan.

“One of the problems that we’re hearing is that the nurses will send in a letter to the doctor with the client, when they go see our palliative doctor, they don’t get it back with his response on the bottom. And they would really like that to happen. Because he will sometimes tell the client well you can take 2 of those pills now every 4 hours, but the nurse isn’t notified and they don’t like the idea of relying on what the patient says when there’s changes involved.” [Key Stakeholder ID6]

- **Travel time:** Due to the large geography of the region travel time in rural areas can be quite lengthy and can significantly increase (e.g., by 1.5 – 2.0 hours) the amount of time required to complete the visit. As mentioned the Resources Nurses are not reimbursed for travel, thus creating a disincentive for the role.

“Some places are maybe an hour away, so they’re driving an hour, they’re there for 1, 2 or 3 hours, then they drive back and that could be 4 -5 hour sand they’re only getting paid two visits, you know, and with all that time involved, that’s a lot of time they could have been in town, now they’ve spent 5 hours for 2 visits, and they could have got 6 visits in if they were working around town.” [Key Stakeholder ID 6]

Resolution of challenges identified in the initial evaluation: The initial evaluation of the PCCT identified a number of challenges related to service delivery issues related to limited use of Resource Nurses, facilitating trust among provider agencies, and timely access to nursing support and the logistics of implementing the team. There was general consensus among the key stakeholders and PCCT representatives that were interviewed that for the most part these challenges have been resolved. The only identified challenged that continues to be an issue is limited support from some family physicians, though it was generally noted that this has improved greatly with the introduction of the LEAP training and physician’s experience with the benefits associated with team. Similarly, logistical issues related to communication among key

players, determining eligibility for the PCCT, service delivery issues imposed by geographical boundaries, and billing issues associated with nurses visiting other-agency clients, have largely been resolved. Although occasionally there continues to be issues associated with pagers not working in certain areas of the region, this is an ongoing issue that affects all community-based care providers and to date has not been problematic. Limited reimbursement for on-call time was identified as a challenge in the previous evaluation and although improvements have been made to financial compensation for visits, adequate reimbursement continues to be an issue for Resource Nurses and their agencies. Similarly, adequate lead time to prepare for case review at rounds continues to be an ongoing challenge for Resource Nurses.

3.4.3 Suggestions for Improvements

Key stakeholders survey respondents identified a number of suggestions for improving the service provided by the team:

- Hire at least one more Nurse Practitioner
- Increase number of Resource Nurses per community service provider agency to prevent burn out of existing Resource Nurses
- Succession planning for palliative care physicians
- Increase access to Nurse Practitioners, Social Workers, and Occupational Therapists on weekends
- Rotate staff within community service provider agencies to act as Resource Nurses in order to increase the capacity of all primary nurses for palliative and end-of-life care.
- Ongoing education and mentoring for all team members (CCAC Internal Providers) and Resource Nurses
- Provide funding for transportation from home to hospice (municipal or private transportation)
- Improve communication with team and among team members by:
 - Allowing verbal referrals in crisis situations, as electronic processing of referrals creates a delay
 - Ensure/ improve documentation of visits made by case managers, nurse practitioners, and physicians, especially when there are medication changes.

These suggestions are reflected in the following comments:

“More NP, expertly trained nurses and physicians. It is the physician and nurses who are making the difference with clients staying at home for as long as possible or preventing unnecessary ED assessments. There needs to be increased education also for OT if that role continues (I do not feel it impacts client ability to stay at home or manage better at home, assess also not taking into account clients condition, inability to operate suggested equip). Also, team members - SW, OT only available Mon - Fri, NP works compressed work week, and also unavailable due to # of meetings etc. One other thing is team is set up in "consultative role" not hands on role, which also increased the # of providers having to see clients.”

“The driving force behind the palliative care community model in Sarnia-Lambton directly revolves around the core palliative physicians. Without them the palliative care system would be incomplete and a return to increased ER visits would occur. Succession planning for palliative physicians is paramount.”

“Importance of education for more nurses for quality assessments and more resources for shift care to maintain client in their home, rather than admit to hospice.”

“More verbal referral and interaction with team, due to sudden changes in clients referred to the PCCT there is not always the time for electronic processing. If NP is a way or not available there needs to be an approach that considers the client’s needs.”

“I feel that the team members should rotate in each organization. This would enable other members of the organizations to gain valuable expertise and expand the role of palliative EXPERT to more nurses.”

“Hire at least one more nurse practitioner in order to allow for more rapid responses to patient’s needs. One NP tends to be overworked and is being pulled in many directions.”

“We need more resource nursing in the community. The staff are becoming over worked and are not available for PCCT resource nursing visits some of the time due to their large visiting lists for the day. It makes it hard for them to fit in our palliative visits that require a quick response. We may need an extra layer of resource nursing that could be alternated through to allow time for the three from each agency at present time to have a break.”

Interviewed key stakeholder and PCCT representatives identified a number of suggestions for improvements, sustainability and further development of the PCCT; some of these suggestions address the challenges were identified earlier. Suggestions were also made regarding general improvements to palliative care service delivery in this region; these suggestions are summarized in Table 16.

Table 16: Summary of Suggestions for Improvements to the PCCT and Palliative Care in General

Suggestions for improvements, sustainability and further development

- Provide ongoing opportunities for advanced palliative care education
 - Recruit more Resource Nurses
 - Succession planning for team member roles
 - Expand and sustain the NP role
 - Increase education opportunities for family physicians
 - Resolve Resource Nurse visit reimbursement issues
 - Create opportunities for team building
 - Market/ promote the Resource Nurse Role
 - Promote the team more widely outside of the region
 - Increase time allotted for social work and chaplaincy services
 - Explore opportunities for using Occupational Therapists to the full scope of their practice
 - Recognize Case Managers as formal members of the PCCT
 - Improve communication between team physician and Resource Nurses
 - Create clear criteria for Resource Nurse activities
 - Ensure wise accountability and allocation of funding
 - Provide Resource Nurses enough lead time to prepare for rounds
-

General suggestions for improvements to palliative care

- Increase opportunities for palliative care education for hospital staff
 - Increase availability of shift nursing hours at end of life
 - Improve financial support for clients
 - Identification of patients presenting in the Emergency Department with palliative issues who are not currently connected with palliative services
 - Increase availability of respite to support caregivers
-

Suggestions for improvements, sustainability and further development

- ***Provide ongoing opportunities for advanced palliative care education*** to Resource and primary nurses and other team members. Suggested topics included: diabetes and other chronic disease management, medication management and CADD pumps, and PPS and ESAS capacity building among primary nurses. It was suggested that primary nurses have more opportunities and be encouraged to complete the Fundamentals of Palliative Care Education, Advanced Palliative Care Education Program and the CAPCE program. It was noted that the EOLCN Education Blueprint has increased opportunities for palliative care education and has contributed significantly to improved palliative care in this region; there is support for continuing this across sector strategy for education to ensure quality and continuity of care. Similarly, it was suggested that funding be made available for team members and Resources Nurses to attend provincial and national conferences as an opportunity to promote the team and network with other palliative care professionals.
- ***Recruit more Resource Nurses*** to reduce risk of burn out for existing nurses. Suggestions for recruiting more nurses included: rotation of the Resource Nurse role within agencies to reduce risk of burnout and build capacity over time among primary nurses, and agencies generating greater than 70% of care volumes should be supplying more Resource Nurses to the team as they have a greater staffing pool to draw upon. It was noted that is important to ensure the most appropriate nurses, with some existing capacity and expertise in palliative care (CAPCE training at a minimum) be selected for the role.
- ***Succession planning for team member roles*** especially the physician and Resource Nurse role was identified as critical to the sustainability of the team.
- ***Expand and sustain the NP role*** as it is critical to supporting both the team physician and Resource Nurses as well as other team members.
- ***Increase education opportunities for family physicians*** such as LEAP training, dinner meetings with specific topics and guest speakers, and consider financial incentives for their participation in training events. Similarly, increase opportunities for family physicians to become more familiar with the expertise of team members.
- ***Resolve Resource Nurse visit reimbursement issues*** considering a number of strategies such as retaining the Resource Nurse position as a salaried position and provision of payment for travel time in excess of a specified period of time (e.g., 30 minutes).

