THE *REAL* PROMISE-PALLIATIVE CARE AS PUBLIC HEALTH

HEALTH SYSTEM PERFORMANCE RESEARCH NETWORK
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Public Health Functions

- To assemble and analyze community health needs for disease prevention, health promotion and protection
- To develop health policy through scientific knowledge
- To assure the community by providing health protection services

What is a Public Health Problem?

- Prevalence of condition or exposure
- Impact of condition on society
- Condition is preventable
- Effective interventions available
- Equity considerations

Four Key Questions

1. What health event is to be prevented?
2. What practices and behaviours will be promoted?
3. Who is being protected from what harm?
4. Are we improving community health in an equitable manner (i.e. Special consideration for marginal and vulnerable populations)?

Five Good Reasons

1. Demographics and Population Shift
2. Unmet Need
3. Feasibility
4. Accountability
5. Justice and Equity

The prevalence of human mortality is stable

We know who dies, when and where…

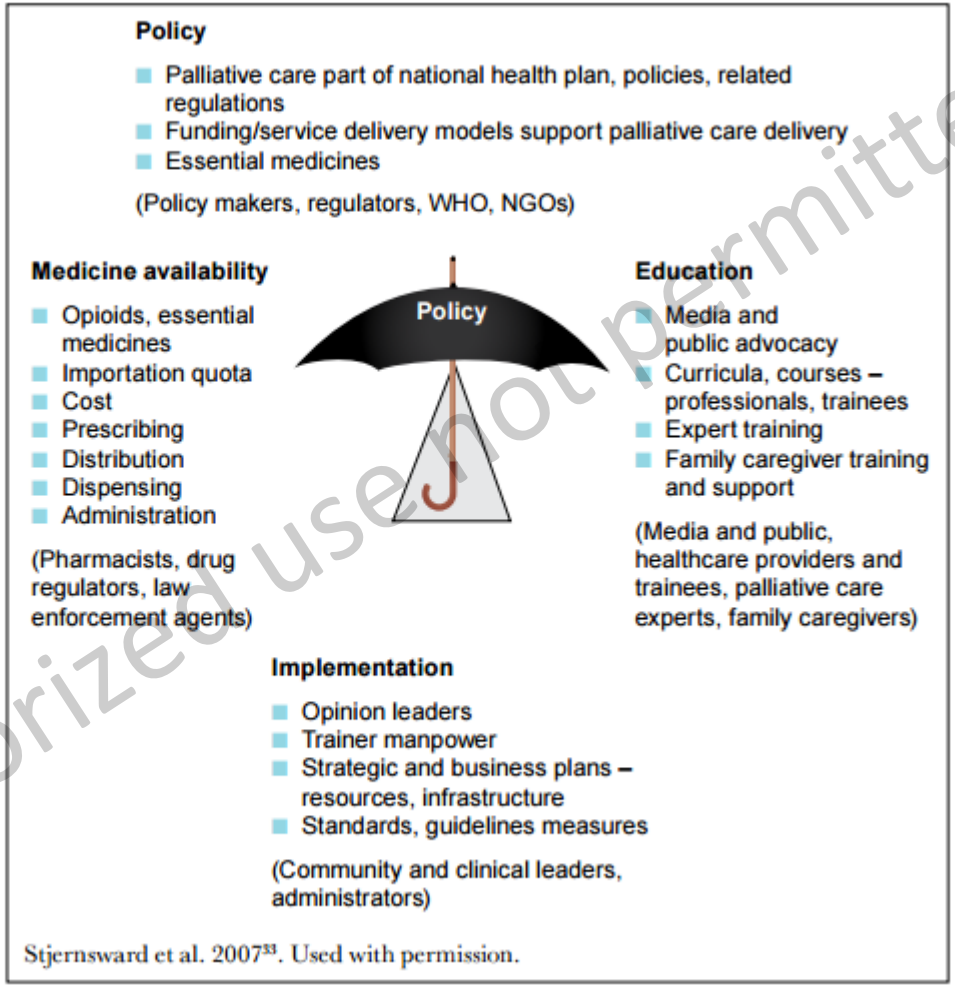
Current Canadian ‘stats’

- 1% of our population is always in the last year of life
- 3 out of 4 visits to the GP/Family doctor in the last two months of life are for social concerns (reassurance, affirmation, accompaniement)
- CIHR grant on end stage heart failure- theme extraction, elderly women and sources of suffering

….*not being able to get out and get your hair done*

Feasibility

Figure 29
Public health model for palliative care development



Stjernsward et al. 2007[33]. Used with permission.

