2013-2016
Central East Regional Palliative Plan

Central East LHIN Board Meeting

April 23, 2014

Presentation Objectives

- To present the Central East Regional Palliative Plan to support achievement of the 2013-16 Central East LHIN Integrated Health Services Plan (IHSP) Palliative Strategic Aim including:
  - Key provincial frameworks and planning partners
  - Current state services and capacity
  - Gaps, barriers and challenges
  - Priority recommendations
  - Governance and implementation
- To receive Board endorsement for the Central East Regional Palliative Plan

Palliative & End of Life Care

BACKGROUND

What is Palliative & End of Life Care?

- An approach to caring for people who are living with a life-threatening illness focusing on achieving comfort for the person nearing death and maximizing quality of life for the patient, family and loved ones
- It is holistic in nature and aims to:
  - Address physical, psychological, social, spiritual and practical issues and associated expectations, needs, hopes and fears
  - Prepare for and manage self-determined life closure and the dying process
  - Cope with loss and grief during the illness and bereavement

Why is Palliative & End of Life Care Important?

- Over 14% of the LHIN's population are seniors aged 65 years and over
- By 2016, seniors will account for 16% of the LHIN's population; by 2021 they will account for 18%
- Chronic conditions account for 6 out of 10 deaths, 1 out of 5 acute hospital discharges, and 1 out of 4 acute hospital days for LHIN residents
- Heart disease accounts for an additional 10% of all hospital days and 9% of all acute care discharges
- **In 2011-2012, 4,716* residents were admitted into hospital for palliative care, accounting for 59,195 hospital days**

Source: Central East LHIN Integrated Health Services Plan, 2013-16.

What are Current Challenges Associated with Palliative & End of Life Care?

- Aging population with increased co-morbidities
- Increased death and hospital stays
- Silos of care – inconsistent transitions across care setting
- Variable communication across settings
- Gaps in health service provider education and training
- Limited advance care planning in primary, secondary and tertiary care
- Need for heightened community capacity and resources to support patients in local settings
- No dedicated Interdisciplinary Palliative Community Outreach Teams
- No formalized palliative care programs across Long-Term Care Homes (LTCHs)
- No Residential Hospices

Sustainable Access Report (2011) – Key Recommendations

- Within the next decade, sustainable health services will require a **mix of funding and capacity increases alongside improvements in the use of existing resources**
- Pursue opportunities for **optimizing resource use** for Alternative Level of Care (ALC) and **end of life patients**
- Pursue opportunities to **improve the mix of seniors' services**
- Among all programs, the analysis suggests expansions for:
  - Community Support Services
  - Assisted Living Services in Supportive Housing
  - Complex Continuing Care (Age 65+)
  - **Residential Hospice**

Local Initiatives - Past Successes

Palliative Pain & Symptom Management Consultation (PPSMC)	Expansion and equal distribution of service access across community organizations in Durham, Scarborough and Northeast clusters
Community Palliative Care Nurse Practitioner Program (CPCNP)	Program expansion across Scarborough, Durham and the Northeast clusters
Community Hospice Services	Strengthened services through investments in innovative hospital-community partnerships in an effort to improve access to end of life care in all settings
Interdisciplinary Palliative Education	Standardized service delivery model across community organizations in the Durham, Scarborough and the Northeast clusters
Durham Regional Cancer Centre's (DRCC) Aboriginal Patient Navigator	Enhanced communication focusing on improved linkages and partnerships supporting improved cultural competencies and awareness regarding First Nations Inuit and Métis (FNIM) communities

Central East LHIN Contributions to Ontario HPC

Provincial Hospice Palliative Care Data & Performance Subcommittee	Ongoing support for the development and implementation of a data and performance measurement strategy for the delivery of palliative care across Ontario
Data Quality Research & Review	Continued research Development of 2 *Applied Health Research Question (AHRQ)* Proposal submissions helping to ensure complete and accurate information is reported, supporting identified deliverables at both local and provincial levels

Developing the Palliative Strategic Aim

2013-16 CENTRAL EAST LHIN INTEGRATED HEALTH SERVICE PLAN

2013-16 Central East LHIN Integrated Health Service Plan

Community

FIRST

Help Central East LHIN residents spend more time in their homes and their communities.

