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Local Health Integration Network
Réseau local d'intégration des services de santé

South West Hospice Palliative Care Network

CCO South West Regional Cancer Program
in partnership with Cancer Care Ontario

Palliative Care in the South West

Our Journey

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Agenda

- The “Declaration”
- Palliative care – Let’s Step Back in Time
- Improving Palliative Care in the South West
  - Leadership
  - Capacity Planning
  - Hospice Growth
  - Community Outreach / e-shift
  - Early Identification
  - Education
  - SWAHN
  - Communication
- A New Partnership

Lets Step Back in Time

2011

- The “Declaration”” released - Advancing High Quality, High Value Palliative Care In Ontario - A Declaration of Partnership and Commitment to Action (http://health.gov.on.ca/en/public/programs/ltc/docs/palliative%20care_report.pdf)
  - “This Declaration of Partnership and Commitment to Action is the result of a collaborative effort from more than 80 stakeholders from across Ontario. Each person involved brought a special set of insights and expertise to the table. Together, we have achieved a common consensus on a vision for palliative care in Ontario.”
- The Vision
  - Adults and children with progressive life-limiting illness, their families and their caregivers will receive the holistic, proactive, timely and continuous care and support they need, through the entire spectrum of care both preceding and following death, to:
  - Help them live as they choose, and
  - Optimize their quality of life, comfort, dignity and security.
- Top Three Goals
  - Quality: To improve client/family, caregiver and provider experience by delivering high quality, seamless care and support
  - Population Health: To improve, maintain and support the quality of life and health of people with progressive life-limiting illnesses
  - Sustainability: To improve system performance by delivering better care more cost-effectively and creating a continuously self-improving system

Clinical Care

- No community based palliative care outreach teams existed
- There was an inconsistent level of hospice / palliative care expertise in long term care and home and community.
- Inconsistent availability of primary and specialized palliative care services
- Residential Hospice Services included one Residential Hospice in Oxford County
- Education focused on LEAP, CAPCE and Fundamentals and was delivered by the Palliative Pain and Symptom Management Consultation Team

Leadership

- Provincially, no single agency or secretariat guided and provided oversight to hospice / palliative and end of life care.
- In the South West a network of volunteer participants provided input within a regional End of Life Committee which lacked the responsibility and accountability to effect change.
- How would the province and our region advance palliative care?
- How would the recommendations of the “Declaration” be brought to life?

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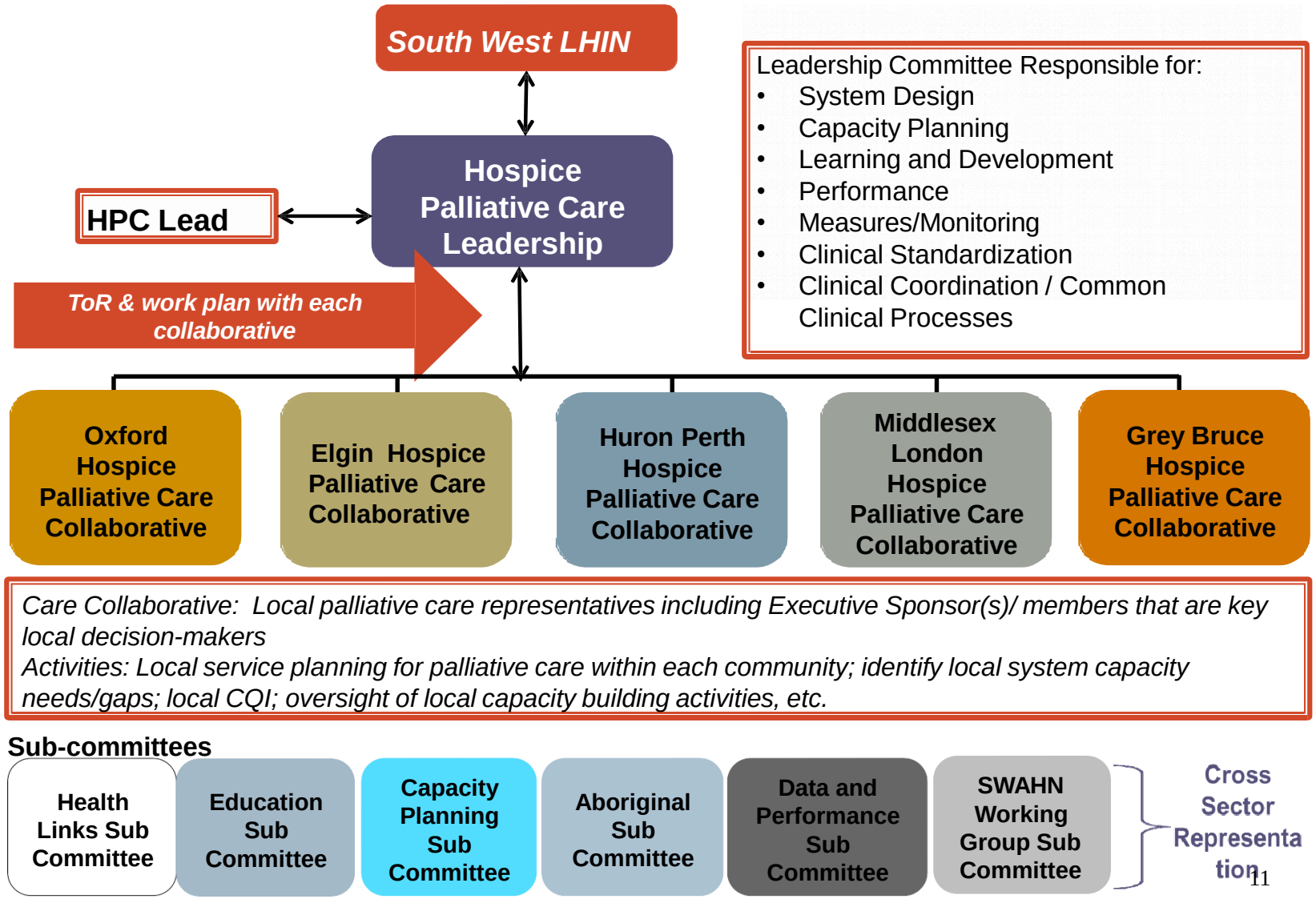
Improving Palliative Care in the South West

