Central East LHIN
RLISS du Centre-Est

Central East LHIN Strategic Aims

Palliative Care

Semi-Annual update to the Central East LHIN Board of Directors
October 22, 2014

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

Agenda

- Background on Central East Regional Palliative Care Plan
- Update on Palliative Care Metrics
- Update on 5 Priority Recommendations from Central East Regional Palliative Care Plan
- Request for Proposal – Palliative Care Community Teams
- Risks & Mitigation Strategies

Palliative Care Strategic Aim

REGIONAL PALLIATIVE CARE PLAN BACKGROUND AND OVERVIEW

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.

Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

Palliative Care

Central East Regional Palliative Care Plan: Five Priority Recommendations

Establish Dedicated Interdisciplinary Palliative Care Community 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

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Palliative Care

AIM METRICS UPDATE

Background

How were savings calculated?

- Cumulative Days Saved = Projected Total Length of Stay minus Estimated Total Length of Stay

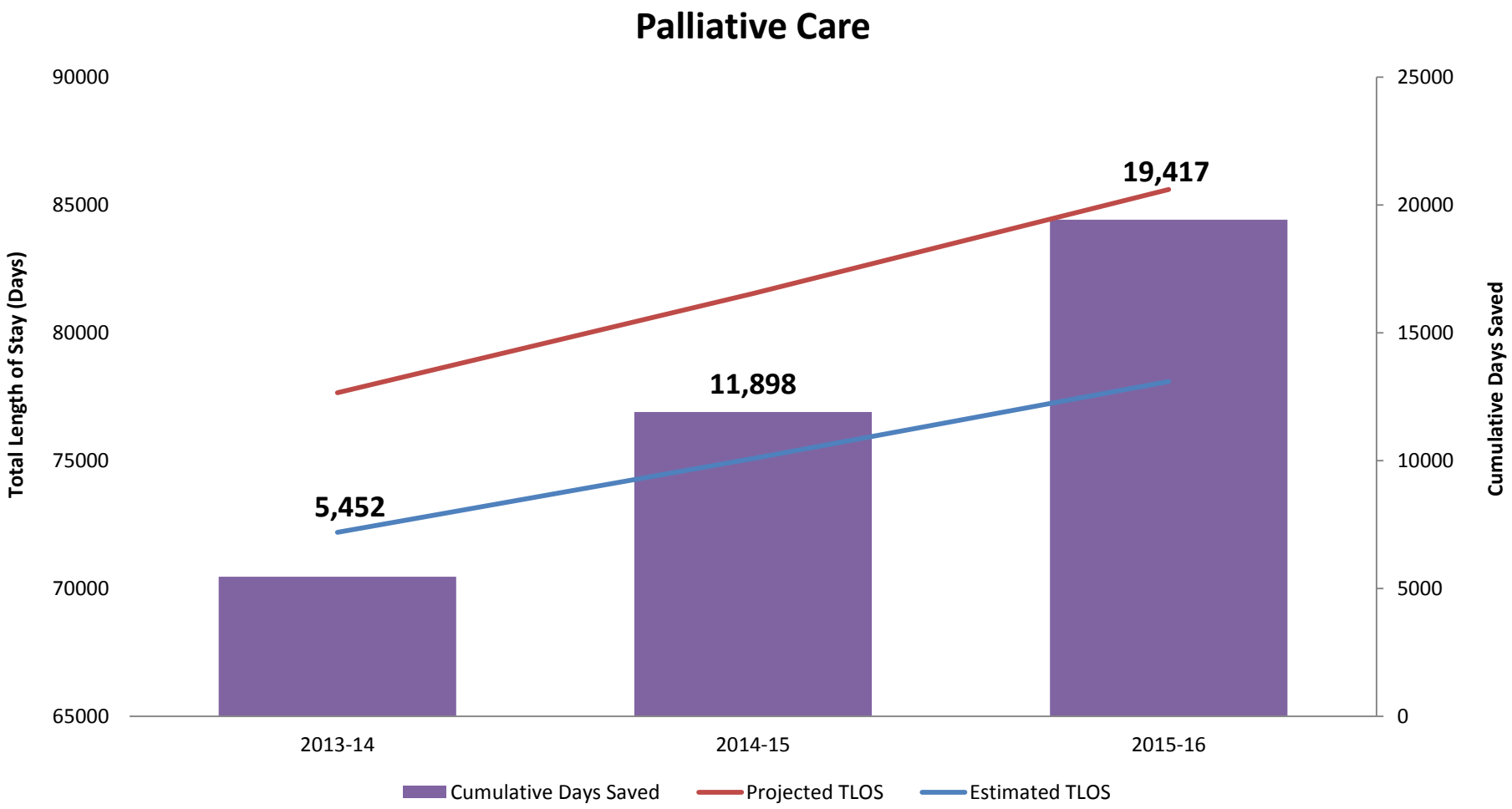
Assumptions:

- Number of palliative cases will increase
- Population Growth (aged 65+) will increase annually

2013/14 Observations:

- Decrease in the number of palliative cases and
- Decrease in the number of total days

Aim Metrics Update



Engaged Communities.
Healthy Communities.

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Supporting Indicators – Definitions

Terms	Definition
Indicator Name **(increase) or (decrease)**	The desired direction of performance is shown in purple colored text after the indicator name.
Baseline	Where there is sufficient data, the baseline is the average 2011/12 and 2012/2013.
CE LHIN Target	The formal Central East LHIN target for that indicator (typically developed for use in existing scorecards, such as the MLPA). This formal target is indicated by **bold formatting**. Where there is no formal target, the baseline less 10% is used as an informal Central East LHIN Target to track the performance of supporting indicators for the IHSP aims.
Current Performance	The CE LHIN performance for the indicator using the most current data available.
Current Status	The current performance is compared with the CE LHIN target and the result is summarized by a colored dot following the parameters below: • A red dot indicates that the current performance deviates from the desired target by more than 10%. • A yellow dot indicates that the current performance is within 10% of the target • A green dot indicates that the current performance meets the target or is performing better than the desired target
Compared with Most Recent Past Performance	The CE LHIN performance for the indicator using the most recent reporting period prior to the current performance.

Aim Metrics Update

Indicators	Baseline	CE LHIN Target	Current Performance[1]	Current Status	Trend
Average Hospital Length of Stay (Days) for Palliative Patients (Goal: decrease)	14.82	13.34	13.24		
Percentage ALC days for Palliative Patients (Goal: decrease)	16%	14%	14%		
Percentage of Palliative Patients Discharged Home with Supports (Goal: increase)	69%	76%	75%		
Percent of Palliative Patients Died in Hospital (Goal: decrease)	66%	59%	65%		

Note:
1 Most recent available data: 13/14 Q4

PATIENT STORY

Lisa and Mrs. H.

" As caregivers, we feel that the health care system failed Mom… and us."

Mrs. H. was diagnosed with Parkinson's and severe dementia. Mr. H suffers from multiple co-morbidities including dementia. Mrs. H's daughter, Lisa, moved Mr. and Mrs. H. into her home with her husband and son. The basement of their home was completely redone for a living space for Lisa and her family while Mr. and Mrs. H. took the rooms upstairs. Mrs. H. was receiving a few hours of PSW support. It was the wish of Mrs. H. and Lisa to keep Mrs. H. at home and allow her to die at home. Lisa took a leave from work to be able to care for her parents at home.

Within a 2 week period…..

Mrs. H became increasingly unwell and had a fall at home. She was sent to the ER with severe spiral fracture in her right arm. She was discharged from hospital without any pain medication. Lisa used over the counter Tylenol, but was unsuccessful in relieving the pain. Mrs. H. was bed-bound. After several days of extreme pain, Lisa unsure of what do to or who to contact, was able to contact Mrs. H.'s geriatrician who was able to prescribe pain medication. It wasn't enough, Mrs. H. was still in pain. Lisa felt stress when trying to navigate the system and who to contact to manage the pain. She made numerous phone calls to different care providers looking for assistance. Mrs. H. became non-verbal.

