Advancing Integrated Palliative Care: The Toronto Central Experience

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Agenda

- WHY we made the changes we did
- WHAT we did
- HOW we are making a difference
- WHERE we would like to go from here

Evidence Base

- Toronto Central ICCP Palliative Pilot in 2011.
- Patient and Caregiver Feedback from ICCP: Ipsos Reid Qualitative Survey and VOICES caregiver survey. (2011)
- Seow, Hsien et. Al. (2014). Impact of community based, specialist palliative care teams on hospitalisations and emergency department visits late in life and hospital deaths: a pooled analysis. *BMJ* 2014;348:g3496

"[The most important aspect of the care] was that it allowed me to keep him at home. I did not want to have him in hospital but without the support and help I had I couldn't have kept him here. That made it possible and that is what I am so grateful for." Caregiver

Why change

Walter A. Shewhart

"Postulate 3:

Assignable causes of variation may be found and eliminated."

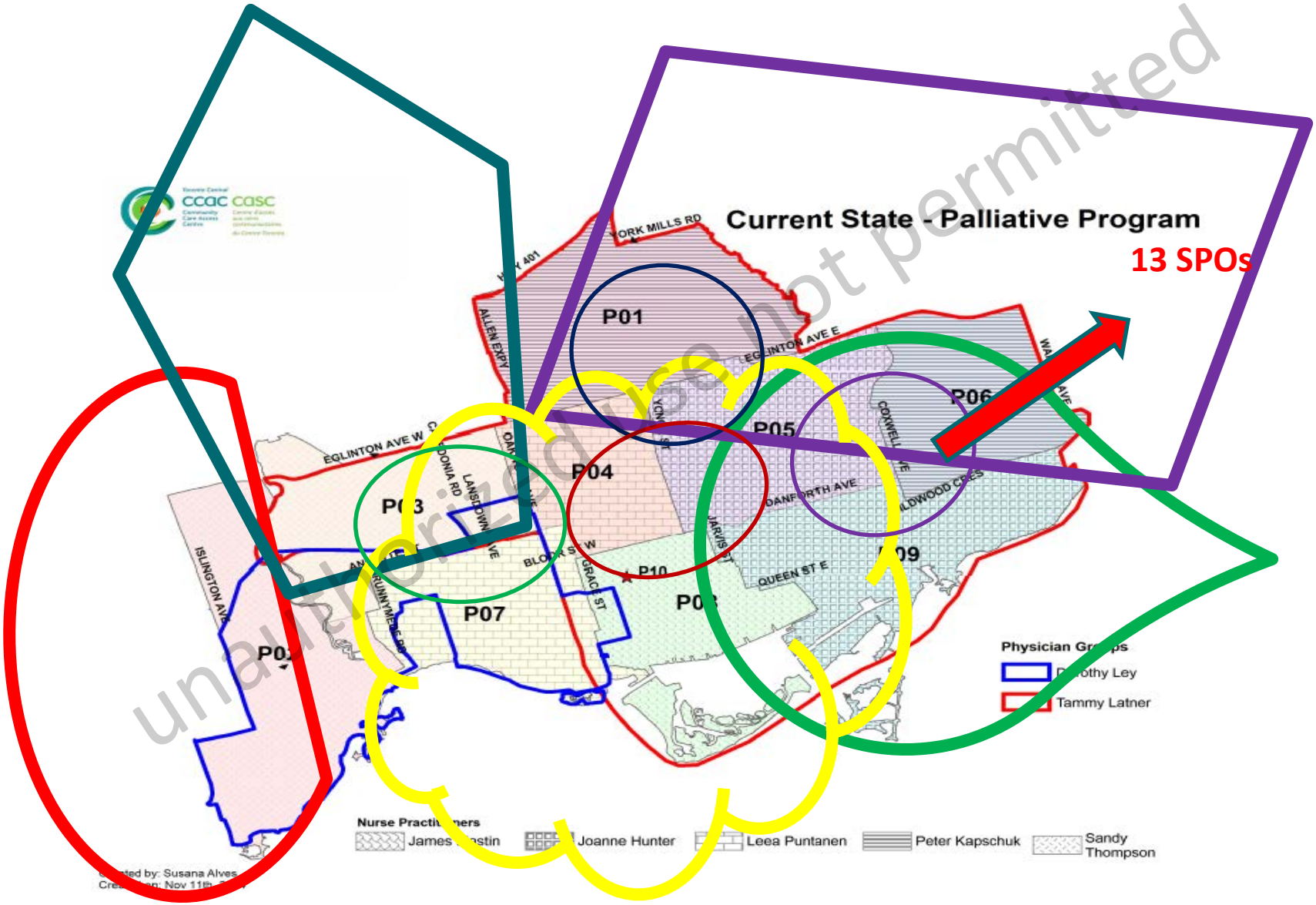
Shewhart, Walter A. (1931). Economic control of quality of manufactured product. D. Van Nostrand Company. p. 8.

http://izquotes.com/author/walter-a.-shewhart

Two patients with same condition living on the same street

- Two different nursing agencies
  - Two different nurses
- Two other PSW agencies
- Variability in provider palliative care specialization and experience
- Varying levels of 24/7 coverage

Variability in client experience



Defining the problem

"Here is the broader point: whatever problem you're trying to solve, make sure you're not just attacking the noisy part of the problem that happens to capture your attention. Before spending all the time and resources, it's incredibly important to properly define the problem-or, better yet, redefine the problem."