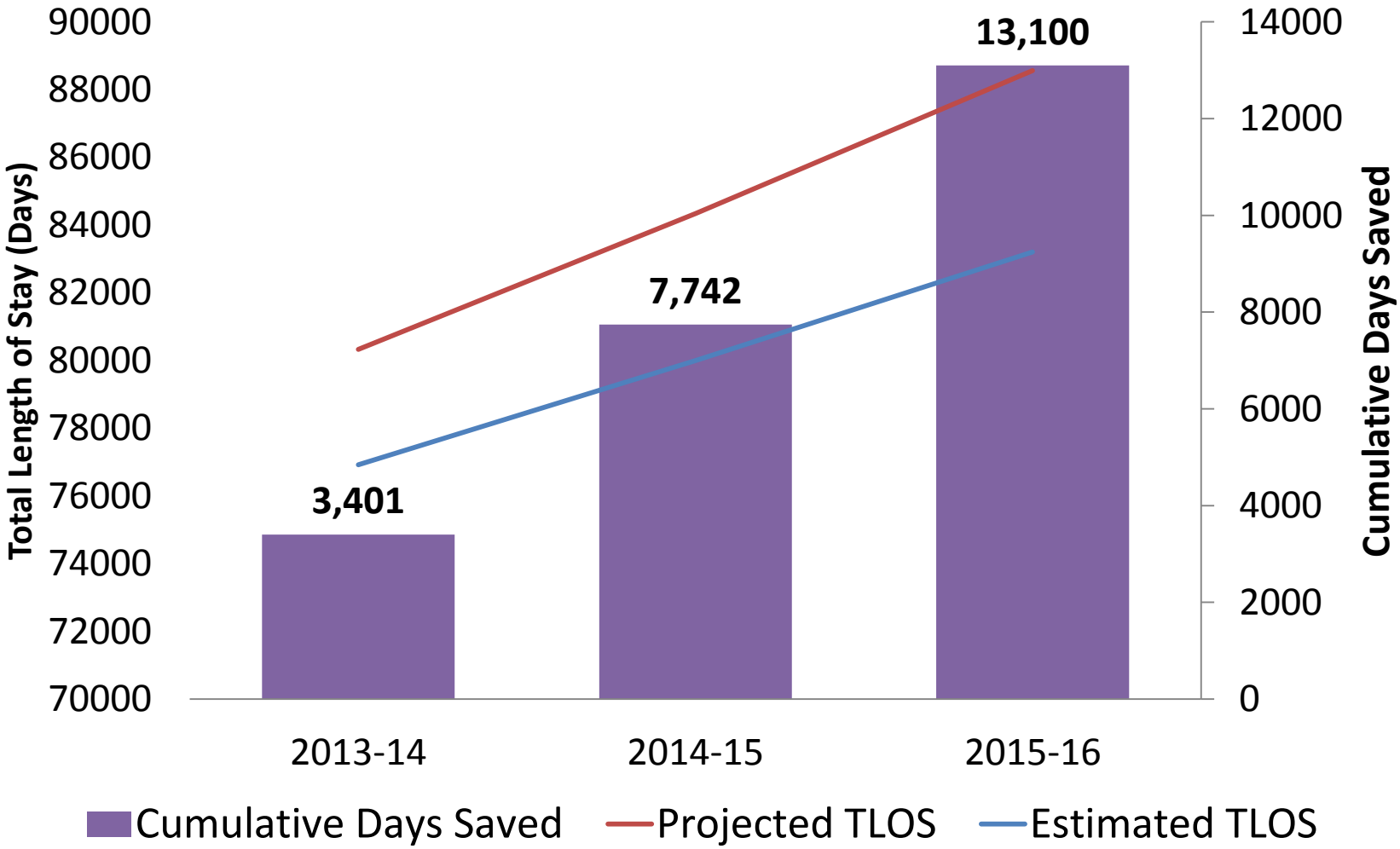
Assumptions

- Number of palliative care cases will continue to increase
- Projected total length of stay will increase by 5%
- Palliative initiative will be a factor in decreasing the total length of stay

How were savings calculated?

- *Cumulative Days Saved = Projected Total Length of Stay – Estimated Total Length of Stay*

Palliative Care Aim - Days Saved



Supporting Indicators - Definitions

Baseline	Average of the two most recent fiscal years
Central East LHIN Target	• Formal Central East LHIN target for that indicator (typically developed for use in existing scorecards e.g. MLPA) • Where there is no formal target, the baseline less 10% is used as an informal Central East LHIN target to track performance of supporting indicators for IHSP aims
Current Performance	• Central East LHIN performance for the indicator using the most current data available
Current Status	Current performance is compared with LHIN target and result is summarized by a colored dot following the parameters below: • Red dot indicates current performance deviates from desired target more than 10% • Yellow dot indicates current performance is within 10% of target • Green dot indicates current performance meets target or is performing better than desired target
Compared with Most Recent Past Performance	• LHIN performance for the indicator using the most recent reporting period prior to current performance

Palliative Aim - Supporting Indicators

Indicators	Baseline	CE LHIN Target	Current Performance [1]	Current Status	Compared to Most Recent Past Performance [2]
Average Hospital Length of Stay for Palliative Patients, in Days (decrease)	14.8	13.3	14.1		
Percentage ALC days for Palliative Patients (decrease)	16%	14%	15%		
Percentage of Palliative InPatients who were discharged "Home with Support Services" (increase)	66%	73%	67%		
Percentage of Palliative InPatients who Died in Hospital (decrease)	66%	59%	61%		

Notes:

1 Current reporting period: 13/14 Q3

2 Most recent previous reporting period: 13/14 Q2

Summary

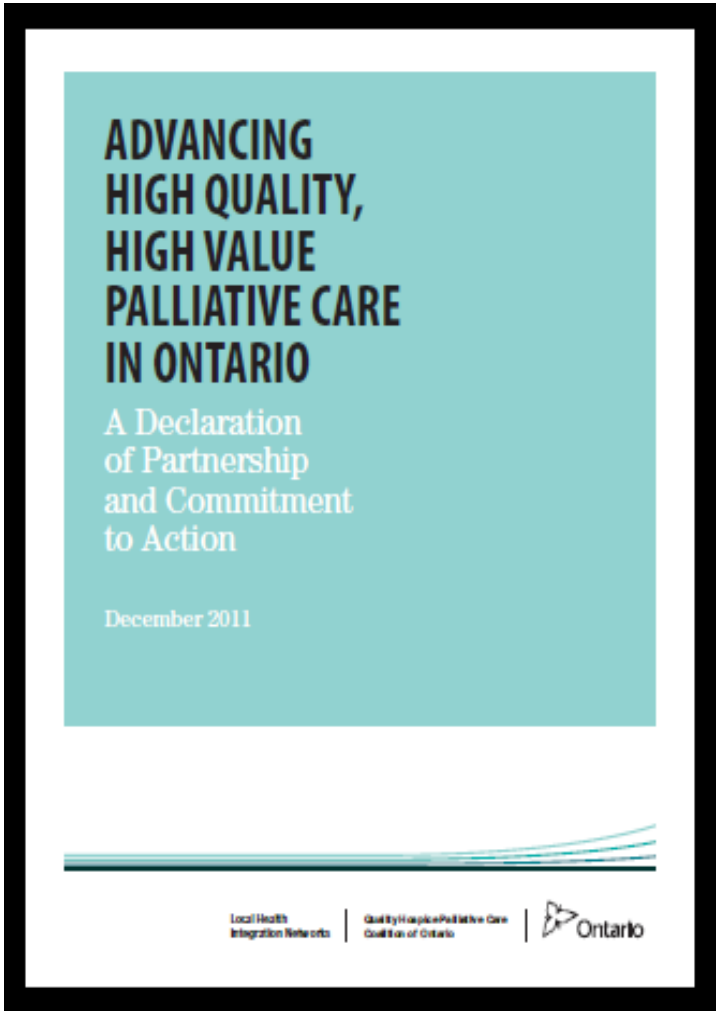
- It is projected that Central East LHIN will meet its target of saving 12,000 days
- However, there are identified risks which could change this projection
  - Historical trending may not be entirely representative of future state
  - Data limitations across the continuum of care
  - Data quality and coding issues
- Central East LHIN will monitor 4 supporting indicators to further understand the effect of regional initiatives implemented during the IHSP period

