REGIONAL PALLIATIVE CARE PROGRAM

ANNUAL REPORT

APRIL 1, 2000 - MARCH 31, 2001

and

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Introduction</td>
<td>5</td>
</tr>
<tr>
<td>II. Structure</td>
<td>6</td>
</tr>
<tr>
<td>III. Vision, Mission, Philosophy and Goals</td>
<td>7</td>
</tr>
<tr>
<td>IV. Continuity of Care</td>
<td>11</td>
</tr>
<tr>
<td>V. Components</td>
<td>12</td>
</tr>
<tr>
<td>A. Regional Palliative Care Office</td>
<td>12</td>
</tr>
<tr>
<td>B. Tertiary Palliative Care Unit</td>
<td>17</td>
</tr>
<tr>
<td>C. Referral Hospitals</td>
<td>18</td>
</tr>
<tr>
<td>D. Palliative Hospices</td>
<td>18</td>
</tr>
<tr>
<td>E. Home Care</td>
<td>19</td>
</tr>
<tr>
<td>F. Cross Cancer Institute</td>
<td>20</td>
</tr>
<tr>
<td>G. Grey Nuns Palliative Care Clinic</td>
<td>22</td>
</tr>
<tr>
<td>VI. Clinical Interpretation of Data</td>
<td>22</td>
</tr>
<tr>
<td>VII. Summary</td>
<td>23</td>
</tr>
<tr>
<td>VIII. Appendices</td>
<td>24</td>
</tr>
<tr>
<td>Appendix 1: Figure 1 - Continuum of Palliative Care</td>
<td></td>
</tr>
<tr>
<td>Appendix 2: Access to Palliative Care as Measured by Patients Receiving</td>
<td></td>
</tr>
<tr>
<td>Palliative Care Consultation to Actual 2000 &amp; Predicted 2001 Number of</td>
<td></td>
</tr>
<tr>
<td>Deaths Due to Cancer for Region 10 Population</td>
<td></td>
</tr>
<tr>
<td>Appendix 3: Palliative Care Services in the Capital Health Region</td>
<td></td>
</tr>
<tr>
<td>Appendix 4: Regional Palliative Care Program Criteria for Admission</td>
<td></td>
</tr>
<tr>
<td>Appendix 5: Total Capital Health Hospital Deaths with a Most Responsible</td>
<td></td>
</tr>
<tr>
<td>Diagnosis of Cancer, and Deaths at the Cross Cancer Institute</td>
<td></td>
</tr>
<tr>
<td>Appendix 6: Average Length of Stay - Capital Health Hospital and Cross</td>
<td></td>
</tr>
<tr>
<td>Cancer Institute (CCI) Deceased Patients with a Most Responsible</td>
<td></td>
</tr>
<tr>
<td>Diagnosis of Cancer</td>
<td></td>
</tr>
<tr>
<td>Appendix 7: Total Days in Hospital – Capital Health Hospital and Health</td>
<td></td>
</tr>
<tr>
<td>Centres and Cross Cancer Institute (CCI)</td>
<td></td>
</tr>
</tbody>
</table>
VIII. APPENDICES … continued

Appendix 8 Regional Palliative Care Model
Appendix 9 Regional Palliative Care Program - RPCP Structure
Appendix 10 Regional Palliative Program Council Membership List, January 2002
Appendix 11 Palliative Performance Scale version 2 (PPSv2)
Appendix 12 Regional Palliative Care Program Staffing
Appendix 13 Referral Flow Chart – Regional Palliative Care
Appendix 14 Regional Palliative Care Program (RPCP) Community Consult Team Patient Profile for Patients Referred between Apr 1, 2000 and Mar 31, 2001
Appendix 15 Regional Palliative Care Program (RPCP) Community Consult Team Patient Profile for Patients Referred between Apr 1, 2001 and Mar 31, 2002
Appendix 16 Regional Palliative Care Program (RPCP) Community Consult Team ESAS Scores First Averages For Patients Referred between Apr 01, 2000 and Mar 31, 2002
Appendix 17 Regional Palliative Care Program (RPCP) Community Consult Team Abnormal MMSE Scores First Measure by Reason of Referral For Patients Referred between Apr 01, 2000 and Mar 31, 2002
Appendix 18 Physician Referrals to Community Consultant Teams
Appendix 19 Education Presentations by Regional Palliative Care Community Consultants Team
Appendix 20 Visitors, Fellows and Trainees to Regional Palliative Care Program - All Areas
Appendix 21 Regional Palliative Care Program Publications 2000 - 2002
Appendix 22 Regional Palliative Care Program Volunteer Hours Contributed by Year 1996 – 2002
Appendix 23 Tertiary Palliative Care Unit (TPCU) Patient Profile - For Patients Discharged between Apr 01, 2000 and Mar 31, 2001
Appendix 24 Tertiary Palliative Care Unit (TPCU) Patient Profile - For Patients Discharged between Apr 01, 2001 and Mar 31, 2002
Appendix 25 Tertiary Palliative Care Unit (TPCU) ESAS Scores - First, Mid and Last Measures - For Patients Discharged between Apr 01, 2000 and Mar 31, 2001
Appendix 26 Tertiary Palliative Care Unit (TPCU) ESAS Scores - First, Mid and Last Measures - For Patients Discharged between Apr 01, 2001 and Mar 31, 2002
Appendix 27 Tertiary Palliative Care Unit (TPCU) Abnormal MMSQ* - First, Mid Point and Last Measures by Discharge Location For Patients Discharged between Apr 01, 2000 and Mar 31, 2001
Appendix 28 Tertiary Palliative Care Unit (TPCU) Abnormal MMSQ* - First, Mid Point and Last Measures by Discharge Location For Patients Discharged between Apr 01, 2001 and Mar 31, 2002
Appendix 29  Referral Hospital Royal Alexandra Hospital* Palliative Consult Team Patient Profile For Patients Discharged Between Apr 01, 2000 and Mar 31, 2001

Appendix 30  Referral Hospital Royal Alexandra Hospital* Palliative Consult Team Patient Profile For Patients Discharged Between Apr 01, 2001 and Mar 31, 2002

Appendix 31  Referral Hospitals Royal Alexandra Hospital* Palliative Consult Team ESAS Scores - First and Last Measures For Patients Discharged Between Apr 01, 2000 and Mar 31, 2001

Appendix 32  Referral Hospitals Royal Alexandra Hospital* Palliative Consult Team ESAS Scores - First and Last Measures For Patients Discharged Between Apr 01, 2001 and Mar 31, 2002

Appendix 33  Referral Hospitals Royal Alexandra Hospital* Palliative Consult Team Abnormal MMSQ First and Last Measures for Patients Discharged by Site of Discharge Between Apr 01 2000 and Mar 31, 2001

Appendix 34  Referral Hospitals Royal Alexandra Hospital* Palliative Consult Team Abnormal MMSQ First and Last Measures for Patients Discharged by Site of Discharge Between Apr 01 2001 and Mar 31, 2002

Appendix 35  Palliative Hospices Patient Profile: All Sites For Patients Discharged between Apr 01, 2000 and Mar 31, 2001

Appendix 36  Palliative Hospices Patient Profile: All Sites For Patients Discharged between Apr 01, 2001 and Mar 31, 2002

Appendix 37  Palliative Hospices ESAS Scores First and Last Measures For Patients Discharged Between Apr 01, 2000 and Mar 31, 2001

Appendix 38  Palliative Hospices ESAS Scores First and Last Measures For Patients Discharged Between Apr 01, 2001 and Mar 31, 2002

Appendix 39  Palliative Hospices Abnormal MMSQ Scores* - First and Last Measures For Patients Discharged between Apr 01, 2000 and Mar 31, 2001

Appendix 40  Palliative Hospices Abnormal MMSQ Scores* - First and Last Measures For Patients Discharged between Apr 01, 2001 and Mar 31, 2002

Appendix 41  Palliative Home Care Palliative Patient Profile For Patients Discharged Between Apr 01, 2000 and Mar 31, 2001

Appendix 42  Palliative Home Care Palliative Patient Profile For Patients Discharged Between Apr 01, 2001 and Mar 31, 2002

Appendix 43  Palliative Home Care ESAS Scores First and Last Measures For Patients Discharged Between Apr 01, 2000 and Mar 31, 2001

Appendix 44  Palliative Home Care ESAS Scores First and Last Measures For Patients Discharged Between Apr 01, 2001 and Mar 31, 2002

Appendix 45  Palliative Home Care Abnormal MMSQ Scores* - First and Last Measures For Patients Discharged between Apr 01, 2000 and Mar 31, 2002

Appendix 46  Expected and Actual Outcomes - Regional Palliative Care Program
I. INTRODUCTION

The Regional Palliative Care Program (RPCP) is a community based program of care designed to provide broad access to high quality palliative care services in a variety of settings.

The following updated definition for (2002) palliative care describes the focus of the program:

Palliative Care – Palliative care aims to relieve symptoms and improve the quality of living and dying for a person and/or family living with a life threatening illness.

Palliative care strives to help individuals and their families:
- address physical, psychological, social, spiritual and practical issues and associated expectations, needs, hopes and fears,
- prepare for, and manage, life closure and the dying process, and
- cope with loss and grief during the illness and bereavement.

Palliative care may:
- complement and enhance treatment of the disease at anytime during the disease trajectory, or
- become the total focus of care. (see figure 1)

Palliative care may be provided to individuals:
- with any diagnosis,
- regardless of age, and
- when they have unmet needs and are prepared to accept care.

Services in palliative care are arranged in a coordinated network, delivered by an interdisciplinary team, and provided in an atmosphere of respect for human dignity. (adapted from Canadian Hospice Palliative Care Association, 2002).

This definition updates the earlier focus in palliative care from primarily end-of-life care for cancer patients, to more clearly include any disease and to offer support earlier in a disease trajectory. The definition is consistent with the Canadian Hospice Palliative Care Association, and with current international literature.

The Regional Palliative Care Program (RPCP) began as a response to the need for a population-based approach in providing palliative care in the Capital Health Region. Prior to 1995, access to palliative care, a main ingredient of a population-based program, was inconsistent. At that time, two palliative care units existed (Edmonton General Hospital and Misericordia Hospital) providing care in 1992 to 290 patients, 21% of all cancer patients that year. The focus of the RPCP is to provide broad access, based on where people are, to
palliative care services. In 2000, 77% of all cancer patients accessed palliative care consultation, and in 2001, access was 69% (University of Alberta Hospital palliative care team data not available since November 2000) (Appendix 2). This high level of access has been maintained annually. Overall, the program provided services for 1203 people in 2001/02, including people with diagnoses other than cancer (6% in 2000/01 and 7% in 2001/02) and those admitted to acute care from other regions. However, only cancer patients are included in measurement of community access, due to the difficulty in determining the denominator of other groups.

The community-based model recognizes that the family, home care and the family physician will provide the majority of palliative care (Appendix 3). Acute and tertiary level services are available when needed, allowing persons to choose settings such as home and palliative hospice when stable. Criteria of admission for each area of the program enable staff to assess for appropriate care options (appendix 4). The ability to provide options for site of care other than acute care has been a major focus of the program in the first 7 years. In 1992, 78% of oncology patients died in acute care hospitals utilizing 20,000 bed days (Appendices 5-7). Resources were enhanced in home care, and palliative hospice and community consultation services were created. The result has been a decrease of 14,687 and 13,609 acute care bed days in 2000/01 and 2001/02, from 1992 levels.

II. STRUCTURE

The central focus of the program is the person and their family (Appendix 8). The program is outcomes-based with goals set for each area of the program. The RPCP reports to Community Care Services and the Medical Officer for Primary Care. A central office coordinates the components of the program. The Regional Palliative Care Office liaises closely with the Tertiary Palliative Care Unit (Grey Nuns Community Hospital), Referral Centres, Community Hospitals, Palliative Hospices and Continuing Care, Home Care, Family Physicians, the Cross Cancer Institute and the Division of Palliative Care Medicine, to meet the goals and objectives of the program (Appendix 9).

The next priority for the council will be to review the role of the palliative hospices. (see Hospices).

The RPCP is supported by a regional database where demographic and clinical data is entered from all areas of the program (the palliative home care database could be accessed beginning November, 2001) utilizing common assessment tools:

- Edmonton Symptom Assessment System (ESAS)
- Mini Mental State Examination (MMSE)
- CAGE
- Edmonton Staging System for Cancer Pain (ESS)
- Palliative Performance Scale (trialed winter 2001/02, and to be implemented program wide April 2002). The PPS is a functional assessment tool designed for palliative care patients (Appendix 11). This tool provides common language and a consistent method of measuring mobility and level of alertness. The PPS score is included in assessment data used to determine the most appropriate care setting.
- In 2001, all diagnostic categories were updated to be consistent with 17 Alberta Cancer Board groupings, throughout all areas of the program.
In a survey of family physicians completed in 1999, referral access was identified as a major concern. In October 2001, access to tertiary care, community consultation and home care was centralized as Information & Intake became the community referral link. Information & Intake and the RPCP received a REACH team award for the integration process.

To provide regional direction, the Palliative Care Program Council was established in September 2001 (Appendix 10). The key areas of responsibility are quality improvement, utilization management, health technology assessment, service delivery planning, research and education, and physician workforce planning.

