

Palliative Care Initiative

October 2009

Summary Document

Project Charter of Palliative Care Initiative (PCI)

Background and rationale:

- 93% of patients wish to die at home (D. Marshall. *Enhancing Family Physician Capacity to Deliver Quality Palliative Home Care*. Dec. 2008.
- Many die in hospital
- Palliative ALC days for MH residents in 2007/08
 1. 24,708 acute care days for 1,462 patients
 2. 4,653 days waiting in hospital to go to community
 3. hospital is not where the patient wants to die

Focus for palliative care- need to have a system shift to community/home

The Vision

A palliative care model in the community setting that meets the needs of patients and their families

- which is accessible, coordinated, comprehensive, patient-centred,
- and will avoid unnecessary use of acute hospital settings. (ED visits and admissions),
- Will proactively facilitate moving palliative ALC patients from the hospital to the community.

Guiding principles for this initiative:

- Our strategies must improve patient/family experience and outcomes. The patients/families should never feel they are going through a “system” but instead feel they are being “cared for.”
- System-wide focus on patient-centred care and at the appropriate level of care.
- Support innovated and system oriented best practices.

- Significant input from palliative families & providers in an effective way to guide the development of LHIN-wide community palliative care model and achieve positive outcomes.
- Practice open and transparent communication.
- Review evidence based models.
- Guided by best practices and quality care.

Purpose and Objectives of this Initiative:

To establish a LHIN-wide Palliative Care Model and recommendations focused on patient-centred and responsive palliative care.

Objective: To focus our local delivery systems on providing palliative care services in the community that are built upon current and new partnerships to enhance coordination across the full continuum resulting in positive outcomes.

This palliative care model will focus on avoiding unnecessary palliation services in acute care setting (ED visits and admissions) and proactively facilitate moving palliative ALC patients from the hospital to the community.

Project Scope:

In Scope:

- Target population 18 years and older.
- Patient/family-centred thinking and deliverables
 - *what is needed for patient and family*
 - *development of patient/family education and professional education addressing the management of palliative illnesses*
 - *input from family focused group.*

Development of an integrated community-based and responsive palliative care model including strategies for 24-hour availability.

Project Scope (cont'd):

- Communication, coordination, and collaboration both within and across all service providers and within health care system.
- Local diversity needs included in all planning activities.

Criteria for Performance Success

- A model that reduces unnecessary ED visits, admissions, and ALC days for palliative patients.
- To have a responsive process for access to palliative care services within community sector of the LHIN.

Our Palliative Care Journey:

- Developed a Palliative Care Framework of the current state.-
May 2009
- Established a cross sector palliative care working group that convened July 20, 2009
- Reviewed Palliative Care Models from local LHINs, CCO, PEOLN model, national (CHPCA) & international models.
- Reviewed MH LHIN palliative care data

- Reviewed research data of *Ontario End of Life Homecare patients*: -by Dr Hsien Seow. March 2009
- Developed Key Elements for the model
- Family focus group engagement
- Developed Palliative Care Model and the recommendations for the model
- Stakeholder event to obtain feedback on the model and recommendations

MH Palliative Care ALC days for 2007/08

29,361 Palliative Care ALC days equates to:

- average admission is 20 days
- 80 hospital beds a year are occupied by palliative patients