Mrs. H. was transferred to a CCAC palliative case load 2 weeks prior to her death. At that time, nursing support was provided. Mrs. H. developed a wound on her back and was assessed on a Thursday. A wound care specialist was engaged and special materials ordered. Unfortunately the materials (coming from Toronto) didn't arrive until the following week. The wound was not addressed and became infected. Lisa was asked "why bother". Due to lack of communication between health service providers around the health status of Mrs. H., she was rolled onto her broken arm numerous times throughout her care increasing her pain.

In absence of Advance Care Planning , health service providers were not aware that both Lisa and Mrs. H. wanted Mrs. H. to die at home. Lisa was told "if you want her out of here, I can make it happen". Lisa' felt that her wishes to manage Mrs. H.'s pain and keep her comfortable while she died at home were not discussed.

- "We often thought that the health care workers forgot about the family around the patient "
- "We felt bullied about keeping mom at home and felt pressure to fill out LTC papers"
- "We had to constantly tell our story – where the fracture was, the severity of the pain and the extent of the wound. There was no continuity in the provision of mom's care"
- "We felt there was a lack of qualified staff to manage her pain"

CENTRAL EAST REGIONAL PALLIATIVE CARE PLAN UPDATE AND NEXT STEPS

Establish Dedicated Interdisciplinary Palliative Care Community Teams

Promote Community Hospices as Central Hubs

Enhance Hospice Palliative Care (HPC) Education & Training

Create Integrated HPC Programs in LTCHs

Create Integrated HPC Hospital Programs

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Acute vs. Home Care

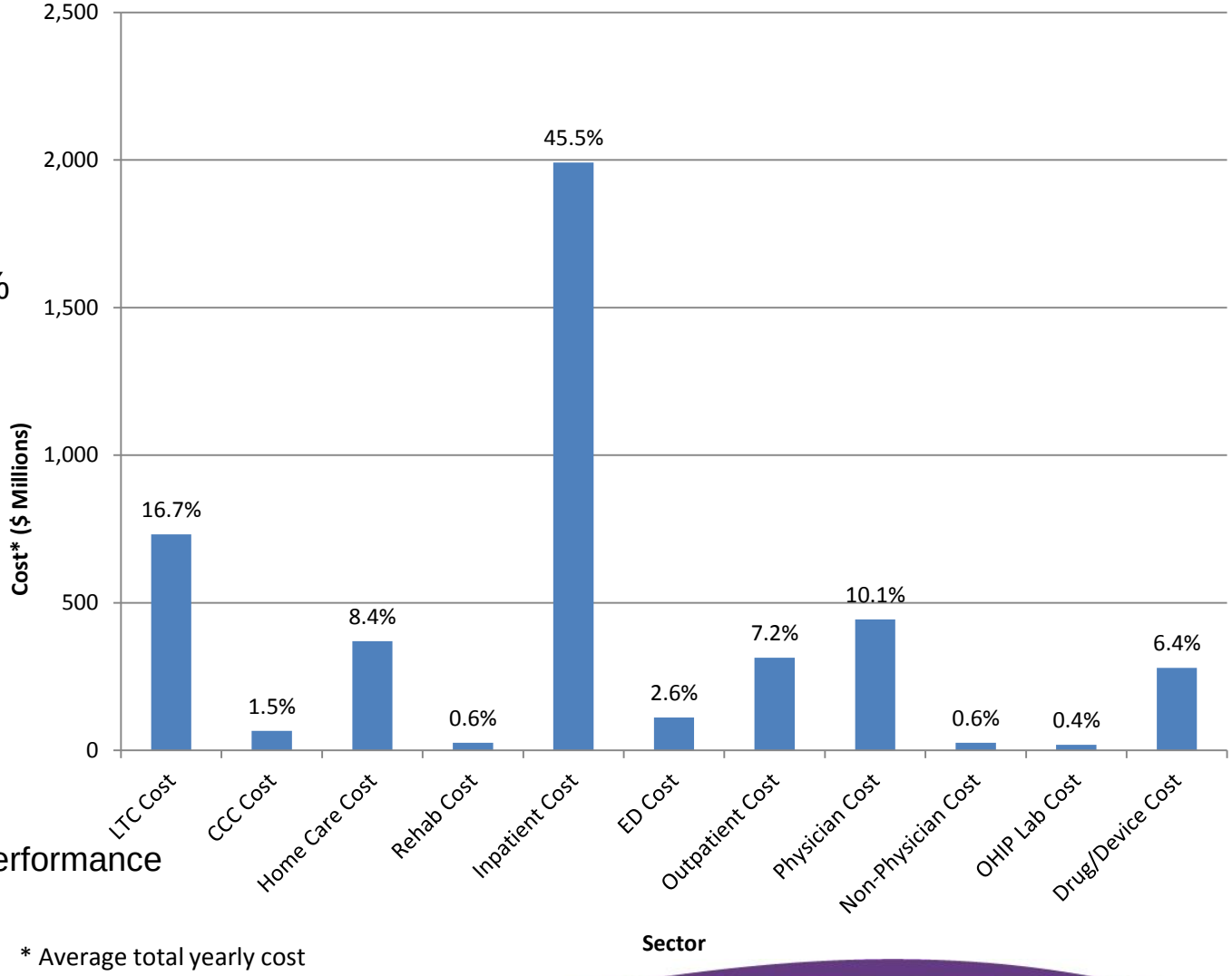
- On average it costs $36,000 to die in a chronic care facility, compared to $16,000 to die at home.
- Shifting 10% of patients who are nearing end of life from acute to community hospice palliative care services could save the health care system $9 million.
- 72% of end-of-life health care costs are for acute care services (excluding ICU).