WHO Public Health Strategy

1. Appropriate policies;
2. Adequate drug availability
3. Education of policy makers, health care workers, and the public
4. Implementation of palliative care services at all levels throughout the society.
5. The WHO Catalon 20 year experience

Accountability

- Measurement Capacity exists
- Benchmarking a standard quality exercise
- Target can be set , action taken
- Global Good Death Index

Dr Joachim Cohen-Four Key Points

1. Past and current interests in Palliative Care (research) have virtually excluded public health approaches

   Health service and bedside approaches dominant

2. The public health approach is more appropriate to describe and address problems on a population level
3. A public health approach requires bringing the “public” back in
4. The public health approach requires specific research methods

   Both classic population assessment and monitoring AND new public health approaches

Ethical Considerations

- Minimize harm
- Protecting vulnerable persons
- Vulnerability occurs when persons or populations are unable to optimally protect themselves from hazards or advocate for their own best interests, thus requiring enhanced protections.
- Significant moral failure to not move in the direction of palliative care as a public health issue

Who bears the responsibility?

- “For public health strategies to be effective, they must be incorporated by governments into all levels of their health care systems and owned by the community .” (WHO PH Strategy)
- Community engagement and education required
- Leadership from Palliative Care AND Public Health Communities
- Imaginative Collaboration Needed

Dying “in the past”

- Normal and routine
- Built on community relationships
- Whole person care- ie. whole “citizen “ care, not just service-based
- End of life care is more than medical care
- Death and loss are inevitable and universal

Palliative Care as Public Health

- Developing the wider community context within which palliative care services make their contribution
- "Beyond mere services"
- Involves the well, and wellness (beyond illness)
- Palliative care is *"everybody's business"*

“Health Promoting Palliative Care” (HPPC) …..

- is public health guiding palliative care and end of life care
- Built on idea that healthcare is participatory
- Applies the WHO Ottawa Charter of Public Health to palliative care
- Not what we do to others but with others and is essentially social
- Recognizes the limits of service provision and global provision

Antecedent conditions….

- WHO Ottawa Charter
- ‘New’ public health responses to AIDS
- A new political agenda of individual and community responsibility
- Recognition of the limits to service provision
- WHO Healthy Cities Movement and Age Friendly cities
- Dr Alan Kellehear

…..Applies our *own* Ottawa Charter for Public Health, to end of life care

- building healthy public policy
- creating supportive environments
- Strengthening community action
- Developing personal skills
- Re-orienting health services
- Re-orients volunteers to community development

….*normalizes* this aspect of living…..

- Every other area of health care has a public health agenda
- Health promotion is part of health- we need the well!
- Synergy with DDLB of all kinds, not just those who intersect Palliative Care
- When DDLB is normalized, so too shall ACP
- Engagement of the 95% of the time that people are not with their healthcare provider

….builds social capitol

- A community that interacts with itself frequently has a high level of trust, social support and morale
  - is interested in its own health and welfare
  - Fostering interest in matters that affect their family friends, co workers, neighbours
- means community capitol, not just occupational
- Requires upfront leadership and facilitation
- Transition out from HPC and community continuation
- As evidenced by **CHPCA Way Forward** campaign and the national **Speak Up** campaign

The Compassionate Cities (CC) model

- Is an end of life care community application **of WHO Healthy Cities model**
- is ***a theory of practice*** for HPPC
- the principle of healthy communities – health is everyone's responsibility
- the principle of compassionate communities – palliative and end of life care is everyone's responsibility

- IN BOTH – communities and services create partnerships where *both* lead in areas where they have authority and responsibility