- **Create opportunities for team building** to nurture team relationships and capacity. As an example it was suggested that a weekend event/ retreat be held as facilitated by an external facilitator as opportunity to identify and discuss issues affecting the team and working relationships in a safe environment.
“I see that Sarnia Lambton has gone through the forming and norming to some degree, they’ve gone through the honeymoon stage and now they’re kind of in that phase where there needs to be some intentional work done to maintain the team.”
 [PCCTID4]
- **Market/ promote the Resource Nurse Role** to increase awareness of the role so that it is used appropriately as a consultation service and to encourage other primary nurses to assume the role.
- **Promote the team more widely outside of the region** in order to celebrate successes and provide other regions with a viable strategy to improve palliative care.
- **Increase time allotted for social work and chaplaincy services** to increase client access to these services and meet the increasing demands for these services.
- **Explore opportunities for using Occupational Therapists to the full scope of their practice** as it is a role that has the potential to be more active than it is currently.
- **Recognize Case Managers as formal members of the PCCT** as they contribute to care coordination
- **Improve communication between the team physician and Resource Nurses** as related to changes to the care plan
- **Create clear criteria for Resource Nurse activities** so that it is clear when they provide a consultation service and when they can provide direct service. It was suggested that an algorithm be developed to show the criteria used to determine when direct care is provided.
- **Ensure wise accountability and allocation of funding** to reduce risk of losing on-going funding.
- **Provide Resource Nurses enough lead time to prepare for rounds** as obtaining updates from primary nurses is time consuming.

General suggestions for improvements to palliative care

- **Increase opportunities for palliative care education for hospital staff** (ED and inpatient medical units) to ensure continuity of care; although there have been increased education opportunities through the EOLCN Education Blueprint, there continues to be a need for more capacity building in hospital settings (ED and inpatient units).

- **Increase availability of shift nursing hours at end-of-life** to better support more clients at home. It was noted that it is difficult to staff 24 hour nursing care in the community as many nurses choose community nursing to avoid 24 hours shifts. Moreover, given that community nurses are paid less than nurses working in hospital, if they were to do 24 hours shifts within the community they would switch sectors in order to be better compensated.
- **Improve financial support for clients** needed support to cover care related expenses.
- **Identification of patients presenting in the Emergency Department with palliative issues who are not currently connected with palliative services** so that they can access care that goes beyond just treatment for the issue that brought them to hospital and availability of comprehensive assessment to inform the development of treatment plans to prevent unnecessary visits to hospital.
- **Increase availability of respite to support caregivers** (reduce caregiver stress and burden) so that they are better able to manage their loved one's care at home.

3.4.4 Key Lessons Learned In the Ongoing Implementation of the PCCT

The following resources and supports were identified as important for expansion/ creation of PCCTs in other areas:

- **Expert human resources are essential**, namely a physician with expertise in and passion for palliative care and the ability to build team relationships and capacity and a NP to support the team physician, Resource Nurses, and other team members. The team physician and NP are perceived as vital to ensure timely access to care.
- **Capacity building for Resource Nurses** is necessary to ensure retention and succession planning.
- **Succession planning** is necessary to ensure sustainability of the team; attention should be paid to ensuring that succession planning is in place for all positions on the team.
- **Ongoing education and team building opportunities** are needed for all team members to ensure that they are informed of new information and advances in the field. Ongoing team building was valued to support healthy and functional working relationships.
- **Dedicated funding is essential** as the team cannot be effective within existing resources.
- **Interprofessional care reinforces a holistic approach to care** and enhances quality of care; interprofessional care includes occupational therapists, social workers, chaplains and music therapists.
- **Team building takes time** and continuous attention to the identification and resolution of issues that threaten the effectiveness of the team.

4.0 Conclusions

Based on the findings of this evaluation, the following conclusions can be made about the Palliative Care Consultation Team:

- The PCCT continues to provide a vital palliative and end-of-life care service in Sarnia Lambton. There is much support for team; it has been well received by caregivers, health professionals across disciplines and key stakeholders across sectors. The team has had significant impact on increasing timely client and caregiver access to expert support. This support has improved patient care, has prevented unnecessary visits to the Emergency Department and has contributed to reduced lengths of hospital stay for clients involved with the team. The introduction of a Nurse Practitioner, Social Worker and Chaplain to the team has increased the team's capacity to respond to crises and to provide a more holistic approach to end-of-life care. This client-centred approach to care is further supported by the availability of in-home laboratory services and extended equipment rental.
- The team continues to achieve its objectives related to improved client care as well as health system improvements related to improved care coordination, efficient use of existing resources and reduced use of acute care resources (i.e., reduced ED visits and admissions). Although there are positive impacts associated with being a member of the team, such as increased job satisfaction and increased opportunity for capacity building in palliative care, challenges identified in this evaluation related to the Resource Nurse role places them at high risk for burnout and threaten their sustainability on the team. Attention to and resolution of these challenges will go far to supporting and sustaining their role on the team. Suggestions for improvements identified by key informants for this evaluation can also further support the efforts of team, such as opportunities for team building (e.g., team retreat), improving communication, and building capacity for interprofessional care. Commitment to team building has been identified as a key characteristic of effective health care teams.¹⁸
- Despite some implementation and logistical challenges, team members are very satisfied with their accomplishments as are key stakeholders. The team has in its favor inherent characteristics of effective health care teams: good collaboration and communication and attention to conflict resolution.¹⁹ Continued attention to the identification and resolution of challenges will work to further support the sustainability of the team. A significant challenge to the work of the team is the limited capacity for palliative care among some family physicians in the region. This challenge was also identified in the initial evaluation of the team and is well documented in the literature.²⁰ Although beyond the scope of the team to resolve, suggestions for increased access to LEAP training and opportunities to learn about the expertise of the team may help to ameliorate this issue.

¹⁸ Mickan, S.M., & Rodger, S.A. (2005). Effective health care teams: A model of six characteristics developed from shared perceptions. *Journal of Interprofessional Care*, 19(4), 358-70.

¹⁹ Lemieux-Charles, L., & McGuire, W.L. (2006). What do we know about health care team effectiveness: A review of the literature. *Medical Care Research Review*, 63(3), 263-300.

²⁰ Grande, G.E., Barclay, S.I., Todd, C.J., (1997). Difficulty of symptom control and general practitioners' knowledge of patients' symptom. *Palliative Medicine*, 11(5), 399-406.

Groot, M.M., Vernooji-Sassen M.J., Crui, B.J., & Grol, R.P. (2006). General practitioners (GPs) and palliative care: perceived tasks and barriers in daily practice. *Palliative Medicine*, 2005; 19(2): 111-8.

Marshall, D., Howell, D., Brazil, K., Howard, M., & Taniguchi, A. (2008). Enhancing family physician capacity to deliver quality palliative home care. An end-of-life shared care model. *Canadian Family Physician*, 54, 1703e1-7.

- A significant theme arising from this evaluation is improved coordination of palliative care across sectors. A number of factors contribute this improvement: the efforts of the PCCT and its strong partnership with St. Joseph's Hospice and Bluewater Health (hospital), the increased use of standardized assessment tools such as the PPS and ESAS, which work to create a common language to facilitate continuity of care across sectors, as well as increased educational opportunities as provided through the ESC Education Blueprint. Ongoing capacity building through opportunities for palliative and end-of-life education across sectors and disciplines will work to further facilitate an integrated palliative care system in this region.
- There is much support in the literature for the establishment of palliative care teams as an opportunity to improve quality and coordination of palliative care and to reduce costs associated with acute care use.²¹ However, despite the research evidence to support the use of palliative care teams, very few exist in community settings across the province. The continued success of the Sarnia Lambton PCCT makes it a potential model for other regions of the province with lessons learned in the development and implementation of the team informing expansion in other areas. To this end, the work of the team should be promoted. Attendance and presentations at regional, provincial, and national conferences would allow the team to celebrate its successes and also to network with other palliative care experts to learn about new best practices and opportunities for on-going performance improvement. Capacity building opportunities for team members were supported by key informants in this evaluation as an opportunity to retention membership and sustain the team.