(Source: Cost-Effectiveness of Palliative Care: A Review of the Literature, 2012)

Cost by sector

Total population cost for patients deceased in the last 12 months

- Inpatient cost - 46%
- LTC - 17%
- Home Care - 8.4%



(Source: Health System Performance Research Network, 2014)

* Average total yearly cost

Why do we Need Palliative Care Community 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.

What Makes Dedicated Palliative Care Community Teams Effective?

- Quality Patient Care
  - “Not feeling alone”
  - “Having an expert team for support”
  - “Not having to ask for, or repeat, the patient story time after time”
- Help avoid unplanned and potentially avoidable hospital utilizations
  - Anticipate clinical problems early
  - Make care arrangements in advance
  - Rapid response to changes in the patient’s condition
  - Holistic palliative and end of life care for patients and care givers (i.e. pain and symptom management, psycho social support, spiritual)
  - Connection with Primary 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.

Request for Proposal: Palliative Care Community Teams (PCCT)

- Develop PCCT to improve access to interdisciplinary team-based care in the community for palliative patients and their caregiver(s) allowing patients to die at home.

- Target audience
  - Patients in hospital diagnosed as palliative that could be cared for in the community (initial target population)
  - Palliative patients living in the community at risk of entry into the hospital that could be cared for at home (future target population)

- Current Status
  - Request for Proposal (RFP) has been developed
  - Alignment with current services (e.g., Community Palliative Care Nurse Practitioner)
  - Implementation will be a 2-year phased approach across the LHIN

Palliative Care Community Teams (PCCT)

- Next Steps
  - Proposals due to the Central East LHIN - November 17, 2014
  - LHIN Board Approval – December 17, 2014
  - Phase 1 Implementation of Teams – January 2015