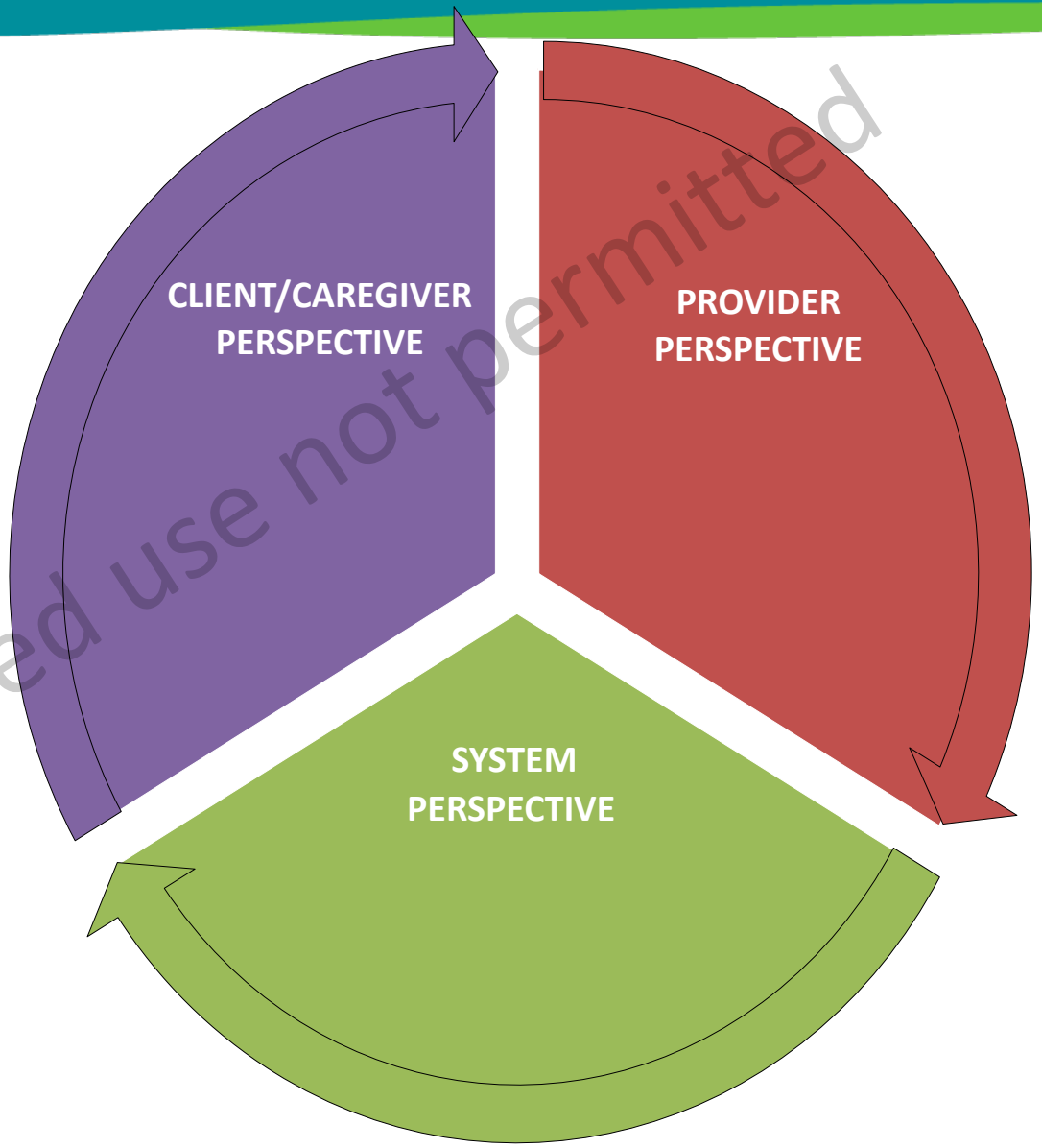
Asking the right questions

How do we create a care system to meet the needs of people who wish to be cared for at home with advanced progressive disease?

What Did We Envision?

One Client, One Team

An integrated, inter-professional, specialized palliative care team that works together to meet the needs of patients and their families in a community setting.



