NCARE

Navigating, Connecting, Accessing, Resourcing, Engaging

Feasibility of a volunteer/healthcare provider navigation partnership to support frail rural-dwelling older adults.

Acknowledgements

Investigative Team

- Barbara Pesut, UBC
- Wendy Duggleby, U of A
- Grace Warner, Dalhousie
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- Carole Robinson, UBC

Knowledge Partners

- Brenda Hooper, Nurse Navigator
- Elisabeth Antifeau, Interior Health
- Lorraine Gerard, BCHPCA
- Kathryn Downer, Pallium
- Sharon Baxter, CHPCA
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- Marg Malcolm, Trail Hospice
- Jane DiGiacomo, Nelson Hospice

TVN Improving care for the frail elderly™

cpsi icsp Canadian Patient Safety Institute / Institut canadien pour la sécurité des patients

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- Canadian Hospice Palliative Care Association.
- Pallium
- Interior Health
- University of Alberta, Faculty of Nursing
- Canada Research Chairs Program

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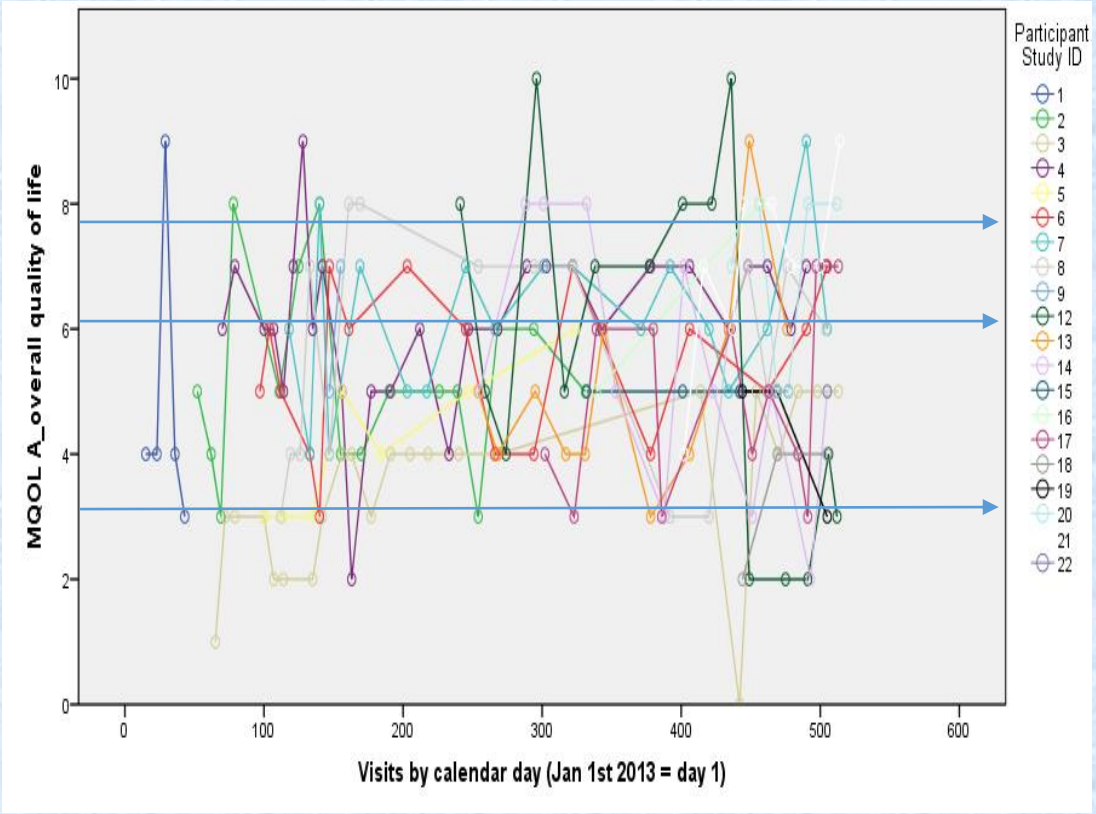
Doubly Vulnerable Rural Older Adults

Quality of Life Ideal

Quality of Life Real



Rural Capacity for High Quality Care

Palliative and Supportive Care, page 1 of 12, 2013.
© Cambridge University Press, 2013 1478-9515/13 $20.00
doi:10.1017/S1478951512001046

Among neighbors: An ethnographic account of responsibilities in rural palliative care

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(RECEIVED June 22, 2012; ACCEPTED September 16, 2012)

Trail Castlegar Augmented Response: Enhancing supportive services for persons and families living with life-limiting chronic illness