Developing the Central East Regional Palliative Plan

KEY FRAMEWORKS & PLANNING PARTNERS

A Declaration of Partnerships - Provincial Framework

- **MODEL**
  - Supporting adults and children with advanced chronic conditions and their informal support network to receive care that is proactive, holistic, person and family-focused
  - Centered on quality of life and symptom management
  - Delivered by virtually integrated inter-professional team across all settings
- **ACTION**
  - **Provincial End of Life Care Networks to develop a comprehensive integrated Regional Palliative Plan**



Central East Hospice Palliative Care Network

MANDATE

To provide direction, coordination and leadership for the development of a coordinated and integrated system of hospice palliative care

VISION

A comprehensive, integrated and coordinated system of hospice palliative care services that meets peoples' needs

MISSION

To provide leadership for the development and evolution of a comprehensive, integrated and coordinated system of hospice palliative care for the Central East Region through:

- *Development of standards and supports for delivery of care*
- *Support for implementation of best practices*
- *Support for building system capacity and access to hospice palliative care*
- *Education and knowledge transfer*

Assessing Current State Services & Capacity

ENVIRONMENTAL SCAN – 2013/14

Hospital / Acute Care

Hospital	Palc Beds/Inpatient Units	Clinic/Centre	Palliative Team/Approach
LH	Palc patients cared for in Supportive Care Unit 24 beds (LHO); CCC Unit 24 beds (LHB)	LHO/DRCC Pal Supportive Care clinic full day/M-F; Urgent Pal Supportive Care ½ day/M-F	1 FT palc physician on site daily (LHO); 13 palc physicians, 3 PPSMs collaborate with CCAC nurses (LHO/DRCC) Pal at Home & Hospital Care Team (LHB); Palc physician follows community patients, inpatient consults (LHPP)
PRHC	20 palc beds in Palc Unit	PPSM Clinic 2 half-day	Collaborative community approach
CMH	Palc patients cared for in acute beds; if possible managed in 6 private rooms		Collaborative community approach
RMH	6 palc beds in Palc Unit	PPSM Clinic 2X/ month	Interdisciplinary team supports Inpatient Unit
TSH	18 palc beds in Acute Palc Unit; 2 flex palc beds in Oncology Unit (General)	Outpatient Palc Clinic: 2 palc physicians, 1 RN, SW support (General)	Inpatient consultation 3 rotating palc physicians, Clinical Resource Leader (General); Inpatient consultation; 1 Oncologist (Birchmount)
RVHS	Palc patients cared for throughout both campuses	Outpatient Oncology Clinic	Decentralized approach; Inpatient consultation 3 rotating palc physicians; NP consults in Oncology Clinic
HHHS	1 palc bed + partnership with SIRCH		Collaborative community/ hospital patient rounds
NHH	6 palc beds in Palc Unit		RNs specializing in PPSM, end of life care

Visiting Hospice Service*

CSS Agency	# of Volunteers	Volunteer Visiting	Bereavement	Interdisc. Education	PPSMC
HP	180 active volunteers	**Caregiver Support** through visiting volunteers/day hospice; 2X/weekly; group support 2X/month;	**Adult Grief** 3 groups, 3X/year; 3X/month; **Children Grief** 2 groups offered 3X/year; 1X/month group; **1:1 Volunteer** as needed	**FHPC AHPC CAPCE	1 FTE
SCHC	78 active volunteers		**Adult Grief** 4 groups, 3X/year; **Therapeutic Art** group offered 3X/year; **1:1 Volunteer** as needed	FHPC AHPC CAPCE	Hiring 1 FTE
Durham Hospice VON	232 active volunteers	**Caregiver Support/Day Hospice** weekly	**Adult Grief** 2 groups, 2X/year for spousal/parental loss; **Therapy Group Session** 6 weeks; **1:1 Volunteer** as needed	FHPC AHPC CAPCE	Hiring 1 FTE
CCN	143 active volunteers	**Caregiver Support** through visiting volunteers	**Adult Grief** 2X/year or as needed; **1:1 Volunteer** offered regularly, as needed		
CCCKC	80 active volunteers	**Caregiver Support** monthly groups	**Adult Grief** 4 groups; **Children Grief** 2X/year; **1:1 Volunteer** as needed in community/hospital		
SIRCH	63 active volunteers	**Caregiver Support** in community and hospital	**Grief/Bereavement Training** for volunteers to facilitate adult support; **1:1 Volunteer** as needed		

Central East Community Care Access Centre

Service/Program	Description	Cluster/Location
Palliative Case Management	12 FTEs	Scarborough: 3 FTEs; Peterborough: 2 FTEs; Lindsay: 1 FTE; Whitby: 5 FTEs; Port Hope: 1 FTE
Community Palliative Care Nurse Practitioner Program	8 NPs 0.5 Program Coordinator	**Scarborough**: 4 FTEs; **Peterborough**: 1.0 FTE **Lindsay:** 1.0 FTE; **Whitby/Northumberland:** 2.0 FTEs; **LHIN Program Coordinator:** 0.5 FTE
General Nursing Services **(Not consistently specialized in palliative care)**		**Paramed**: Haliburton, Lindsay, Scarborough, Whitby, **St Elizabeth Health Care**: Campbellford, Port Hope, Scarborough, Whitby **We Care**: Peterborough **VON**: Port Hope, Peterborough, Scarborough, Campbellford **Nightingale Nursing Inc**: Peterborough **Partners in Community Nursing**: Whitby **Red Cross Care Partners**: Whitby **SRT Med Staff**: Scarborough **VHA**: Scarborough Whitby **Revera**: Scarborough
Physician Education (LEAP)	3 courses per year	Locations rotate across Central East LHIN Regions

Long-Term Care Homes

- There are a total of 68 LTCHs homes within the Central East LHIN
  - All LTCHs have policies that address requirements outlined in the *LTCH Act* related to pain and symptom management, end of life care, staff training
  - However, there few formalized palliative programs across LTCHs e.g. with designated/lead staff, palliative teams and beds, identified community partnerships etc.

Geography	# of LTCHs
Scarborough	22
Durham	19
Peterborough/ Kawartha Lakes	8
Northumberland	8
Lindsay	8
Haliburton	3

Establishing the Central East Regional Palliative Plan

PRIORITY RECOMMENDATIONS

Establish Dedicated Interdisciplinary Palliative Outreach Teams

Enhance Hospice Palliative Care (HPC) Education & Training

Create Integrated HPC Hospital Programs

Create Integrated HPC Programs in LTCHs

Promote Community Hospices as Central Hubs

Recommendation

ESTABLISH DEDICATED INTERDISCIPLINARY PALLIATIVE OUTREACH TEAMS

What are the Suggested Principles of Dedicated Outreach Teams?