Limitations: Data related to impacts of the team on the health care system is largely anecdotal. Empirical evidence based on hospital data (e.g., ED readmission rates, reduced hospital admissions, reduced length of hospital stay) among PCCT clients and a comparison group (of clients not seen by PCCT) would provide stronger evidence of the PCCT's ability to manage care effectively within the community. It is acknowledged that availability of this data related specifically to palliative care is limited. Some of the data that was initially to be included as part of the description of the client population served and the services provided by the team were not available either because they are not tracked and/ or not easily accessible. For example, PPS scores are recorded on clients individual consultation reports, but these are not entered into an information system, the palliative care physicians' visits are not tracked as this position on the team is not internal to the CCAC (thus not tracked in CHRIS), and date of referral to the team is not tracked in the CHRIS so it is not possible to calculate timeliness of access to service once referred (e.g., referral date minus the date of first contact with the team²²). Although the perspective of consumers is highly valued and the evaluation plan included interviews with the caregivers of PCCT clients, it was extremely difficult to access these individuals for inclusion. At the time that team members were providing information to caregivers about the evaluation study, many of the clients were either in crisis or in transition between sectors so that it was an inappropriate time to recruit them for the evaluation.

²¹ Hearn, J. & Higginson, I.J. (1998). Do specialist palliative care teams improve outcomes for cancer patients? A review of the literature. *Palliative Medicine*, 12, 317-332.

Speck, P. (2006). *Teamwork in palliative care*. London: Oxford University Press.

²² Date of referral was recently added to the CHRIS, so this information may be available in the future.

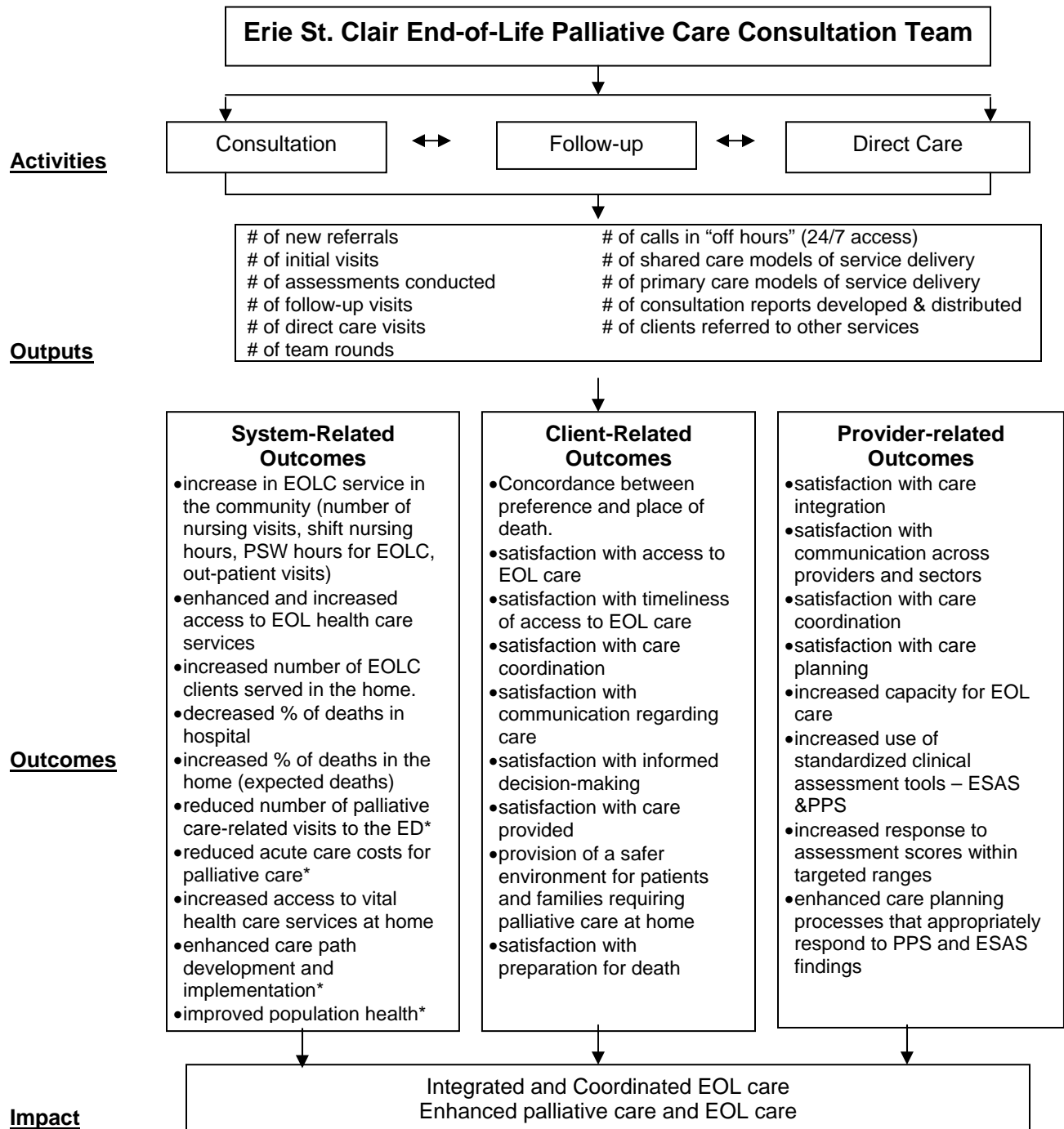
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Program Logic Model



EOL = End-of-life; EOLC – End-of-life care; ED = Emergency Department
 * long-term outcomes that require >2-3 years for evidence of achievement

Evaluation Framework

Objective 1: describe the services provided by the Palliative Consultation Team and the population served

Outcomes	Indicators	Sources of Information	Design/ Timeline
Description of services provided by the PCCT	<ul style="list-style-type: none"> • Number/type of professionals on the team • # of new referrals • Referral sources • # of initial visits • # of assessments conducted • # of follow-up visits • # of direct care visits • #of calls in “off hours” (24/7 access) • # of each type of model of service delivery (shared care with primary care, consultation only, consultation and follow-up) • # of consultation reports developed & distributed • Providers receiving a consultation report (primary care, client, Community Support Service agency, CCAC, acute care) • # of clients referred to other services • time per visit, per client • # of team members involved per client • Disciplines of team members involved per client • # of visits per client per team member (NP, SW, Chaplain, OT, MD, others) • # of clients on each team members’ case load. • # of clients seen by Physician. • Location of service (home/ clinic/ other location) 	CHRIS; additional information generated by team /administrative assistant as needed	Sarnia Lambton: Service tracking from January 1, 2009 to September 30, 2010. Chatham Kent: January 2010 – September 2010

Outcomes	Indicators	Sources of Information	Design/ Timeline
	<ul style="list-style-type: none"> • Length of client stay on service • Response time to referrals • Response time to consultation report distribution • Place of client death 		
Description of the patient population served by the PCCT	<ul style="list-style-type: none"> • Age • Gender • Place of residence • Available caregiver support • Location at time of assessment • Diagnosis • Palliative Performance Score • Place of death 	CHRIS; additional information generated by team /administrative assistant as needed	Sarnia Lambton: Service tracking from January 1, 2009 to September 30, 2010. Chatham Kent: January 2010 – September 2010

Objective 2: Identify the impacts associated with the Palliative Consultation Team

Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
<p><u>Client-related:</u></p> <ul style="list-style-type: none"> • Concordance between preference and place of death. • satisfaction with access to EOL care • satisfaction with timeliness of access to EOL care • satisfaction with care coordination • satisfaction with communication regarding care • satisfaction with informed decision-making • satisfaction with care provided • satisfaction with preparation for death 	Caregiver ratings of satisfaction	90% of patients/ caregivers satisfied with service	CHRIS; additional information generated by team /administrative assistant as needed Caregiver Interviews	Satisfaction interviews (telephone) conducted with caregivers of clients on the PCCTs current caseload; to be conducted in August-September 2010
<ul style="list-style-type: none"> • provision of a safer environment for patients and families requiring palliative care at home 	Key stakeholder reports of safer home environments for EOL care as a result of the PCCT	90% of providers reporting safer home environments for EOL care as a result of the PCCT	Key stakeholder survey Key stakeholder interviews	Key stakeholder survey distributed in September 2010 Key stakeholder interviews conducted in Sept/ October 2010

Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
<p><u>Provider-related outcomes:</u></p> <ul style="list-style-type: none"> • satisfaction with care integration • satisfaction with communication across providers and sectors • satisfaction with care coordination • satisfaction with care planning • increased capacity for EOL care 	<p>Provider ratings of satisfaction</p> <p>Provider ratings of increased capacity for EOLC as a result of the PCCT</p>	<p>90% of providers satisfied with care integration, coordination, planning and communication</p> <p>90% of providers reporting increased capacity for EOLC as a result of the PCCT</p>	<p>Key stakeholder survey</p> <p>Key stakeholder interviews</p>	<p>Key stakeholder surveys distributed in September 2010</p> <p>Key stakeholder interviews conducted in September/ October 2010</p>
<ul style="list-style-type: none"> • increased use of standardized clinical assessment tools – ESAS & PPS • increased response to assessment scores within targeted ranges • care planning processes which appropriately responded to PPS and ESAS findings. 	<p>Documented use of ESAS & PPS in client records (e.g., reports, assessments etc)</p>	<p>90% of clients screened for symptom severity using the ESAS</p> <p>90% of clients have functional status assessed using the PPS</p> <p>Scores used to inform care planning for 90% of clients</p>	<p>CHRIS – potential information on use of PPS – to be explored further</p> <p>Provider agencies – potential information on use of ESAS – to be explored further</p>	<p>Sarnia Lambton: Service tracking from January 1, 2009 to September 30, 2010.</p> <p>Chatham Kent: January 2010 – September 2010</p>

Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
<p><u>System-related outcomes:</u>²³</p> <ul style="list-style-type: none"> • Increase in EOLC service in the community • Enhanced and increased access to EOL health care services • Increase in number of EOLC clients served in the home. 	<ul style="list-style-type: none"> • increase number of nursing visits • increase in shift nursing hours • increase in PSW hours for EOLC • increase in number of visits to outpatient clinic 	<p>2% increase in MIS 95 coded volumes in 2009/2010 compared to 2007/2008 in the following categories:</p> <ul style="list-style-type: none"> • total number of clients • total number of visits/hours-nursing/PSW/social work <p>2% increase in number of clinic visits in 2009/2010 compared to 2007/2008</p>	CHRIS: CCAC code 95	Retrospective analysis of submitted data
Decrease in % of deaths in hospital	<p>Key stakeholder/ PCCT perceptions of impact of the team on the % of deaths in hospital</p> <p>Number of palliative care related deaths in hospital</p>	<p>Perceptions of reduced % of deaths in hospital</p> <p>Reduced number of palliative care related deaths over time</p>	<p>Key stakeholder survey</p> <p>Key stakeholder and PCCT interviews</p> <p>Hospital data (Chatham-Kent Health)</p>	<p>Key stakeholder survey distributed in September 2010</p> <p>Key stakeholder interviews conducted in</p>

²³ Note: Data on many of the system related outcomes are not available to due to how information systems code and record data. For example, it is not possible to identify the number of palliative care related visits to the Emergency Department because “palliative care” is not a code used to track ED visits; presenting problems are coded according to symptom (e.g., abdominal pain, shortness of breath) so that it is not possible to indentify palliative care related visits by presenting problem.

Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
			Alliance) – Z51.5 codes for palliative deaths in hospital	September/ October 2010 Quarterly reports of palliative care related deaths in hospital
Increase in % of deaths in the home (expected deaths with EDITH protocols in place)	Percent increase in home deaths in 2009/2010 compared to quarterly reports in 2007/2008.		CHRIS (potentially – to be explored further)	
Reduced hospital length of stay	Key stakeholder/ PCCT perceptions of impact of the team on the hospital length of stay	Perceptions of reduced hospital length of stay	Key stakeholder survey Key stakeholder and PCCT interviews	Key stakeholder survey distributed in September 2010 Key stakeholder interviews conducted in September/ October 2010
Reduction in number of palliative care-related visits to the ED	Key stakeholder/ PCCT perceptions of impact of the team on ED use	Perceptions of reduced ED visits	Key stakeholder survey Key stakeholder and PCCT interviews	Key stakeholder survey distributed in September 2010 Key stakeholder interviews conducted in September/ October 2010

Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
	Caregiver reports of ED visits in previous 30days; perceptions of impact of the team on ED use	Perceptions of reduced ED visits	Caregiver Interviews	Satisfaction interviews (telephone) conducted with caregivers of clients on the PCCTs current caseload; to be conducted in August-September 2010
	ED avoidance (change in service status)	Increase in number of ED avoidances over time	CHRIS	Service tracking from January 1, 2009 to date.
	ED diversions (intervention prevents ED visit)	Increase in number of ED diversions over time	CHRIS	Service tracking from January 1, 2009 to date.
Reduced hospital admissions	Caregiver reports of hospital discharge in previous 7 days, and number of hospital admissions in previous 90 days Reduction in palliative care related hospital admissions over time.	Perceptions of reduced hospital admissions Number of palliative care related hospital admissions	Caregiver Interviews Discharge Abstract Database (DAD) ²⁴ – number of admissions related to palliative care.	Satisfaction interviews (telephone) conducted with caregivers of clients on the PCCTs current caseload; to be conducted in August-September 2010

²⁴ DAD is a database maintained by the Canadian Institute for Health Information (CIHI) that maintains information on hospital admissions and discharges. This data will be accessed for the Chatham-Kent Health Alliance.

Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
				DAD data for 2009 and 2010
Reduced acute care costs for palliative care	Long-term outcome – unable to evaluate in the short time frame of this evaluation			
Reduced hospital admissions through the Emergency Department vs Direct admissions (for patients requiring admission to hospital).	Key stakeholder reports	Increase in direct admissions to palliative care unit	Key stakeholder interviews	Key stakeholder interviews conducted in September/ October 2010
Increased access to vital health care services at home	Key stakeholder (Provider) reports of increased access	90% of providers reporting safer home environments for EOL care as a result of the PCCT	Key stakeholder survey Key stakeholder interviews	Key stakeholder survey distributed in September 2010 Key stakeholder interviews conducted in September/ October 2010
Enhanced care path development and implementation	Long-term outcome – unable to evaluate in the short time frame of this evaluation			
Improved population health	Long-term outcome – unable to evaluate in the short time frame of this evaluation			

Objective 3: Describe the development and implementation of the Palliative Consultation Team

Outcomes	Indicators	Sources of Information	Design/ Timeline
<p>Description of the development and implementation of the PCCT (ongoing development and implementation for Sarnia Lambton; initial development and implementation for Chatham Kent)</p>	<ul style="list-style-type: none"> • Factors that facilitated or enabled the ongoing development and implementation of the PCCT • Challenges, or barriers, to role development and implementation • Resolution of challenges identified in the initial evaluation of the Sarnia Lambton PCCT • Service delivery issues • Key lessons learned in ongoing implementation • Suggestions for improvement? For sustainability? For expansion to other counties? • Next steps/ goals for the PCCT? 	<p>Key stakeholder interviews</p>	<p>Key stakeholder interviews conducted in September/ October 2010</p>

Referral and Service Tracking: List of Information Tracked

Referrals/ Services:

- # of referrals to team
- # of referrals per month
- # of clients on active caseload
- # of clients discharged from service
- # of clients that have died
- Length of stay on service (measured in days)
- # of “on call” contacts calls
 - # of contacts with core team members as a result of “on call” contact
- Discharge disposition
 - # of clients that died at home
 - # of clients that died in hospital
- Service recipient categories at time of referral
- # of home laboratory service orders
- # of team members involved per client
- Discipline of team members involved per clients
- # of visits per client per team member
- # of client interactions considered Emergency Department avoidance/ diversion
 - # of clients with an interaction considered ED avoidance/ diversion

Client demographics:

- Age
- Gender
- Living arrangements
- Diagnosis at time of assessment

Caregiver Satisfaction Interview Guide

1. Interview with:

- the caregiver of a patient? What is your relationship to the patient?
 - Spouse/partner
 - Child
 - Extended family member
 - Friend
 - Other, please specify: _____

Is your care receiver still at home? Yes No
 Care receiver is in hospital: Yes No
 Care receiver is in hospice: Yes No
 Care receiver has died:²⁵ Yes No

2. I'd like to ask you about how satisfied you were with various aspects of the Team.

Overall, how satisfied were you with your first visit with the team? I'm going to read out some words that describe different levels of satisfaction and I'd like you to select the one that best describes how satisfied you were with your first visit with the Team.

Extremely dissatisfied	Very dissatisfied	Somewhat dissatisfied	Not satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Extremely satisfied
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3. How satisfied were you with the amount of time that you waited to see the team, that is, the timeliness in which you saw them?