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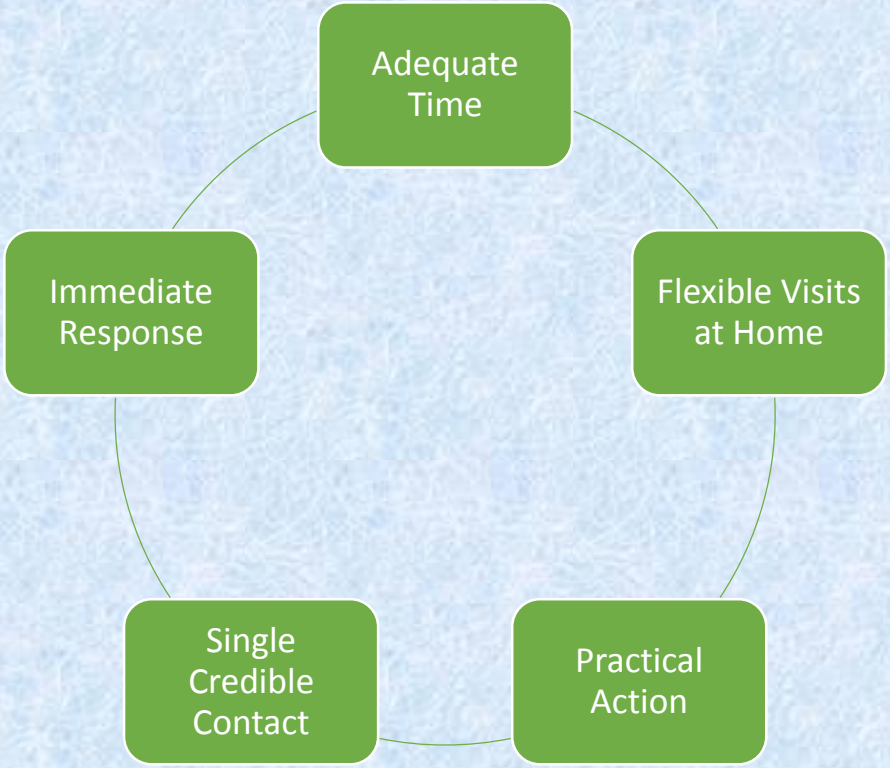
PILOT 2012-2014

- Nurse Navigator conducted regular in-home visits over a 2 year period with 25 older adults living with life-limiting chronic illness; 11 FCG.
- **Primary reasons for registering with the service**: social isolation, poor access to information, need for emotional support, family conflict, challenges getting outside the home, desire to die in their preferred location, difficulties negotiating physician relationships – particularly when multiple physicians involved.
- Longitudinal collection of quality of life, healthcare utilization and older adult and family caregiver need.