Goals for the Program Council during its first year (chosen by a facilitated goal-setting process) were:

- orientate the members of the council (completed over the first year with site presentations, and annual meeting).
- update the philosophy, goals and palliative care definition for the program, and to create a vision and mission (complete, see section III) .

The vision and mission work involved consultation with staff and the council during the annual meeting and follow-up email distribution. Families and patients from each setting also had opportunity to review a draft document. The completed work is consistent with the newly released Canadian Hospice Palliative Care Model to Guide Hospice Palliative Care (March 2002).

III. VISION, MISSION, PHILOSOPHY AND GOALS

The vision, mission, philosophy and goals are consistent with Capital Health, Caritas Health Group and the Alberta Cancer Board visions and missions.

**Our Vision**

*Regional Palliative Care Program*

*'Improving the Quality of Living and Dying'*

**Our Mission**

Through an integrated program of compassionate and accessible palliative services, care is provided to patients and families within the Capital Health Region. Our caring tradition embraces all aspects of person. As we engage in the work of our mission, we strive to exceed the ordinary, endeavoring always to provide exemplary care.

**Caring**

being with each individual, providing care that aims to improve the quality of living and dying,
EDUCATION
ongoing learning for patients, families and caregivers,

RESEARCH
the advancement of care through research,

LEADERSHIP
accountability and continuance of program excellence, and

OUTREACH
providing clinical consultation, education and tertiary level care.

This is our mission.

Our Philosophy

The Regional Palliative Care program recognizes, respects, and incorporates into their practices the following fundamental values based in part on the values and ethical principles identified by the Canadian Palliative Care Association in the document 2001 Proposed Norms of Practice for Hospice Palliative Care:

We believe

- *Access is Foundational* - Palliative care services should be available to all who require care.

- *Care is Patient-Focused* - Palliative care strives to meet the physical, psychological, spiritual and social needs of patients and families. It is sensitive to personal, cultural and religious values, beliefs and practices, developmental state, and readiness to deal with the dying process.

- *People Have the Right To Choice* - Each person is an autonomous and unique individual with the right to participate in informed discussion related to care and to choose the best possible options and outcomes based on that information.

- *Dying is Part of Life* - Palliative care affirms life. Euthanasia and physician assisted suicide are not considered options. Palliative care never intentionally hastens death.

- *Quality of Life Guides Decisions* - Care choices should be guided by quality of life as defined by the patient.
• **Team Work Is Essential** - Palliative care is a network of services most effectively delivered by an interdisciplinary team who rely on shared knowledge, expertise and effective interactions.

• **Service is Coordinated** - A palliative care program should promote continuity of care across settings and coordination amongst all involved caregivers and programs/services.

• **Accountability is Demonstrated Through Outcomes** - We are accountable to ourselves, each other, to our individual sites, to the regional program and to the public we serve. Accountability is demonstrated through measurable goals.

• **Confidentiality is Central** - Patient information is treated with the utmost respect. Team members must adhere to this principle.

• **Care Setting Is Important** - Palliative care is provided in a patient and family-focused environment in the most appropriate care setting such as the home, hospice, continuing care centers, acute hospitals or on a tertiary palliative care unit. The needs and preferences of the patient and family, as well as the resources available, are taken into consideration.

• **Caregiver Well-Being Is Fundamental** - The provision of ongoing support to enhance formal and informal caregivers' well-being is integral to a successful palliative care program.

• **On-going Education is Essential** - Patient, family, caregiver and public education is important to the maintenance and enhancement of the quality of palliative care.

• **Research Leads to Advancement in Care** - The development, dissemination and integration of research are critical to palliative care.

• **Resources Influence Program Quality** - Adequate resources, responsibly managed, are imperative to maintain and advance palliative care programming.

• **Collaborative Leadership is Advantageous** - The development and maintenance of a quality palliative care program requires the active involvement of all stakeholders in the decision-making processes.
Our Goals

Broad Program Goal

Access to exemplary palliative care provided in the most appropriate setting.

Specific Program Goals - The goals of the Regional Palliative Care Program are to:

1. Ensure a coordinated, continuous plan of care that minimizes duplication of efforts and is maintained across all settings from referral of the patient to support of the bereaved family.

2. Review and follow relevant norms of practice based on CHPCA guidelines at each site of care.

3. Provide timely access to palliative care services 24 hours a day, 7 days a week, throughout the region.

4. Ensure consultation team availability in all settings to support primary caregivers.

5. Support community based care by providing proactive palliative care in the home and hospice, thereby decreasing the use of emergency and acute care services.

6. Offer tertiary level palliative services to patients with complex care needs that exceed care levels available in other settings.

7. Support the interdisciplinary nature of palliative care emphasizing that the patient and family are key members of the team.

8. Further the development of the bereavement program to ensure that the needs of bereaved family members and caregivers are addressed.

9. Recognize and support the essential role of volunteers on the palliative care team.

10. Offer effective palliative care education, based on norms of practice, to patients, caregivers, health professionals and the public.

11. Facilitate a program of ethically based research, which advances palliative care practice.
12. Develop accountability and program excellence through a collaborative regional leadership model.

13. Increase support for formal and informal caregivers.

14. Advocate for resources to maintain and further enhance a program of excellence.

15. Review and articulate the palliative care needs of non-malignant populations and of cancer patients with needs that arise as treatment options advance.

IV. CONTINUITY OF CARE

A person who requires palliative care services can be identified in any setting and referred through a single access number. Persons will be assessed for palliative care by Palliative Home Care, in any facility by a Palliative Care Consultant service, by the Community Liaison Nurse or Palliative Consultation Team at the Cross Cancer Institute. A brochure outlining palliative care services is provided (Palliative Care Support - A Guide to Resources) and a video, which describes the services (Palliative Care Services: Helping You Find the Right Place) is available through Home Care, the Consultants and at the Cross Cancer Institute.

The Family Physician and Palliative Home Care provide the majority of palliative care (Appendix 3). If the person is unable or unwilling to remain at home, but does not require acute care services, the family physician can refer to the Palliative Care Consultants to assess for Palliative Hospice. Also available is the Pain & Symptom Control Clinic for cancer patients, at the Cross Cancer Institute, and the ability to refer to the Palliative Consultation team who will visit in the community (any setting within the original Capital Health region) for symptom management.

If a person requires acute care services for acute palliative needs or diagnostic work that cannot be completed on an outpatient basis, any hospital can admit and request a palliative care consultation for symptom assessment and management. The Consultant will work with the discharge site to ensure that all necessary information is shared.

A request for admission to the Tertiary Palliative Care Unit for management of severe symptoms can originate from any care setting. A Palliative Care Consultant will assess the person and refer to the unit if symptoms cannot be managed in the present setting. If the person is in another region, the Tertiary Unit will work directly with the Attending Physician and Nursing Staff to assess and arrange admission. The Tertiary Unit will work carefully on discharge planning, as the average length of stay is 23 days.

The Palliative Care Consultants utilize a single assessment form and common symptom assessment tools to ensure that the most appropriate care setting is chosen. The components of the program are described in section V.
V. COMPONENTS

Regional Palliative Care Office

The Regional Palliative Care Program office (RPCO) is located at the Grey Nuns Community Hospital. The RPCO:

- Coordinates the delivery of care in the region.
- Provides four consult teams (physicians/nurses) to assist primary caregivers in providing care to palliative persons and families at home, in continuing care, community hospitals and other health care institutions in the region.
- Is responsible for the development of standards, and common assessment tools.
- Identifies and advocates for funding needs.
- Provides education in palliative care for professionals and the public.
- Coordinates research with the Division of Palliative Care Medicine and Alberta Cancer Board Palliative Care Research Initiative.
- Provides education and support for Palliative Care volunteers.
- Identifies, coordinates and encourages development of bereavement services.
- Manages the data and identifies outcomes.
- Identifies and plans for the future direction of the program.

The regional nurse and physician consultants, data manager, volunteer & bereavement manager and secretarial staff report directly to the RPCO. All other areas liaise with the program according to the above responsibilities (Appendix 9). There have been significant staff changes in RPCO in the past two years after several stable years (Appendix 12). All positions have been filled following ongoing recruitment efforts.

Community Consultation

The regional office coordinates palliative consultation teams who travel to see referred patients in the Community, Palliative Hospice, Continuing Care and any other health care institutions with the exception of the Royal Alexandra Hospital, University of Alberta Hospital, and the Cross Cancer Institute. Referrals to the consultants are from the person’s primary physician, for consultation on symptom management and/or access to palliative hospice beds (Appendix 13).

The program provides 24 hour, 7 days per week on call coverage to provide support to the primary caregivers. The program physician consultants share coverage of the Tertiary Unit as well as the Royal Alexandra and Community Hospitals and the community. The RPCO nurse consultants also provide coverage to the community and community hospitals.

The teams have access to an emergency drug box, which can be sent to a home if required. Due to the decrease in availability of 24-hour access of pharmacies in the region, use of the drug box is being closely monitored in 2002.

Nurse consultants will assess the person for all hospice referrals and frequently for symptom management. Physician consultants will complete assessments for
symptom management, and also assess each new person when admitted to the hospices. People are contacted to arrange an appointment within 24 hours (Monday – Friday). Urgent referrals are seen as soon as possible any day of the week.

Referrals to the program have remained stable over the last two years (1000 in 2000/01, 1060 in 2001/02 verses 1033 in 1999/00 (Appendix 14, 15). The continued increase of cancer patients of about 50 people per year has not yet significantly impacted the community consultants.

The symptom profile for patients seen on initial referral demonstrates an average of moderate pain 4-5/10 on ESAS, and higher levels of tiredness and lack of appetite. (Appendix 16). Further research is needed to better understand and treat the complicated cachexia/anorexia syndrome and to improve treatment of lack of appetite and fatigue. The appointment of Dr. Vickie Baracos, a Professor of Nutritional Sciences, as research director for the Alberta Cancer Board Research Initiative (with an interest in cachexia, anorexia and appetite) will greatly enhance this area of needed research. A high level of cognitive impairment as measured by the Mini Mental State Examination (36% 2000/01 and 31% 2001/02) is also noted (Appendix 17).

In 2001 the community consultants began reporting on the pain stage for each referral. The Edmonton Staging System provides prognostic information about the likelihood of managing the person’s pain. Stage 3 has a poor prognosis for pain management. 50% of the people assessed were categorized as Stage 3, compared with 77% on the tertiary unit and 30% in acute care (Appendix 12, 13). This suggests that the Regional Consultants continue to be involved in the more complex palliative care problems in the community.

The number of distinct physicians referring to the RPCO is 391 (2000/01) and 406 (2001/02) representing a wide referral base. Of this group 74% each year are family physicians and 26% are specialists (Appendix 18). We will continue to monitor the referral patterns from physicians to ensure a wide number of physicians are aware of the program and able to refer people when required. Physician and health provider knowledge of the availability of consultants is critical to access for palliative care persons.
Education

Basic and continuing education is provided to a wide range of health professionals in a variety of settings to support them in providing quality palliative care to patients and caregivers (Appendix 19). Educational initiatives for persons receiving palliative care and caregivers are also fundamental. In collaboration with the Division of Palliative Medicine, new initiatives have been added to ongoing education:

Educational Resources

- A video about palliative care services for persons and families titled “Palliative Care Services: Helping You Find the Right Place” is available to be shown to new persons and families and is used in educational opportunities to describe the program. (Joint project of the RPCP, Cross Cancer Institute and Caritas Health Group).

- The video is complemented by a brochure on the program describing aspects of the program from wherever site the person may be at (in redesign for 2002).

- The family physician handbook, titled “Alberta Palliative Care Resource” is provided to all medical residents and new physicians. (Joint project with the Alberta Cancer Board and Calgary Regional Health Authority). The Alberta Cancer Board now undertakes to provide it free of charge to all family physicians in Alberta.

- Nursing handbook titled “99 common Questions (and answers) About Palliative Care: A Nurses’ Handbook” is being updated this year with increased input from Clinical Nurse Specialists from 4 other regions in Alberta. Available in the fall of 2002.

- A handbook for family caregivers “A Caregiver’s Guide A handbook about end of life care” is provided to every palliative care client at home by palliative home care. (Collaborative project between RPCP and Palliative Care Association of Alberta and Order of Lazarus). The handbook is available free of charge to all palliative caregivers in Alberta. The Caregiver Guide is also installed on the website www.albertapalliative.net as part of the Ed Net Project.

- The “palliative care tips” are updated and sent to all family physicians in the region on a monthly basis and are posted on the website. This is a highly popular method of education for physicians.

- The Regional Palliative Care website www.palliative.org has been redesigned in 2001. Program description, journal watch, palliative care “tips”, divisional publications, nursing notes, and the assessment tools as well as the annual report are contained on the website.
Educational Initiatives

- The Annual Conference, “Palliative Care Education and Research Days” was held in the fall of 2000 and 2001. The conference attendance was 370 in 2000, and in 2001 registration was closed at 384 due to lack of space. The conference committee has considered a larger venue for this popular conference, and has decided to stay at the Fantasyland Hotel venue to keep the conference affordable.

- A clinical placement Main-Pro C course on palliative care is available to family physicians (by Dr. Anna Taube). Beginning in January 2000, twelve family physicians have completed training, providing highly positive evaluations of the course.

- RPCO nurse consultants have designed and offered a three level palliative care continuing education half day session to staff in Palliative Hospices with components designed for RN’s, Licensed Practical Nurses (LPN) and Nursing Attendants (NA). Designed as a continuing education and retention initiative these sessions are positively evaluated by staff.