RISKS AND MITIGATION STRATEGIES

Identified Risks

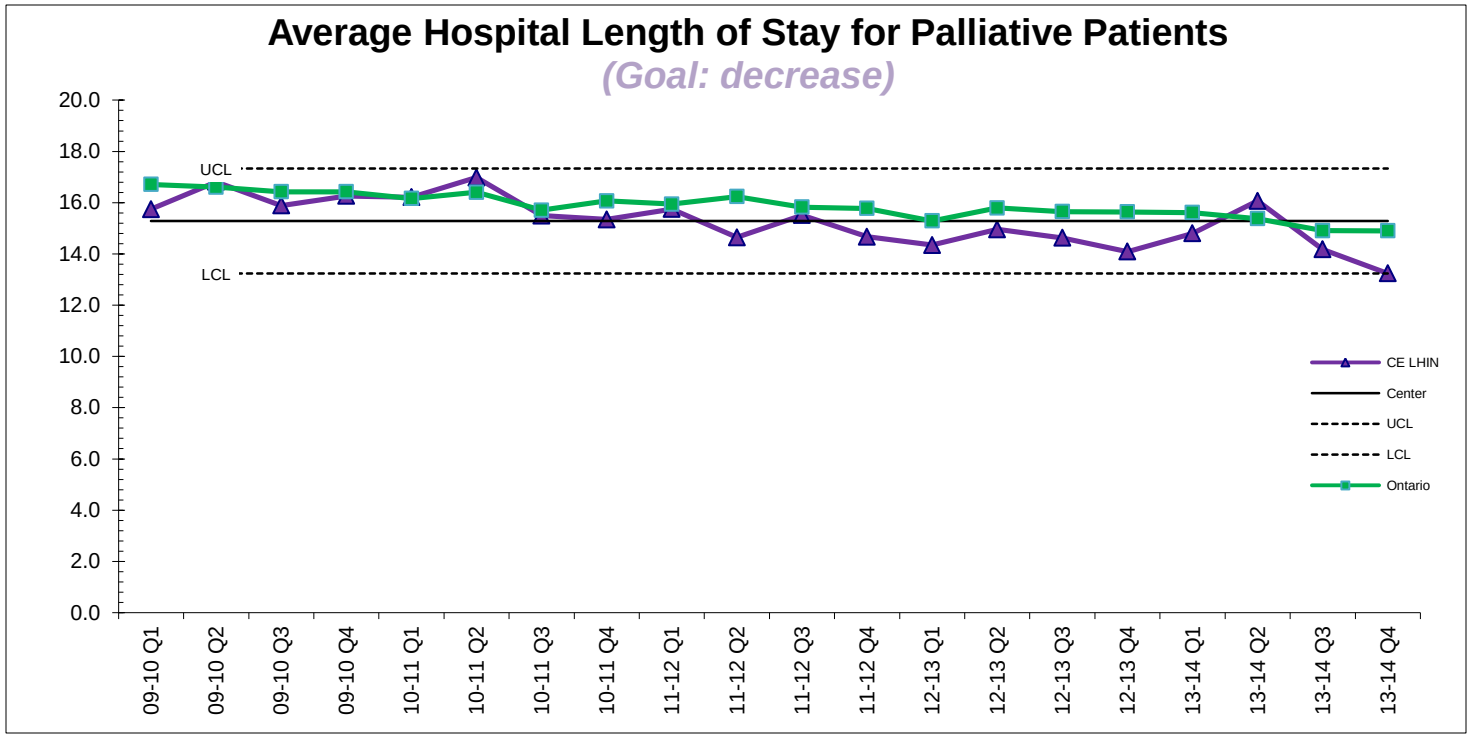
- Health Service Provider and stakeholder resistance to change; lack of commitment and/or confidence
- Family and caregiver demands
- Client perception of need (i.e. only acute care settings are able to meet their needs)
- Minimal effective working relationships and referral patterns between hospital and community providers
- Lack of appropriately trained staff