Leadership

- The End of Life Committee was reformatted with a more purposeful approach to ensuring leaders and decision makers owned the work.
- The new Hospice Palliative Care Leadership Committee was formed with a partnership between executive leadership of the South West LHIN, South West CCAC and the South West Regional Cancer Program.
- Began to build a future state model and Driver Diagram for Hospice Palliative Care after the release of the Declaration.
- Began to look at the model transitioned of palliative care as an overall system.
- From the beginning the work of the Leadership Committee included feedback and input from patients and families into the committee's work.


South West LHIN
Hospice Palliative Care Leadership
HPC Lead
ToR & work plan with each collaborative
Leadership Committee Responsible for:
• System Design
• Capacity Planning
• Learning and Development
• Performance
• Measures/Monitoring
• Clinical Standardization
• Clinical Coordination / Common Clinical Processes
Oxford Hospice Palliative Care Collaborative
Elgin Hospice Palliative Care Collaborative
Huron Perth Hospice Palliative Care Collaborative
Middlesex London Hospice Palliative Care Collaborative
Grey Bruce Hospice Palliative Care Collaborative
Care Collaborative: Local palliative care representatives including Executive Sponsor(s)/ members that are key local decision-makers
Activities: Local service planning for palliative care within each community; identify local system capacity needs/gaps; local CQI; oversight of local capacity building activities, etc.
Sub-committees
Health Links Sub Committee
Education Sub Committee
Capacity Planning Sub Committee
Aboriginal Sub Committee
Data and Performance Sub Committee
SWAHN Working Group Sub Committee
Cross Sector Representation

Leadership - Collaboratives

- Five local collaboratives were formed to provide on the ground input into development of palliative care and to encourage and facilitate local quality improvement and innovation.
- They include local palliative care providers and leaders that are key local decision-makers / influencers
- Local service planning for palliative care within each community; identify local system capacity needs/gaps; local CQI; oversight of local capacity building activities, etc.
- Quality Improvement training was provided to the collaboratives to enable them to make local system improvements in their areas.

Alignment with Future State

- Early identification–the primary care provider/ team regularly screens patient, family and caregiver for needs and follow-ups as required, by getting involved earlier on in trajectory, improved patient care (stable phase of future state)
- Outreach – provide consultation with secondary level supports (i.e. Palliative Nurse Practitioner, Palliative Pain and Symptom Management Consultation Program, Hospice Palliative Care Nurse Practitioner) as required (i.e. stable, transitional, end of life phases of future state)
- Residential Hospice Support – connect to supports as needed, last days of life requiring change in destination (patient choice). Aligns to early “plan” conversations where patients and families are connected with information regarding supports needed in the future
- Education – provide support and education to increase comfort level in community and competency in providers (stable, transitional, end of life phases of future state)

Capacity Planning

- Modeled overall population based reports related to deaths within the South West
- Looked at all causes of death, not solely those related to life threatening / limiting illnesses
- Combined various administrative data sets to determine the locations of death and potential capacity constraints
- Recommendations focused on determining priorities for residential and community palliative services recognizing the interdependence between the two types of services

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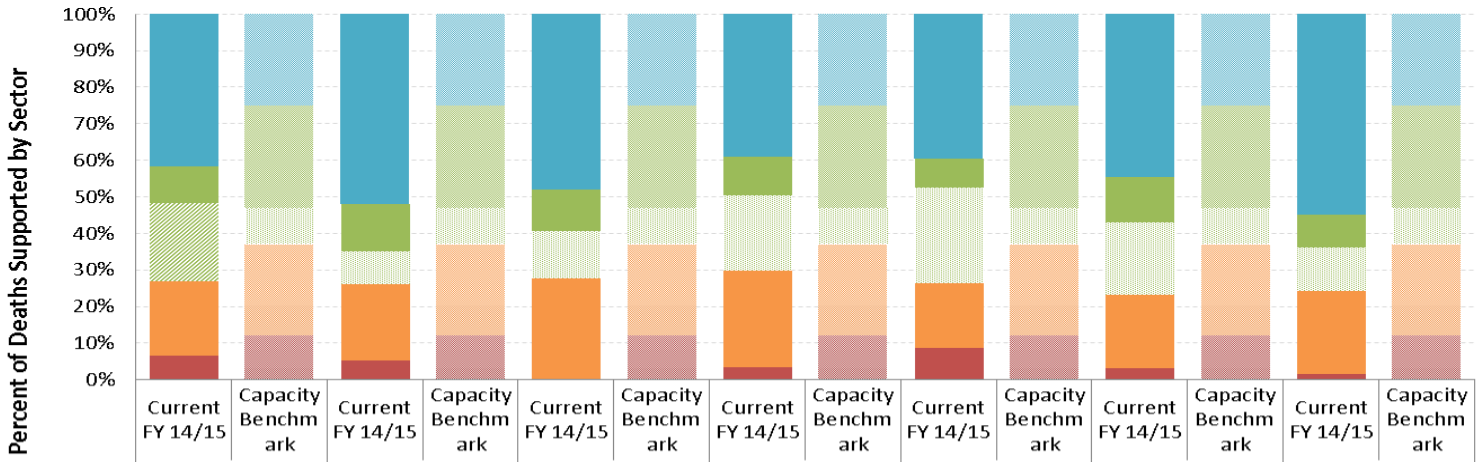
Deaths in the South West LHIN by Sector by county, FY 2014/15 Current Capacity compared to Capacity Planning Benchmarks