- Comprehensive palliative and end of life care for patients with advanced chronic conditions
- Enhanced access to:
  - Intensive home care
  - Rapid team mobilization
  - 24/7 availability of on-call expertise
- Integrated approach to client care across settings supported by community partnerships
- Holistic palliative and end of life care for individuals and their loved ones (i.e. pain and symptom management, psycho social support, spiritual)
- Capacity building for primary care providers

Order of Magnitude – Why do we Need Dedicated Outreach Teams?

- Compared to "usual care", expert consult teams have:
  - *Less late-life ED and hospital use*
    - Risk of being in hospital late-life reduced by 30%
    - Risk of having a late-life ED visit reduced by 30%
  - *More non-hospital deaths*
    - Risk of dying in hospital reduced by half
    - Risk of dying outside acute care facility (i.e. home/hospice) more than doubled
  - *Lower costs from avoided hospitalizations*
    - Generally ↓ costs (from ↓ hospitalizations) in last 60 days
    - Fewer hospital days in the last 30 days

Source: The Effectiveness of Expert Palliative Consult Teams: A Pooled Analysis. Hsien Seow, 2013.

Order of Magnitude – What Makes Dedicated Outreach Teams Effective?

- Help avoid unplanned and potentially avoidable hospital utilizations by:
  - Anticipate clinical problems early
  - Make care arrangements in advance
  - Rapid response to changes in the patient's condition
  - Advocate for additional/enhanced care
  - Provide more than just health care
  - Available 24/7 by phone or home visit
  - Support the family and prevent caregiver burnout

Source: The Effectiveness of Expert Palliative Consult Teams: A Pooled Analysis. Hsien Seow, 2013.

How will Dedicated Outreach Teams be Implemented?

- By establishing Working Group to develop functional implementation:
  - Direct/indirect intervention and follow-up
  - Comprehensive case management, navigation role
  - Synergies, lessons learned from GAIN community teams
    - Focusing on emerging chronic conditions, advance care planning
    - Leveraging resources to fill out teams
- By promoting awareness and uptake of *Community Palliative Care On Call (CPOC) initiative for physicians
- By issuing a Call for Expressions of Interest to establish Outreach Teams
  - Focusing on ability to leverage existing resources within Community Health Centres (CHCs), Family Health Teams (FHTs), community/ visiting hospices, hospitals, other

Recommendation

ENHANCE HPC EDUCATION & TRAINING

What are the Suggested Principles for Enhancing HPC Education & Training?

- Access to specialized HPC education and training opportunities across all settings
- Expansion of advance care planning and standardized toolkits in primary care settings
- Cultural awareness and sensitivity of populations
  - E.g. FNIM palliative and end of life practices and beliefs
- Promote variety of education and training methods
- Consistent navigation, registration and coordination of workshops, tools and resources

Order of Magnitude – Why do we Need HPC Education & Training?

- According to the March 2012 Ipsos-Reid National Poll:
  - Patients who have end of life conversations with their doctors and family members are much more likely to be satisfied with their care, will require fewer aggressive interventions at the end of life, place less of a strain on caregivers and are more likely to take advantage of hospice resources or die at home
  - 86% of Canadians have not heard of advance care planning
  - Only 9% had ever spoken to a healthcare provider about their wishes for care

How will HPC Education & Training be Implemented?

- By promoting spread of advance care planning resources in primary care settings
  - Focusing on ACP Toolkit for Health Care Professionals
- By ensuring all LTCHs have dedicated access to PPSMC and specialized palliative care training
- By ensuring CCAC contracted services providers support specialized education and training
- By working in collaboration with DRCC's Aboriginal Patient Navigator to engage with FNIM communities
  - Enhancing access to local services, supports, education, training i.e. cultural educating toolkit
  - Spreading cultural awareness i.e. history, spiritual traditions

Recommendation

DEVELOP INTEGRATED HPC HOSPITAL PROGRAMS

What are the Suggested Principles of Integrated HPC Hospital Programs?

- *"Hospice Friendly Hospital"* culture
- Comprehensive palliative and end of life care for patients with advanced chronic conditions
- Interprofessional palliative team model/approach
- Enhanced patient outcomes/seamless transitions
- 24/7 access to palliative and end of life expertise and services
  - Acute palliative unit, inpatient consultation, ambulatory/outreach services, strong linkages between inpatient/outpatient units, synergies of care
- Enhanced communication and collaboration across units, sites, acute care settings, community organizations
  - Care coordination, planning and records sharing

Order of Magnitude – Why do we Need Integrated HPC Hospital Programs?

- Significant amount of time in the last 90 days of life is spent in health care institutions
  - Between 2010-12, 71% of Ontarians died in hospital or in LTCH, with the majority (46% of all deaths) dying in an acute care
  - Patients who received palliative care accounted for 97% of total hospital and ALC bed days*
- Considerable time and death in hospital carry a considerable cost burden to the health care system
  - Half of the total cost incurred in the last year of life occurred in the last 3 months, of which 60% is attributed to inpatient services

Source: Applied Health Research Question: Palliative and End of Life Care. MOHLTC. Central East LHIN. U of T Health System Performance Research Network.

How will Integrated HPC Hospital Programs be Implemented?

- By establishing regionally defined HPC Programs in ALL hospitals
  - Ensuring programs are supported in specialized hospital location fostering growth in expertise and excellence
  - Providing education, training, development opportunities for staff
- By creating formal partnerships with local community hospice organization allowing volunteers to support patients, families, caregivers and staff within hospitals settings
- By establishing consistent Palliative Patient Rounds involving local hospices and other community supports, as appropriate
- By identifying opportunities to incorporate Quality Improvement initiatives focusing on patients with and advanced progressive illnesses

Recommendation

CREATE INTEGRATED HPC PROGRAMS IN LTCHS

What are the Suggested Principles of Integrated HPC Programs in LTCHs?