349 ALC patients had 4,653 days waiting in hospital for community which equates to:

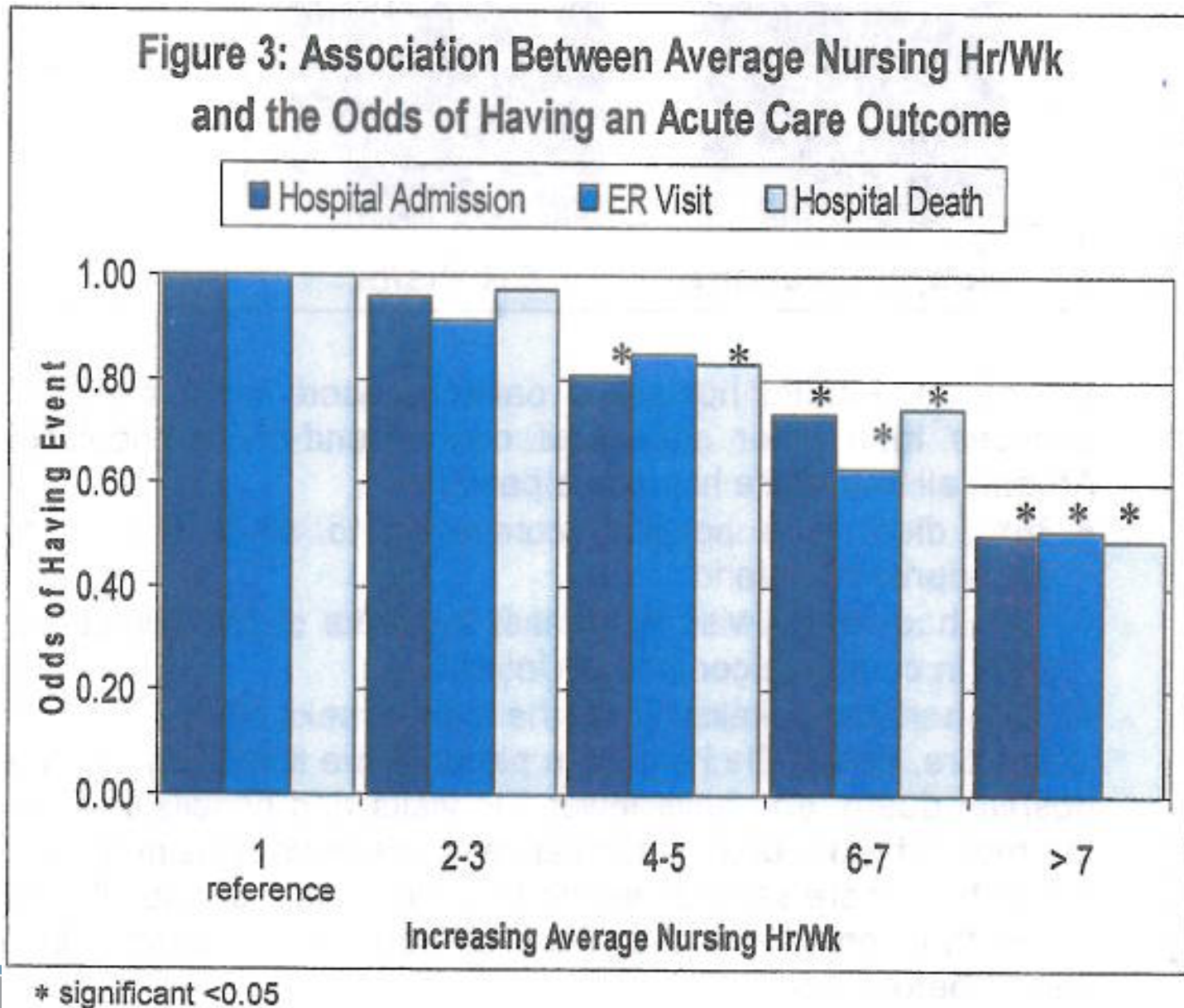
- average of 13.33 extra days/patient
- 13 hospital beds a year are occupied by palliative patients waiting to go to community

Ontario's EOL Homecare Patients- Hsien Seow Study

- 11,867 decedents in April 2005- Dec. 2006
- Average nursing time 3.1 hours/wk
- Average PSW time 3.3hrs/wk
- In last 4 weeks of life- there is a sharp increase in nursing and PSWs hours/wk
- Increase of 20% nursing and 11% PSW for the last 4 weeks.

EOL non cancer patients	Cancer patients
38% died in hospital	53-56% died in hospital
<u>last 2 weeks of life</u> 16% had ED visit	<u>last 2 weeks of life</u> 28% had ED visit
32 % had hospitalization in last 2 weeks	

More Nursing Hours Matters- Hsien Seow Study



Home is the place to be

- 93% want to stay at home to die
- Validated by our family focus group
- Home provides the best environment
- Home is more culturally appropriate
- Home is where family and friends are