- Two-day home care palliative orientation has been redesigned and in 2001 became open to all new Hospice RN’s and in 2002 to RN’s working for home care vendor organizations.

- Community Case Rounds occur twice per month and rotate between palliative care sites. The case rounds replaces the traveling bus rounds in 2002 as a means to provide education and clinical discussion for the regional consultants, site staff and students.

- A monthly city wide round is held at the Grey Nuns Hospital. This round includes presentations by national and international speakers on education and research aspects of palliative care. Weekly palliative care rounds continue to take place. These rounds focus on the continuing education of palliative care health professionals in the region.

- The quarterly “palliative care newsletter” by RPCO is a communication tool within the palliative care community. The newsletter is utilized as a wide communication tool to update all staff of what is happening nationally, provincially and regionally including clinical, program, research and wellness notes.

- Family medicine residents attend the Tertiary Palliative Care Unit for a two-week rotation or arrange a community rotation.

- In 2001/02 seven nursing students were precepted specifically in palliative care (verses oncology) in Nursing 495 in collaboration with Dr. Karin Olsin.

- The Tertiary Palliative Care Unit and RPCP have educated 12 physician trainees and fellows in each of the last two years, and 11 (2000/01) and 7 (2001/02) international visitors (physicians and other health professionals) (Appendix 20). Visitors spend varying amounts of time in other areas of the program, (Acute Care, Hospice, Community) depending upon their objectives, providing exposure to a regionalized community based program.

Research:
The RPCP in collaboration with the Division of Palliative Medicine continues to maintain a strong research program in support of evidenced-based practice. Current publications are listed in Appendix 21. Staff changes will impact the number of research protocols and publications over the next few years as new staff begin their academic careers.

The Alberta Cancer Board continues to support a province wide palliative care research initiative. We are in the third year of three-year funding of the Initiative in May 2001. Dr. Vickie Baracos, Professor of Nutritional Sciences has been appointed Research Director in 2002 and Dr. Konrad Fassbender, a health economist and Adjunct Professor of Public Health Sciences, was appointed as a Senior Research Associate of the Alberta Cancer Board Palliative Care Research Initiative on May 1, 2001. This team together with administrative support in Calgary and Edmonton provides strong expertise to collaborate among disciplines and with other regions.

**Volunteers:**

Volunteers play a crucial role in the interdisciplinary approach to palliative care. Over the past two years 107 (2000/01 and 129 (2001/02) specially trained volunteers gave 14,324 and 14,442 hours, respectively, to help support patients and families at the Hospices, Tertiary Palliative Care Unit, Royal Alexandra and Sturgeon Hospital, Cross Cancer Institute and in the home (Appendix 22). Although the support and retention of these volunteers is an ongoing challenge we have continued to increase numbers of active volunteers each year (61% increase since 1996).

Volunteers are provided with support through the volunteer department in each place where our program operates. In addition regular newsletters, team meetings, an annual retreat and a training program are provided through the staff and volunteers from the program.

All volunteers are required to take 27 hours of training. This provides them with information relating to the physical, psychological, emotional and spiritual aspects of palliative care, as well as culture, family dynamics and personal wellness. The training continues to prove popular and in addition to the 35 (2000/01) and 53 (2001/02) new volunteers, we also trained 11 (2000/01) and 5 (2001/02) people from other organizations who provide support to palliative persons and their families.

**Bereavement:**

The bereavement support program operates as a bridging system for bereaved family and friends between the place where palliative care is provided prior to the patient’s death and the community support available after the death. In 2001, Palliative Home Care was successfully included in this program.

Following on specially developed guidelines the program strives to support the bereaved in a variety of ways depending upon their needs. Within one month of the patient’s death, 445 (2000/01) and 858 (2001/02) families received a bereavement package giving them information about grief and ways that they might use to help
them deal with it. In addition they received a bookmark which lists phone numbers and places to call should they require bereavement help.

One month later 243 (2000/01) and 603 (2001/02) families received a follow-up phone call from a staff member or volunteer to offer appropriate support, and where requested, referrals to agencies and individuals specializing in bereavement care within Capital Health Region 10.

In order to provide the most current information, the program annually updates its Bereavement Resource list (revised March, 2002) and circulates copies to over 200 information and support facilities in the region.

Grief and bereavement support is available on an ongoing basis for persons and their families and for the staff who provide their care. Staff may attend monthly onsite bereavement support meetings at St. Joseph’s Hospice and Mel Miller Hospice at the Edmonton General Continuing Care Facility. The bereavement manager, who is also available for one-on-one support when required, facilitates these sessions. Bereavement education is provided for hospice and homecare staff, medical students, fellows and family physician residents on the tertiary unit and in other educational and community care facilities when requested.

B. Tertiary Palliative Care Unit

The 14-bed Tertiary Palliative Care Unit (TPCU) is located at the Grey Nuns Community Hospital. The primary focus of the TPCU is to treat persons with the most complex palliative physical and psychosocial issues within Northern Alberta. The expected length of stay is 2 weeks, to treat symptoms and discharge to the most appropriate setting. In the past two years the average length of stay has decreased from 27 to 25 (2000/01) and 23 (2001/02) days with a median stay of 19 and 18 days. (Appendix 23, 24). The decreased length of stay has allowed a 9% (2000/01) and 7% (2001/02) increase in admissions. There continues to be a group of people where the most appropriate setting for end-of-life care is the Tertiary Unit, due to the severity of symptoms and psychosocial support needed.

We continue to monitor the frequency and severity of symptoms with the daily completion of the ESAS. In comparison to persons admitted to Hospice, Acute Care or seen by the RPCO Consultants, persons admitted to the Tertiary Unit have the most severe reporting of symptoms as expected (Appendices 25-28).

There have also been significant staff changes on the TPCU including the manager, director and both full time physicians in the last two years. The unit has focused on developing the nursing staff, having both LPN’s and RN’s working to full scope of practice and team building. The TPCU plans to develop five-year goals and objectives, reflecting the vision, mission and philosophy of the Caritas Health Group and the RPCP.

The TPCU is part of a regional initiative and the utilization of all acute care beds and may admit "off service" patients when occupancy is down. These occasional patients are not included in patient profiles.
C. Referral Hospitals

As large tertiary referral centres, the Royal Alexandra (RAH) and the University of Alberta Hospitals both have full time nurse/physician palliative care consultants. Interdisciplinary support is available at both sites. Data from the University of Alberta Hospital is not available. Data collection and complete coverage at the UAH is being addressed in 2002.

At the RAH, the number of referrals has increased from 421 (1999/00) to 460 (2000/01) and 455 (2001/02) (Appendix 29, 30). The ongoing focus on discharge planning is demonstrated in a decrease of length of stay to 16.9 (2001/02) from 17.9 days (2000/01). The team in Acute Care tends to see people earlier in the disease trajectory, at times just receiving a palliative care diagnosis. Time is needed to absorb information, address symptoms and consider different options for care. As expected the severity of symptoms and frequency of cognitive impairment are lower than the tertiary or community consultant population (Appendix 31-34).

D. Palliative Hospices

Palliative Hospices consist of 57 beds located on four sites:

- Mel Miller Hospice, Edmonton General Hospital (Caritas) 22 beds
- Norwood Hospice, Capital Care Norwood 20 beds
- St. Joseph Hospice, St. Joseph Auxiliary Hospital 14 beds
- Youville Nursing Home 1 bed

With the support of 24 hour RN coverage, Palliative Hospices provide end of life care to 467 (2000/01) and 495 (2001/02) persons per year (Appendix 35, 36). All Palliative Hospices are located in continuing care facilities and are considered specialty programs. Interdisciplinary, nursing and medication support is enhanced as compared with continuing care staffing. Attending physicians are asked to visit twice per week, and may be called at any time to address symptom issues. There was an increase in the average length of stay (ALOS) to 40 days with wide variation (standard deviation of 48 days) in 2001/02, although the median stayed consistent at 20 days. There were five long term residents staying for 300-600 days, with one other person over 600 days accounting for 2757 bed days. Residents staying over six months are reviewed to ensure that Palliative Hospice is the appropriate setting. However, there is a small group of people who have significant symptom issues where Hospice is the right setting despite the longer length of stay. There were no particular diagnoses that led to longer length of stays.

The occupancy rate remains quite stable at 89 (2000/2001) to 92% (2001/02) allowing for rapid admissions from home to avoid emergency visits or acute care (Appendix 35, 36). This means that an average of 40 admission and discharges to the 57 hospice beds occur every month representing a 70% turnover. Admissions require tours of Hospices by families, family conferences on the goals of care, admission orders with pharmacy assistance. Care at the end of life often requires multiple adjustment to medications, hypodermoclysis to prevent dehydration, family and resident psychosocial support, involving significant staff and volunteer support.
One of the goals of the palliative care program council this year is to review workload and expectation of Hospices and their staff. Although according to admission criteria (Appendix 4) persons admitted should be “stable”, there are multiple needs and expectations for this population, particularly when discharged from acute care to hospice.

Access to the Hospices is centralized through the Regional Palliative Care Community Team. Assessment is completed wherever the person is located in the region. A primary principle of the program is that the person’s family physician is able to provide palliative care in Hospices, maintaining the continuum of care. Family physicians are able to receive admitting privileges to every hospice on the same day it is requested. The RPCP database identifies both the referring and admitting physicians. In 2001/02, 112/458 (24% 2001/02 and 28% in 2000/01) had the same physician continue to provide care. When the referring physician is not able to provide care in Palliative Hospice, a family physician interested in palliative care is approached to transfer care. It was expected that specialists would transfer care to a family physician, and this occurred in 44% (155) referrals in 2001/02. In all cases, an initial consult is completed on admission by a Palliative Physician Consultant, with follow-up by the Consultants until stable.

The symptom profile in ESAS scores remains very consistent between the two years being reviewed and the previous year (Appendix 37, 38). The proportion of persons with cognitive impairment on admission as measured by the MMSE has increased from 44% (1999/00) to 50% in 2000/01 and 53% 2001/02 (Appendix 39, 40).

Transfers from Palliative Hospice to Acute Care sites continue to be monitored and remain low (2%), suggesting the Palliative Hospice staff and Consultants continue to deal with symptom issues proactively in the Hospice setting.

E. Home Care

Consistent with the new national norms of practice, Palliative Home Care provides coverage 24 hours per day, seven days per week. A centralized community access number is provided to each person and they are encouraged to call Home Care first. Nursing is available to visit during days and evenings 7 days per week and is on call at night. Care is provided collaboratively with the Family Physician, with Consultants available upon request of the physician. The expected length of stay is 3 to 4 months (Appendix 4), with persons requiring symptom management and psychosocial support.

A wide variety of services are available in the home, including case management, professional nursing, rehabilitation services, social work, respiratory therapy, contracted support services (LPN and personal care). Treatment for hypercalcemia, delirium with treatments such as hypodermoclysis, opioid rotation, and respite support are common practices in the home.

Home care has dedicated Palliative Case Managers in the north and south offices of Edmonton, and integrated teams in the surrounding areas. Home charts are utilized in the north and south palliative care offices for the majority of people.
Diagnosis continues to be primarily cancer. The average length of stay of 101 days is within expected parameters for persons requiring active care to alleviate symptoms (Appendix 41, 42). As expected, ESAS scores reveal mild to moderate symptom management issues, with a more stable population in relation to symptom management as compared with other areas (Appendices 43-45).

One third of palliative home care persons die at home. In 2000, this constituted 14% of all cancer deaths. This percentage is lower than planned, and it is expected the number of home deaths will increase with adjustments made in the last year. In each of the last two years, 26% are admitted to hospice. As well, each year several persons (14% 2000/01 & 7% 2001/02) stabilize and are appropriately transferred to long term home care or are discharged (Appendix 41,42).

A palliative home care database was created by home care November 2001. The database contains specialized data such as the ESAS, MMSE and Home Death Assessment Tool that the regular home care database (HCIS) does not accommodate. This information is accessed by the RPCO data manager to create reports.

F. Cross Cancer Institute:

The RPCP maintains a strong relationship with the Cross Cancer Institute and their palliative care services:

- Pain & Symptom Control Clinic: This highly interdisciplinary clinic provides assessment and consultation to cancer patients from any health care region. The clinic remains heavily booked (maximum of 4 new and 4 follow up patients per clinic), creating the need for mini clinics during the week (Table 1). Thirty percent of referrals are from family physicians, with the majority from within the Institute.
- Consultants: .5 FTE physician consultant and .8 FTE nurse consultant and .5 pharmacist provides in & acute patient consultations and run the clinic with the assistance of the interdisciplinary team and a regional physician consultant. (Table 2). Outpatients are followed with telephone calls until stable and are referred to the regional palliative consultants if required.
Table 1

CROSS CANCER INSTITUTE – PAIN & SYMPTOM STATISTICS
FOR PEOPLE SEEN BETWEEN
April 1, 2000 - March 31, 2002

<table>
<thead>
<tr>
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<tr>
<td>Clinic(^a)</td>
<td>132</td>
<td>147</td>
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<tr>
<td>Referral(^b)</td>
<td>242</td>
<td>315</td>
</tr>
<tr>
<td>Total</td>
<td>374</td>
<td>462</td>
</tr>
</tbody>
</table>

\(^a\) Follow up visits to clinic were 90 (00/01) and 95 (01/02)
\(^b\) Referrals to Pain & Symptom team seen outside of clinic.