Evaluation

Benefits

Person-Centred Approach



The Vision of NCARE

Volunteer Navigators

+

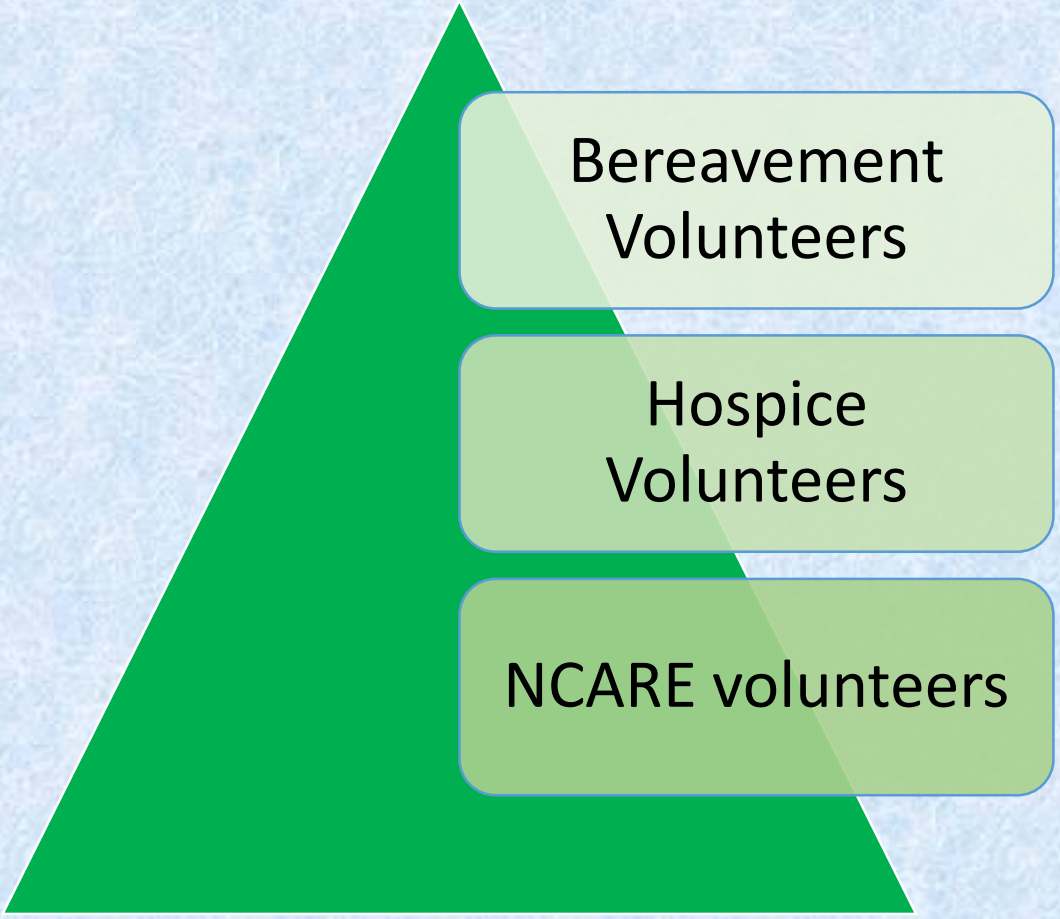
Healthcare Navigators

→

Older Adult

QOL in Community

An Upstream Role for Volunteers within Hospice

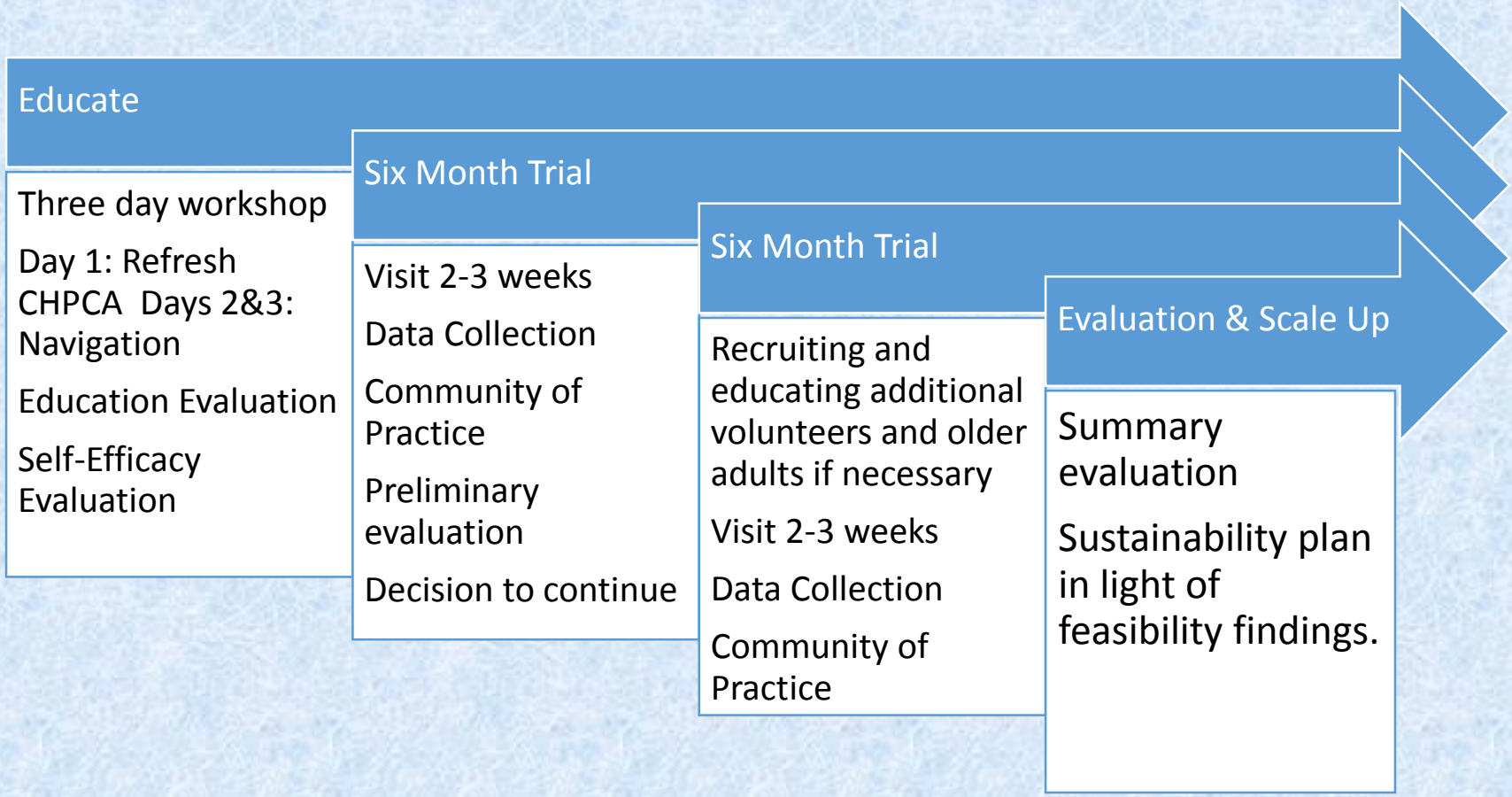


Navigation

- *"Working in collaboration with patients, families, and communities to: a) negotiate the "best fit" for the needs of older rural persons, their families and communities and resources; b) improve access to needed services and resources at the end of life (including death) and bereavement; and, c) to promote quality of life, foster independence, and facilitate community connections utilizing a culturally safe, palliative approach."*

Which Way from Here
http://www.nurs.ualberta.ca/livingwithhope/library/Which%20Way%20from%20Here%20Final%20Report.pdf

Research Implementation



Research Progress

- Curriculum completed for volunteers and healthcare providers.
- Seven volunteer navigators completed 3-day training.
- Three healthcare navigators recruited for consultation.
- Volunteers supervised by dedicated navigator.
- Fourteen older adults and two family caregivers recruited. Illnesses include cancer (n=6), CHF (n=1), COPD (n=1), multiple chronic conditions (n=6).
- Volunteers paired with 2 older adults each and visiting q2-3 weeks.
- Three community of practice teleconferences.

TVN HQP Poster.pdf - Adobe Reader
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Curriculum:

Module 1: Introduction to the Navigator Role
What is a navigator?
Why are navigators necessary?
Navigator competencies, knowledge, and skills

Module 2: Individual and Family Screening
What is screening?
Using a family centric approach
Quality-of-life and transitions

Module 3: Advocating
What is successful advocacy?
How to support self navigation
How to use the "Changes Toolkit"

Module 4: Facilitating Community Connections
Getting to know a community
The "Windshield Survey"
Creating and brokering linkages
Values influencing "Best Fit"

Module 5: Coordinating Access to Services & Resources
