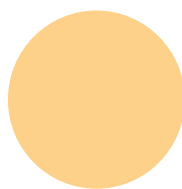
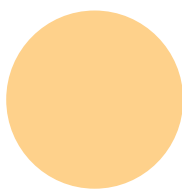
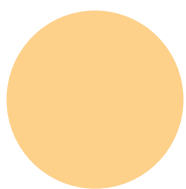


The Pan-Canadian Gold Standard for Palliative Home Care

Toward Equitable Access to High Quality Hospice Palliative and End-of-Life Care at Home



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Canadian Hospice Palliative Care Association
Association canadienne de soins palliatifs



Canadian Home Care Association
Association canadienne de soins et services à domicile

The Gold Standard for Case Management for Hospice Palliative and End-of-Life Care at Home

Palliative home care is provided by a number of different professionals, volunteers and family members who work together as a team to meet the client's physical, psychological, emotional, social, spiritual, practical, end-of-life care and grief needs as well as the family's needs. Team members collaborate to provide comprehensive, coordinated, compassionate care that can enhance the client's/patient's and family's quality of life throughout the advanced illness, the process of dying, the last days of living, the event of death, and bereavement.

Case management is “a collaborative client-driven strategy for the provision of quality health and support services through the effective and efficient use of resources in order to support the client’s achievement of goals.”

Canadian Home Care Association (CHCA)

Team members work effectively together to coordinate care for the client/patient and family, and ensure they have access to the services they need when they need them. Effective case management strategies help link the client/patient, family and palliative home care team with other health and social services in the community, such as hospital services, hospice care, legal advice, and mental health services. Case management includes identifying and understanding the client/patient's and family's needs, communicating clearly with the client/patient, family and other service providers, identifying and coordinating

services for the client and family, educating clients/patients, families and other service providers about the services available, and advocating on behalf of the client/patient and family for timely access to services to meet their needs. It also includes making the most effective use of resources for the client and family, and for the health care system.⁵

Effective case management is an essential part of the care provided for all home care clients, but it is particularly important for people receiving palliative home care because:

- their health and needs may change often and suddenly
- their family is likely to have intense psychological, spiritual and practical needs.

Case management is part of the scope of practice of all health professionals. Organizations providing palliative home care may take a range of approaches to managing and coordinating care. Some will have designated or specialized case managers, whose only role is to provide case management services. Some will assign the case management responsibilities to one member of the palliative home care team, such as a nurse, social worker or personal care worker. In some cases, all members of the team are responsible for implementing case management strategies.

Regardless of how home care organizations provide case management, they should strive to meet the pan-Canadian Gold Standard for Case Management in Palliative Home Care, which is based on the Norms of Practice for Hospice Palliative Care in Canada.⁶

⁵ Canadian Home Care Association, 2005, Case Management: A Strategy for Health Systems Integration

⁶ Canadian Hospice Palliative Care Association, 2002 A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice. See also Nursing Gold Standard.

The Gold Standard for Case Management for Hospice Palliative and End-of-Life Care at Home

1. Home care organizations have a timely responsive process for designating clients/patients who need hospice palliative care.

Some clients will be referred to home care for hospice palliative care; others will develop hospice palliative care needs in the course of receiving home care. Home care organizations have the clinical skills to determine when clients with complex illnesses (e.g., Alzheimers Disease, multiple sclerosis, renal disease) require hospice palliative care.

Eligibility for palliative home care is not based solely on an arbitrary time limit (e.g., six months from death), but on the client's need for hospice palliative care. Even clients in the early phases of a life-threatening illness who are receiving curative treatment may benefit from hospice palliative care services, such as pain and symptom management and comfort care. Hospice palliative care is appropriate for clients whose goals include reducing suffering and improving or maintaining quality of living and dying. As their illness progresses, the clients' need for hospice palliative care will tend to increase, while interventions aimed at cure will decrease.

To ensure that clients who need and would benefit from palliative home care services receive them, organizations have a process to assess where a client is in the illness trajectory and to match services to client needs.

2. Clients/patients and their families have access to timely, knowledgeable, compassionate case management, 24 hours a day, seven days a week.

All clients/patients nearing end of life, regardless of diagnosis, race, religion, culture or sexual orientation have access to timely compassionate case management, 24 hours a day, seven days a week. Case management services are designed to address a client's or family's urgent needs as they arise, avoid inappropriate use of emergency and acute care facilities, and keep the client/patient at home as long as possible.