- Community Liaison Nurse: This nurse provides discharge planning to outpatients who are identified as requiring palliative care (Table 2). This position is instrumental in ensuring persons discharged from the Institute have a Family Physician, are referred to Home Care as appropriate and are aware of resources available in the community. A total of 304 referrals to support services (e.g.: home care, new family physician, pain & symptom clinic) were made for 288 patients discharged. The nurse ensures continuity of care by sending a letter to the family physician and home care including an information package on symptom assessment, and about palliative care services.

- Hospice Referrals: In or outpatient referrals for Palliative Hospice are completed by the community liaison nurse. The same assessment form is utilized and the referrals are triaged by the Regional Palliative Community Team.

Table 2

COMMUNITY REFERRALS TO PALLIATIVE CARE
CROSS CANCER INSTITUTE
April 1 2000-March 31, 2000

<table>
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<tr>
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<th>Capital Health Region</th>
<th>Other Regions</th>
<th>Total</th>
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<tr>
<td>Total</td>
<td>244</td>
<td>270</td>
<td>64</td>
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<tr>
<td>Monthly Average</td>
<td>20.3</td>
<td>22.5</td>
<td>5.3</td>
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</table>

K:\DATA\Annual Report 01 & 02\annual report 01 & 02.doc
March 13, 2003
G. Grey Nuns Palliative Care Clinic:

Once per week, the staff of the Tertiary Palliative Care Unit support a small outpatient clinic for palliative care patients with symptom issues requiring multidisciplinary input. The number of people booked into the clinic remains low (24 in 2001/02). Space (2 rooms), staffing and performance status of the patients are limiting factors.

VI. CLINICAL INTERPRETATION OF DATA

As well as providing individual clinical information, the averages of ESAS scores allows the program to review and describe the types of palliative care issues occurring in the different areas of the program. Clearly the TPCU admits persons with the highest symptom scores, requiring the intense management available from the interdisciplinary team. The average pain score on admission is more than 5/10 indicating severe pain. Increased psychosocial support is needed for the younger population, as indicated by the higher depression (3-4/10), anxiety (4/10) and sense of wellbeing (5/10) scores than other areas of the program (Appendix 25, 26).

Scores from the Community Consultants reflect people assessed in their home, community setting or hospital and demonstrate moderate symptom distress. Average pain scores are more than 4/10. Higher symptom scores are expected than Home Care where Consultants should be seeing those requiring advice on symptom management.

Consultations to the Royal Alexandria Hospital appear to demonstrate the more mixed population seen often earlier in the disease trajectory. Average pain scores are 2/10 (Appendix 31, 32). Cognitive impairment is more frequently noted in this population than for community or TPCU often reflecting the need for referral to Hospice. Discharge planning to the most appropriate setting remains a strong focus for the Consultation team.

Hospices ESAS scores reflect mild to moderate symptoms. The average pain score is 3/10. Higher abnormal MMSE of 50% and drowsiness scores of 4/10 begin to describe the nursing care needed to provide safe, quality palliative care (Appendices 37-40). Criteria of admission and guidelines are being reviewed to ensure the level of need for care can be matched with the nursing and interdisciplinary care available.

Palliative Home Care ESAS scores reflect the more stable population of mild symptom profile. Average pain scores are 2/10. Cognitive impairment is less common (10% with abnormal MMSE on admission) (Appendices 43-45). The steady increase in persons requiring palliative care in the home is expected to continue as the palliative population grows by 50 cancer deaths each year.

The high ESAS scores in all areas of the program in tiredness and appetite reflect the burden of cancer and are important quality of life indicators. Programs of research being conducted in Edmonton on the cachexia/anorexia syndrome by Dr. Vickie Baracos, and on fatigue by Dr. Karin Olsin may begin to shed light on these symptoms that are difficult to provide interventions for and to further improve the quality of living and dying.
VII. SUMMARY

The publication of the “A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice” (Canadian Hospice Palliative Care Association, March 2002) will help guide the future development of our Regional Palliative Care Program. Upon initial review of the model, the program is well structured to provide accessible, well integrated quality palliative care. The program’s common principles, goals, assessment tools and clinical guidelines, education and research program provide a strong foundation. The work over the past year in creating a mission and vision to provide direction also facilitates program development.

Further work on performance indicators will be occurring over the next year with the assistance of the results of the research study “Economic Evaluation of Two Regional Palliative Care Programs for Terminally Ill Cancer Patients”, funded by the Canadian Health Services Research Foundation (report due winter 2002). The study will refine definitions of present indicators such as access and identify other areas where regular monitoring will assist in quality review.

The trajectory of care sites for persons requiring Palliative Care has changed since the program began in 1995 (Appendix 5,6,7 & 46). The decrease in Acute Care bed days has been transferred to Palliative Hospice as well as Palliative Home Care, resulting in decreased costs to Acute Care services. The above mentioned Economic Evaluation Study will review all public dollars from 1993 until 2000, describing this shift in care and costs.

The percentage of cancer patients who died in Acute Care decreased by 6% between 1999 and 2000 (Appendix 46), although the actual number and length of stay increased (Appendix 4,5). The predicted rise in the number of palliative care persons overall creates the need to plan for increases in all areas of the program over the next few years. Increased capacity will be required in Palliative Home Care in particular, as it is not expected that the number of Acute Care and Hospice beds will increase at the same rate as population growth. It is expected that Palliative Home Care will report an increase in home deaths in the next year, as some resource issues have been addressed. A further indicator, which will be reported by the economic evaluation study, is the length of time a person spends in each part of the program. This information will highlight the significant role Palliative Home Care plays in the palliative care trajectory.
VIII. APPENDICES

Figure 1 - Continuum of Palliative Care (modified from the CPCA, 2001 Proposed Norms of Practice for Hospice Palliative Care)
### Access to Palliative Care as Measured by Patients Receiving Palliative Care Consultation to Actual 2000 & Predicted 2001 Number of Deaths Due to Cancer for Region 10 Population

#### Historic figures

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<thead>
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<th>Year</th>
<th>Description</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>Number of Patients Receiving Palliative Care Services (1)</td>
<td>290</td>
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<tr>
<td>1992</td>
<td>Actual Number of Deaths Due to Cancer (2)</td>
<td>1341</td>
<td>21.6%</td>
</tr>
</tbody>
</table>

**NOTE**
1 - Estimate of patients seen in the Acute Palliative Care Unit and at the Misericordia Hospital in 1992.
2 - Information provided by the Alberta Cancer Board, Epidemiology. Includes Edmonton, St. Albert, and Strathcona County.
Subtotals for areas include: Edmonton: 1275 deaths. St. Albert: 59 deaths. Strathcona County: 7 deaths.

#### Present figures

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Number of Region 10 Cancer Patients Receiving Palliative Care Consultations (3)</td>
<td>1060(4)</td>
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<tr>
<td>2000</td>
<td>Actual Number of Deaths Due to Cancer (5)</td>
<td>1368</td>
<td>77.5%(6)</td>
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<tr>
<td>2001</td>
<td>Number of Region 10 Cancer Patients Receiving Palliative Care Consultations (3)</td>
<td>1073(4)</td>
<td></td>
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<tr>
<td>2001</td>
<td>Predicted Number of Deaths Due to Cancer (5)</td>
<td>1549</td>
<td>69.3%(7)</td>
</tr>
</tbody>
</table>

**NOTE**
3 - Number of unique admissions/referrals to CHA palliative care consultations from Jan 01, 2000 to Dec 31, 2000 and Jan 01, 2001 to Dec 31, 2001 respectively.

4 - UAH Palliative Care team consultation numbers are not available.

5 - Information provided by the Alberta Cancer Board, Epidemiology. Includes Edmonton, St. Albert, and Strathcona County on all regional cancer deaths.

6 - Actual percentage of cancer patients receiving consultations from Jan 01, 2000 to Dec 31, 2000.

7 - Predicted percentage of cancer patients receiving consultations from Jan 01, 2001 to Dec 31, 2001.
Palliative Care Services in the Capital Health Region

Appendix 3
CRITERIA FOR ADMISSION

Based upon the definition of palliative care, all people admitted to the program will:

- be experiencing progressive disease where the focus of care is on comfort, not cure, and improving their quality of life
- require active care to alleviate distressing symptoms related to physical, psychosocial and spiritual needs

Approximately 85-90% of these people will have a cancer diagnosis.

Admission Criteria to Specific Areas:

**Home**
- above criteria
- expected length of stay on the program of approximately 3-4 months
- does not require acute hospital or tertiary care
- the ability to provide services within financial resources
- desire for the person/family to be cared for at home

**Palliative Hospice**
- above criteria
- cannot be managed at home
- does not require acute/tertiary care in a hospital setting
- expected length of stay of approximately 2 months
- over 18 years
- accepting of no code status

**Acute Care Hospital**
- for management of acute medical problems (i.e. pathological fracture, bleed, acute respiratory distress)
- anticipated short stay

**Tertiary Palliative Care Unit**
- severe symptom problems for which management has not been successful in any of the other settings, and requiring intensive management
- expected length of stay of approximately 2 weeks
- over 18 years
- accepting of no code status

Appendix 4
TOTAL Capital Health Hospital Deaths\textsuperscript{a} with a Most Responsible Diagnosis of Cancer, and Deaths at the Cross Cancer Institute

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{chart.png}
\end{figure}

NOTE:  ICD-9-CM diagnostic codes used to determine cancer are 140.* to 208.* and 230.* to 234.* (malignant neoplasms)

ICD-9-CM diagnostic codes used to determine palliative care, chemotherapy or radiotherapy are V58.0, V58.1 and V58.89 (to 97/03/31) and V66.7 (from 97/04/01) with a secondary diagnosis of 140.* to 208.* and 230.* to 234.*, or V10.* to V10.9*

\textsuperscript{a}Source: Capital Health Evaluation, Information and Research, April 2002

\textsuperscript{b}Cross Cancer Institute April, 2002. The numbers provided in the tables are provisional as some cases (or deaths) may be registered in subsequent years.

Methods of coding of cancers on the Alberta Cancer Registry have varied through the years; therefore, caution should be exercised when comparing this data to that of previous years.

Appendix 5
NOTE: ICD-9-CM diagnostic codes used to determine cancer are 140.* to 208.* and 230.* to 234.* (malignant neoplasms)
ICD-9-CM diagnostic codes used to determine palliative care, chemotherapy or radiotherapy are V58.0, V58.1 and V58.89 (to 97/03/31) and V66.7 (from 97/04/01)
with a secondary diagnosis of 140.* to 208.* and 230.* to 234.*, or V10.* to V10.9*

Source: Capital Health Evaluation, Information and Research, April 2002

Methods of coding of cancers on the Alberta Cancer Registry have varied through the years; therefore, caution should be exercised when comparing this data to that of previous years.

Appendix 6
NOTE: ICD-9-CM diagnostic codes used to determine cancer are 140.* to 208.* and 230.* to 234.* (malignant neoplasms)
ICD-9-CM diagnostic codes used to determine palliative care, chemotherapy or radiotherapy are V58.0, V58.1 and V58.89 (to 97/03/31) and V66.7 (from 97/04/01)
with a secondary diagnosis of 140.* to 208.* and 230.* to 234.*, or V10.* to V10.9*

aSource: Capital Health Evaluation, Information and Research, April 2002
bCross Cancer Institute April, 2002. The numbers provided in the tables are provisional as some cases (or deaths) may be registered in subsequent years.
Methods of coding of cancers on the Alberta Cancer Registry have varied through the years; therefore, caution should be exercised when comparing this data to that of previous years

Appendix 7
The Regional Office maintains a liaison role, in the areas of standards, guidelines, education, research and program outcomes with all areas of the program. The program also liaises with the Alberta Cancer Board.