Extremely dissatisfied	Very dissatisfied	Somewhat dissatisfied	Not satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Extremely satisfied
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4. How satisfied were you with the way your loved one's care was coordinated with all the other health professionals that were involved, such as your family physician, visiting nurses, or the hospital? (Prompt: For example, all the other services and supports outlined in the care plan were in place, for example, the pharmacy was informed of drug changes, the visiting nurse provided necessary equipment)

Extremely dissatisfied	Very dissatisfied	Somewhat dissatisfied	Not satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Extremely satisfied
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²⁵ This was not an interview question, but was discerned from the conversation with the care giver.

5. How satisfied were you with the way the team responded to your questions and concerns?

Extremely dissatisfied Very dissatisfied Somewhat dissatisfied Not satisfied nor dissatisfied Somewhat satisfied Very satisfied Extremely satisfied

6. How satisfied were you the level of communication among all of the different care providers or services involved in your loved one's care? (Prompt: did everyone know what they needed to do as part of the care plan that was in place?)

Extremely dissatisfied Very dissatisfied Somewhat dissatisfied Not satisfied nor dissatisfied Somewhat satisfied Very satisfied Extremely satisfied

7. How satisfied are you that you have had enough information with which to make treatment or care decisions?

Extremely dissatisfied Very dissatisfied Somewhat Dissatisfied Not satisfied nor dissatisfied Somewhat satisfied Very satisfied Extremely satisfied

8. Do you think that the Team helped you to be a better caregiver, that is, did they give you information or suggestions that helped you to better care for your loved one at home?

- Yes
- No
- Not sure

9. Did the team offer you with emotional or spiritual support?,

- Yes No

If yes, did you accept a visit from the team Chaplain or Social Worker?

- Yes No

If yes, how satisfied are you with the way your needs for emotional or spiritual support were met?

Extremely dissatisfied Very dissatisfied Somewhat Dissatisfied Not satisfied nor dissatisfied Somewhat satisfied Very satisfied Extremely satisfied

Do you have any comments you would like to make about this?

10. Did the team suggest or recommend any special equipment for you to have at home, for example, a walker or bathroom equipment such as shower grab bars, raised toilet seat, or shower bench?

Yes No

If yes, did you accept this recommendation for equipment?

Yes No

If yes, how satisfied are you with the way the team met your needs for equipment at home?

Extremely dissatisfied	Very dissatisfied	Somewhat Dissatisfied	Not satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Extremely satisfied
---------------------------	----------------------	--------------------------	--------------------------------------	-----------------------	-------------------	------------------------

Do you have any comments you'd like to make about this?

11. In the event that clients have died:

Did your loved one die at home? in hospital? in long-term care? hospice?

10.1 Was this the plan?

Yes No Not sure

10.2 Do you have any comments you'd like to make about this? (Prompts: What did you think about this? Was this the location you wanted?)

11.3 How satisfied were you with the way in which your loved one's care was managed at the end of his/her life?

Extremely dissatisfied	Very dissatisfied	Somewhat dissatisfied	Not satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Extremely satisfied
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12. For clients who have not died:

How satisfied are you with the way that you and your loved one have been prepared for what will happen next?

Extremely dissatisfied	Very dissatisfied	Somewhat dissatisfied	Not satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Extremely satisfied
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13. Do you think that the help that you've received from the team has helped to keep your loved one out of the hospital or from visiting the Emergency Department?
- Not sure
 - No
 - Yes – in what ways (how) has the team done this?
14. Could you please tell me about at least one thing that you really liked about the team and service or care they provided?
15. Was there anything that you didn't like about the team and the service or care they provided?
16. Do you have any suggestions for improving the services or care provided by the team or for improving palliative care or end-of-life care in general?
17. We are at the end of the interview now, do you have any final or additional comments that you'd like to make about the team or the care you have received?

Key Stakeholder Survey

you for taking the time to complete this survey. Your opinions are important to us. **This survey is anonymous and confidential – you do not need to give your name and we will not collect any information that will tell us who you are.**

Please note that this survey is not intended to evaluate the performance of any particular Palliative Care Consultation Team member, but is intended as an evaluation of the role of the team in palliative care service delivery.

1. In the past three months, how much contact have you had with members of the team in regards to clients you are dealing with who require palliative care?

- In regards to more than 21 clients
- In regards to 11 – 20 clients
- In regards to 6 – 10 clients
- In regards to 1 – 5 clients
- Not at all

2. Overall, how would rate the work of the Team?

Poor fair good very good excellent

3. How satisfied are you with the following elements of the team?

	Not at all satisfied 1	2	3	4	Extremely satisfied 5
Timeliness of access to assessment	1	2	3	4	5
Follow-up	1	2	3	4	5
Direct provision of care	1	2	3	4	5
Quality of assessment	1	2	3	4	5
Treatment recommendations/ planning	1	2	3	4	5
Provision of multidisciplinary/ interprofessional care	1	2	3	4	5
Availability of team members for informal consultation (questions, follow-up)	1	2	3	4	5

11. Do you think that the work of the Team has helped to keep clients out of the hospital or from visiting the Emergency Department?

- Not sure
- No
- Yes – in what ways (how) has the Team done this?

12. What impact do you think the Team has had on the following uses of the health care system.

As a result of the work of the Team has...	Increased	Stayed the Same	Decreased
client's length of hospital stay...	Increased	Stayed the Same	Decreased
the number of clients dying in hospital....	Increased	Stayed the Same	Decreased
access to vital health care services at home....	Increased	Stayed the Same	Decreased

Additional Comments

Do you have any additional comments you would like to make about the Team or the provision of palliative and end-of-life care in this region?

Demographic Information

The following information will be used to analyse the results and will be reported as group information only. It will NOT be used in an attempt to identify you.

Tell us about yourself:

Which of the following best describes your discipline/profession?

- Physician
- Registered Nurse
- Registered Practical Nurse
- Personal Support Worker
- Nurse Practitioner
- Case Manager
- Agency nursing supervisor
- Pharmacist
- Volunteer coordinator
- Pastoral/spiritual care
- Other, please specify: _____

Which of the following best describes your practice setting?

- Community-based agency/ organization
- Hospital
- Private Practice
- Long-term care
- Other, please specify:

How many years have you been employed in your current profession? _____ years

What percentage of the clients that you work with require palliative or end-of-life care?

- Not applicable
- None
- Less than 25%
- 26% - 50%
- 51% - 75%
- Over 75%

Which of the teams have you been involved with?

- Sarnia Lambton
- Chatham Kent
- Both teams

You have come to the end of the survey. Thank you for completing this survey.

Guide for the Interview with Key Stakeholders

Potential Impacts

We're interested in learning more about the impacts associated with the team.

1. What are some of the patient-related impacts or positive outcomes associated with the Team?

Prompts:

Patient-related outcomes:

- Concordance between preference and place of death
- satisfaction with access to EOL care
- satisfaction with timeliness of access to EOL care
- satisfaction with care coordination
- satisfaction with communication regarding care
- satisfaction with informed decision-making
- satisfaction with care provided
- satisfaction with the provision of multidisciplinary/ interprofessional care
- satisfaction with the provision of emotional and spiritual support
- satisfaction with provision of equipment (assistive devices, equipment for home safety)
- provision of a safer environment for clients and families requiring palliative care at home
- satisfaction with preparation for death

2. What are some of the care provider-related impacts or positive outcomes associated with the Team?

Provider-related outcomes:

- satisfaction with care integration
- satisfaction with communication across providers and sectors
- satisfaction with care coordination
- satisfaction with care planning
- increased capacity for EOL care – access to EOL education/ resources
- increased use of standardized clinical assessment tools – ESAS & PPS
- increased response to assessment scores within targeted ranges
- enhanced care planning processes that appropriately respond to PPS and ESAS findings

3. What are some of the health system-related impacts or positive outcomes associated with the Team?

System-related outcomes:

- care planning that's responsive to PPS and ESAS findings
- increase in EOLC service in the community (number of nursing visits, shift nursing hours, PSW hours for EOLC, out-patient visits)
- enhanced and increased access to EOL health care services
- increased number of EOLC clients served in the home.
- decreased visits to ED/ hospitalizations
- decreased % of deaths in hospital
- increased % of deaths in the home (expected deaths with the home pronouncement plan in place)
- increased access to vital health care services at home

4. Can you provide an example based on your experience to illustrate a key impact of the Team? Can you share with me any cases that stand out in your mind as being particularly illustrative of the benefits associated with the Team?