- Strong HPC philosophy and culture
- Enhanced capacity of LTCHs to provide quality palliative end of life care
- Increased access and collaboration with local services and programs i.e. hospice volunteers
- Frequent assessment, advance and regular care planning and dialogue with residents and families
- Integrated programming with behaviourally complex patient populations and specialized services supporting enhance knowledge and awareness
  - Dementia, Alzheimer's linkages to palliative and end of life care

Order of Magnitude – Why do we Need Integrated HPC Programs in LTCHs?

- LTC is a unique palliative care context
  - Frail older people living with progressive life limiting disease
  - A home where residents will both live and die
  - Majority of LTCHs in Canada lack formalized palliative care programs
  - It is common for 40% - 50% of residents to die each year in LTCHs
- In accordance with section 42 of Regulation 79 of the *LTCHs Act, all LTCHs shall ensure that every resident receives end of life care when required in a manner that meets their needs*

***Source: Quality Palliative Care in Long Term Care: Tools for Change Presentation. Palliative Alliance. 2013.**

How will Integrated HPC Programs in LTCHs be Implemented?

- By establishing *Working Groups in each Cluster to develop functional program plan/programming
  - Identifying LTC Champion with established Palliative Program
- By ensuring all LTCHs have an identified PPSMC and ability to access ongoing training and consultation
  - Collaborating with Behavioural Supports Ontario and Nurse Practitioners Supporting Teams Averting Transfers Program, building clinical capacity and expertise
- By promoting consistent use of palliative assessments, care planning
  - Ensuring all residents have established advance care plan
  - Supporting common assessment tools
  - Involving resident and family councils

Recommendation

PROMOTE COMMUNITY HOSPICES AS CENTRAL HUBS

What are the Suggested Principles of Community Hospice Hub Programs?

- Publically visible profile for local hospice information, services
- Centre of Excellence in HPC, grief and bereavement services
- Common basket of core programs and services across local hospice settings, based on need
- Enhanced support for patients who may not be ready for clinically-based palliative care services, however would benefit from early hospice support
- 24/7 patient, family and caregiver volunteer support
- Strong linkages and partnerships between local community and acute care settings
- Consistent teaching programs, interdisciplinary training and education
- Integrated communication through advanced technological systems
- Support for residential hospice programming through innovative, functional integrations and partnerships

Order of Magnitude – Why do we Need Community Hospice Hubs Programs?

- Each year death in Canada affects the immediate well-being of an average of 5 people, or more than 1.25 million Canadians annually
  - In 2006–2008, more than 57% of palliative clients in Ontario were cared for primarily by their spouses or partners, while 29% received most of their primary informal care giving from their children
  - More than 22% of caregivers showed signs of distress, including anger, depression, being overwhelmed and unable to continue providing care

Source: Canadian Hospice Palliative Care Association. Hospice Palliative Care Fact Sheet. Updated 2013.

How will Community Hospice Hub Programs be Implemented?

- By tasking the Central East Community Hospice Working Group to develop a functional implementation plan
  - Identifying current and future state needs and strategies
- By developing formal partnerships with local hospitals and LTCHs to provide volunteer support within and across settings
- By establishing consistent involvement in local hospital palliative patient rounds
- By ensuring all hospices have access to Ontario Telemedicine Network (OTN) services
- By promoting the spread and uptake of RAI-Palc

Leading & Executing the Central East Regional Palliative Plan

GOVERNANCE & IMPLEMENTATION

Central East LHIN Role - Operationalizing, Funding & Accountability

- Operationalize Central East Regional Palliative Plan implementation
- Receive, review and consider funding request from local Health Service Providers in relation to Regional Plan priority recommendations
- Monitor LHINs progress in achieving the 2013-16 IHSP Palliative Care Strategic Aim
- Provide system level knowledge, expertise and guidance to the Network
- Report LHIN and Network activities to Provincial Hospice Palliative Care Steering Committee

Central East Hospice Palliative Care Network Role - Oversight & Reporting

- Provide direction, coordination and leadership for the development and evolution of a comprehensive, integrated and coordinated system of hospice palliative care in the Central East LHIN
- Ensure Network activities align with overall LHIN strategy
- Advise Central East LHIN leadership on strategic opportunities and require recourse in relation to palliative integration activities
- Promote knowledge, awareness and spread of Regional Palliative Plan
- Monitor and report to the LHIN on Regional Palliative Plan implementation progress

Progress to Date 2013-14

Priority	Q1	Q2	Q3	Q4
Central East LHIN IHSP	LHIN/Network developed IHSP 2013-16 Palliative Strategic Aim and supporting metrics			
Declaration of Partnership Action	Network drafted Central East Regional Palliative Plan, including priority recommendations and implementation strategy			
Network Membership		Created Expression of Interest Network Memberships application process		Network finalized Membership refresh
LHIN Governance Approval				LHIN/Network prepared to present Regional Plan to Senior Team and Board in April 2014-15

Proposed Implementation 2014-15

Priority	Q1	Q2	Q3	Q4
Dedicated Outreach Teams	-LHIN/Primary Health Care Advisory Group (PHCAG) to promote uptake of CPOC; -LHIN/Network to establish Working Group to develop a functional plan		LHIN to issue Call for Expressions of Interest	
Enhanced Education & Training	- LHIN/PHCAG to spread advance care planning resources in primary care - LHIN/Network to collaborate with Aboriginal Patient Navigator to engage FNIM Communities in palliative planning			
Integrated HPC Hospital Programs	Hospitals to establish regionally defined HPC Divisions/Programs: - *Supporting Palliative Patient Rounds* - *Creating partnership agreements with local hospice organization*			
Integrated HPC LTCH Programs	LHIN to create Working Groups in each Cluster to develop a functional implementation plan		Established Working Groups to ensure all LTCHs have dedicated access to PPSMC, specialized palliative training	
Community Hospice Hub Programs	Central East Community Hospice Working Group to develop a functional implementation plan			

Proposed Implementation 2015-16

Priority	Q1	Q2	Q3	Q4
Dedicated Outreach Teams	LHIN to implement roll out of outreach teams			
Enhanced Education &Training	Network to collaborate with CCAC to ensure contracted services providers support palliative education and training			
Integrated HPC Hospital Programs	Hospitals to identify opportunities to incorporate QI initiatives focusing on patients with advanced progressive illnesses			
Integrated HPC LTCH Programs	Working Group to promote consistent use of assessments, care planning - Ensure all residents have established advance care plan			
Community Hospice Hub Programs	LHIN/Hospice Working Group to enhance PPSMC, respite, bereavement, client case management services		- LHIN/Hospice Working Group to ensure all hospices have access to OTN services; promote spread/uptake of RAI- Palc	

