



# **Promising Practice: Palliative Care Outreach and Advocacy Team (PCOAT)**

Healthcare Excellence Canada (HEC) and the Canadian Partnership Against Cancer (the Partnership) would like to formally acknowledge the generosity of the PCOAT team in sharing their skills, knowledge, expertise and experiences to form this promising practice document. For our program team, it is a privilege to share the details of this work; however, we recognize that the contributions PCOAT has made to equity in palliative care reach far beyond what can be captured in this brief document. PCOAT has graciously shared their work and their time with us and for that we are deeply grateful.



## About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaboration with patients, caregivers and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence. Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement.

The views expressed herein do not necessarily represent the views of Health Canada.

## About the Canadian Partnership Against Cancer

The Canadian Partnership Against Cancer (the Partnership) is an independent organization funded by the federal government to accelerate action on cancer control for all Canadians. The Partnership is the steward of the Canadian Strategy for Cancer Control (the Strategy) and works to implement the Strategy to reduce the burden of cancer on Canadians. The partner network—cancer agencies, health system leaders and experts and people affected by cancer—brings a wide variety of expertise to every aspect of our work to support multi-jurisdictional uptake of the knowledge emerging from cancer research and best practices in order to optimize cancer control planning and drive improvements in quality of practice across the country.



# The Promising Practice

## Goals

PCOAT has five long-term goals to guide the team:

1. To promote health equity for all who need palliative care.
2. To overcome any barriers that stand in the way of accessible, early and high-quality palliative care.
3. To demonstrate to and educate policymakers, care providers and other stakeholders about the connection between social determinants of health and symptom management in palliative care.
4. To collaborate with all requisite service providers to offer end-of-life care to vulnerable populations.
5. And, most importantly, to allow patients to die in a dignified way while reaching their care goals.

## Model

According to the 2017 Program Report, PCOAT focuses on two primary activities: providing the requisite services to ensure that socially vulnerable people living in Edmonton receive patient-centred and equitable palliative care, and building relationships to develop and implement a delivery model for palliative care that is primarily informed by community members.

Services provided include addressing the social determinants of health, including linking the client with food (e.g. food hampers), clothing, housing, Assured Income for the Severely Handicapped funding, family reunification, connection to cultural supports, assisting the client with appointments, medical care (e.g. providing medication, wound care), and facilitation of complex case discussions with multiple partners. Health equity is critical, and the delivery of care goes beyond addressing physical needs. Clients are seen in clinic, hospice, home, hospital or wherever the client is.

## Program history

The project began in 2015, following a review by Dr. Jennifer Lau on Boyle McCauley Health Centre patients who had died. End-stage liver disease was the most common cause of death (38 percent of patients), and inner-city patients had a greater likelihood of dying in a tertiary hospital. Based on this work, the Palliative Triple Aim Project started. Dr. Cara Bablitz started working at the Indigenous Wellness Clinic in 2016, and in the spring of 2017 met a palliative patient via Debby Wiedman, the mental health system case manager. The team supporting the work included the Alberta Health Service Program and home care director. Next, a name and logo for PCOAT was created with assistance from the Royal Alexandra Hospital Foundation, and it received funding from the M.S.I. Foundation for one year. Wednesday morning team rounds began.

## Funding

Dr. Bablitz works for the Indigenous Wellness Council and is paid a salary via an Alternative Relationship Plan. Clients are referred to palliative home care; staff are from the Edmonton Zone (Alberta Health Services). Many partners supporting these clients do not have funding directly for this palliative care work, but they collaborate to ensure that time is made for patients. The Royal Alexandra Foundation has provided small grants for end-of-life wishes. Research funding has also been secured for registered nurse support from the M.S.I. Foundation and the Alberta Health Palliative and End-of-Life Care Grant Fund.

## Team

The PCOAT team composition fluctuates depending on funding. The hope is to build the team to have sustainable funding over time. In 2017, with M.S.I. Foundation funding, a nurse was hired for one year. In 2022, a registered nurse was hired for two years with funding from the Alberta Health Palliative and End-of Life Care Grant Fund with a focus on delivery of care to Indigenous peoples in Alberta. A research associate will also join the team with funding from Alberta Health for one year.