Development and Implementation of the Palliative Care Consultation Team

I'd like to discuss the development and implementation of the Palliative Care Consultation Team.

I'd like to start by talking about the secondary expert team from the service provider agencies (Resource Nurses).

Do you have any comments to make about the secondary level expert team? (facilitating factors, challenges, suggestions for improvement)?

- a. To what extent were they able to manage their on-call responsibilities (timeliness, quality of care)?
- b. What suggestions for further education/ capacity building do you have for secondary expert team members?

I'd like to now focus on the development and implementation of the Palliative Care Consultation Team.

5. What has worked well with the (Sarnia Lambton: ongoing) development and implementation of the Team? What are some of the things that facilitated its development and implementation (e.g., needs, support)?
6. The results of the initial evaluation of the team identified some challenges related to service delivery and day to day logistical issues. To what extent do think that these challenges have been resolved:
Service delivery issues:
- Limited use of resource nurses
 - Limited family physician support
 - Facilitating trust among provider agencies
 - Timely access to nursing support

Logistical issues:

- Communication among key players
- Determining eligibility for the PCCT
- Issues of pagers not working in certain areas of the region
- Service delivery issues imposed by geographical boundaries
- Limited reimbursement for on-call time
- Billing issues associated with nurses visiting other-agency clients

For those issues that still pose a challenge: Do you have any suggestions for overcoming these challenges/ barriers?

Are there any other or new challenges that have been experienced to date with the team? What some of the factors that hindered optimal implementation (barriers at individual, project, system levels)?

7. What suggestions do you have for improvement, sustainability or further development and implementation of the Team?
8. Do you have any general suggestions for enhancing palliative or end-of-life care service delivery in this region?

Additional Comments

Do you have any additional/final comments you'd like to make about the Team?

Guide for the Interview with PCCT Members and Leaders

Development and Implementation of the Palliative Consultation Team

We're interested in learning more about the implementation of the team over the past year.

1. What has worked well with the (Sarnia Lambton: ongoing) development and implementation of the Team? What are some of the things that has facilitated its ongoing development and implementation (e.g., needs, support)?
2. What are some of the challenges that have been experienced to date with the team? What are some of the factors that hindered optimal implementation (barriers at individual, project, system levels)?
3. Do you have any suggestions for overcoming these challenges/ barriers?
4. The results of the initial evaluation of the team identified some challenges related to service delivery and day to day logical issues. To what extent do think that these challenges have been resolved:
 - Service delivery issues:
 - Limited use of resource nurses
 - Limited family physician support
 - Facilitating trust among provider agencies
 - Timely access to nursing support
 - Logistical issues:
 - Communication among key players
 - Determining eligibility for the PCCT
 - Issues of pagers not working in certain areas of the region
 - Service delivery issues imposed by geographical boundaries
 - Limited reimbursement for on-call time
 - Billing issues associated with nurses visiting other-agency clients

For those issues that still pose a challenge: Do you have any suggestions for overcoming these challenges/ barriers?

5. Are there any service delivery issues that have not already been identified that threaten the effectiveness of the team or palliative/ end-of-care service delivery in this region?
6. What do you think are some of the key lessons learned in the development and implementation of the Team?
7. What suggestions do you have for improvement, sustainability or further development and implementation of the Team in this setting?

Expansion to other counties

8. What do you think needs to be in place in order for the expansion of this initiative to other counties? What resources/ supports are needed for expansion to be successful?
9. Do you have any general suggestions for enhancing palliative or end-of-life care service delivery in this region?

Potential Impacts

10. What are some of the patient-related impacts or positive outcomes associated with the Team?

Prompts:

Patient-related outcomes:

- Concordance between preference and place of death
- satisfaction with access to EOL care
- satisfaction with timeliness of access to EOL care
- satisfaction with care coordination
- satisfaction with communication regarding care
- satisfaction with informed decision-making
- satisfaction with care provided
- satisfaction with the provision of multidisciplinary/ interprofessional care
- satisfaction with the provision of emotional and spiritual support
- satisfaction with provision of equipment (assistive devices, equipment for home safety)
- provision of a safer environment for clients and families requiring palliative care at home
- satisfaction with preparation for death

Provider-related outcomes:

- satisfaction with care integration
- satisfaction with communication across providers and sectors
- satisfaction with care coordination
- satisfaction with care planning
- increased capacity for EOL care – access to EOL education/ resources
- increased use of standardized clinical assessment tools – ESAS & PPS
- increased response to assessment scores within targeted ranges
- enhanced care planning processes that appropriately respond to PPS and ESAS findings

System-related outcomes:

- care planning that's responsive to to PPS and ESAS findings

- increase in EOLC service in the community (number of nursing visits, shift nursing hours, PSW hours for EOLC, out-patient visits)
- enhanced and increased access to EOL health care services
- increased number of EOLC clients served in the home.
- decreased visits to ED/ hospitalizations
- decreased % of deaths in hospital
- increased % of deaths in the home (expected deaths with home pronouncement plans in place)
- increased access to vital health care services at home

11. Can you provide an example based on your experience to illustrate a key impact of the Team? Can you share with me any cases that stand out in your mind as being particularly illustrative of the benefits associated with the Team?

Additional Comments

Do you have any additional/final comments you'd like to make about the Team?

Results of the Referral and Service Tracking

Note: Percentages may not sum to 100% due to missing data.

REFERRALS	Number
Number of clients of referred: ²⁶ (April 1, 2009 – September 30, 2010)	341
Referrals per month:	
April 2009	17
May 2009	20
June 2009	21
July 2009	12
August 2009	19
September 2009	23
October 2009	17
November 2009	24
December 2009	21
January 2010	12
February 2010	16
March 2010	21
April 2010	21
May 2010	20
June 2010	27
July 2010	17
August 2010	15
September 2010	18
Average per month (+/-)	18.9 (3.9)
Range	12 – 27
Number of months	18
Number of clients on active caseload:	23.8% (81)
Number of discharges from Service:	76.2% (260)
Number of clients that have died	205/260 (78.9%)
Length of stay on service	
Average (+/-) days	70.7 (79.7)
Range	0 ²⁷ – 345
Number of clients	260

²⁶ For seven clients, the team (Sarnia Lambton or Chatham Kent) to which they were referred is not known. This may be due to a number of reasons: the referral is pending or the client was originally registered with the Patient Master Index, the information system used by the CCAC prior to the use of the CHRIS, so that this information was not recorded. These seven clients are not included in the total number of clients referred to the Sarnia Lambton PCCT.

²⁷ 0 Length of stay = same day service and discharge

REFERRALS	Number
Discharge Disposition: ²⁸	
Hospitalized (>14days)	12.7% (33)
Died (while under CCAC care) ²⁹	57.7% (150)
Died in hospital (< 14 days)	21.2% (55)
Admitted to Long-Term care	2.3% (6)
Client preference ³⁰	1.2% (3)
Treatment complete	1.9% (5)
Service incomplete – change in service specialty	0.4% (1)
Other	2.3% (6)

CLIENT POPULATION	Percentage (#) N = 341
Age (at time of referral):	
< 19 years	0.3% (1)
20 – 49 years	6.2% (21)
50 – 59 years	15.2% (52)
60 – 69 years	25.8% (88)
70 – 79 years	26.1% (89)
80 – 89 years	21.4% (73)
> 90 years	5.0% (17)
Age (years)	
Average (+/-)	70.0 (13.5)
Range	12 – 95
Gender:	
Female	50.4% (172)
Male	49.6% (169)
Living Arrangements:	
Alone	17.0% (58)
Spouse/ Life partner	49.6% (169)
With Spouse and family	8.2% (28)
With family	7.6% (26)
Non-private residence	0.9% (3)
Other arrangement	1.8% (6)
Diagnosis (at time of assessment):	
Cancer ³¹	83.3% (284)
Other conditions	16.7% (57)

²⁸ Percentages are based on the number of clients discharged from service per team (N = 260). Note: Clients admitted to Hospice are not discharged from the team.

²⁹ This represents the number of clients that have died at home.

³⁰ Client has chosen to no longer receive service.