Appendix 9
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carleen Brenneis</td>
<td>Program Director</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Regional Palliative Care Program, Grey Nuns Community Hospital</td>
</tr>
<tr>
<td>Robin Fainsinger</td>
<td>Director, Division of Palliative Care Medicine</td>
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<tr>
<td>Co-Chair</td>
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<tr>
<td>Marion Boyd</td>
<td>Executive Director</td>
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<td>Pilgrim's Hospice Society</td>
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<td>Paula Brindley</td>
<td>Volunteer and Bereavement Manager</td>
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<td>Donna deMoissac</td>
<td>Advanced Nursing Practice, Palliative Care</td>
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<td>Miriam Dobson</td>
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<td>Kim Kisko</td>
<td>Patient Care Manager of Medicine, Pediatrics and IV Therapy</td>
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<td>Priscilla Koop</td>
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<td>Peter Lawlor</td>
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<td>Karen MacMillan</td>
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<td>Tom Martin</td>
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<td>Janice Chobanuk</td>
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<td>Sharon Watanabe</td>
<td>Director, Palliative Care Program</td>
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<td>Cross Cancer Institute</td>
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### Palliative Performance Scale (PPSv2)
#### version 2*

<table>
<thead>
<tr>
<th>PPS Level</th>
<th>Ambulation</th>
<th>Activity &amp; Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Conscious Level</th>
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<tbody>
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<td>100%</td>
<td>Full</td>
<td>Normal activity &amp; work No evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90%</td>
<td>Full</td>
<td>Normal activity &amp; work Some evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
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<tr>
<td>80%</td>
<td>Full</td>
<td>Normal activity <em>with</em> Effort Some evidence of disease</td>
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<td>Normal or reduced</td>
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<td>70%</td>
<td>Reduced</td>
<td>Unable Normal Job/Work Significant disease</td>
<td>Full</td>
<td>Normal or reduced</td>
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<td>60%</td>
<td>Reduced</td>
<td>Unable hobby/house work Significant disease</td>
<td>Occasional assistance necessary</td>
<td>Normal or reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>50%</td>
<td>Mainly Sit/Lie</td>
<td>Unable to do any work Extensive disease</td>
<td>Considerable assistance required</td>
<td>Normal or reduced</td>
<td>Full or Confusion</td>
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<td>40%</td>
<td>Mainly in Bed</td>
<td>Unable to do most activity Extensive disease</td>
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<td>Normal or reduced</td>
<td>Full or Drowsy +/- Confusion</td>
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<td>30%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Normal or reduced</td>
<td>Full or Drowsy +/- Confusion</td>
</tr>
<tr>
<td>20%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Minimal to sips</td>
<td>Full or Drowsy +/- Confusion</td>
</tr>
<tr>
<td>10%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Mouth care only</td>
<td>Drowsy or Coma +/- Confusion</td>
</tr>
<tr>
<td>0%</td>
<td>Death</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Copyright © 2001 Victoria Hospice Society

* See Palliative Performance Scale version 2 Program Guidelines

---

**Appendix 11**
# REGIONAL PALLIATIVE CARE PROGRAM STAFFING

*(April 1, 2000 - March 31, 2002)*

<table>
<thead>
<tr>
<th>Title</th>
<th>FTE</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Director</td>
<td>1.0</td>
<td>Carleen Brenneis*</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>0.5</td>
<td>Robin Fainsinger*</td>
</tr>
<tr>
<td>Secretary</td>
<td>1.0</td>
<td>Barb Jones</td>
</tr>
<tr>
<td>Secretary</td>
<td>1.0</td>
<td>Odette Mohler*</td>
</tr>
<tr>
<td>Secretary</td>
<td>0.5</td>
<td>Myrtle Gauld*</td>
</tr>
<tr>
<td>Data Manager</td>
<td>0.5</td>
<td>Hue Quan*</td>
</tr>
<tr>
<td>Volunteer &amp; Bereavement Manager</td>
<td>1.0</td>
<td>Paula Brindley*</td>
</tr>
<tr>
<td>Consult Physician</td>
<td>1.0</td>
<td>Peter Lawlor</td>
</tr>
<tr>
<td>Consult Physician</td>
<td>1.0</td>
<td>Doreen Oneschuk</td>
</tr>
<tr>
<td>Consult Physician</td>
<td>1.0</td>
<td>Anna Taube*</td>
</tr>
<tr>
<td>Consult Physician</td>
<td>1.0</td>
<td>Ingrid deKock*</td>
</tr>
<tr>
<td>Consult Physician</td>
<td>1.0</td>
<td>Debra Slade*</td>
</tr>
<tr>
<td>Consult Physician</td>
<td>1.0</td>
<td>Yoko Tarumi*</td>
</tr>
<tr>
<td>Consult Physician</td>
<td>1.0</td>
<td>Pablo Amigo</td>
</tr>
<tr>
<td>Consult Physician</td>
<td>.6</td>
<td>Lemore Alima</td>
</tr>
<tr>
<td>Consult Nurse</td>
<td>1.0</td>
<td>Gary Frank*</td>
</tr>
<tr>
<td>Consult Nurse</td>
<td>1.0</td>
<td>Sally Turco*</td>
</tr>
<tr>
<td>Consult Nurse</td>
<td>1.0</td>
<td>Sharon Hunter*</td>
</tr>
<tr>
<td>Consult Nurse (temp. Full Time)</td>
<td>1.0</td>
<td>Susan Campbell*</td>
</tr>
<tr>
<td>Consult Nurse</td>
<td>1.0</td>
<td>Larissa Podilsky</td>
</tr>
<tr>
<td>Consult Nurse</td>
<td>Casual</td>
<td>Kate Squires*</td>
</tr>
<tr>
<td>Consult Nurse</td>
<td>Casual</td>
<td>Patsy Cantwell*</td>
</tr>
<tr>
<td>Consultant Nurse</td>
<td>Casual</td>
<td>Shirley Paterson*</td>
</tr>
<tr>
<td>Consultant (Education)</td>
<td>Casual</td>
<td>Beth Perry</td>
</tr>
<tr>
<td>Consultant (Education)</td>
<td>Casual</td>
<td>Linda Read-Paul</td>
</tr>
<tr>
<td>Consultant (Education)</td>
<td>Casual</td>
<td>Jacque Peden</td>
</tr>
</tbody>
</table>

* Staff on March 31, 2002
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2000</td>
<td>Barb Jones resigned as secretary. Odette Mohler hired as secretary.</td>
</tr>
<tr>
<td>November 2000</td>
<td>Sharon Hunter hired as casual Nurse consultant.</td>
</tr>
<tr>
<td>December 2000</td>
<td>Tami Shandro resigned as physician consultant.</td>
</tr>
<tr>
<td>February 2001</td>
<td>Shirley Paterson hired as casual Nurse consultant.</td>
</tr>
<tr>
<td>April 2001</td>
<td>Jose Pereira resigned as Acting Director of the Tertiary Palliative Care Unit. Peter Lawlor resigned from the Regional Palliative Care Program to become Acting Director of Tertiary Palliative Care Unit. Doreen Oneschuk resigned as physician consultant to become physician on the Tertiary Palliative Care Unit.</td>
</tr>
<tr>
<td>May 2001</td>
<td>Pablo Amigo hired as senior clinical fellow.</td>
</tr>
<tr>
<td>June 2001</td>
<td>Ingrid deKock hired as physician consultant. Yoko Tarumi hired as senior clinical fellow.</td>
</tr>
<tr>
<td>July 2001</td>
<td>Debra Slade hired as physician consultant.</td>
</tr>
<tr>
<td>August 2001</td>
<td>Lemore Alima contract completed as physician consultant.</td>
</tr>
<tr>
<td>September 2001</td>
<td>Larissa Podilsky, Nurse consultant, begins 1-year maternity leave of absence.</td>
</tr>
<tr>
<td>September 2001</td>
<td>Sue Campbell hired as temporary nurse consultant for one year.</td>
</tr>
<tr>
<td>October 2001</td>
<td>Kate Squires hired as casual Nurse Consultant for on-call.</td>
</tr>
<tr>
<td>November 2001</td>
<td>Patsy Cantwell, nurse consultant, retired. Re-hired as casual nurse consultant.</td>
</tr>
<tr>
<td>February 2002</td>
<td>Sharon Hunter hired as nurse consultant.</td>
</tr>
<tr>
<td></td>
<td>Pablo Amigo resigned as physician consultant to become physician on Tertiary Palliative Care Unit.</td>
</tr>
</tbody>
</table>
Referral Flow Chart - Community Consultants

- Only physicians can refer to consultants for both streams
  - sites are anywhere but UAH, RAH, we cover all community, hospitals, continuing care, CHOICE etc.
  - consultant service, not primary care (secondary level care)

- Referral assigned to consultant based on urgency, reason, geography & workload

1. Receive Referral
2. Screen for Eligibility
3. Is Client Appropriate?
   - Yes
   - No

4. If hospice, RN calls in 24 hours to arrange completion of comprehensive assessment
5. Eligible for hospice - add to site specific admission list based on clinical need
6. Communicate with referral source (provide symptom management support)
7. Is client appropriate?
   - Yes
   - No

8. Outcome communicated to referral source

9. Is Other Hospice Site Appropriate?
   - Yes
   - No

10. Will Hospice consider in a few days?
11. Appropriate? - discuss with hospice manager
12. Waitlist?
   - Yes
   - No

13. If waitlist - add to waitlist - site specific waitlist
   - triage on clinical need
14. Communicate with referral source (provide symptom management support)
15. Agreed appropriate - arrange admission

16. Is client stable?
   - Yes
   - No

17. Provide ongoing consultative support until stable
18. Provide other referrals (acute care, tertiary, hospice) as appropriate
19. Exit

Forms:
- PAF, which includes tools:
  - MMSE
  - ESAS
  - CAGE
  - ESS
  - PPS
  - gather collateral information (CCI)

Outcome communicated to referral source

Appendix 13
Regional Palliative Care Program (RPCP) Community Consult Team
Patient Profile
For Patients Referred between Apr 01, 2000 and Mar 31, 2001

n = 1000

AGE at Time of Referral

<table>
<thead>
<tr>
<th></th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>70.8</td>
</tr>
<tr>
<td>Minimum</td>
<td>20</td>
</tr>
<tr>
<td>Maximum</td>
<td>99</td>
</tr>
</tbody>
</table>

Gender

<table>
<thead>
<tr>
<th>GENDER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>47.6%</td>
</tr>
<tr>
<td>Female</td>
<td>52.4%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Pain Stage (n=119)\(^c\)

<table>
<thead>
<tr>
<th>STAGE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>26.90%</td>
</tr>
<tr>
<td>2</td>
<td>16.00%</td>
</tr>
<tr>
<td>3</td>
<td>57.10%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

CAGE Scores (n=650)

<table>
<thead>
<tr>
<th>SCORE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>86.0%</td>
</tr>
<tr>
<td>2 to 4</td>
<td>14.0%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Initial Reason for Referral to RPCP

Assessment & Placement 1.2%

Symptom MGT 42.6%

Placement 56.2%

\(^a\)TPCU - Tertiary Palliative Care Unit
\(^b\)Cont. Care - Continuing Care
\(^c\)Pain Stage data collection started June, 2000
Source: Palliative Care Information System

Appendix 14
Regional Palliative Care Program (RPCP) Community Consult Team
Patient Profile  n = 1060
For Patients Referred between Apr 01, 2001 and Mar 31, 2002

Referred From Location
- Home 38.8%
- Hospice 0.1%
- TPCUa 3.4%
- Acute care 47.6%
- Cross Cancer Inst 4.5%
- Cont.Carec 3.0%
- Other 2.5%

AGE at Time of Referral
- Mean 70.1
- Minimum 20
- Maximum 97

Gender
- Male 46.7%
- Female 53.3%

Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>BONES &amp; CONNECTIVE TISSUE</td>
<td>0.4%</td>
</tr>
<tr>
<td>BREAST</td>
<td>12.5%</td>
</tr>
<tr>
<td>ENDOCRINE GLANDS</td>
<td>0.3%</td>
</tr>
<tr>
<td>EYE, BRAIN &amp; OTHER PARTS OF CNS</td>
<td>2.5%</td>
</tr>
<tr>
<td>GASTRO-INT</td>
<td>27.5%</td>
</tr>
<tr>
<td>GENITO-URI</td>
<td>15.0%</td>
</tr>
<tr>
<td>HEAD&amp;NECK</td>
<td>3.6%</td>
</tr>
<tr>
<td>HEMATOLOGY</td>
<td>5.1%</td>
</tr>
<tr>
<td>LUNG</td>
<td>23.3%</td>
</tr>
<tr>
<td>MELANOMA</td>
<td>0.6%</td>
</tr>
<tr>
<td>OTHER CANCER</td>
<td>5.9%</td>
</tr>
<tr>
<td>PERIPHERAL NERVES &amp; ANS</td>
<td>0.1%</td>
</tr>
<tr>
<td>RETROPERITONEUM &amp; PERITONEUM</td>
<td>0.1%</td>
</tr>
<tr>
<td>SARCOMA</td>
<td>0.4%</td>
</tr>
<tr>
<td>NON-CANCER-CARDIOPULMONARY</td>
<td>0.3%</td>
</tr>
<tr>
<td>NON-CANCER-NEUROMUSCULAR</td>
<td>0.5%</td>
</tr>
<tr>
<td>NON-CANCER-OTHER</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

TOTAL 100.0%

Pain Stage(n=113)d

<table>
<thead>
<tr>
<th>STAGE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>32.70%</td>
</tr>
<tr>
<td>2</td>
<td>16.80%</td>
</tr>
<tr>
<td>3</td>
<td>50.50%</td>
</tr>
</tbody>
</table>

TOTALS 100.00%

TPCU - Tertiary Palliative Care Unit
Method of categorizing diagnosis changed this year to be consistent with Alberta Cancer Board diagnosis groupings
Cont. Care - Continuing Care
Pain Stage data collection started June, 2000
Source: Palliative Care Information System
Date: May 14, 2002

Appendix 15
For Patients Referred between Apr 01, 2000 and Mar 31, 2001

*Edmonton Symptom Assessment Scale-scores are ratings of symptoms on 0 to 10 scale*

*Pain: Total First Pain assessment count is 636*

*Wellbeing: total First Wellbeing assessment count is 400*

Source: Palliative Care Information System

Date: Aug 23, 2001
Abnormal Mini Mental State Examination: <80% of answers correct is an indicator for cognitive impairment