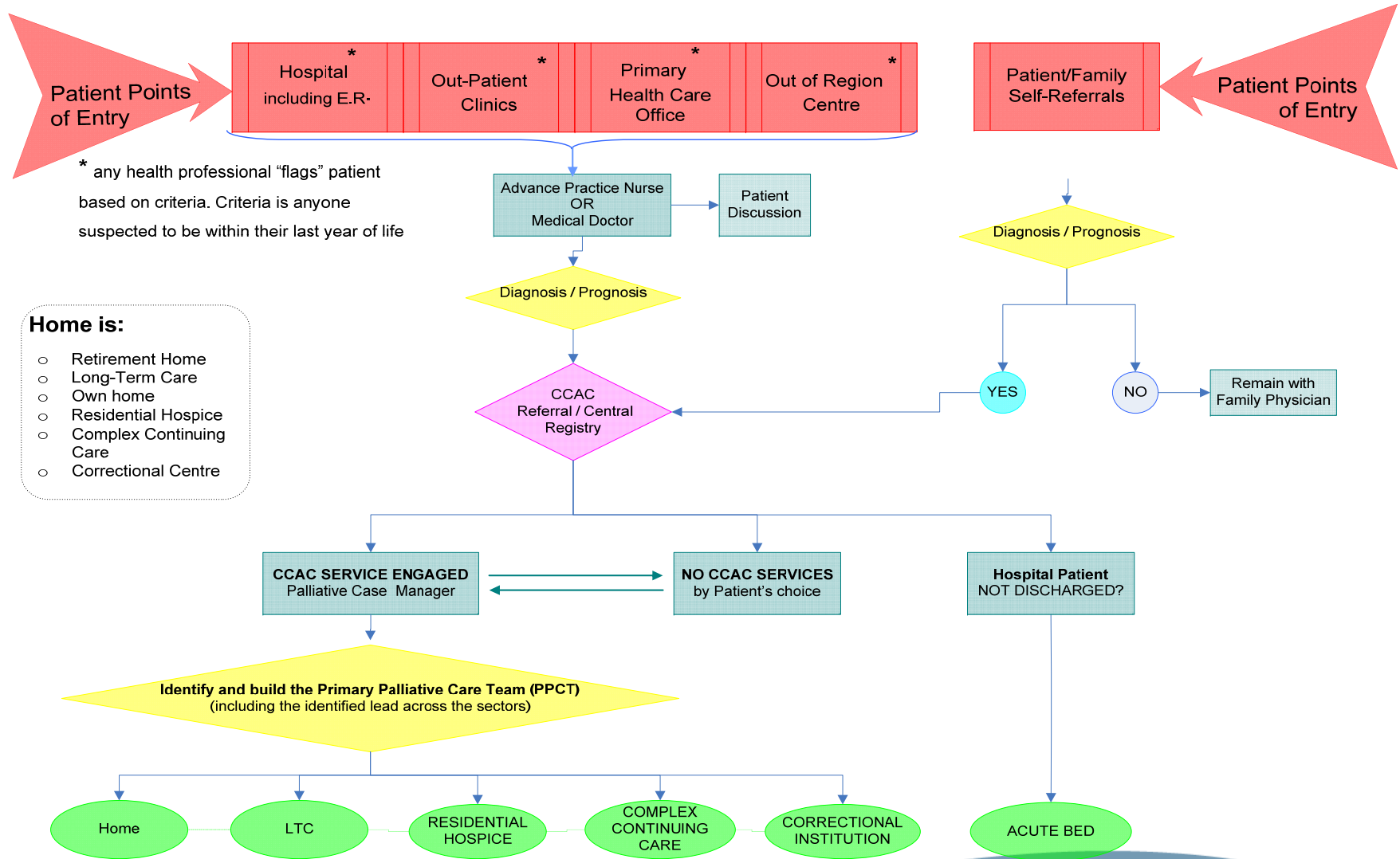
How do we shift palliative care to community?

- We need to strengthen support and linkages for patient/family and for frontline staff.
- Community nurse and family physician need to be available 24/7.
- Palliative care physicians need to be available 24/7 to the Primary Palliative Care Team (PPCT).

- Identification of each team member roles and responsibilities and we hold each other accountable.
- Palliative Care Consultants enhance involvement in education and mentorship of nurses and PSWs.
- Advance care planning to be done by primary nurse and reinforced throughout the journey.
- Nurse practitioners to take the Care Coordinator role in LTC homes for palliative residents.
- Palliative care supports enhanced for patient and family needs.

- Direct care increased for last weeks of life as the patient and family needs increase.
- Care coordinator to carry the baton and coordinate all care and navigate the patient/family through our system.
- Clear communications to patient/family and to the team members.
- Leverage and enhance community resources.

Mississauga Halton LHIN Palliative Care Patient Flow Chart – Appendix A



- Home is:**
- Retirement Home
 - Long-Term Care
 - Own home
 - Residential Hospice
 - Complex Continuing Care
 - Correctional Centre

Mississauga Halton LHIN PALLIATIVE CARE MODEL

10/8/2009

The vision for palliative care is accessible, coordinated, comprehensive, and patient-centred. It will avoid unnecessary use of acute hospital care and will proactively facilitate moving palliative ALC patients from hospital to the community.