³¹ Lung cancer: N = 82; 24.0%; GI (esophagus, bowel, intestines, colon): N = 51; 15.0%; Breast: N = 28, 8.2%; Prostrate: N = 14; 4.1%; Leukemia/ Lymphoma (Hodgkin's & Non-Hodgkins): N = 7; 2.1%; All other types (cervix, ovary, endometrium, brain, gall bladder, liver, kidney, pancreas, occur in less than 7, 2.1%, clients each): N = 102, 29.9%.

Service/ Care Provision	Percentage (#)
Service Recipient Categories at Time of Referral (N = 341):³²	
Acute	1.2% (4)
End of Life	79.8% (272)
Long Term Supportive	10.6% (36)
Maintenance	7.9% (27)
Rehabilitation	0.6% (2)
Home Laboratory Services (May 1 – October 29, 2010)	5
Number of Interactions with CCAC Internal Providers (Core Team Members):	985
Number of interactions per client:	
Average (+/-)	7.4 (9.1)
Range	1 – 63
Number of clients	134
CCAC internal providers involved per interaction (N = 985):	
Nurse Practitioner	34.9% (344)
Occupational Therapist	36.9% (363)
Chaplain	8.5% (84)
Respiratory Therapist	2.9% (29)
Social Worker	16.8% (165)
Average number of CCAC internal providers involved per client (N = 134)	
Average (+/-)	1.5 (.73)
Range	1 – 4
1 service involved	58.2% (78)
2 services involved	32.1% (43)
3 services involved	7.5% (10)
4 services involved	2.2% (3)

³² * Clients' overall service goals at the time of admission. *Acute*: to address the client's need for short term education, care or support as a result of illness, disability or injury; *End of Life*: to alleviate distressing symptoms to achieve the best quality of life by providing complex support in the last stages of their illness; *Long term support*: to delay institutionalization by providing supportive care, and relief of symptoms to preserve the client's level of function and autonomy, OR the client is in a Residential hospice setting. *Maintenance*: to maintain the client's independence by preventing/ minimizing the premature decline in health and/or functional status; *Rehabilitation*: to optimize the client's functional status within limits of their disability and to facilitate social integration and independence.

Service/ Care Provision	Percentage (#)
Type of Interactions (N = 985):	
Case Conference	0.5% (5)
Face-to-face visit	48.2% (475)
Telephone call	51.3% (505)
Number of Consultations with CCAC Internal Providers (Core Team Members):	224
Number of consultations per client:	
Average (+/-)	3.0 (3.1)
Range	1 – 18
Number of clients	76
Number of client interactions considered hospital avoidance/ diversion	298
Number of clients with an interaction considered hospital avoidance/ diversion (N = 341)	12.6% (43)
Average number of interactions per client considered hospital avoidance/ diversion (N = 43)	
Average (+/-)	4.42 (4.6)
Range	1 - 18
Number of ‘On-Call’ interactions	86
Number of ‘On-Call’ interactions per provider agency (N = 86)	
Provider A	48.8% (42)
Provider B	32.6% (29)
Provider C	17.4% (15)
Type of On-Call interaction (N = 86)	
Telephone consults	68.6% (59)
Face-to-face visits	31.4% (27)
On-Call telephone consults - discipline involved (N = 59)	
Resource Nurse	100% (86)
Physician ³³	22.0% (19)
Nurse Practitioner ³⁴	1.2% (1)

³³ This indicates the number of times a Resource Nurse contacted a physician as a result of an “on-call” telephone contact with a client.

³⁴ This indicates the number of times a Resource Nurse contacted a Nurse Practitioner as a result of an “on-call” contact with a client.

Service/ Care Provision	Percentage (#)
On-Call face-to-face consults – discipline involved (N = 27) Resource Nurse Physician ³⁵	100% (27) 3.7% (1)

³⁵ This indicates the number of times a Resource Nurse contacted a physician as a result of an “on-call” face-to-face contact with a client.

Results of the Key Stakeholder Survey

N = 19 (79.2% response rate)

Note: Percentages may not sum to 100% due to missing responses.

In the past three months, how much contact have you had with members of the team in regards to clients you are dealing with who require palliative care?

57.9% (11)	In regards to more than 21 clients
5.3% (1)	In regards to 11 – 20 clients
26.3% (5)	In regards to 6 – 10 clients
5.3% (1)	In regards to 1 – 5 clients
5.3% (1)	Not at all

Overall, how would rate the work of the Team?

poor	fair	good	very good	excellent
0	0	26.3% (5)	42.1% (8)	31.6% (6)

How satisfied are you with the following elements of the team? (5-point rating scale: 1 = not all satisfied; 5 = extremely satisfied)

	Avg (+/-)	Range
Timeliness of access to assessment (N = 18)	4.06 (1.0)	2 – 5
Follow-up (N = 19)	4.11 (.81)	2 – 5
Direct provision of care (N = 19)	4.37 (.68)	3 – 5
Quality of assessment (N = 19)	4.32 (.75)	3 – 5
Treatment recommendations/ planning (N = 19)	4.26 (.87)	3 – 5
Availability of team members for informal consultation (questions, follow-up) (N = 19)	4.05 (1.0)	2 – 5
Communication between the team and other care providers (N = 19)	3.79 (1.1)	1 – 5
Integration of care across care providers (N = 19)	3.72 (1.3)	1 – 5
Integration of care across health sectors (community – hospital) (N = 19)	3.84 (1.2)	1 – 5

	Avg (+/-)	Range
Care coordination (N = 19)	4.00 (1.0)	2 – 5
Patient/ family readiness for death (N = 19)	4.21 (.92)	2 - 5
Capacity building for end of life care (education/ resources) for team members, including Resource Nurses (N = 19)	4.16 (.90)	2 - 5
Ability to support clients to die in their preferred location (N = 18)	4.56 (.71)	3 – 5

Do you have any suggestions for how the team can improve the services it provides to clients, caregivers, and other care providers or how it can better support your efforts to assess and manage clients requiring palliative or end-of-life care? (N = 10; 52.6%)

- *More verbal referral and interaction with team, due to sudden changes in clients referred to the PCCT there is not always the time for electronic processing. If NP is a way or not available there needs to be an approach that considers the client's needs.*
- *Require more Nurse Practitioners on the Team*
- *We need a paper trail of every visit made to clients by Nurse Practitioners, case managers and Doctor to primary nurse especially if medications are added or discontinued in their home.*
- *I feel that the team members should rotate in each organization. This would enable other members of the organizations to gain valuable expertise and expand the role of palliative EXPERT to more nurses.*
- *Hire at least one more nurse practitioner in order to allow for more rapid responses to patient's needs. One NP tends to be overworked and is being pulled in many directions.*
- *I am in a supportive capacity for the team and do not provide direct care. My answers may skew this survey. One way to continue to improve individual team members performance is for one to one mentoring.*
- *Intentional mentoring of each PCCT team nurse.*
- *More NP, expertly trained nurses and physicians. It is the physician and nurses who are making the difference with clients staying at home for as long as possible or preventing unnecessary ED assessments. There needs to be increased education also for OT if that role continues (I do not feel it impacts client ability to stay at home or manage better at home, assess also not taking into account clients condition, inability to operate suggested equip). Also, team members - SW, OT only available Mon - Fri, NP works compressed work week, and also unavailable due to # of mtgs etc. One other thing is team is set up in "consultative role" not hands on role, which also increased the # of providers having to see clients*
- *Better team education would assist in providing enhanced expert care.*
- *We need more resource nursing in the community. The staff are becoming over worked and are not available for PCCT resource nursing visits some of the time due to their large visiting lists for the day. It makes it hard for them to fit in our palliative visits that require a quick response. We may need an extra layer of resource nursing that could be alternated through to allow time for the three from each agency at present time to have a break.*

Impacts

As a result of the team, do you think that the overall quality of palliative and end-of-life care provided to clients has:

63.2% (12)	Much improved
31.6% (6)	Improved
0	Neither improved nor worsened
0	Worsened
0	Much worsened

How would you rate the current level of safety within home environments for end-of-life care? (5 point rating scale: 1 = not at all safe; 5 = extremely safe) (N = 18)

4.11 (.58)	Average (+/-)
3 – 5	Range

How does this compare with the level of safety within home environments prior to the inception of the Team?