Client Caregiver Perspective

- Consistent team
- Skilled and compassionate providers
- Access to the services we need
  - 24/7
- Inspire confidence in the patient and family

"It is wonderful [to have the same person] because they know you and they get to know your needs. For a while there they kept sending me different ones and you would have to explain things all over again." Client, ICCP Palliative Survey

Better Client & Caregiver Experience

Healthcare Provider Perspective

- Unlock the power of team
  - Team members know and trust one another
  - Seamless communication
  - Ability to act on each others' behalf
  - Culture of mutual support and accountability
  - Practicing within one's full scope of practice and beyond
  - Decreasing isolation common in home care

Job satisfaction and retention

System Perspective

- Increased efficiencies
  - Team shares care; team member with right expertise sees the patient.
  - Decreased travel times: teams organized geographically
  - Expert providers decrease utilization?
- Decreased “avoidable” ED visits and admissions
  - Patient and caregiver access to team, 24/7
  - Enhanced communication between team members

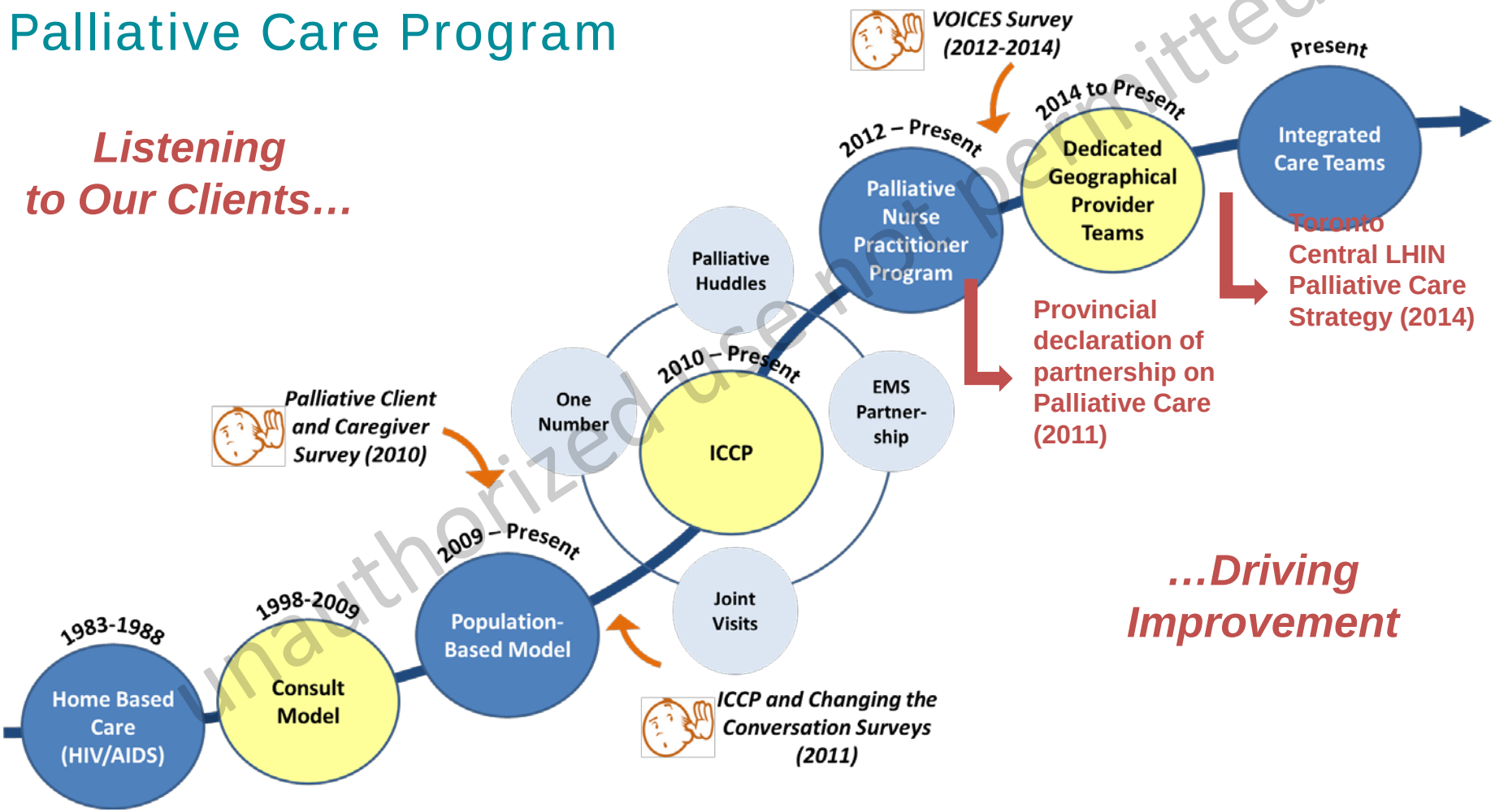
Increase in Program Capacity (cost effectiveness)