The team currently consists of a physician lead and a registered nurse. There is collaboration from many partners including agencies that help provide housing, clothing and food. The team works closely with home care (especially palliative home care to get nursing support and care). Inner

city pharmacies help to ensure low cost or no cost medications. Rounds include the physician, Indigenous Palliative Care Nurse Navigator staff from George's House, pharmacy and palliative home care systems case managers.

The team is fluid and is based on the needs of the client as well. If the client has a respiratory therapist that they see, they will be involved in care and collaboration, for example.

## Referrals

People can self-refer, or referrals can come from those providing care (including community workers, healthcare providers, etc.). Many referrals come from community agencies and home care. The intent is to make referrals as barrier free as possible.

## Population served

The population served by PCOAT includes people who are “vulnerably housed, living below the poverty line and/or, (have an) active or recent history of substance use disorder” (PCOAT Program Report December 2017). If the client has any of these three needs, they can be referred.

For PCOAT, the amount of time remaining in a person's life is flexible, but typically less than one year remaining. Some people do graduate from PCOAT, thanks to a harm reduction approach, receiving medical care and improved quality of life.



# Outcomes and Impacts

## PCOAT Program Report December 2017

- **Demographics:** At the point of this report, there had been 59 clients with an average age of 57; 22 had died (18 from cancer and three non-cancer). Sixty-six percent had a cancer diagnosis; 34 percent had a non-cancer diagnosis. Fifty-six percent of patients were male. Forty-five percent were Indigenous and 45 percent Caucasian.
- **Population served:** Ninety percent of clients were living below the poverty line. Forty-two percent were in stable housing, 38 percent were in unstable housing and 17 percent were homeless when first consulted (3 percent had unknown housing status). Sixty-eight percent had active substance use.
- **Referrals:** Forty-one percent of referrals came from home care, and 22 percent from the Edmonton Zone Palliative Care Program. Twenty-five percent came from other community partners, 9 percent from Inner City Housing Programs and 3 percent from other physicians.
- **Involvement from PCOAT:** The number of days that PCOAT was involved with the patients who had died ranged from two to 116 days.
- **Location of death:** Thirty-two percent died at home, 27 percent in hospital, 36 percent in hospice and the remaining at St. Joseph Ministry. In Dr. Lau's review (2015), prior to team formation, only 6 percent died at home and 4 percent in hospice, with 54 percent dying in hospital and 30 percent unknown.

- **Other data:** Data in the report also include the Edmonton Symptom Assessment System data and palliative performance scale.
- **Qualitative data collection, including with clients:** The 2017 report also includes patient stories, with agreement from patients to share these.

## Ongoing research

The PCOAT team is working to collect quantitative and qualitative data to help continue advocacy for improved patient care and sustainable funding. A study published in 2023 (Santos Salas et al., 2023) found improvements in access to services (health, social services, wellness) amongst PCOAT participants. The key features of PCOAT that participants identified included trust building, coordination of complex care needs, assistance with decisions at the end of life, improved access to services, care provided in a culturally safe manner, improved wellness and that hope was built over time.



## Collaboration

Many collaborative partners take part to ensure services are provided. These include:

- pharmacy
- close collaborations with hospital and home care (both palliative home care and regular home care)
- Edmonton Zone Palliative Care program
- the Indigenous Wellness Clinic (which pays Dr. Cara's salary)
- George's House
- Royal Alexandra Hospital
- George Spady Society
- Homeward Trust
- Alberta Health Services (Mental Health and Addiction)
- Community agencies
- M.S.I. Foundation (which provided funding)
- Radius Health
- the ARCH program (substance use consultation team) (Addiction Recovery and Community Health)
- Emergency Medical Services (community paramedics who do a lot of referrals, and they also do blood work and help clients)

PCOAT is involved in a community of practice that is also useful.