	Grey		Bruce		Huron		Perth		Oxford Norfolk		London - Middlesex		Elgin	
	Current FY 14/15	Capacity Benchmark	Current FY 14/15	Capacity Benchmark	Current FY 14/15	Capacity Benchmark	Current FY 14/15	Capacity Benchmark	Current FY 14/15	Capacity Benchmark	Current FY 14/15	Capacity Benchmark	Current FY 14/15	Capacity Benchmark
Hospital	41.6%	25.0%	52.0%	25.0%	47.9%	25.0%	39.1%	25.0%	41.2%	25.0%	44.6%	25.0%	55.0%	25.0%
Home	10.1%	28.0%	13.0%	28.0%	11.6%	28.0%	10.6%	28.0%	8.2%	28.0%	12.5%	28.0%	9.0%	28.0%
Other	21.4%	10.0%	8.9%	10.0%	13.1%	10.0%	20.5%	10.0%	27.3%	10.0%	19.9%	10.0%	11.9%	10.0%
Longterm Care	20.4%	25.0%	20.9%	25.0%	27.0%	25.0%	26.6%	25.0%	18.2%	25.0%	19.9%	25.0%	22.6%	25.0%
Residential Hospice	6.5%	12.0%	5.2%	12.0%	0.5%	12.0%	3.2%	12.0%	9.0%	12.0%	3.1%	12.0%	1.5%	12.0%

Margin of Difference	Grey	Bruce	Huron	Perth	Oxford Norfolk	London Middlesex	Elgin
Hospital	+16.60%	+27%	+22.90%	+14.10%	+16.20%	+19.60%	+30%
Home	-17.90%	-15.00	-16.40%	-17.40%	-19.80%	-15.50%	-19%
Other	+11.40%	-1.10%	+3.10%	+10.50%	+17.30%	+9.90	-1.90%
Longterm Care	-4.60	-4.60%	+2%	+1.60%	-6.80%	-5.10%	-2.40%
Residential Hospice	-5.50%	-6.80%	-11.50%	-8.80%	-3%	-8.90%	-10.50%

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Residential Hospice Capacity Expansion

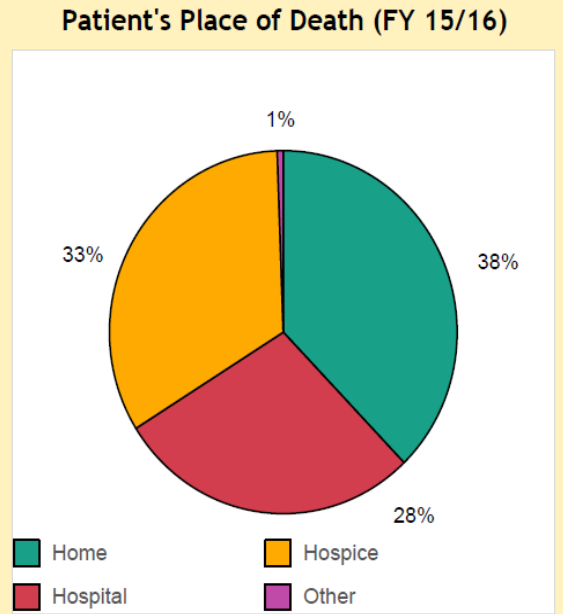
- 2009
  - Sakura House, Oxford – 10 beds
- 2013
  - Residential Hospice of Grey Bruce-6 Beds
  - Expansion to 8 beds in March of 2017
  - Planning for satellite Site in Bruce County
- 2014
  - St. Joseph's Hospice, London – 10 beds
- Future
- Huron Perth developing 10 bed capacity
  - Clinton site 4 beds opening in 17/18
  - Stratford site 6 beds opening in 2018
- Elgin currently planning for 7-10 bed capacity in 2019

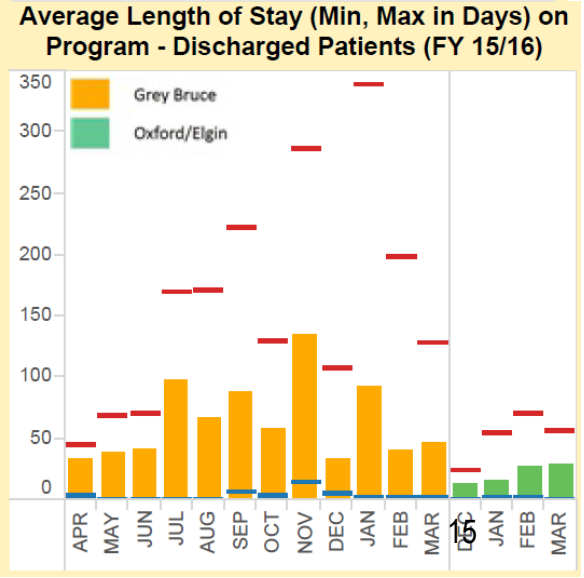
Hospice Palliative Care Outreach Services