Source: Palliative Care Information System

Date: May 14, 2002

Appendix 17
# PHYSICIAN REFERRALS TO COMMUNITY CONSULTANT TEAMS

## REGIONAL PALLIATIVE CARE PROGRAM

For the Period Between April 1, 2000 and March 31, 2002

<table>
<thead>
<tr>
<th>REFERRALS</th>
<th>PHYSICIANS</th>
<th>PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>170</td>
<td>181</td>
</tr>
<tr>
<td>2</td>
<td>88</td>
<td>90</td>
</tr>
<tr>
<td>3</td>
<td>66</td>
<td>57</td>
</tr>
<tr>
<td>4</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>5</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>6</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>16</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>19</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>26</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>30</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>391(1)</strong></td>
<td><strong>406(2)</strong></td>
</tr>
</tbody>
</table>

(1) of the 391 physicians listed above, 289 (73.9%) are family physicians

(2) of the 406 physicians listed above, 300 (73.9%) are family physicians

---

Source: Palliative Care Information System

Date: May 14, 2002

Appendix 18
**EDUCATION PRESENTATIONS**

**BY**

**REGIONAL PALLIATIVE COMMUNITY CONSULTANTS TEAM***

**April 1, 2000 - March 31, 2001**

<table>
<thead>
<tr>
<th></th>
<th>In Region</th>
<th>Out of Region</th>
<th>Out of Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inservices/Lectures/Orientations **</td>
<td>243</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Workshops</td>
<td>14</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Conference presentations or posters</td>
<td>16</td>
<td>3</td>
<td>23</td>
</tr>
</tbody>
</table>

**EDUCATION PRESENTATIONS**

**BY**

**REGIONAL PALLIATIVE COMMUNITY CONSULTANTS TEAM***

**April 1, 2001 - March 31, 2002**

<table>
<thead>
<tr>
<th></th>
<th>In Region</th>
<th>Out of Region</th>
<th>Out of Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inservices/Lectures/Orientations **</td>
<td>305</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Workshops</td>
<td>21</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Conference presentations or posters</td>
<td>21</td>
<td>4</td>
<td>25</td>
</tr>
</tbody>
</table>

* Does not include Clinical Director

** Inservices/Lectures/Orientations includes Bus Rounds, Case Rounds, Training Sessions, etc.

Appendix 19
### Visitors, Fellows and Trainees to Regional Palliative Care Program (All Areas)

#### Visitors & Fellows - 2000

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fujimoto, Naoko</td>
<td>Japan</td>
<td>May 25-30</td>
</tr>
<tr>
<td>Takanashi, Yoshihiro</td>
<td>Japan</td>
<td>Feb 8-10</td>
</tr>
<tr>
<td>Drefs, Terry RN</td>
<td>Medicine Hat, AB</td>
<td>Mar 27-31</td>
</tr>
<tr>
<td>Chenier, Ginny RN</td>
<td>Medicine Hat, AB</td>
<td>Mar 27-31</td>
</tr>
<tr>
<td>Manning, Loretta RN</td>
<td>Edmonton, AB</td>
<td>Apr 17-28</td>
</tr>
<tr>
<td>Santos Salas, Anna</td>
<td>Edmonton, AB</td>
<td>July</td>
</tr>
<tr>
<td>DeMeulenaere, Peter</td>
<td>Belgium</td>
<td>Aug. 10</td>
</tr>
<tr>
<td>Baumgartner, Johann</td>
<td>Graz, Austria</td>
<td>Aug 14-15</td>
</tr>
<tr>
<td>De Klerk, Braan</td>
<td>Inuvik, NWT</td>
<td>Aug 24</td>
</tr>
<tr>
<td>Isom, Marg (Hospice Manager)</td>
<td>Geelong, Australia</td>
<td>Sep 19,20</td>
</tr>
<tr>
<td>Takigawa, Chizuko</td>
<td>Sapporo, Japan</td>
<td>Nov 6-9</td>
</tr>
</tbody>
</table>

#### Visitors & Fellows - 2001

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lari, Harris</td>
<td>Pakistan</td>
<td>Aug 13-24</td>
</tr>
<tr>
<td>Novak, Mariana</td>
<td>Buenos Aires, Argentina</td>
<td>Nov 01-30</td>
</tr>
<tr>
<td>Neto, Isobel</td>
<td>Lisbon, Portugal</td>
<td>Dec 17-20</td>
</tr>
</tbody>
</table>

#### Visitors & Fellows - 2002

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>De Muria, Mariano</td>
<td>Buenos Aires, Argentina</td>
<td>Jan 2-31</td>
</tr>
<tr>
<td>Belcher, David</td>
<td>Drayton Valley, AB</td>
<td>Feb 28</td>
</tr>
<tr>
<td>Kawabata, Hidenobu</td>
<td>Sapporo, Japan</td>
<td>Mar 08</td>
</tr>
<tr>
<td>Dozono, Fumiko*</td>
<td>Kagoshima, Japan</td>
<td>Apr 29-May 03</td>
</tr>
<tr>
<td>Sakanoue, Kaori, RN</td>
<td>Kagoshima, Japan</td>
<td>Apr 29-May 03</td>
</tr>
<tr>
<td>Yano, Mihoko, RN</td>
<td>Kagoshima, Japan</td>
<td>Apr 29-May 03</td>
</tr>
<tr>
<td>Swenia, Mohamed</td>
<td>Fort McMurray, AB</td>
<td>Jun 11</td>
</tr>
</tbody>
</table>
Palliative Care Trainees - 2000

ESCHER IMHOF, Monica Carouge, Switzerland Apr 1-30/00
BURTON, Gordon Fort MacLeod, AB Mar 6-31/00
WU, Beatrice Edmonton, AB Aug 14-Sep 1/00
IRELAND, Brenda Lethbridge, AB Jun 1-27/00
KRITZINGER, Irma Bonnyville, AB May 22- June 30 /00
SLADE, Debra* Edmonton, AB Jul 01/00-Jun 30/01
AMIGO, Pablo Buenos Aires, Argentina Jul 2/00 - Jun 30/01
JOY, Anil Edmonton, AB Jul 2-30/00
SHEARGREN Jennifer Edmonton, AB Aug 17 - 25/00
BOYCE, Cory Austin, Minnesota Sep 4 - 22/00
SIMMONDS, Mark England Nov. 20-Dec. 31/00
SINHA, Richie Edmonton, AB Nov 27 - Dec 08/00

Palliative Care Trainees - 2001

GRANT, Sydney New Maryland, NB Jan 29 - Feb 09/01
WU, Beatrice Edmonton, AB Feb 19 - Mar 11/01
BEAVER, Richard Edmonton, AB Mar 12 - 25/01
VIGANO, Antonio Edmonton, AB May 01/01 - Apr 30/02
HUNTER, Brad Edmonton, AB Jun 04 - 24/01
HAMiLTON, Marlene Edmonton, AB Jun 04 - 30/01
BARRETH, Angela* Edmonton, AB Jul 01/01-Jun 30/02
STRASSER, Florian Houston, TX Aug 07-31/01
STOYKO, Larry Vegreville, AB Jul 30 - Sep 09/01
AL-SHAHRI, Mohammad Riyadh, Saudia Arabia Aug 06/01-Aug 05/02
HERRERA, Emilio Sevilla, Spain Sep 01 - Nov 30/01
KUSHI, Al Edmonton, AB Sep 10 - Oct 07/01

Palliative Care Trainees - 2002

LETCHER, Giang Edmonton, AB Feb 25/02 - Mar 10/02

* Cantel/Overton Fellow
** Research Fellow
† Clinical Research Fellow
‡ Clinical Fellow

Page 2 of 2

Appendix 20
Publications 2000


Appendix 21


Appendix 21


Publications 2001


Appendix 21


Publications 2002


### Regional Palliative Care Program

#### Volunteer Hours Contributed by Year

1996 - 2002

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Norwood hospice</td>
<td>2002</td>
<td>1722</td>
<td>1262</td>
<td>1449</td>
<td>996</td>
<td>1926</td>
</tr>
<tr>
<td>Mel Miller Hospice, EGH</td>
<td>2404</td>
<td>2491</td>
<td>1651</td>
<td>1295</td>
<td>1445</td>
<td>1590</td>
</tr>
<tr>
<td>St. Joseph’s Hospice</td>
<td>565</td>
<td>602</td>
<td>855</td>
<td>890</td>
<td>378</td>
<td>934</td>
</tr>
<tr>
<td>Unit 43 Grey Nuns</td>
<td>1308</td>
<td>2016</td>
<td>1922</td>
<td>1063</td>
<td>1683</td>
<td>1006</td>
</tr>
<tr>
<td>Royal Alexandra Hospital</td>
<td>153</td>
<td>246</td>
<td>200</td>
<td>271</td>
<td>249</td>
<td>406</td>
</tr>
<tr>
<td>Univ. of Alberta Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Home Care</td>
<td>720</td>
<td>1561</td>
<td>551</td>
<td>940</td>
<td>124</td>
<td>552</td>
</tr>
<tr>
<td>Sturgeon Hospital</td>
<td>373</td>
<td>361</td>
<td>285</td>
<td>25</td>
<td>163</td>
<td>294</td>
</tr>
<tr>
<td>Youville Nursing Home</td>
<td>52</td>
<td>52</td>
<td>104</td>
<td>200</td>
<td>156</td>
<td>150</td>
</tr>
<tr>
<td>Bereavement Support Team</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>218</td>
<td>63</td>
<td>0</td>
</tr>
<tr>
<td>Regional Palliative Care Program</td>
<td>92</td>
<td>78</td>
<td>0</td>
<td>110</td>
<td>127</td>
<td>42</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>7669</strong></td>
<td><strong>9129</strong></td>
<td><strong>6966</strong></td>
<td><strong>6461</strong></td>
<td><strong>5384</strong></td>
<td><strong>6900</strong></td>
</tr>
<tr>
<td>Training Hours</td>
<td>1341</td>
<td>819</td>
<td>1485</td>
<td>1512</td>
<td>1431</td>
<td>1646</td>
</tr>
<tr>
<td>Cross Cancer Institute</td>
<td>6707</td>
<td>5385</td>
<td>6281</td>
<td>5104</td>
<td>2752</td>
<td>1563</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15717</strong></td>
<td><strong>15333</strong></td>
<td><strong>14732</strong></td>
<td><strong>13077</strong></td>
<td><strong>9567</strong></td>
<td><strong>10109</strong></td>
</tr>
</tbody>
</table>

Appendix 22
Tertiary Palliative Care Unit (TPCU)

Patient Profile  n = 177

For Patients Discharged between Apr 01, 2000 and Mar 31, 2001

**AGE at Time of Admission**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>59.1</td>
</tr>
<tr>
<td>Minimum</td>
<td>20</td>
</tr>
<tr>
<td>Maximum</td>
<td>90</td>
</tr>
</tbody>
</table>

**Gender**

<table>
<thead>
<tr>
<th>GENDER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>55.6</td>
</tr>
<tr>
<td>Female</td>
<td>44.4</td>
</tr>
</tbody>
</table>

**Length of Stay (days)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>24.8</td>
</tr>
<tr>
<td>Median</td>
<td>19</td>
</tr>
<tr>
<td>Mode</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>167</td>
</tr>
</tbody>
</table>

**Diagnosis**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRAIN</td>
<td>2.3%</td>
</tr>
<tr>
<td>BREAST</td>
<td>10.7%</td>
</tr>
<tr>
<td>GASTRO-INT</td>
<td>20.3%</td>
</tr>
<tr>
<td>GENITO-URI</td>
<td>24.3%</td>
</tr>
<tr>
<td>HEAD&amp;NECK</td>
<td>6.2%</td>
</tr>
<tr>
<td>HEMATOLOGY</td>
<td>6.8%</td>
</tr>
<tr>
<td>LUNG</td>
<td>19.2%</td>
</tr>
<tr>
<td>OTHER</td>
<td>2.3%</td>
</tr>
<tr>
<td>OTHER CANCER</td>
<td>6.8%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**CAGE Scores (n=144)**

<table>
<thead>
<tr>
<th>SCORE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>77.8</td>
</tr>
<tr>
<td>2 to 4</td>
<td>22.2</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Pain Stage (n=134)**

<table>
<thead>
<tr>
<th>STAGE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13.1</td>
</tr>
<tr>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>3</td>
<td>76.9</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Discharge To Location**

<table>
<thead>
<tr>
<th>Location</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>26.6%</td>
</tr>
<tr>
<td>Hospice</td>
<td>13.0%</td>
</tr>
<tr>
<td>Other</td>
<td>5.6%</td>
</tr>
<tr>
<td>Cross Cancer Inst</td>
<td>0.6%</td>
</tr>
<tr>
<td>Deceased</td>
<td>54.2%</td>
</tr>
</tbody>
</table>

**Occupancy Stats**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Beds</td>
<td>14</td>
</tr>
<tr>
<td>Total LOS</td>
<td>4693</td>
</tr>
<tr>
<td>%Occupancy(adjusted)</td>
<td>86.00%</td>
</tr>
</tbody>
</table>

\(^a\)excluding non-palliative patients

\(^b\)Grey Nuns Health Records

\(^c\)LOS- Length of Stay

Source: Palliative Care Information System

Date: Aug 24, 2001
Tertiary Palliative Care Unit (TPCU)
Patient Profile \( n = 190^a \)

For Patients Discharged between Apr 01, 2001 and Mar 31, 2002

### AGE at Time of Admission

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>61.5</td>
</tr>
<tr>
<td>Minimum</td>
<td>27</td>
</tr>
<tr>
<td>Maximum</td>
<td>89</td>
</tr>
</tbody>
</table>

### Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>46.8</td>
</tr>
<tr>
<td>Female</td>
<td>53.2</td>
</tr>
</tbody>
</table>