Advancing & Sustaining the Central East Regional Palliative Plan

RISKS & MITIGATION

Identified Risks

- Health Service Provider and stakeholder resistance to change; lack of commitment and/or confidence
- Family and caregiver demands
- Client perception of need (i.e. only acute care settings are able to meet their needs)
- Minimal effective working relationships and referral patterns between hospital and community providers
- Limited human resources and lack of appropriately trained staff (i.e. increased demand for community Nurse Practitioners, physicians and Personal Support Workers
- Poor working relationships, collaboration between CHC sectors and other primary care providers both on the ground and in communities

Mitigation Strategies

- LHIN collaboration with the Ministry of Health and Long-Term Care, the Network, Provincial End of Life Network Partners, Cancer Care Ontario, other LHINs
- Continuation of Network leadership to support and inform IHSP planning and implementation
- Ongoing quality improvement initiatives and activities
- Building strong project management capacity within programs and initiatives throughout implementation
- Identification of opportunities for LHIN level re-investment toward achieving palliative and end of life care priorities
- Continued data quality research and review to ensure complete and accurate information is reported
- Engagement of LHIN level primary health care leadership to champion system changes

Questions

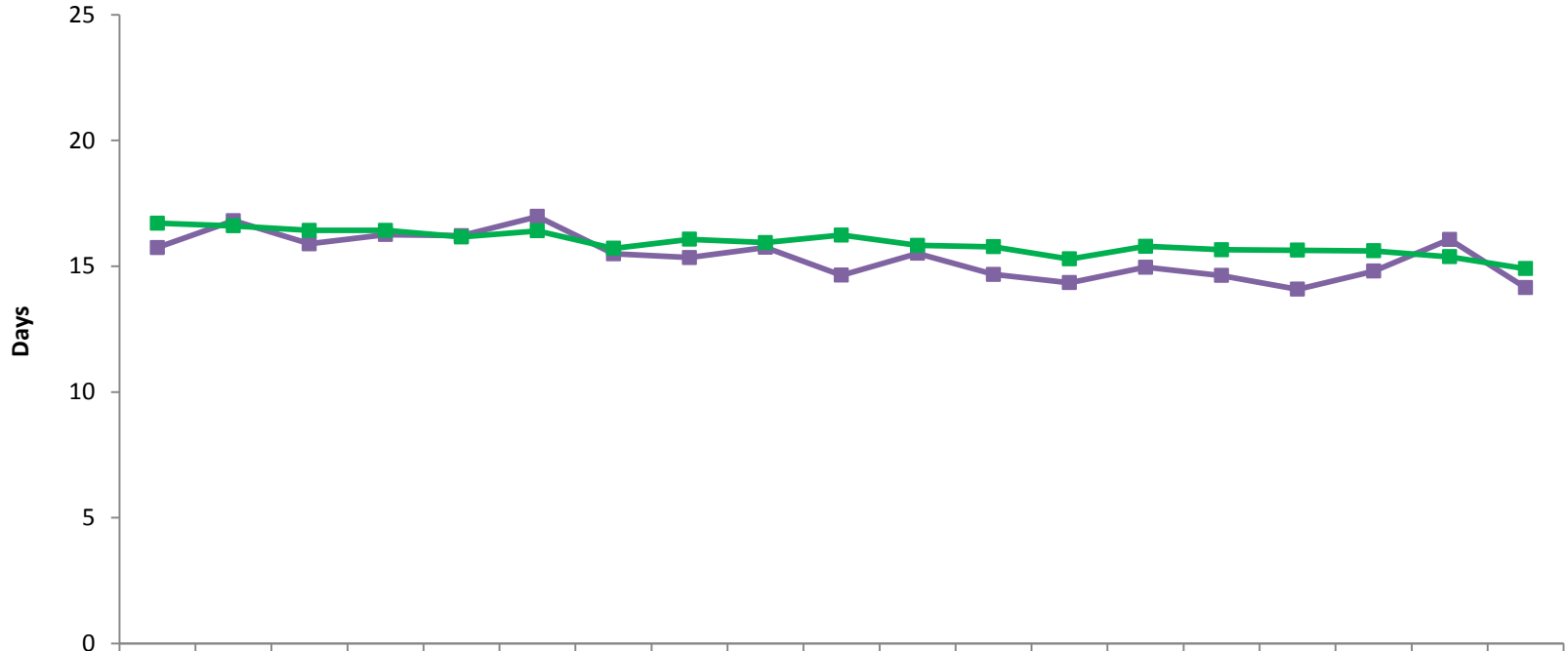
Discussion

Board Motion

IHPS Palliative Strategic Aim – System Level Indicator Analysis

APPENDIX

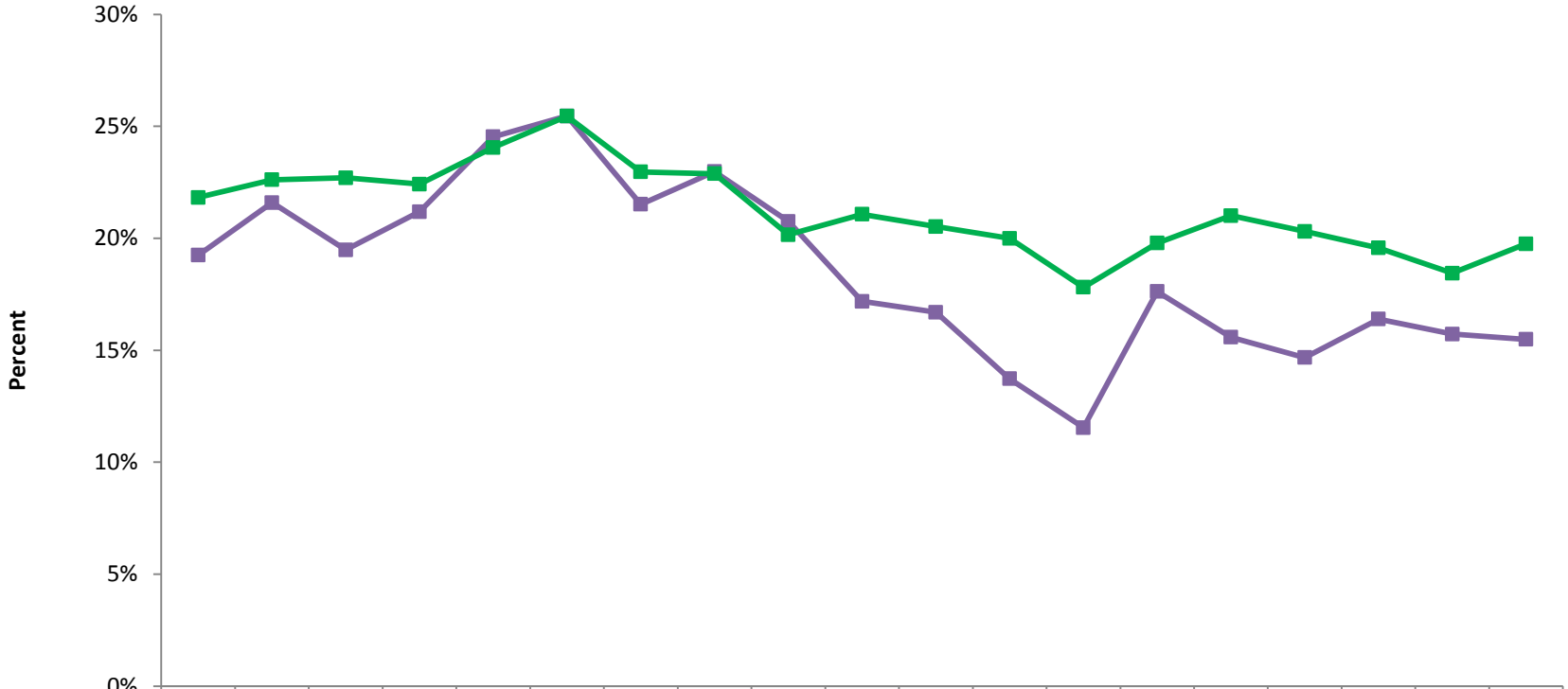
Average Hospital Length of Stay for Palliative Patients *(decrease)*



	09-10 Q1	09-10 Q2	09-10 Q3	09-10 Q4	10-11 Q1	10-11 Q2	10-11 Q3	10-11 Q4	11-12 Q1	11-12 Q2	11-12 Q3	11-12 Q4	12-13 Q1	12-13 Q2	12-13 Q3	12-13 Q4	13-14 Q1	13-14 Q2	13-14 Q3
CE LHIN	15.7	16.8	15.9	16.3	16.2	17.0	15.5	15.3	15.7	14.6	15.5	14.7	14.3	15.0	14.6	14.1	14.8	16.1	14.1
Ontario	16.7	16.6	16.4	16.4	16.2	16.4	15.7	16.1	15.9	16.2	15.8	15.8	15.3	15.8	15.7	15.6	15.6	15.4	14.9

- ALOS for palliative patients has been below 15 days (median 15.5 days)
- In Q2 2013-14, there was a slight increase in ALOS. TSG (23.3 days) and LHPP (27.3 days) both contributed to the increase in this quarter
- ALOS for palliative patients has been slightly lower than the Provincial ALOS

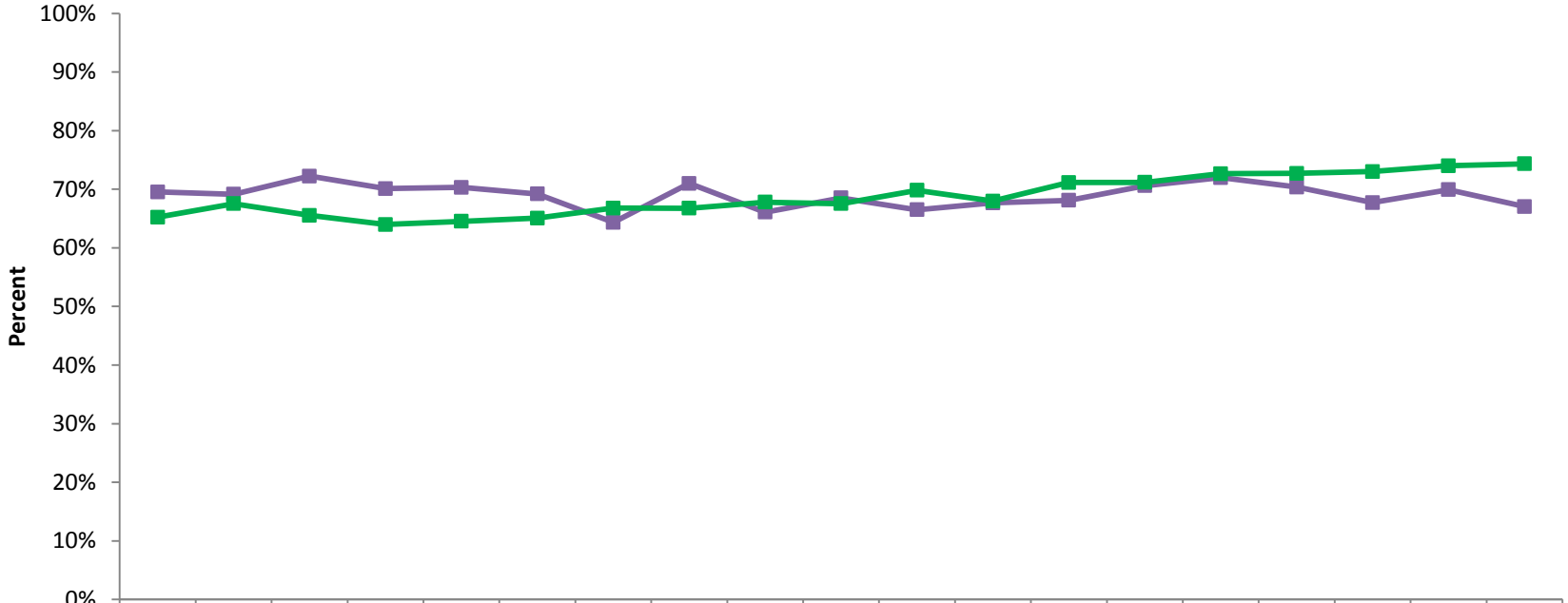
Percentage ALC Days for Palliative Patients *(decrease)*