Principles of Capacity Development

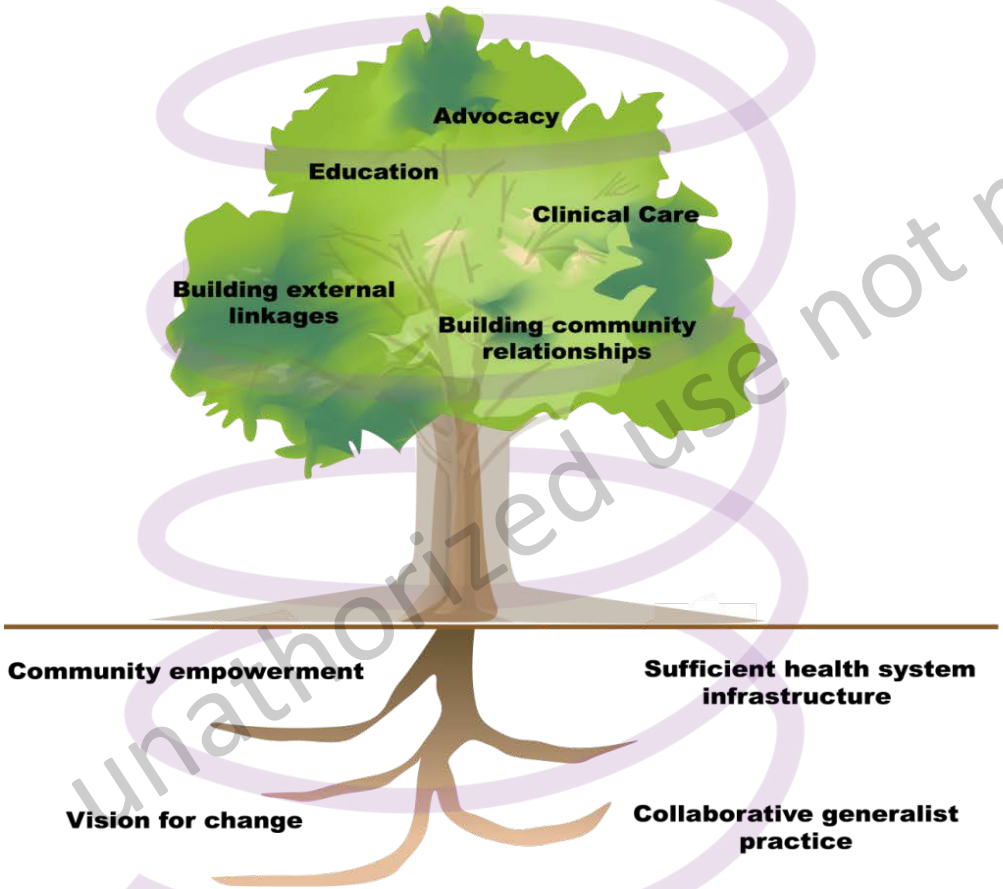
- Development is essentially about building on existing capacities within people, and their relationships

- Development is an embedded process; it cannot be imposed or predicted
- The focus is initially about change not performance

- Development takes time and has no end
- Development process engages other people & social systems
- individuals, teams, organizations and communities are interconnected in new ways

(Kaplan 1999; Lavergne & Saxby, 2001)

The Kelley Model of Community Capacity Development



Process of Palliative Care Development

Sequential phases of the capacity development model:

4. **Growing the PC program**
3. **Creating the PC team**
2. **Community Catalyst**
1. **Antecedent community conditions**

Kelley, M. L. (2007). Developing rural communities' capacity for palliative care: A conceptual model. Journal of Palliative Care, 23(3), 143-153.

International and national examples

- Hospice friendly hospitals (HfH)
- Frailty index- evidence based, longstanding
- Compassionate Watch ie. neighbourhood Watch
- Death education elementary schools/hospice partnerships
- Spiritual companions
- Integration of formal and informal care networks
- LTC pubs/beer coasters
- Carers' day
- Airport posters
- Death café- in ThunderBay- "Die-alogues"

Hospice Northwest Presents

Dialogues

Conversations on Life and Death

CONTACT US!
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HOSPICE NORTHWEST