### Length of Stay (days)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>23.2</td>
</tr>
<tr>
<td>Median</td>
<td>18</td>
</tr>
<tr>
<td>Mode</td>
<td>7</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>159</td>
</tr>
</tbody>
</table>

### Discharge To Location

- Deceased: 54.5%
- Home: 24.1%
- Other: 4.7%
- Hospice: 15.7%
- Cross Cancer Inst: 0.5%
- Cont. Care: 0.5%

### Referred From Location

- Other: 5.2%
- Hospice: 5.8%
- Home: 40.3%
- Cross Cancer Inst: 16.2%

### Diagnosis \( b \)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>BREAST</td>
<td>15.3%</td>
</tr>
<tr>
<td>EYE, BRAIN, OTHER CNS</td>
<td>1.6%</td>
</tr>
<tr>
<td>GASTRO-INT</td>
<td>22.1%</td>
</tr>
<tr>
<td>GENITO-URI</td>
<td>17.9%</td>
</tr>
<tr>
<td>HEAD&amp;NECK</td>
<td>3.2%</td>
</tr>
<tr>
<td>HEMATOLOGY</td>
<td>4.2%</td>
</tr>
<tr>
<td>LUNG</td>
<td>24.1%</td>
</tr>
<tr>
<td>OTHER</td>
<td>1.1%</td>
</tr>
<tr>
<td>OTHER CANCER</td>
<td>7.9%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### CAGE Scores (\( n = 160 \))

<table>
<thead>
<tr>
<th>SCORE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>71.9%</td>
</tr>
<tr>
<td>2 to 4</td>
<td>28.1%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### Pain Stage (\( n = 155 \))

<table>
<thead>
<tr>
<th>STAGE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15.5</td>
</tr>
<tr>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>3</td>
<td>76.8</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Occupancy Stats \( c \)

- Number of Beds: 14
- Total LOS \( d \): 5110
- \%Occupancy (adjusted) \( a \): 90.20%

---

\( a \)excluding non-palliative patients

\( b \) Method of categorizing diagnosis changed this year to be consistent with Alberta Cancer Board diagnosis groupings

\( c \)Grey Nuns Health Records

\( d \)LOS- Length of Stay

Source: Palliative Care Information System

Date: May 14, 2001

---

Appendix 24
Tertiary Palliative Care Unit (TPCU)

ESAS\(^a\) Scores First, Mid and Last Averages
For Patients Discharged between Apr 01, 2000 and Mar 31, 2001

\(^a\)Edmonton Symptom Assessment Scale-scores are patients' ratings of symptoms on 0 to 10 scale
\(^b\) Pain: total First, Mid and Last Pain assessment counts are 166, 154 and 154 respectively
\(^c\) Wellbeing: total First, Mid and Last Wellbeing assessment counts are 161, 140 and 147 respectively

Source: Palliative Care Information System
Date: Aug 24, 2001

Appendix 25
Tertiary Palliative Care Unit (TPCU)

ESAS\(^a\) Scores First, Mid and Last Averages
For Patients Discharged between Apr 01, 2001 and Mar 31, 2002

---

\(^a\)Edmonton Symptom Assessment Scale - scores are patients' ratings of symptoms on 0 to 10 scale

\(^b\) Pain: total First, Mid and Last Pain assessment counts are 181, 150 and 153 respectively

\(^c\) Wellbeing: total First, Mid and Last Wellbeing assessment counts are 164, 150 and 149 respectively

Source: Palliative Care Information System

Date: May 14, 2001

Appendix 26
Tertiary Palliative Care Unit (TPCU)
Abnormal MMSE\(^a\) - First, MidPoint and Last Measures by Discharge Location
For Patients Discharged between Apr 01, 2000 and Mar 31, 2001

<table>
<thead>
<tr>
<th>Overall</th>
<th>First</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>142</td>
</tr>
<tr>
<td>MidPoint</td>
<td>57</td>
</tr>
<tr>
<td>Last</td>
<td>109</td>
</tr>
</tbody>
</table>

\(^a\)Abnormal Mini Mental State Examination: <80% of answers correct is an indicator for cognitive impairment

Source: Palliative Care Information System
Date: Aug 24, 2001

Appendix 27
Tertiary Palliative Care Unit (TPCU)

Abnormal MMSE\(^a\) - First, MidPoint and Last Measures by Discharge Location
For Patients Discharged between Apr 01, 2001 and Mar 31, 2002

<table>
<thead>
<tr>
<th>Overall</th>
<th>First</th>
<th>MidPoint</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>152</td>
<td>29</td>
<td>74</td>
</tr>
</tbody>
</table>

\(\text{MMSE}\) is the Mini Mental State Examination. Abnormal MMSE is less than 80% of answers correct, which is an indicator for cognitive impairment.

Source: Palliative Care Information System
Date: May 14, 2001

Appendix 28

\(^a\) Abnormal Mini Mental State Examination: <80% of answers correct is an indicator for cognitive impairment
Referral Hospitals Royal Alexandra Hospital Palliative Consult Team
Patient Profile  n = 460
For Patients Discharged Between Apr 01,2000 and Mar 31, 2001

AGE at Time of Admission

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>68</td>
</tr>
<tr>
<td>Minimum</td>
<td>20</td>
</tr>
<tr>
<td>Maximum</td>
<td>101</td>
</tr>
</tbody>
</table>

Gender

<table>
<thead>
<tr>
<th>GENDERS</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>53.30%</td>
</tr>
<tr>
<td>Female</td>
<td>46.70%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Length of Stay (days)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>17.9</td>
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<tr>
<td>Median</td>
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<td>Mode</td>
<td>8</td>
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<tr>
<td>Minimum</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>135</td>
</tr>
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</table>

Diagnosis

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRAIN</td>
<td>0.20%</td>
</tr>
<tr>
<td>BREAST</td>
<td>5.90%</td>
</tr>
<tr>
<td>GASTRO-INT</td>
<td>31.10%</td>
</tr>
<tr>
<td>GENITO-JRI</td>
<td>15.40%</td>
</tr>
<tr>
<td>HEAD&amp;NECK</td>
<td>3.00%</td>
</tr>
<tr>
<td>HEMATOLOGY</td>
<td>3.30%</td>
</tr>
<tr>
<td>LUNG</td>
<td>22.40%</td>
</tr>
<tr>
<td>OTHER CANCER</td>
<td>9.80%</td>
</tr>
<tr>
<td>SARCOMA</td>
<td>1.10%</td>
</tr>
<tr>
<td>OTHER</td>
<td>7.80%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

CAGE Scores(n=293)

<table>
<thead>
<tr>
<th>SCORE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>87.00%</td>
</tr>
<tr>
<td>2 to 4</td>
<td>13.00%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Pain Stage(n=379)

<table>
<thead>
<tr>
<th>STAGE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>42.00%</td>
</tr>
<tr>
<td>2</td>
<td>30.60%</td>
</tr>
<tr>
<td>3</td>
<td>27.40%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

*aTPCU-Tertiary Palliative Care Unit
Source: Palliative Care Information System
Date: Aug 24,2001

Discharge To Location

Hospice 20.2%
Home 38.0%
Other 12.6%
4.3%Deceased 24.8%

Appendix 29

K:\DATA\Annual Report 01 & 02\Appendices - Word\Appendix 29 - RAH Patient Profile 00-01.doc
March 13, 2003
Referral Hospitals Royal Alexandra Hospital Palliative Consult Team
Patient Profile  n = 455
For Patients Discharged Between Apr 01, 2001 and Mar 31, 2002

AGE at Time of Admission

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>70.4</td>
<td>22</td>
<td>99</td>
</tr>
</tbody>
</table>

Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>48.40%</td>
</tr>
<tr>
<td>Female</td>
<td>51.60%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Length of Stay (days)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>16.9</td>
<td>13</td>
<td>12</td>
<td>0</td>
<td>251</td>
</tr>
</tbody>
</table>

Diagnosis\(^a\)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>BONE CT</td>
<td>0.2%</td>
</tr>
<tr>
<td>BREAST</td>
<td>4.4%</td>
</tr>
<tr>
<td>EYE, BRAIN, OTHER CNS</td>
<td>1.3%</td>
</tr>
<tr>
<td>GASTRO-INT</td>
<td>30.8%</td>
</tr>
<tr>
<td>GENITO-URI</td>
<td>18.0%</td>
</tr>
<tr>
<td>HEAD&amp;NECK</td>
<td>2.6%</td>
</tr>
<tr>
<td>HEMATOLOGY</td>
<td>4.6%</td>
</tr>
<tr>
<td>LUNG</td>
<td>23.1%</td>
</tr>
<tr>
<td>MELANOMA</td>
<td>0.2%</td>
</tr>
<tr>
<td>RETROPERITONEUM &amp; PERITONEUM</td>
<td>0.4%</td>
</tr>
<tr>
<td>OTHER CANCERS</td>
<td>6.6%</td>
</tr>
<tr>
<td>NON-CANCER-CARDIOPULMONARY</td>
<td>1.8%</td>
</tr>
<tr>
<td>NON-CANCER-INFECTIOUS DISEASES</td>
<td>0.2%</td>
</tr>
<tr>
<td>NON-CANCER-NEUROMUSCULAR</td>
<td>0.4%</td>
</tr>
<tr>
<td>NON-CANCER-OTHER</td>
<td>5.3%</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

CAGE Scores (n=283)

<table>
<thead>
<tr>
<th>SCORE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>85.20%</td>
</tr>
<tr>
<td>2 to 4</td>
<td>14.80%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Pain Stage (n=364)

<table>
<thead>
<tr>
<th>STAGE</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>40.70%</td>
</tr>
<tr>
<td>2</td>
<td>29.60%</td>
</tr>
<tr>
<td>3</td>
<td>29.70%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

\(^a\)TPCU-Tertiary Palliative Care Unit

\(^b\) Method of categorizing diagnosis changed this year to be consistent with Alberta Cancer Board diagnosis groupings

Source: Palliative Care Information System

Date: May 14, 2002

Appendix 30
Referral Hospital: Royal Alexandra Hospital Palliative Consult Team
ESAS \(^a\) Scores First and Last Averages
For Patients Discharged Between Apr 01, 2000 and Mar 31, 2001

\(^a\)Edmonton Symptom Assessment Scale-scores are patients' ratings of symptoms on 0 to 10 scale
\(^b\)Pain: Total First and Last Pain assessment counts are 450 and 450 respectively
\(^c\)Wellbeing: Total First and Last Wellbeing assessment counts are 312 and 316 respectively
Source: Palliative Care Information System
Date: Aug 24, 2001

Appendix 31
Referral Hospital: Royal Alexandra Hospital Palliative Consult Team
ESAS\(^a\) Scores First and Last Averages
For Patients Discharged Between Apr 01, 2001 and Mar 31, 2002

\(^a\)Edmonton Symptom Assessment Scale-scores are patients' ratings of symptoms on 0 to 10 scale
\(^b\)Pain: Total First and Last Pain assessment counts are 452 and 275 respectively
\(^c\)Wellbeing: Total First and Last Wellbeing assessment counts are 294 and 189 respectively

Source: Palliative Care Information System
Date: May 14, 2002

Appendix 32
Referral Hospital: Royal Alexandra Hospital Palliative Consult Team
Abnormal MMSE\(^a\) First and Last Measures
For Patients Discharged by Site of Discharge Between Apr 01, 2000 and Mar 31, 2001

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>First</th>
<th>First Total</th>
<th>Last</th>
<th>Last Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>186</td>
<td>407</td>
<td>95</td>
<td>207</td>
</tr>
</tbody>
</table>

\(^a\)Abnormal Mini Mental State Examination: <80% of answers correct is an indicator for cognitive impairment
Source: Palliative Care Information System
Date: Aug 24, 2001

Appendix 33
Referral Hospital: Royal Alexandra Hospital Palliative Consult Team

Abnormal MMSE\(^a\) - First and Last Measures

For Patients Discharged by Site of Discharge Between Apr 01, 2001 and Mar 31, 2002

<table>
<thead>
<tr>
<th>Overall</th>
<th>First</th>
<th>First Total</th>
<th>Last</th>
<th>Last Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>176</td>
<td>422</td>
<td>113</td>
<td>243</td>
</tr>
</tbody>
</table>

\(^a\)Abnormal Mini Mental State Examination: <80% of answers correct is an indicator for cognitive impairment

Source: Palliative Care Information System

Date: May 14, 2002
Palliative Hospices
Patient Profile: All Sites
For Patients Discharged between Apr 01, 2000 and Mar 31, 2001
n = 467

Referred From Location

Age at Time of Admission

Gender

Diagnosis

Length of Stay (days)

Discharge To Location

Occuancy Stats

Ref: Cross Cancer Inst - Cross Cancer Institute
bc: Cont Care - Continuing Care
Source: Regional Continuing Care
Source: Palliative Care Information System
Date: Aug 24, 2001