Care Coordinator

CARE LEVEL 1 Primary Palliative Care Team

Physician (Family MD, Palliative Care MD, Specialist MD)
Nurse (Community nurse, Advanced Practice Nurse)
Palliative Care Coordinator – (care coordinator / identified lead)
Pharmacist



Primary Support Team

Personal Support Worker, Spiritual Care, Volunteers, Social Worker, Physical Therapist Occupational Therapist, Dietician, Grief & Bereavement Counselor, Respiratory Therapist

Primary Palliative Care Services

can be provided in any setting including Long Term Care and Retirement Homes, own home, Residential Hospice, Complex Continuing Care, Correctional Centre, Outpatient Clinic and Community Hospice.

Palliative Care Services

- o Community Hospice: Volunteer visiting & Adult Day Programs
- o Outpatient Clinics providing Palliative Care:
 - Nephrology Cardiology
 - Respirology Transplant
 - Liver Oncology
 - Neurology
- o Grief & Bereavement Services
- o Palliative Care Clinic
- o Residential Hospice
- o Pain and Symptom Management Services
- o Respite Services
- o Spiritual Care
- o Psych-social Services
- o Community Hospice Services

Tertiary Level Services

such as:

- o Radiation Therapy
- o Chemotherapy
- o Interventional Radiology
- o Acute Palliative Care Unit
- o Anesthesiology
- o Surgery

CARE LEVEL 2 Palliative Care Resource Team

Palliative Care Physician (Secondary or tertiary level)
Palliative Care Nurse (Advanced Practice Nurse / Palliative Care Consultants)
Psycho-social – Spiritual care provider
Pharmacist

CARE LEVEL 3 Tertiary Palliative Care Team

Palliative Care Physician (tertiary level)
Physician (Medical/ Radiation/ Surgical Oncologists, other Medical Specialists, Anesthetists)
Advanced Practice Nurse in palliative Care/Oncology/Medical Specialty
Psycho-social care provider with expertise in advanced illness
Pharmacist

MH LHIN Palliative Care Patient Flow Chart
Please see Appendix A

Direct Care will be provided based on the Square of Care, Ferris F. D. et al, "A model to Guide Hospice Palliative Care", 2002.

Roles and Responsibilities of Team Members and Levels of Care. Please see Appendix B

Final- September 4, 2009

Recommendations for Model

- 1) Build Community Capacity- Palliative APN to be integral part of the team. In the community- complete an assessment on complex cases and make recommendations to primary nurse and physician. In the hospital- provide an assessment on palliative ALC patients, complete a plan of care and make referral to CCAC to move patient to the community.
- 2) Build capacity for primary nurse and PSWs for palliative care:
 - a. Palliative Care Consultants continue to build capacity for frontline staff with education and mentorship
 - b. Nursing/PSW agencies to build capacity for frontline staff with education and mentorship.

- 3) Build capacity for family physician for palliative care through palliative care physician mentorship and CME sessions.
- 4) Care Coordinator- is the Identified Lead and pivotal to patient care coordination/system navigation to ensure continuity of care and will pass the baton from one care setting to the next setting. (Care coordination transition will be in both oral and written form.)
- 5) Develop early identification and central access/referral.

- 6) Develop portal for patient database to be shared among involved palliative care providers.
- 7) Develop consistent, common pathway through the system.
- 8) Each organization to be accountable for the standardized roles and responsibilities, clear communication processes, performance expectations are defined and linked to quality indicators.
- 9) Move to shared care with family physicians and palliative care physicians.

- 10) Protected funds for increased CCAC palliative care services for nursing and PSW visits.

- 11) Provide community support for patient/family with:
 - 24/7 availability of frontline nurse
 - 24/7 availability of family physician
 - 24/7 availability of palliative care physician to Primary Palliative Care Team (PPCT).

- 12) Nurse Practitioner to take the role of Palliative Care Coordinator in LTC homes.

- 13) Family physician to have answering machine message to say- if this is a palliative care patient needing urgent care, please call
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- 14) Comprehensive marketing plan of the model and palliative services available.
- 15) Clear process to bypass ER for patients requiring a palliative care admission.
- 16) Training for Advance Care Planning by the Palliative Care Consultant.
- 17) Develop, print, and distribute a Palliative Care Resource Guide: give to patients, caregivers, physicians, and providers.

- 18) Palliative Care Consultants to work with GTA to revise and simplify Common Referral Form.
- 19) Emphasize the need for Pain Management in palliative care through education, mentorship, and cultural change.
- 20) Small palliative care unit in LTC homes with trained staff and change in staffing ratio. (This recommendation was not accepted).
- 21) Increase funding for Hospice Volunteer Visiting Program.