Practice implications

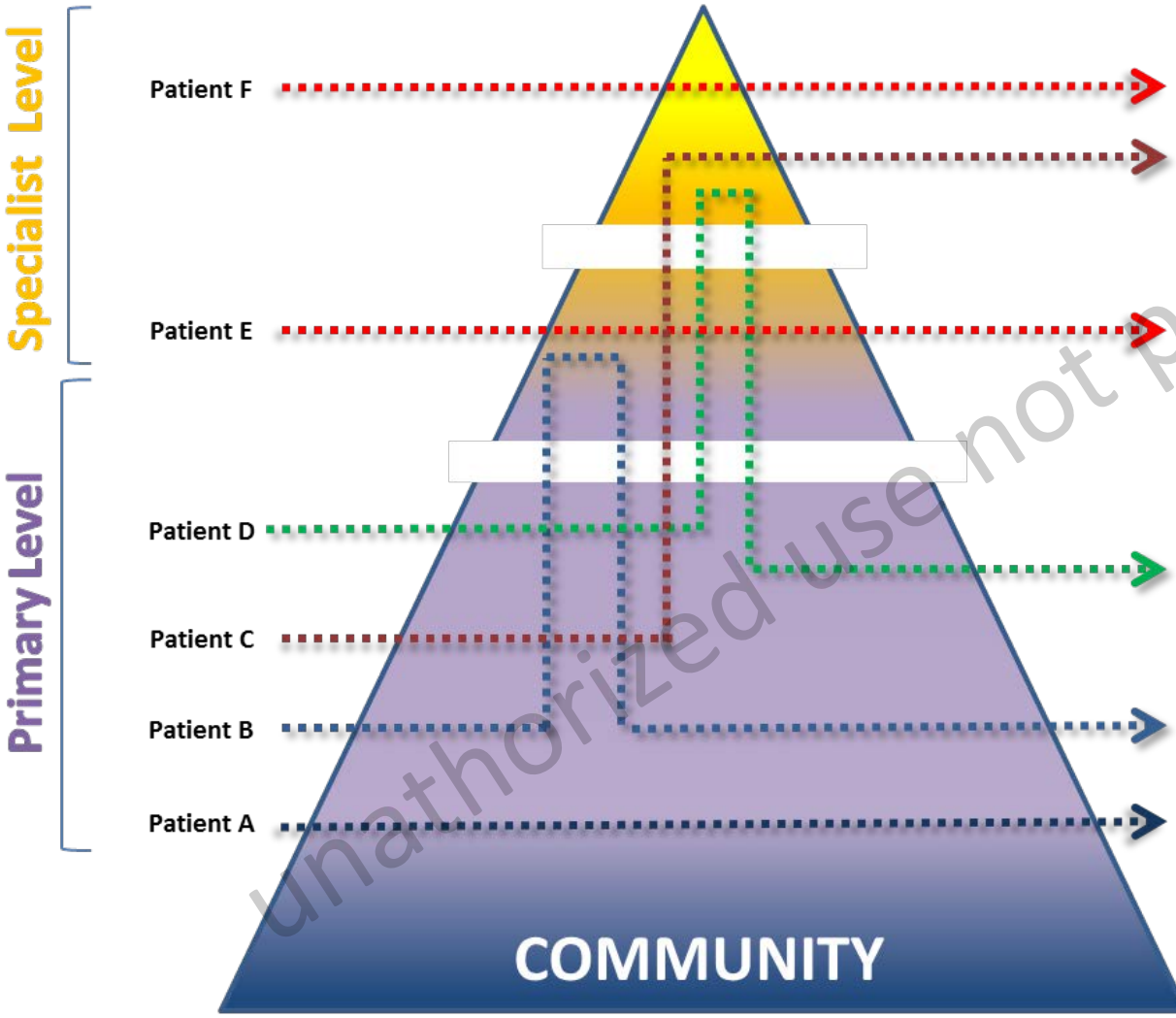
- Death education –the goal is ***normalization***
- Community development initiatives
- Community and service partnerships
- Empowerment of volunteers and informal caregivers
- From bedside to public health (learning to do both)
- Rise of public health workers (making new friends)
- Health promotion starts with our own programs
- Providing leadership not control
- Lifting this up and across systems and society

Barriers ?

- Inability, reluctance or refusal to grasp these concepts ; its more than a “nice description”
- “ Death education” is not what we are currently doing
- Perception of threats to job or organization viability
- Seen as an “add-on” to current care
- Lack of critical mass of champions
- *Did you ask the community?*

Development of Provincial Clinical Standards

Who provides palliative care?



- **A small number of patients with complex needs require transfer of care to specialist palliative care services**
- **May occasionally require assistance of specialist palliative team**
  - consultation or shared care support
- **Most patients require only primary-level Palliative Care (Palliative Care Approach)**
  - Family medicine clinic
  - Oncology team
  - Internal med clinics
  - Cardiology clinics
  - COPD clinics

What next?

- Making our “compassionate community” models explicit; legitimizing what already exists at grassroots
- Environmental scan, scoping, assessment and asset mapping
- Compassionate communities projects based on connection and consortiums including PHA
- Social capital building using third sector organizations
- Greater normalization around DDLB; “back to the future”
- Culture shift driving policy change

Pallium Canada and Compassionate Communities

1. Fostering Conceptual clarity
2. Environmental scan
3. CC toolkits for schools, businesses, municipalities
4. Develop a critical mass of champions who can empower communities
5. Canadian CC Community of Practice
6. Learning commons and portal at **Pallium.ca**
7. Celebrating success and benchmarking achievement

Public Health Palliative Care International

- Global initiative and reach
- A response to the loss of “social” and “community”
- A re-embracing of DDLB of all kinds as a common human experience
- PHPCI.info
- **The 5th International Public Health Palliative Care Conference** *comes to Canada*

  Sept 2017, Ottawa

"A healthcare provider is a poor excuse for a friend."

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