Annual volume of patients served on the program increased 10% per year over last two years and all within existing funding models

Evolution of the Palliative Care Program

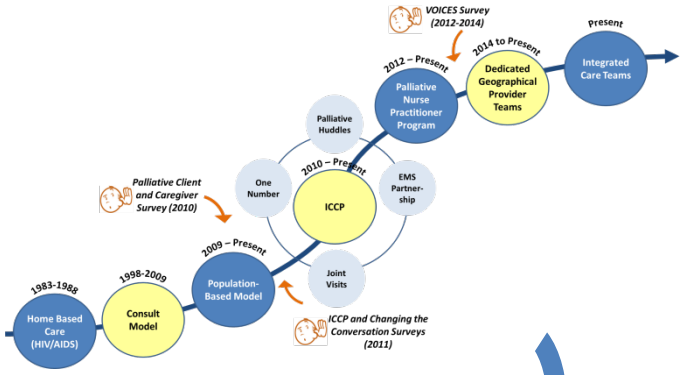
Evolution of the Palliative Care Program

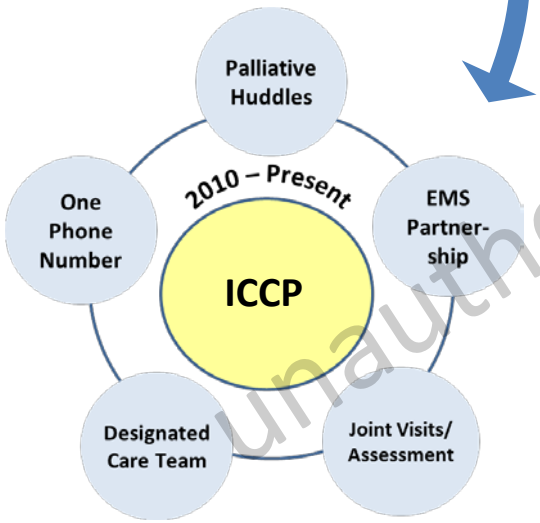
Listening to Our Clients…



…Driving Improvement

Testing Integrated Care Teams





Palliative Team Huddle

A daily huddle led by the Care Coordinator and attended by the integrated care team to discuss change in status of clients, and identify challenges, and quick solutions

Joint Visits/Assessments

An initial joint home visit by the Care Coordinator and Nurse to introduce the team based care approach, conduct a coordinated assessment and plan and reduce duplication for the client/caregiver.

One Number

A single access point for clients/caregivers to call and to ask questions about their care needs related to nursing and physician support, hospice, medical equipment, supplies, medication, health status change, etc.

EMS Partnership

Working with EMS to easily identify when clients are taken to the emergency department and communicate with the integrated care team on status and transition plans.

Dedicated Teams

Dedicated interdisciplinary teams with individuals that have palliative care expertise, providing service to one geography resulting in consistent teams and relationship building with the client

Quality Improvement - Palliative Team Huddle

Identifying quality issues … resulting in quality improvement

WHO ATTENDS:

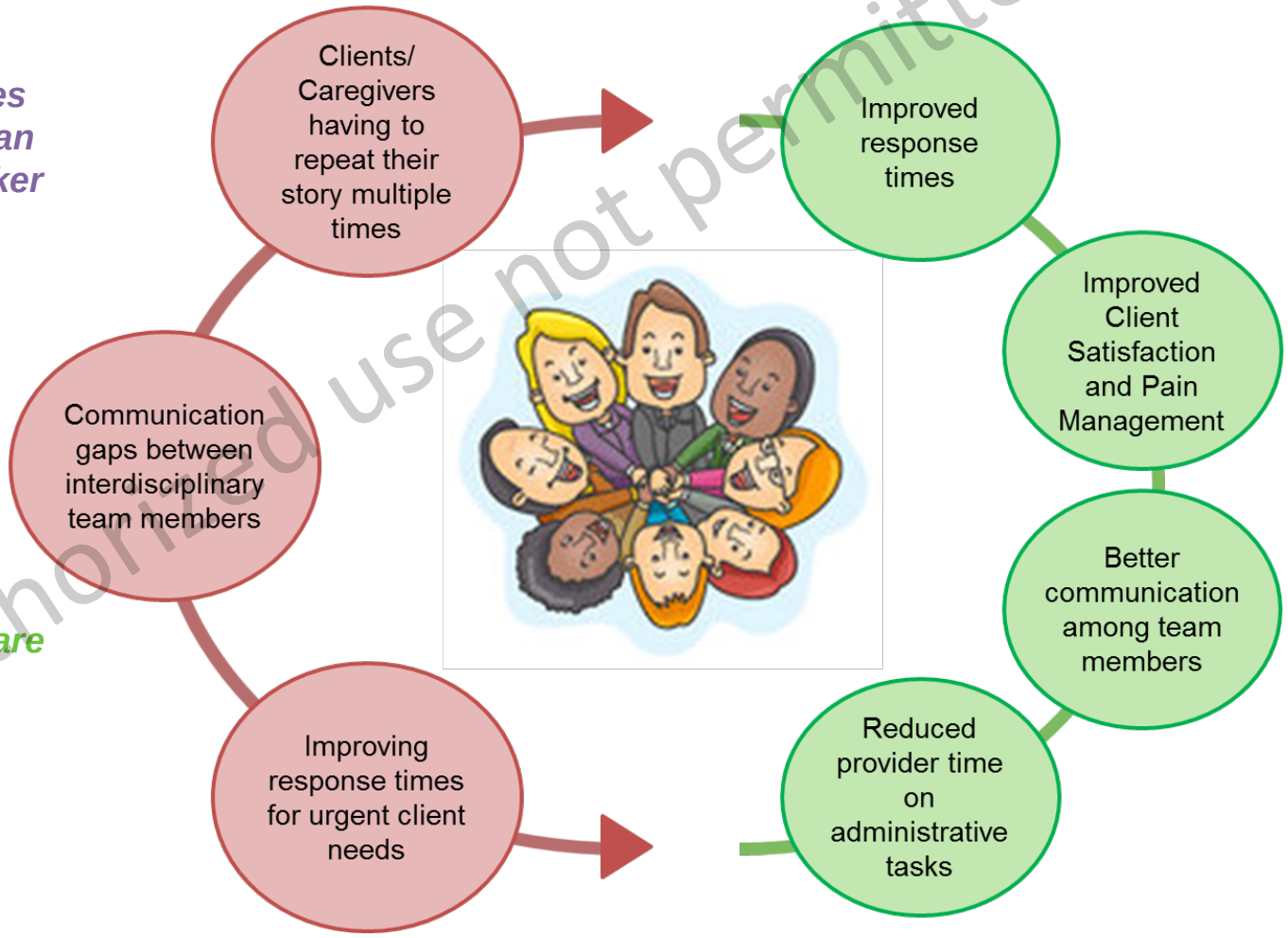
- *Care Coordinator*
- *Nurse Practitioner*
- *Service Provider Nurses*
- *Palliative Care Physician*
- *Personal Support Worker*

WHAT'S DISCUSSED:

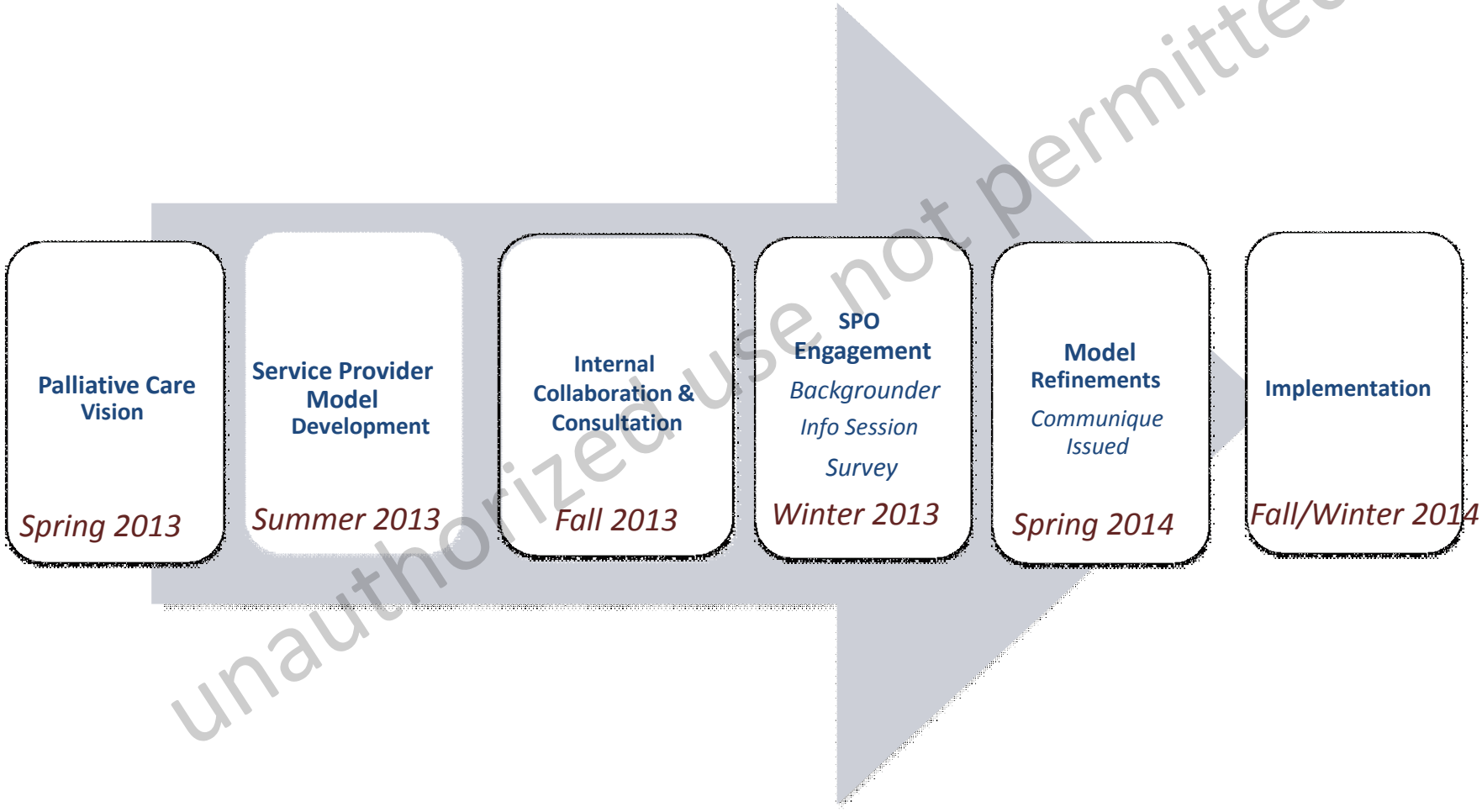
- *Client Status*
- *Client Goals*
- *Identification of urgent needs*
- *Adjustments in plan of care*