- 2014 - Grey Bruce Hospice Palliative Care Outreach Team pilot funded by the SWLHIN
- 2015 - Oxford Elgin Hospice Palliative Care Outreach Team funded by the SW LHIN
- 2016 - Huron Perth Hospice Palliative Care Outreach Team funded by the SW LHIN

- Planning under way to implement Palliative Care Outreach Teams in London Middlesex in 2018

- 72% of patients supported by Outreach Teams are dying at home or hospice.





Hospice Palliative Care Outreach Services

Who is part of the team?

- Patient/Family
- Palliative Care Outreach Physicians/Admin Assistant(Oxford)
- Most Responsible Physician in Full or Shared Model
- LHIN Nurse Practitioners
- St Joseph's Health Care Pain and Symptom Management Consultant(s)
- Spiritual Care Consultant(s)
- Local Residential Hospice Patient Care Director(s)
- Bereavement/Hospice Vol. Visiting Resource Coordinator(s)
- LHIN Care Coordinators/Patient Care Assistants
- Manager/Navigator/Admin Assistant
- Nurses with LHIN Contract Agencies/Other Allied Health
- Hospice Volunteers

Who is served?

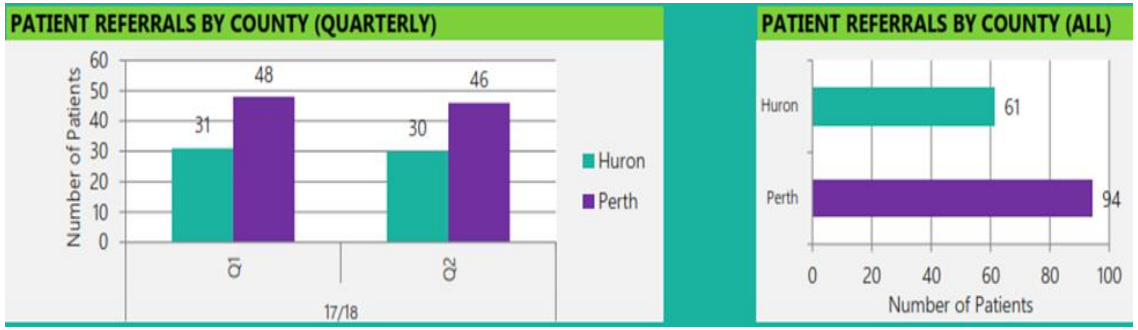
- person with chronic / acute illness with a disease trajectory that will lead to death within a few months.
- using the Palliative Approach to Care inspires us to engage with people "early rather than later"
- The Surprise Question – "Would you be surprised if the person died in the next year"?
- person with palliative performance scale (PPS) is 50% or less and/or disease trajectory is <3 months
- person having frequent emergency room visits and hospital admissions
- person wishes to die at home or be at home before admission to Hospice

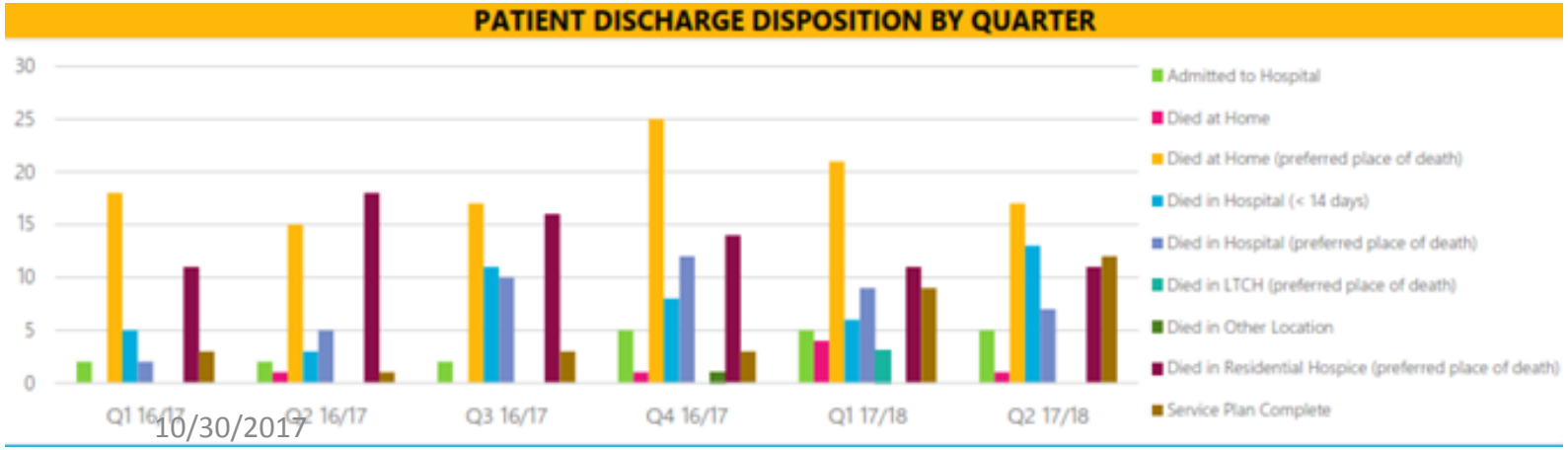
Hospice Palliative Care Outreach Services