Appendix 35
**Palliative Hospices**

**Patient Profile: All Sites**

For Patients Discharged between Apr 01, 2001 and Mar 31, 2002

n = 495

- **Age at Time of Admission**
  - Mean: 72.3
  - Minimum: 20
  - Maximum: 98

- **Diagnosis**
  - DIAGNOSIS PERCENT
    - BONE CT: 0.8%
    - BREAST: 12.1%
    - ENDOCRINES: 1.4%
    - EYE, BRAIN, OTHER CNS: 2.8%
    - GASTRO-INT: 24.4%
    - GENITO-URI: 15.6%
    - HEAD&NECK: 5.5%
    - HEMATOLOGY: 2.0%
    - LUNG: 23.6%
    - MELANOMA: 0.6%
    - OTHER CANCERS: 7.7%
    - RETROPERITONEUM & PERITONEUM: 0.4%
    - NON-CANCER-NEUROMUSCULAR: 0.2%
    - NON-CANCER-OTHER: 2.8%
    - TOTAL: 100.0%

- **Gender**
  - GENDER PERCENT
    - Male: 48.40%
    - Female: 51.60%
    - TOTALS: 100.00%

- **Length of Stay (days)**
  - Mean: 40
  - Median: 20
  - Mode: 2
  - Minimum: 0
  - Maximum: 609

- **Occupancy Stats**
  - Number of Beds: 57
  - Days Occupied: 19040
  - Days Available: 20805
  - Occupancy Rate: 91.5%

- **Discharge To Location**
  - Hospice: 1.2%
  - Home: 1.0%
  - Other: 0.4%
  - TPCU: 0.2%
  - ACUTE CARE: 1.8%
  - Deceased: 94.7%

- **Referred From Location**
  - HOME: 29.7%
  - ACUTE CARE: 54.1%
  - OTHER: 2.2%
  - TPCU: 1.2%
  - CONTINUE CARE: 9.5%
  - CROSS CANCER INST: 22%

---

*a* Cross Cancer Inst - Cross Cancer Institute

*b* Method of categorizing diagnosis changed this year to be consistent with Alberta Cancer Board diagnosis groupings

*c* Cont Care - Continuing Care

*d* TPCU: Tertiary Palliative Care Unit

*e* Source: Regional Continuing Care

Source: Palliative Care Information System

Date: May 14, 2002

Appendix 36
Palliative Hospices
ESAS\textsuperscript{a} Scores First Mid and Last Averages
For Patients Discharged between Apr 01, 2000 and Mar 31, 2001

\textsuperscript{a}Edmonton Symptom Assessment Scale-scores are patients’ ratings of symptoms on 0 to 10 scale
\textsuperscript{b}Pain: Total First, Mid and Last Pain assessment counts are 399, 373 and 415 respectively
\textsuperscript{c}Wellbeing: Total First, Mid and Last Wellbeing assessment counts are 379, 347 and 361 respectively
Source: Palliative Care Information System
Date: Aug 24, 2001

Appendix 37
**Palliative Hospices**

**ESAS\(^a\) Scores  First Mid and Last Averages**

For Patients Discharged between Apr 01, 2001 and Mar 31, 2002

---

\(^a\)Edmonton Symptom Assessment Scale-scores are patients’ ratings of symptoms on 0 to 10 scale

\(^b\)Pain: Total First, Mid and Last Pain assessment counts are 429, 400 and 415 respectively

\(^c\)Wellbeing: Total First, Mid and Last Wellbeing assessment counts are 317, 393 and 190 respectively

Source: Palliative Care Information System

Date: May 14, 2002

---

Appendix 38
### Palliative Hospices

**Abnormal MMSE Scores\(^a\) - First and Last Measures**

For Patients Discharged between Apr 01, 2000 and Mar 31, 2001

<table>
<thead>
<tr>
<th>Hospices</th>
<th>First(Overall)</th>
<th>Last(Overall)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mel Miller</td>
<td>159</td>
<td>93</td>
</tr>
<tr>
<td>Norwood</td>
<td>72</td>
<td>61</td>
</tr>
<tr>
<td>St.Joes</td>
<td>75</td>
<td>46</td>
</tr>
<tr>
<td>Youville</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Overall</td>
<td>312</td>
<td>206</td>
</tr>
</tbody>
</table>

\[^a\]Abnormal Mini Mental State Examination: <80% of answers correct is an indicator for cognitive impairment

Source: Palliative Care Information System

Date: Aug 24, 2001
Abnormal Mini Mental State Examination: <80% of answers correct is an indicator for cognitive impairment

Source: Palliative Care Information System

Date: May 14, 2002
Capital Health Home Care
Palliative Patient Profile
For Patients Discharged Between Apr 01, 2000 and Mar 31, 2001
n = 957

Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>1.2%</td>
</tr>
<tr>
<td>AMYOTROPHIC LATERAL SCLEROSIS</td>
<td>0.8%</td>
</tr>
<tr>
<td>CANCER</td>
<td>84.2%</td>
</tr>
<tr>
<td>CEREBROVASCULAR DISEASE</td>
<td>1.4%</td>
</tr>
<tr>
<td>OTHER</td>
<td>9.4%</td>
</tr>
<tr>
<td>MUSCULOSKELETAL SYSTEM</td>
<td>1.5%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1.5%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Age at Discharge

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>66.04</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>95</td>
</tr>
</tbody>
</table>

Length of Stay (days)

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>115.4</td>
</tr>
<tr>
<td>Median</td>
<td>71</td>
</tr>
<tr>
<td>Mode</td>
<td>41</td>
</tr>
<tr>
<td>Minimum</td>
<td>1</td>
</tr>
<tr>
<td>Maximum</td>
<td>995</td>
</tr>
</tbody>
</table>

Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>48.0%</td>
</tr>
<tr>
<td>Female</td>
<td>51.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>99.0%</td>
</tr>
</tbody>
</table>

Discharge To Location

- DECEASED 33.5%
- HOME 4.4%
- UNKNOWN 2.5%
- OTHER HOME CARE PROGRAM 9.8%
- CROSS CANCER
- ACUTE CARE 20.5%
- LONG TERM CARE 26.4%

Capital Health Home Care Palliative Data-April 23, 2001

Appendix 41
Capital Health Home Care
Palliative Patient Profile
For Patients Discharged between April 1, 2001 and March 31, 2002
n = 1066

Referred from Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>30.5%</td>
</tr>
<tr>
<td>CCI</td>
<td>30.5%</td>
</tr>
<tr>
<td>Community</td>
<td>36.4%</td>
</tr>
<tr>
<td>Other</td>
<td>2.6%</td>
</tr>
<tr>
<td>aLTC</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

Age at Discharge

Mean: 67.2
Minimum: 2
Maximum: 100

Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>50.8%</td>
</tr>
<tr>
<td>Female</td>
<td>49.2%</td>
</tr>
<tr>
<td>Totals</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Length of Stay (Days)

Mean: 106.2
Median: 58.5
Mode: 1
Minimum: 1
Maximum: 915

Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>82.4%</td>
</tr>
<tr>
<td>Non-Cancer-Neuromuscular</td>
<td>1.7%</td>
</tr>
<tr>
<td>Non-Cancer-Cardiopulmonary</td>
<td>3.5%</td>
</tr>
<tr>
<td>Non-Cancer-Infectious Diseases</td>
<td>0.4%</td>
</tr>
<tr>
<td>Non-Cancer-Other</td>
<td>7.8%</td>
</tr>
<tr>
<td>Unknown</td>
<td>4.3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Discharge to Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
<td>28.2%</td>
</tr>
<tr>
<td>Home Death</td>
<td>30.0%</td>
</tr>
<tr>
<td>Home Stable</td>
<td>7.1%</td>
</tr>
<tr>
<td>Other</td>
<td>7.8%</td>
</tr>
<tr>
<td>CCI</td>
<td>4.6%</td>
</tr>
<tr>
<td>Hospice/ aLTC</td>
<td>25.6%</td>
</tr>
</tbody>
</table>

aLTC: Long term care
Source: Home Palliative Care
Information System
Date: May 14, 2002

Appendix 42
Edmonton Symptom Assessment Scale-scores are patients’ ratings of symptoms on 0 to 10 scale

\[ a \]

Pain: total First Pain assessment count is 746, total last Pain assessment count is 550

Source: Home Palliative Care Information System

Date: Oct 07, 2002

Appendix 43
Palliative Home Care
ESAS \(^a\) Scores First and Last Averages
Administered between Apr 01, 2001 and Mar 31, 2002

\(^a\) Edmonton Symptom Assessment Scale-scores are patients' ratings of symptoms on 0 to 10 scale

\(^b\) Pain: total First Pain assessment count is 601, total last Pain assessment count is 410

Source: Home Palliative Care Information System

Appendix 44
Palliative Home Care
Abnormal MMSE Scores\textsuperscript{a} - First and Last Measures

Administered between Apr 01, 2000 and Mar 31, 2002

\begin{tabular}{|c|c|c|}
\hline
 & 00/01 & 01/02 \\
\hline
First & 51 & 55 \\
First Total & 403 & 333 \\
Last & 32 & 27 \\
Last Total & 134 & 104 \\
\hline
\end{tabular}

\textsuperscript{a}Abnormal Mini Mental State Examination: \textless 80\% of answers correct is an indicator for cognitive impairment

Source: Home Palliative Care Information System
Date: Oct 07, 2002

\textbf{Appendix 45}
### Tertiary Palliative Care Unit

<table>
<thead>
<tr>
<th>Outcome</th>
<th>1992</th>
<th>Plan</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td># deaths/year</td>
<td>120 (9%)</td>
<td>96 (8%)</td>
<td>91 (7%)</td>
</tr>
<tr>
<td>ALOS</td>
<td>25</td>
<td>15</td>
<td>26.2 (median 21)</td>
</tr>
<tr>
<td># pts./year</td>
<td>168</td>
<td>273</td>
<td>165</td>
</tr>
<tr>
<td>Criteria</td>
<td>exist</td>
<td>monitor</td>
<td>monitor</td>
</tr>
</tbody>
</table>

### Acute Care Hospitals

<table>
<thead>
<tr>
<th>Outcome</th>
<th>1992</th>
<th>Plan</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td># deaths/year</td>
<td>1050 (78%)</td>
<td>265 (22%)</td>
<td>523 (39%)</td>
</tr>
<tr>
<td>ALOS</td>
<td>25</td>
<td>15</td>
<td>16.3</td>
</tr>
<tr>
<td>Consult Teams</td>
<td>varied</td>
<td>develop</td>
<td>434</td>
</tr>
<tr>
<td>Criteria for Admission</td>
<td>inconsistent/absent</td>
<td>develop &amp; monitor</td>
<td>monitor</td>
</tr>
</tbody>
</table>

### Palliative Hospices

<table>
<thead>
<tr>
<th>Outcome</th>
<th>1992</th>
<th>Plan</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td># deaths/year</td>
<td>62 (&lt;5%)</td>
<td>360 (30%)</td>
<td>444 (33%)</td>
</tr>
<tr>
<td>ALOS</td>
<td>66</td>
<td>37.6 (median 20)</td>
<td></td>
</tr>
<tr>
<td>Consult Teams</td>
<td>varied</td>
<td>develop</td>
<td>exist</td>
</tr>
<tr>
<td>Criteria</td>
<td>varied</td>
<td>develop</td>
<td>exist and reviewed</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>47(4%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Palliative Home Care

<table>
<thead>
<tr>
<th>Outcome</th>
<th>1992</th>
<th>Plan</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td># deaths/year</td>
<td>109 (9%)</td>
<td>480 (40%)</td>
<td>191 (14.1%)</td>
</tr>
<tr>
<td>ALOS</td>
<td>4 months</td>
<td>3 months</td>
<td>not available</td>
</tr>
<tr>
<td>medical care</td>
<td>minimum</td>
<td>↑ education of f.p.</td>
<td>392 distinct MD referrals to RPCP/year; &gt; 776 since July/95</td>
</tr>
<tr>
<td>Consult Teams</td>
<td>absent</td>
<td>develop</td>
<td>exist: in home</td>
</tr>
<tr>
<td>24 hr. service</td>
<td>absent</td>
<td>develop</td>
<td>present</td>
</tr>
<tr>
<td>Criteria</td>
<td>varied</td>
<td>develop</td>
<td>exist</td>
</tr>
<tr>
<td>Drugs 24 hour</td>
<td>minimum</td>
<td>24 hour available</td>
<td>5 - 24 hour delivery</td>
</tr>
<tr>
<td>Lab service</td>
<td>varied</td>
<td>develop</td>
<td>exists</td>
</tr>
<tr>
<td>Died out of region</td>
<td>26 (2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Died</td>
<td>8 (0.6%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

* Plan based on 1200 patients/year.
* Utilizes calendar year; therefore, total death differs on this table.
* Percentages based on number of deaths divided by actual 1992 (1341) and 2000 (1350) cancer deaths for region.
* # deaths/year from Alberta Cancer Board, Division of Epidemiology, Prevention & Screening. Number used in table for 2000 does not include out of region patients who died in region (156) or in region patients who died out of region (26).
* The numbers provided in the table are provisional as some cases (deaths) may be registered in subsequent years. Methods of coding of cancer on the Alberta cancer Registry have varied through the years; therefore caution should be exercised when comparing data to that of previous years.
* Regional Palliative Care Database, Jan 01, 2000 to Dec 31, 2000. Only Cancer deaths are included in #deaths. ALOS and #pts/year include all diagnosis. (7.1 % are non-cancer patients)
* Number of deaths at all acute care sites including Cross Cancer Institute (CCI). Data from Alberta Cancer Board, Division of Epidemiology, Prevention & Screening, Jan. 1, 2000 - Dec. 31, 2000.
* Consultations to RAH palliative care team (UAH data are not available).

Appendix 46