Mitigation Strategies

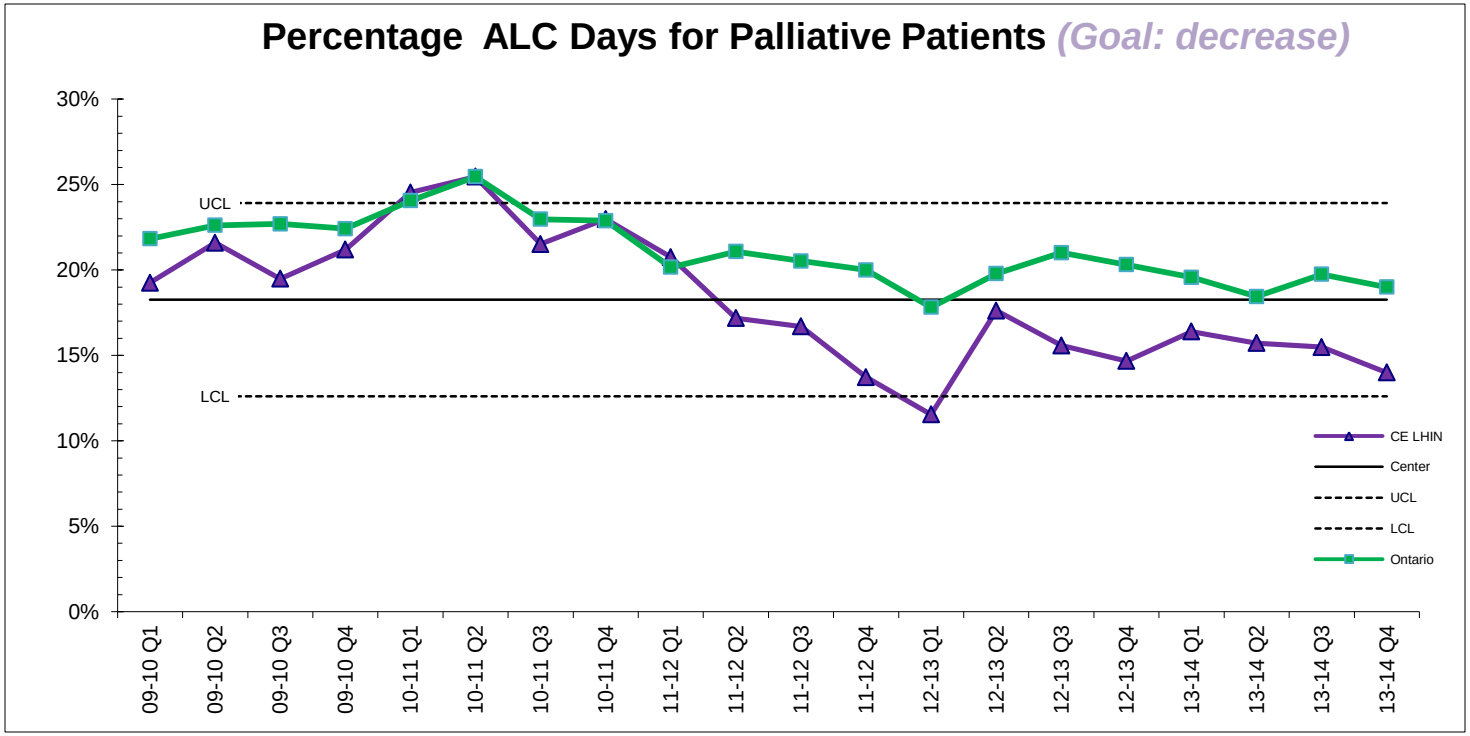
- Continuation of Network leadership to support and inform IHSP planning and implementation
- Ongoing quality improvement initiatives and activities
- Building strong project management capacity within programs and initiatives throughout implementation
- Identification of opportunities for LHIN level 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