Priorities, goals and action plans
Communicating with health care providers
Advanced care planning

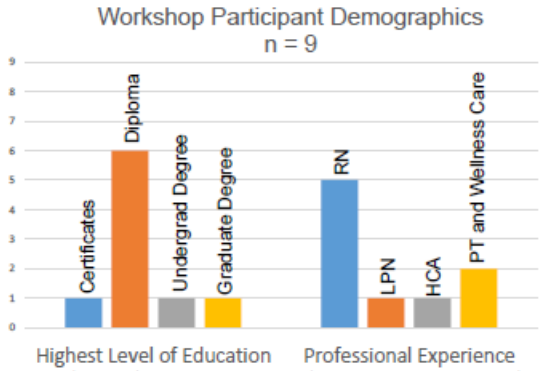
Module 6: Promoting Active Engagement
How to promote active engagement
Contributing to the capacity of older adults
Holistic engagement of older adults

*Much of the curriculum was driven by the Final Report, "Which Way from Here; Navigation Competencies for the Care of older Rural Adults at the End of Life." By Duggleby et al, 2014, funded in part by CIHR.

Curriculum Delivery Method:

Nine individuals participated in a three-day workshop. The curriculum included lectures, role play, skits, and discussions based on the competencies for navigators.

Results:



All participants were female, with an average age between 56-65, many having more than ten years of experience volunteering or working with frail older adults.

"I really appreciated the demos and in depth conversation"

-workshop participant

Preliminary Findings

- Mean visit length: 100 minutes. Range 14-205 minutes.
- Volunteers highly satisfied with the role.
- Examples of services:

CONNECTING: *Loneliness*: schedule planning to facilitate participation in senior center activities. : *Challenges managing chronic illness*: information about community-based chronic illness support programs.

ACCESSING*: Inability to make phone calls to request services due to speech impairment*: practical assistance with calls. *Challenges getting to hospital for intravenous line care*: encouraged consultation with home care nurse. *Difficulty expressing wishes to hospital staff*: assistance with writing out care wishes.

RESOURCING: *Financial barriers to accessing needed services*: creative strategizing that resulted in paying family member to assist.

ENGAGING: *Recent spousal bereavement*: story-telling and reminiscing. *Grief over declining health and memory*: engagement with art work and physical activity.

Preliminary Evaluation Planned for November 2015
Thank you

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