HOW OFTEN:

- *Daily for 10 minutes*



Scaling the Integrated Care Teams



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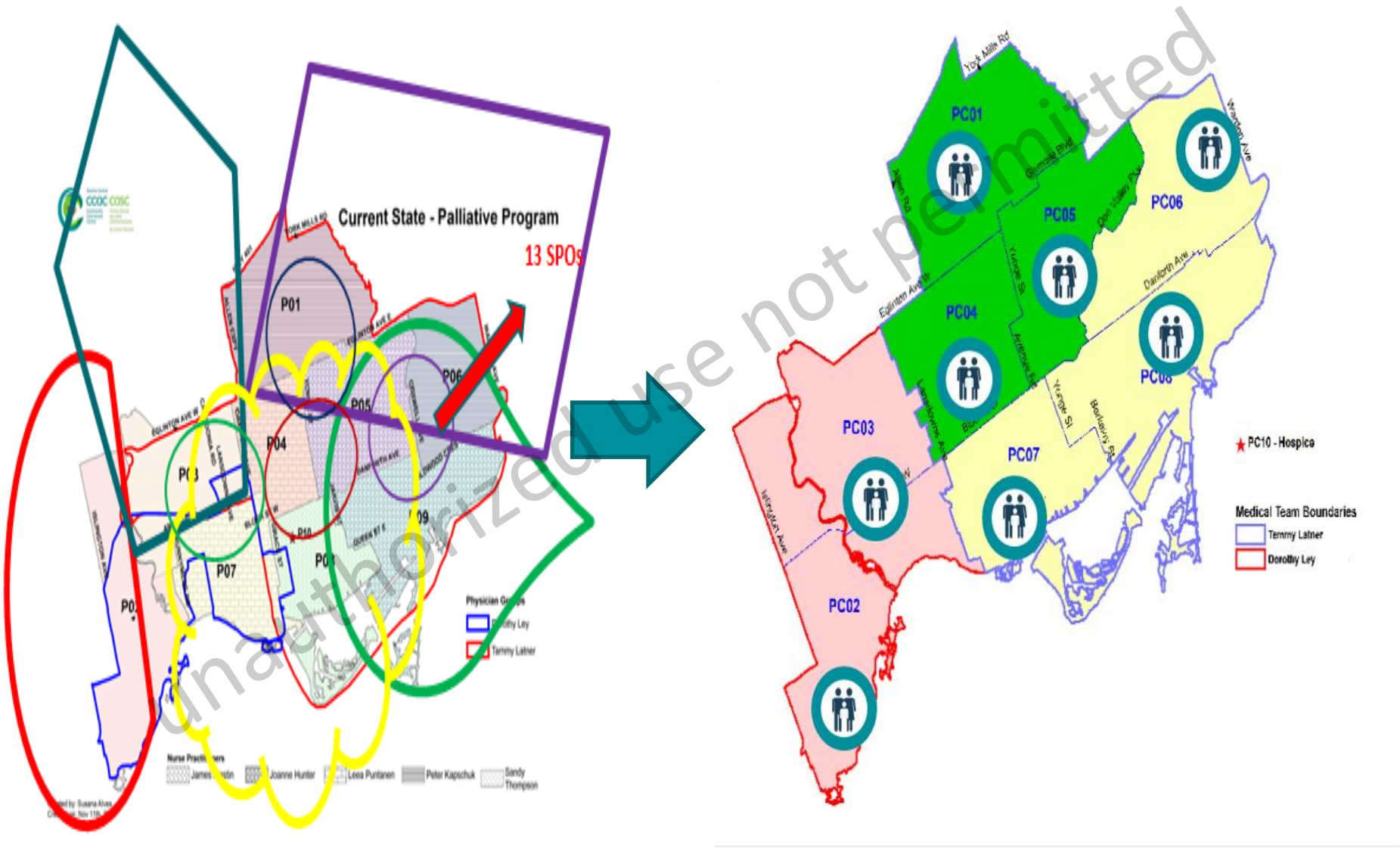
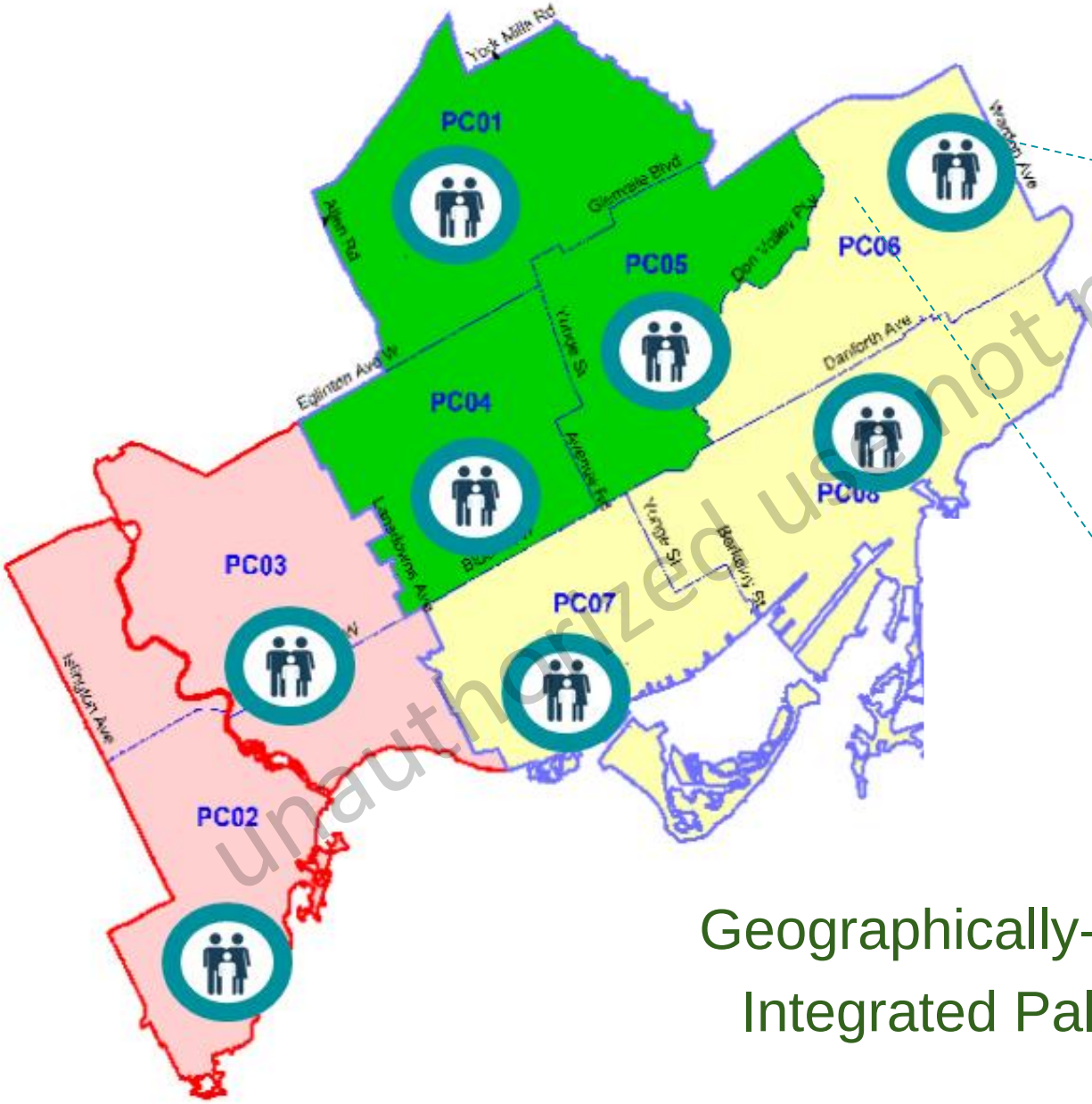
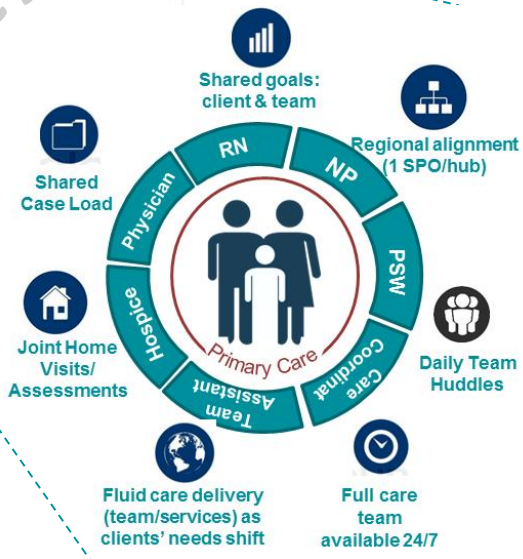