- A partnership to support primary care
  - Resources to minimize most responsible physician house calls/phone calls:
  - LHIN Home and Community Support Services
  - Outreach Team
  - Hospice Referral Process
  - Palliative Approach to Care – Early Identification and setting up of supports
  - Advanced Care Planning (Goals, Wishes, DNR)
  - Symptom Response Kit
  - Expected Death in the Home Plan
  - Proactive Palliative Care Rounds/Huddles – Weekly – Outreach/Nursing
  - Concise Reporting – SBAR
  - Sharing of Teams Consult notes with MRP / Specialist
  - 24/7 Outreach Health Professional Support line

Hospice Palliative Care Outreach Services – Some Results

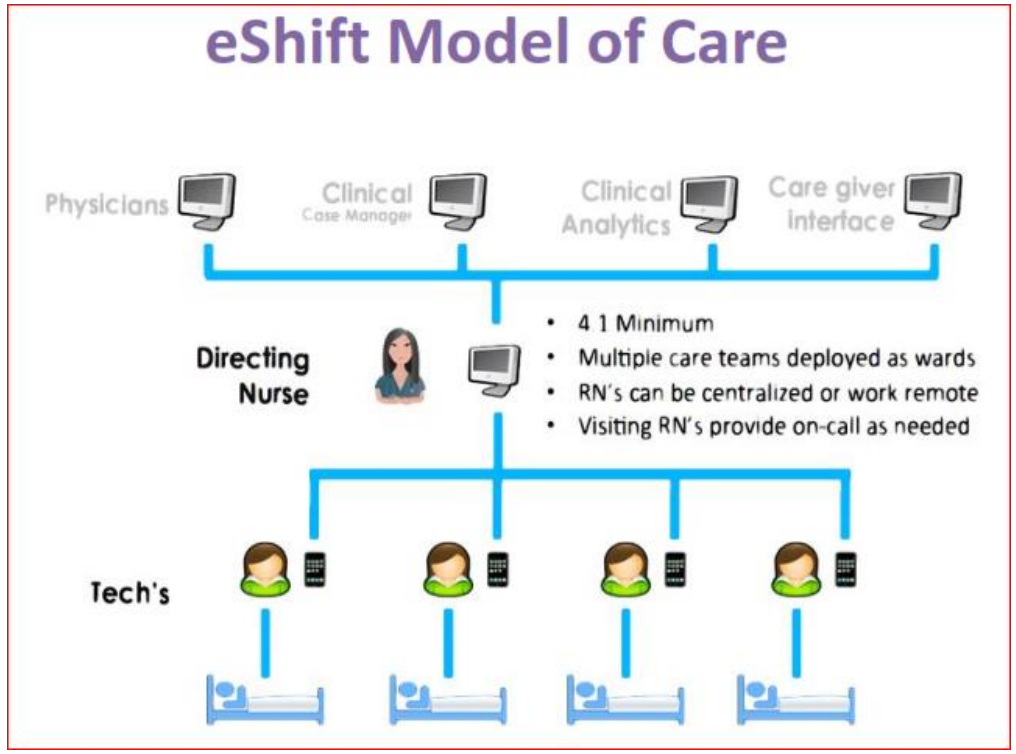
TEAM * approx.	% patients to date who have died outside hospital setting				% of patients with preference recorded died in their place of choice				% of deceased patients have a death preference recorded				Average LOS in Program in Days (Discharged)				Average PPS Score on Admission			
	Sep	L F	1 QC	2 QC	Sep	L F	1 QC	2 QC	Sep	L F	1 QC	2 QC	Sep	L F	1 QC	2 QC	Sep	L F	1 QC	2 QC
Grey Bruce	68*	69	72	79	83*	85	83	79	90*	93	90	87*	82*	84	111	113	33*	45	46	34
Oxford Elgin	73	76 ---- 72	80 ---- 68	75 ---- 53	93	97 ---- 91	91 ---- 100	87 ---- 83	93	94 ---- 93	96 ---- 91	87 ---- 91	74	65 ---- 67	91 --- 76	86 --- 72	38	44 --- 38	43 ---- 44	44 ---- 37
Huron Perth	58	n/a	n/a	70 ---- 48	100	n/a	n/a	100 ---- 100	94	n/a	n/a	93 ---- 100	70	n/a	24 ---- 28	43 --- 50	49	n/a	48 --- 44	41 ---- 51





TEAM	Average Monthly Referrals	Active Patients (Sept)	Referred Patients to Date (Sept)	Discharged Patients to Date (Sept)
Grey Bruce (Start – Jan 2014)	20	76	593	517
Huron Perth (Start – Apr 2017)	26	80	156	76
Oxford Elgin (Start – Dec 2015)	35	112	628	516

E-Shift: An Innovative Model



- Expanding capabilities of specialist Nurses by advanced use of delegated acts between a remote RN and an enhanced-skill Homecare Technician (Tech's)
- Tech's trained in clinical data collection and specialized medical tasks done only under direct supervision and direction of the remote RN (DRN)
- DRN works remotely to monitor, mentor & manage Tech's at the patient bedside in real-time
- Safely and cost-effectively moves patients from hospital back to home and allows for complex patients to be cared for in community with greater health system efficiency