Home care staff work with the larger hospice palliative care team to help clients and families access the right service at the right time depending on their hospice palliative care needs. The mix of providers on the team is based on the client's needs and care plan. The team includes or has access to an on-call physician experienced in hospice palliative care who can adjust orders and medications to meet client needs.

Clients/patients and their families are informed about the range of services and resources – including spiritual and cultural supports – available in the community and how to access them (i.e., either directly or through the hospice palliative care team). They also know who to contact on the care team or at the home care organization with any questions or requests for services.

Jurisdictions explore the use of innovative approaches to provide equitable access to hospice palliative care case management in their regions, such as tele-homecare or using the expertise of other services in the community (e.g., social workers, on-call physicians).

3. Home care organizations that provide palliative home care services establish and maintain partnerships with other service providers required for effective case management.

Home care organizations are knowledgeable about the other services in their community, including spiritual and cultural services, and how they can be used to help palliative home care clients and their families.

Because the needs of someone who is dying at home can change suddenly, the home care program has in place the partnerships, protocols and mechanisms to support timely referrals to key services, such as hospitals, residential hospice programs and respite programs. It is particularly important to have established agreements in place for clients/patients with complex needs (e.g., renal disease, Alzheimers Disease) and those whose needs can no longer be met at home.

The home care team has access to advice and support from hospice palliative care specialists as needed.

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4. Home care providers identify effective case management strategies that reflect the client's/patient's needs and the family's needs and respect diverse cultural beliefs.

Assessment of client and family needs is key to effective case management. Each client's disease management, physical, psychological, social, spiritual, practical, end-of-life and grief needs are identified initially and throughout the time they are receiving palliative home care – as are the family's physical, psychological, social, spiritual, practical and grief needs. Any cultural needs or expectations are also identified.

The needs assessment is used to guide case management and the process of providing care (see Figure 1: The Square of Care) both within the home care program and with other health and social services. Case management strategies are identified based on the client's goals of care.

The home care organization uses a standard needs assessment process and procedures, which include the events or situations that trigger a reassessment.

5. Case management is provided by professionals who have appropriate knowledge and skills.

Palliative home care case management is provided by knowledgeable professionals who have: strong communication skills, advocacy skills, problem-solving skills, negotiation skills, interpersonal skills, cultural competency and experience. The professionals providing case management are also knowledgeable about the health care services in their community and the needs of people nearing end-of-life at home and their families.

To ensure that providers responsible for case management have the knowledge, skills and judgment to support the hospice palliative client and his or her family and to integrate services, the home care organization provides appropriate ongoing interprofessional education and training in hospice palliative care, case management and cultural competency, including distance education for those working in rural and remote areas. The home care organization also provides appropriate support and supervision, including a focus on care for the caregivers.

6. Members of the care team have the information systems and communication tools to support collaborative practice and effective case management/continuity of care.

Communication among all members of the hospice palliative care team – including the client's family physician – is essential to collaborative practice and effective case management. The home care organization develops and maintains information systems and other tools to support effective case management, including assessment protocols, care plans, a common or interdisciplinary client/patient chart, case conferences, regular meetings with the family, service agreements and other mechanisms as required. Providers develop and use evidence-informed case management strategies that make optimal use of the skills and competencies of all providers and community services, and support continuity of care.

7. Canadians are aware of hospice palliative care options available to them, including palliative home care.

As jurisdictions develop their palliative home care services, they educate their citizens about the services and supports provided through federally and provincially funded palliative home care programs. Case managers inform individuals and families of the full range of options, services and supports available to meet their needs so more people consider palliative home care as a viable end-of-life choice.

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8. Home care organizations in partnership with other parts of the health system track services available in their communities for people receiving end-of-life care at home, identify gaps and work collaboratively to meet needs.

Home care organizations are in a strong position to identify the services required to support people who choose to die at home as well as their families, and to identify gaps in service in the community. In their role in hospice palliative care case management, they have a responsibility to track, evaluate and plan for services, and to work with other providers to develop a continuum of hospice palliative care services for their communities.

9. Jurisdictions monitor the quality and effectiveness of hospice palliative care case management strategies.

As part of program evaluation and strategic planning, jurisdictions consistently assess the quality and impact of hospice palliative care case management strategies, using both quantitative and qualitative tools. Home care organizations use this information to refine and improve case management at end-of-life. This information is also used to determine how home care contributes to achieving system goals for hospice palliative care.

Jurisdictions consistently support research that leads to innovation in hospice palliative care case management and improves client and family outcomes.