	09-10 Q1	09-10 Q2	09-10 Q3	09-10 Q4	10-11 Q1	10-11 Q2	10-11 Q3	10-11 Q4	11-12 Q1	11-12 Q2	11-12 Q3	11-12 Q4	12-13 Q1	12-13 Q2	12-13 Q3	12-13 Q4	13-14 Q1	13-14 Q2	13-14 Q3
CE LHIN	19%	22%	19%	21%	25%	25%	22%	23%	21%	17%	17%	14%	12%	18%	16%	15%	16%	16%	15%
Ontario	22%	23%	23%	22%	24%	25%	23%	23%	20%	21%	21%	20%	18%	20%	21%	20%	20%	18%	20%

- Central East palliative patients spend fewer days (15%) designated as ALC in Acute Care setting than Provincially (20%). This indicator is measured only when a patient is discharged from the hospital
- HHHS, LHB and LHPP contributed the largest % of ALC days across Central East LHIN in fiscal 2013-14 YTD

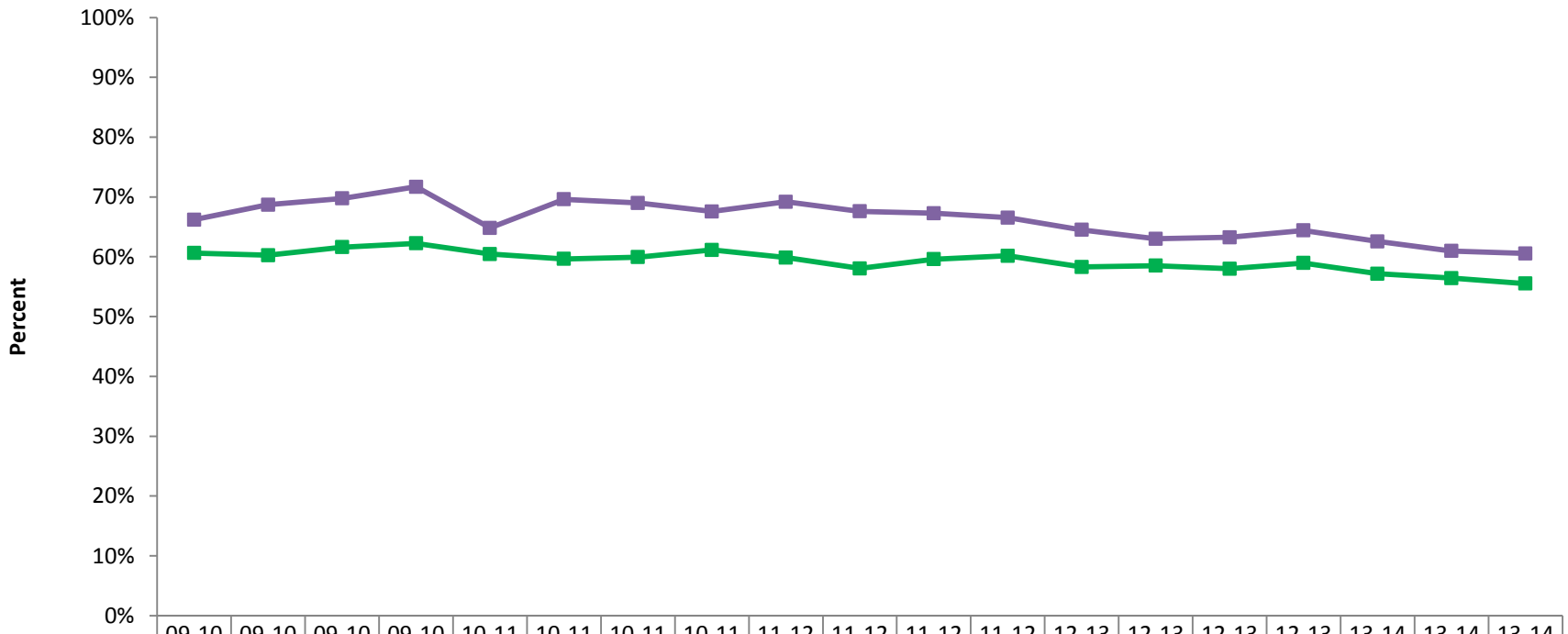
Percentage of Palliative In-Patients who were discharged "Home with Support Services" *(increase)*



	09-10 Q1	09-10 Q2	09-10 Q3	09-10 Q4	10-11 Q1	10-11 Q2	10-11 Q3	10-11 Q4	11-12 Q1	11-12 Q2	11-12 Q3	11-12 Q4	12-13 Q1	12-13 Q2	12-13 Q3	12-13 Q4	13-14 Q1	13-14 Q2	13-14 Q3
CE LHIN	70%	69%	72%	70%	70%	69%	64%	71%	66%	69%	67%	68%	68%	71%	72%	70%	68%	70%	67%
Ontario	65%	68%	66%	64%	65%	65%	67%	67%	68%	68%	70%	68%	71%	71%	73%	73%	73%	74%	74%

- Central East LHIN performs slightly below the Province. 67% of patients were discharged to a home setting with support services (i.e. senior lodge, attendant care, home care)
- Less than 50% of RVHS Palliative patients were discharged home with supports in fiscal 2013-14 YTD

Percentage of Palliative In-Patients who Died in Hospital *(decrease)*



	09-10 Q1	09-10 Q2	09-10 Q3	09-10 Q4	10-11 Q1	10-11 Q2	10-11 Q3	10-11 Q4	11-12 Q1	11-12 Q2	11-12 Q3	11-12 Q4	12-13 Q1	12-13 Q2	12-13 Q3	12-13 Q4	13-14 Q1	13-14 Q2	13-14 Q3
CE LHIN	66%	69%	70%	72%	65%	70%	69%	68%	69%	68%	67%	67%	65%	63%	63%	64%	63%	61%	61%
Ontario	61%	60%	62%	62%	60%	60%	60%	61%	60%	58%	60%	60%	58%	59%	58%	59%	57%	56%	56%

- Most common place of death for palliative patients is in the Acute Care setting. 61% of Central East LHIN patients die in an Acute Care setting
- Central East LHIN has experienced a slight decrease in the % of palliative patients who die in hospital over the last 4 quarters. Central East LHIN has been consistently above the Provincial %

[1]AHRQ Results for CE LHIN, June 2013