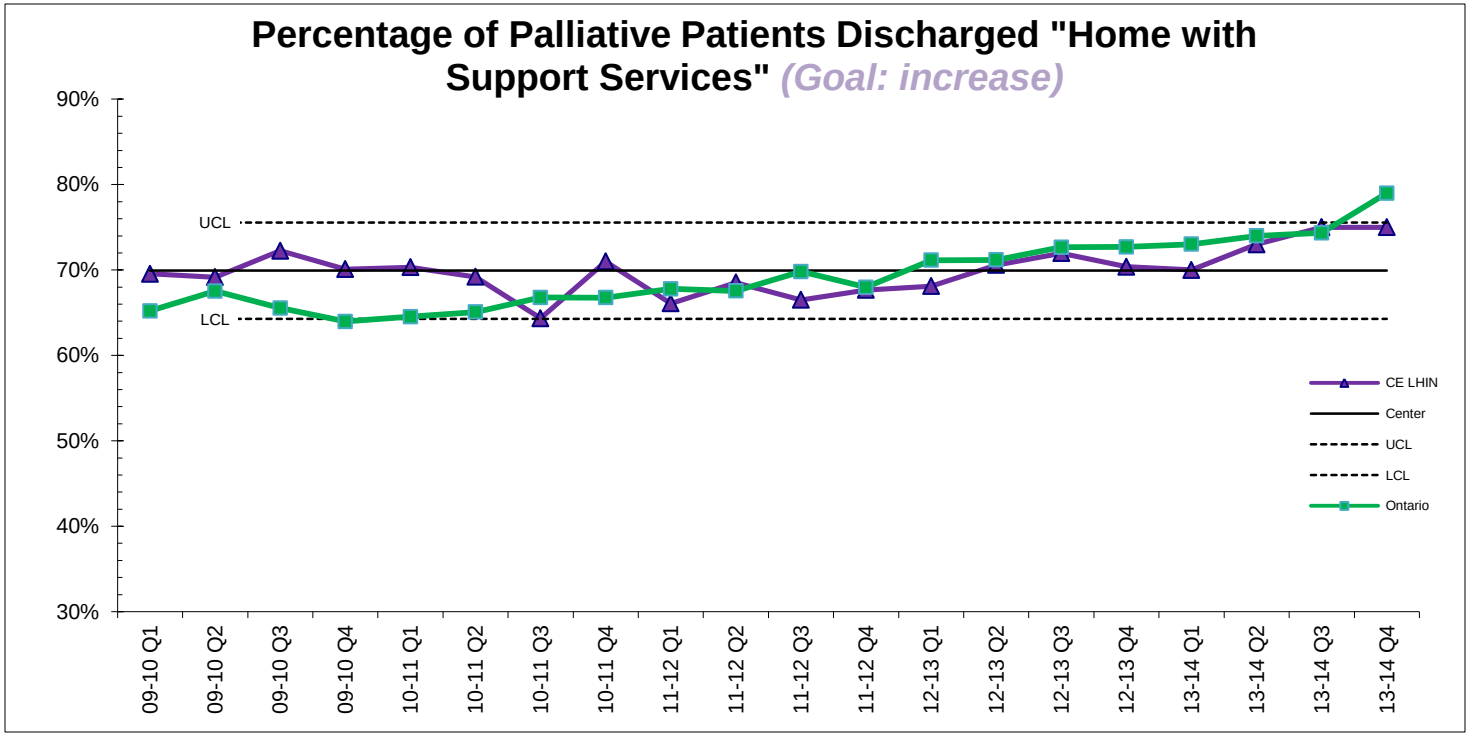
APPENDIX



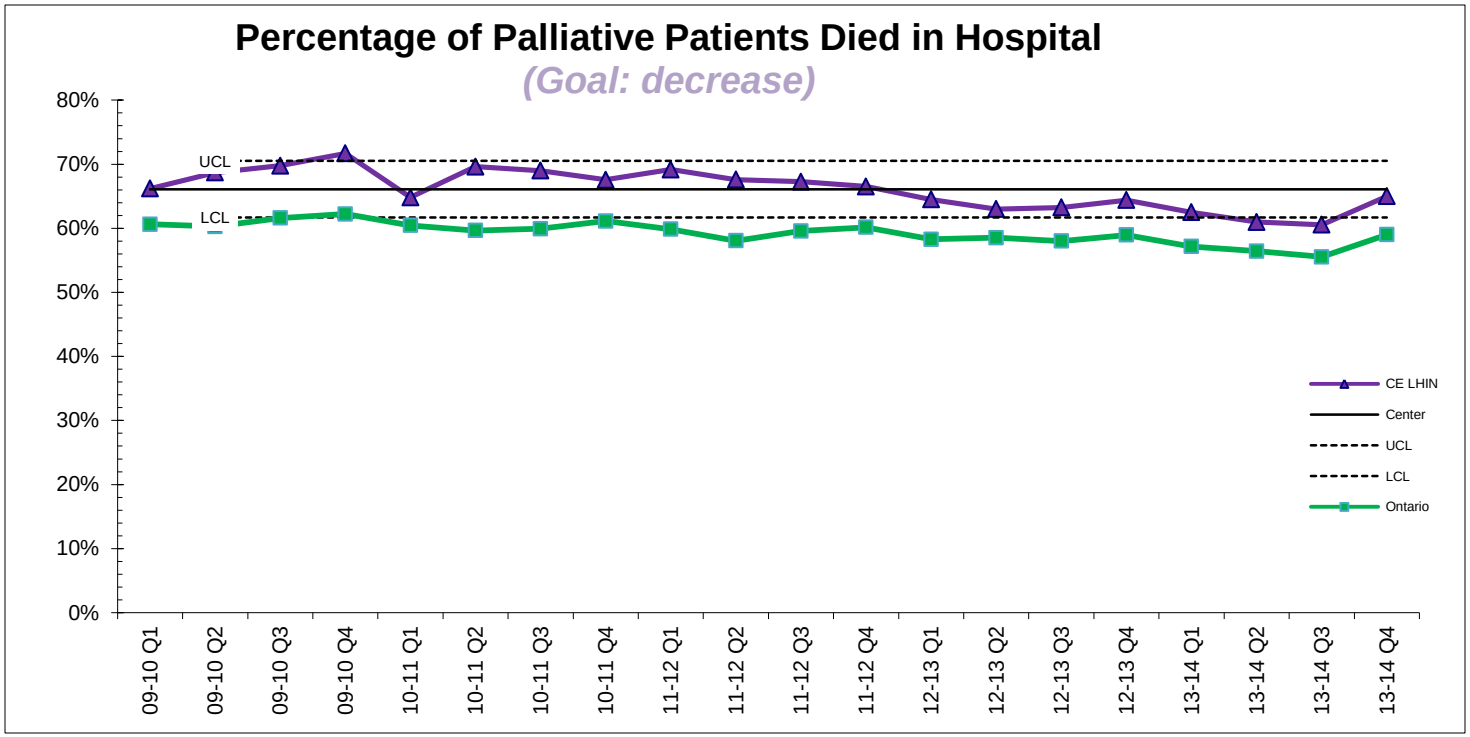
Analysis: The Average Length of Stay (ALOS) for Palliative patients in Central East continues to decline. In Q4 of 2013/14, the ALOS decreased to 13.2 days. This is the lowest quarterly ALOS in five years. The ALOS for Palliative patients in Central East LHIN has been slightly lower than the Provincial ALOS.



Analysis: Central East LHIN Palliative patients spend fewer days (14%) designated as Alternate Level of Care (ALC) in Acute Care setting than Provincially (19%). This indicator is measured only when a patient is discharged from the hospital. Two of the smallest sites in CE LHIN negatively contributed to this indicator by exceeding the FY 2013/14 average of 15%.



Analysis: Central East LHIN performed below the Province. In FY 2013/14, 75% of Central East LHIN patients were discharged to a home setting with support services (i.e. senior lodge, attendant care, home care). The Ontario rate is 79%. Over the last 4 quarters, there has been a steady increase in Palliative patients discharged home with supports.



Analysis: The most common place of death for Palliative patients is in the Acute Care setting [1]. 65% of Central East LHIN patients died in an Acute Care setting. Central East LHIN has experienced a slight increase in the percentage of Palliative patients who die in hospital in Q4 2013/14. Central East LHIN has been consistently above the Provincial percentage.

[1]AHRQ Results for CE LHIN, June 2013