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E-Shift: An Innovative Model

- Approximately 1000 palliative patients receiving home based palliative care at any given time
- Supported by 27 community Care Coordinators across the South West
- An additional blended caseload covered by 1 Care Coordinator & 1 Nurse Practitioner for 3 aboriginal communities in Middlesex
- Care teams are supported for urgent or time sensitive concerns by team of Complex In Office Care Coordinators
- Care augmented by a team of 17 Nurse Practitioners
- Robust care team available through either contracted or SW LHIN direct nursing services: nursing, PSW, eShift, OT, PT, RD, SW, Nurse Practitioners, Rapid Response Nurses
- Palliative and Primary Care Physicians are an invaluable part of the team
- Key partners in the continuum of care are the 3 Hospices and Palliative Care units and LHSC and Parkwood
- Supports provided for the continuum of end of life care expanded July 2016 to include MAID navigation and provision of associated supports

Key Finding's: Western University 3 year Study on E-shift

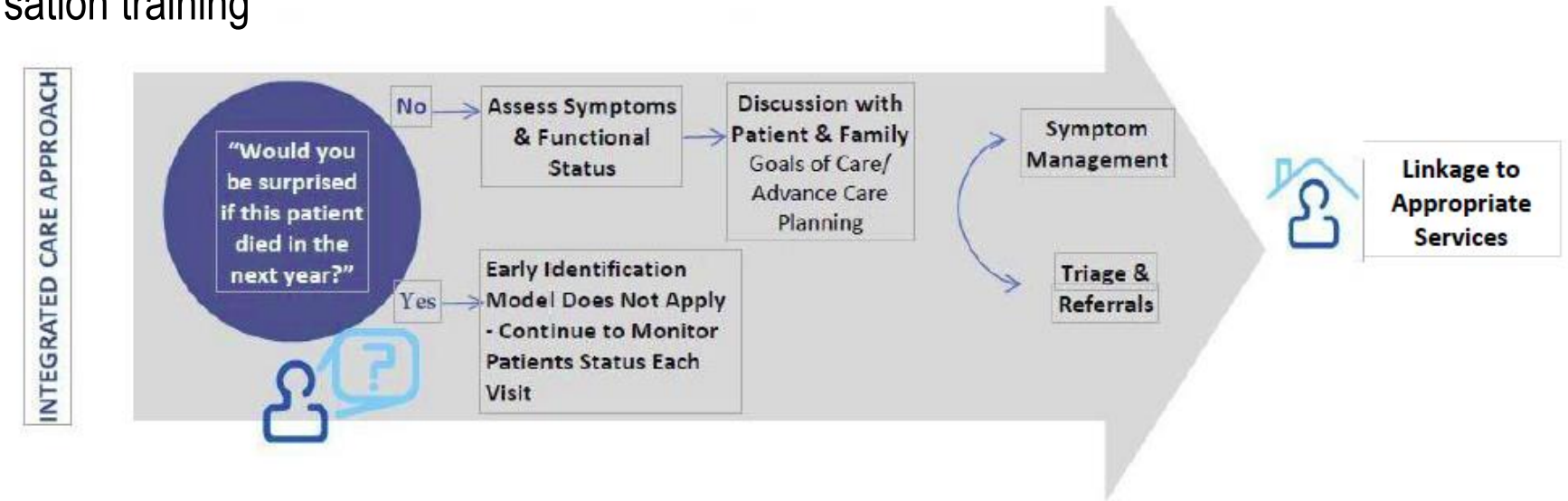
Key Messages

eShift Model of Palliative Home Care:

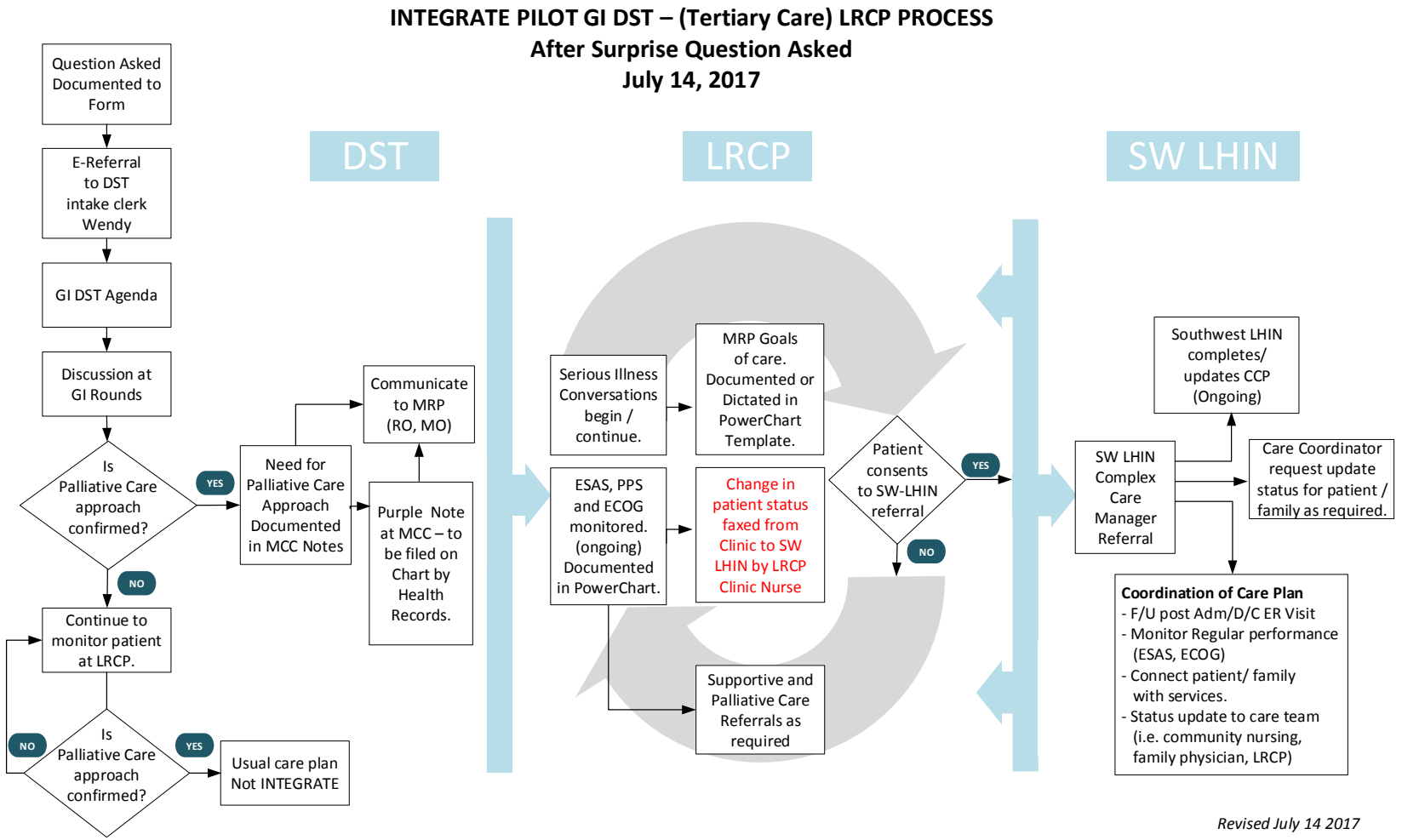
- Patient AND family caregiver = focus of care
- Patients were cared for in a **timely manner;** patient **symptoms** (e.g., pain) were **well managed**.
- Increased **dying in place of choice;** facilitated by adequate **caregiver coping.**
- Facilitated family caregiver respite; decreased **caregiver stress**

Early Identification

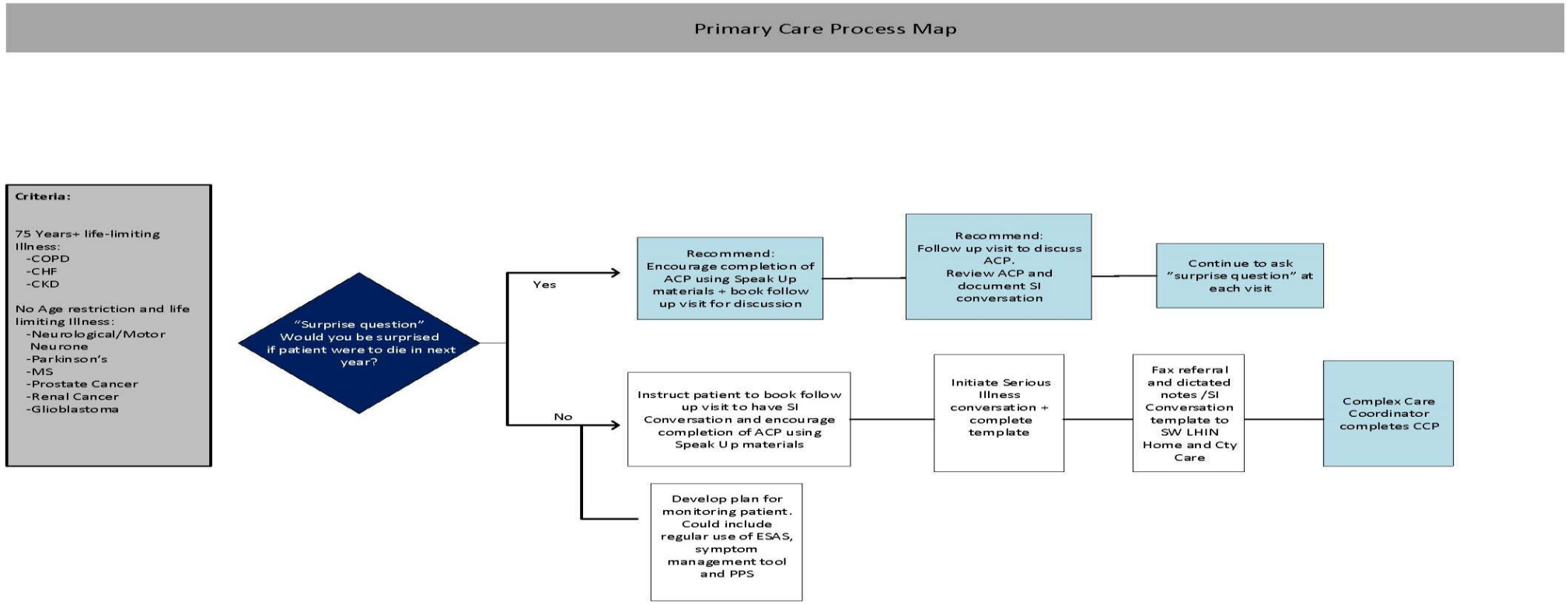
- Asking the Question, Use of Speak Up Ontario Strategy
- Spread of SPICT Tool and Gold Standards Framework.
- Early Identification Model Roll Out - Sub-Regions
- Collaborative pilots in cancer and primary care
- Combines serious illness conversation training