## Partnerships with community

Work has been done collecting data from people who are using the service (see above). There are no peer workers involved currently with PCOAT. PCOAT has worked to engage the community with two palliative care symposiums in 2023 to engage partners and continue to work towards collaboration.

# Lessons Learned

## Principles

- Equity
- Dignity
- Harm reduction
- Meeting clients where they are at

## Enablers

- Many partners are working in collaborative ways to help the client.

## Challenges

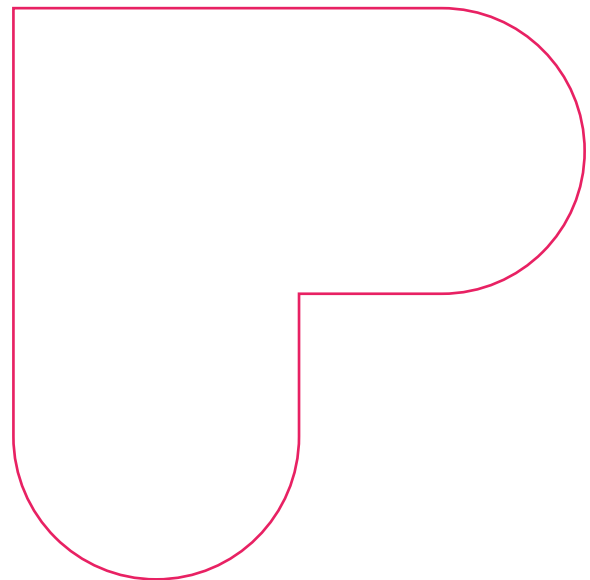
- **Funding and team limitations:** There is a lack of ongoing secure funding to ensure program stability in a sustainable way. Funding tends to focus on emergency clinical needs, and not addressing broader social determinants of health/underlying reasons people are going to emergency departments. Physicians are not compensated for all work (travel, conversations with support workers, etc.) under traditional payment models, which makes recruiting another physician a challenge. Due to these challenges, the team has to be selective about whom they work with as they cannot work with everyone. There are some opportunities to apply for funding, but this also takes time (and this time is taken away from clients needing care).
- **Data collection:** It can be difficult to recruit patients into a study given their level of physical illness, mental health concerns, capacity issues in some cases and the clients' lack of trust with researchers given the colonial history and past negative experiences with research.
- **Harm reduction:** Not all medical systems are

supportive of a harm reduction approach for those who are dying.

- **Education:** The PCOAT team does not have capacity to complete regular education on palliative approach to care and a harm reduction approach to community partners.
- **High burnout rate:** There is a high burnout rate for workers supporting structurally vulnerable palliative care patients. There is stigma and mistreatment, as well as death in crisis and complicated grief.

## Lessons learned

- Clients require flexibility, and the traditional institutional setting of palliative care can be rigid in nature.
- Clients who are structurally vulnerable value trust and relationship building in their healthcare providers.



This promising practice was co-produced with PCOAT. Information was compiled in the fall of 2023. In keeping with the changing and evolving nature of care the information may change in the future. We encourage you to reach out to this team for any further information that may be helpful as you work to improve access to palliative care for those you serve.

## For more information

### To learn more, contact:

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## Additional resources

- [Dr. Cara Bablitz Profile – Alberta Doctors' Digest](#)
- [Dr. Cara Bablitz CMA Award for Young Leaders \(Early Career\) – Alberta Doctors' Digest](#)
- [2020 ROOPH Awards: Recognizing Outstanding Organizations and People in Housing](#)
- Santos Salas A, Bablitz C, Morris H, Vaughn L, Bardales O, Easaw J, Wildeman T, Duggleby W, Salami B, Watanabe SM. Improving access to palliative care for people experiencing socioeconomic inequities: Findings from a community-based pilot research study. *Health Promot Chronic Dis Prev Can.* 2023;43(8), 365-374. doi: [10.24095/hpcdp.43.8.02](https://doi.org/10.24095/hpcdp.43.8.02)