Less safe now 1	2	About the same 3	4	More safe now 5
0	10.5% (2)	36.8% (7)	15.8% (3)	26.3% (5)

As a result of the Team, do you think that your use of standardized clinical assessment tools (e.g., ESAS, PPS) has:

36.8% (7)	Much increased
31.6% (6)	Increased
26.3% (5)	Neither increased nor decreased
0	Decreased
0	Much decreased

Overall, how would you rate your current ability to manage clients requiring palliative care (within your scope of practice)? (5-point rating scale: 1 = not at all capable; 5 = extremely capable) (N=12)

0	Not applicable
4.67 (.49)	Average (+/-)
4 – 5	Range

How does this compare with your ability to manage clients requiring palliative care (within your scope of practice) prior to the inception of the Team?

I am now less capable 1	2	About the same 3	4	I am now more capable 5
0	5.3% (1)	31.6% (6)	21.1% (4)	36.8% (7)

As a result of your involvement with the Team, do you think that the quality of care you provide to clients requiring palliative or end-of-life care has:

42.1% (8)	Much improved
47.4% (9)	Improved
5.3% (1)	Neither improved nor worsened
0	Worsened
0	Much worsened

Are you able to identify any key, or most significant, impacts/ outcomes associated with the Team? These impacts can be patient/caregiver, health professional, or health system-related.

63.2% (12)	No
15.8% (3)	<p>Yes, please describe:</p> <ul style="list-style-type: none"> • Access to a doctor when needed to prevent hospital (emerg) visits. 2. Overall knowledge to anticipate and prevent and actively manage calmly difficult symptoms at home. • PCCT/Oncology Team collaboration and involvement with all engaged community partners and those in the circle of care to ultimately assist/enable the Client to reach their end of life goals, i.e., to pass away at home or the local Hospice. • people are wanting to stay at home the team makes it possible • The availability of spiritual/consultative care has helped the clients feel more connected to the care pathways provided by the entire team. • Increase communication from hospital to community to hospice. All speak the same "language" • More timely access to service • During the course of my internship I have created a case study outlining effective strategies to reduce a client's ESAS Anxiety Scores through Music Therapy interventions. • Increase in ER avoidance. The ability of our palliative physician to direct admit patients to Palliative Care at Bluewater Health is also advantageous. • Patients now have a choice to stay at home with adequate support and symptom management and education regarding the issues they face. More focused and appropriate use of the ED and hospital PCU. Health grief follows a "good death". • increased knowledge of nurses when assessing clients symptoms to prevent ED assess (if physician available to call - works best with Dr Maddison/ Dostaler/ Kolano and a couple of GP's)

	<ul style="list-style-type: none"> • <i>I am finding that we have been able to keep more patients at home (by their choice) when they have very complex issues/concerns. As opposed to before the team, these patients would have been sent to hospital.</i> • <i>The ability to speak directly with the NP or GP in charge of the situation and make changes to the service plan as appropriate in a short period of time has helped to keep the client in their home and create hospital avoidance.</i>
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Do you think that the work of the Team has helped to keep clients out of the hospital or from visiting the Emergency Department?

10.5% (2)	Not sure
0	No
68.4% (13)	<p>Yes – in what ways (how) has the Team done this?</p> <ul style="list-style-type: none"> • <i>Prevention/ anticipation of problems 2. Extensive teaching with families and patients 3. Access to NP and physician to deal with problems at home</i> • <i>Averting hospital/ER admissions/visits by managing the Client in their home, through the professional expertise and compassion of all Team members to create a comfortable and safe home environment, enabling the Client to best achieve their end of life goals.</i> • <i>By having direct, immediate access to Nursing, nurse practitioners and physician this has definitely impacted the patient's ability to remain in their home for treatment instead of the Emergency departments. Access to immediate care is important to patient's and their families.</i> • <i>Sometimes it is simply pain control, nursing care, emotional and spiritual care now we come to them.</i> • <i>Through home assessments, trouble shooting at home, access to palliative physician 24/7 and anticipation of complications that may occur, better education to families and clients</i> • <i>More phone calls to the home Seeing the client and giving reassurance and making clients aware the team is available 24 hours/day Having a Nurse Practitioner involved</i> • <i>The fact that Dr. Maddison and the team of palliative physicians is so readily available</i> • <i>Nurse Practitioner & resource nurse home visits often instrumental in avoiding unnecessary ER visits. Nurses can consult with palliative physician from the home and adjust meds/address medical issues.</i> • <i>allowed a broader scope of options available at home so they could avoid a visit to ER</i> • <i>Education for pt and family support in decision-making management of issues at EOL timely response and support in EOL crises.</i> • <i>Usually - due to speaking with physicians post assess of client to manage symptoms in the home. Still further education needs to be done</i> • <i>Better able to provide care in the home (through collaboration b/w doctor, NP's, nurses, SW, and OT...). Through education and communication, people are collaborating with one another to solve the complex concerns.... as opposed to before the automatic response to any of the concerns would have been "You need to go to the hospital/ER".</i> • <i>Able to provide bowel management, pain management and medication</i>

	<i>management in the home. Comfort measures for the client and family members with appropriate health teaching given.</i>
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What impact do you think the Team has had on the following uses of the health care system.

As a result of the work of the Team has...	Increased	Stayed the Same	Decreased
client's length of hospital stay...	0	21.1% (4)	57.9% (11)
the number of clients dying in hospital....	0	15.8% (3)	63.2% (12)
access to vital health care services at home....	68.4% (13)	10.5% (2)	0

Do you have any additional comments you would like to make about the Team or the provision of palliative and end-of-life care in this region?

- *Need more resource nurses in each agency - we get burned out with small numbers; more well trained nurses, the better for whole area/ county.*
- *The Team is composed of individuals who have a passion for palliative and end-of-life care. The individuals I have had the opportunity to work with have consistently demonstrated Client centered practice and their commitment to providing the best service(s) to end of life Client's in Lambton and Chatham County.*
- *I think we have a great system working here in this region. We are very lucky and blessed to have great care providers that other communities do not have available yet. We are inspiring other communities to provide the same quality of care we have and we are definitely leading the way for quality patient care in this province.*
- *I believe from a chaplaincy perspective that society is learning how to die with dignity and in the presence of family familiar surroundings*
- *Team has been a great asset in this region and hope to continue providing a team effort and build up on the expertise between each professional. Education on end of life care always needs to be ongoing with changes in health care and how it is provided*
- *The driving force behind the palliative care community model in Sarnia-Lambton directly revolves around the core palliative physicians. Without them the palliative care system would be incomplete and a return to increased ER visits would occur. Succession planning for palliative physicians is paramount.*
- *The team is an excellent role model for other areas. Using experienced nurses and supporting them with NP and physician and pastoral care and social to provide holistic care in the home. On-going education is happening with interdisciplinary rounds twice a week. One on one mentoring would also enhance their practice.*
- *Importance of education for more nurses for quality assessments and more resources for shift care to maintain client in their home, rather than admit to hospice*
- *Funds for transportation by ambulance or Voyageur from home to hospice need to be addressed. Funds for equipment rentals beyond what CCAC provides of one month*

needs to be address. Clients are often unable to manage the financial commitment following the one month assistance by CCAC.

Demographic Information

Which of the following best describes your discipline/profession?

0	Physician
26.3% (5)	Registered Nurse
5.3% (1)	Registered Practical Nurse
0	Personal Support Worker
0	Nurse Practitioner
21.1% (4)	Case Manager
0	Agency nursing supervisor
0	Pharmacist
0	Volunteer coordinator
5.3% (1)	Pastoral/spiritual care
21.1% (4)	Other, please specify: <ul style="list-style-type: none"> • Clinic administration • Music therapist • Occupational therapist • Social work

Which of the following best describes your practice setting?

63.2% (12)	Community-based agency/ organization
5.3% (1)	Hospital
5.3% (1)	Private Practice
0	Long-term care
5.3% (1)	Other, please specify: <ul style="list-style-type: none"> • Across all sectors

How many years have you been in employed in your current profession? (N = 14)

19.21 years (13.2)	Average (+/-)
1 – 45	Range

What percentage of the clients that you work with require palliative or end-of-life care?

0	Not applicable
0	None
0	Less than 25%
10.5% (2)	26% - 50%
21.1% (4)	51% - 75%
47.4% (9)	Over 75%