INTEGRATE Pilot GI Cancer – LRCP Process Map



INTEGRATE Pilot – Byron Process Map



Goals of SI Conversations

1. Ensure patient has a good understanding of their illness
2. Communicate goals of care
3. Encourage and initiate ACP
4. Develop plan for monitoring patient using a palliative approach

Palliative Care Education

- Survey completed across the South West gaining insight from HPC service providers.
- Recommendations developed based on survey results.
- Financial Support acquired through one time funding.
- Palliative Pain and Symptom Management Consultation Team increase palliative care education programs in home and community e.g. CAPCE /Fundamentals/LEAP
- $50,000 in base funding was leveraged to support the immediate increase in front line providers of HPC services.
- In partnership with thehealthline.ca, the South West LHIN HPC Network developed an application of an e-learning platform leveraging the Network mini-site
- The South West LHIN HPC team is reporting requirements and a mechanism to support reporting for HSPs on HPC education related statistics in alignment with the Ontario Palliative Care Network
- The South West HPC Network set the goal of a 20% increase in the number of formal caregivers and volunteers taking Fundamentals, LEAP, and CAPCE (or equivalent) over the next 5 year period across the South West LHIN.

SWAHN

- Engaged health care professionals and academia professionals from 3 LHINS; Erie St, Clair, South West and Wellington Waterloo
- Development of an inventory of pre-service education in the field of palliative care to ensure that al HPC providers have a basic level of training/knowledge followed by a review of continuing education
- Report to the SWAHN Education Committee and OPCN HPC Provincial Committee
- Gap analysis of the curriculum based on current state in 2015/16 complete and strategy to improve consistency and standardization of HPC education for identified professionals within the core curriculum through the development of a model for streamlined education (e.g., the ideal future state) is being developed in 2016/17-17/18

Communication

- Development of the Communique to facilitate communication with stakeholders across the South West
- Monthly HPC Network reports to communicate planning and actions to link work at sub-regional, LHIN wide and provincial level
- Ongoing update and monitoring of the HPC Communication Plan including alignment with the Health Links Communication Plan and Indigenous Communication Plan
- Community education and updates on capacity planning focus on RH planning – county councils, Diealogues

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A New Partnership

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A New Partnership

2014 – Auditor General's Report – Palliative Care

- Strategic policy framework not in place for palliative-care delivery system
- Ministry needs better information for decision-making and planning
- Mix of services should be reviewed to ensure patients' needs are met cost-effectively
- Access to palliative-care services is not equitable
- Hospice beds could serve more patients
- Patient care could be improved and healthcare costs reduced:
- Education standards needed for physicians and nurses to help ensure proper patient care
- Most publicly funded services used by cancer patients
- More public awareness and education needed

- 2016 Palliative and End-Of-Life Care: Provincial Roundtable Report
  - A Report from Parliamentary Assistant John Fraser to the Minister of Health and Long-Term Care

Ontario Palliative Care Network

Be a Principal Advisor
We act as a principal advisor to the Ontario government for quality, coordinated hospice palliative care in the province.

Be Accountable
We are accountable for quality improvement, data and performance measurement and system level coordination of hospice palliative care in Ontario.

Support Regional Implementation
We support regional implementation of high-quality, high-value hospice palliative care. Building on Advancing High Quality, High Value Palliative Care in Ontario: The Declaration of Partnership and Commitment to Action as a foundation, we are developing a network to ensure that the priorities identified in the Declaration are implemented at both the provincial and regional levels. This supports and aligns with the Ministry of Health and Long-Term Care's Patients First: A Roadmap to Strengthen Home and Community Care, highlighting a commitment to improved access and equity in hospice palliative and end-of-life care at home and in the community.

We are a coordinated network of individuals and organizations including:

- Academia
- Community Support Services Organizations
- Home Care Providers
- Ministry of Health and Long Term Care
- Palliative Care Regional Multidisciplinary Clinical Co-Leads
- Palliative Health Care Service Providers
- Palliative Pain and Symptom Management Consultants
- Patient, Families and Caregivers
- Provincial Organizations representing community care, long-term care homes, primary care and other parts of the health system
- Regional Palliative Care Networks
- Residential Hospices
- Volunteers

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A New Partnership

- Executive Leadership from the 14 LHINs and Cancer Care Ontario began discussions to determine how their collective agencies can collaborate to lead system level change to improve palliative care services
- In March 2016, the Ministry of Health announced the formation of the Ontario Palliative Care Network along with an investment of a three year - $75 Million investment to provide more options and access to palliative care services
- The responsibility for oversight and advancing palliative care within each LHIN rests with the CEO of the LHIN and the Regional Vice President of the Regional Cancer Program
- The work is supported regionally by clinical and administrative leads dedicated to palliative care as well as staff from both the LHIN and the Regional Cancer Program
- A three year action plan is being finalized that will guide the development of palliative care at the provincial and regional level

Reflections on the Journey