One Client, One Team – Where we are today





Geographically- Based, Dedicated Integrated Palliative Care Teams

How do we know we are making a difference?

98%

Positive experience rating by clients and caregivers

*"Having just lost my beloved wife, after a very, very long battle with cancer my angels were in the form of **Zaid, Dr Marnie, Nash** and, in the background coordinating everything, **Leslie.** No words could ever express the deep gratitude I feel to these wonderful people and the caring meaningful way they helped me survive this very difficult time. They were more than caregivers, they became family, and that made all the difference. Thank God for CCAC, the team and the wonderful work you do. This team will forever be in my prayers."*

81%

Percent of our patients who die outside of an acute care hospital

10%

More patients receiving palliative care at home

Ontario Minister's Medal for Quality and Safety for the highest achievement in quality for our integrated palliative care program 2014

Improved frontline clinician experience

What's Next In Our Improvement Journey?

"One Client – One Team Experience"

Client & Caregiver Advisory Panel:
Enabling client and family driven care.

Caregiver Support
Support programs and support structures for caregivers and families

One Brand:
Clients and families cannot distinguish between organizations that make up their care team

Single Access Point with One Number:
One number for clients and families to use to reach their care team

One EMR:
Enables communication and clinical documentation amongst all members of the care team and clinical

Remote Monitoring :
Virtual monitoring of client conditions and client/family care needs – enabling greater access to care

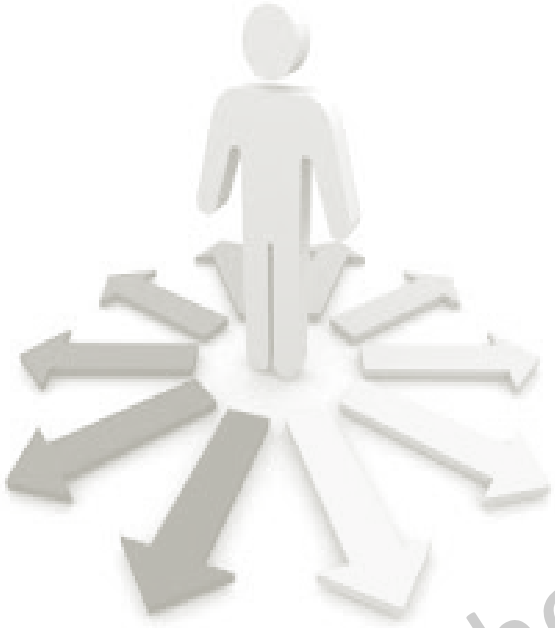
Core Elements for Integrated Palliative Care

Core Program Elements

"One Client – One Team"

- Client and family centered care
- One Care Team with expertise in palliative care encompassing medical care, home care and hospice services
- 24/7 Access to the team
- Shared Communications (One EMR, Daily huddles)
- One Care Plan (Joint Assessments and visits)
- One Phone Number - Single Point of Access
- Integrated Care Coordination

Guiding Principles for Success



Guiding Principles

- **Needs of client/caregivers placed ahead of individual organization priorities, needs and aspirations**
- **Decision not to be constrained by policies that present barriers to seamless service**
- **Build upon local partnerships and relationships and not be constrained by existing roles and ways of doing things**
- **Optimize existing resources in the system**
- **Share accountability for outcomes and the client experience**
- **Explore and AdvanceSimple Solutions**

The future

A lens into the future of the home care for chronic and complex patients:

- Creating a continuum of care that addresses complexity
  - Opportunity to develop a model that reaches upstream (24 months)
  - Looking at needs rather than life expectancy
  - LTCH in-reach
- Meeting the rising tide of those in need of palliative care
  - Primary care integration
  - Shared care models

“If you want to go fast, go alone. If you want to go far, go together.”

African Proverb

“Patient/Caregiver Video”

Thank You to Our Partners

Delivering integrated care for palliative clients is only possible because of our partnerships…

Visiting Volunteer Hospices

PHILIP AZIZ CENTRE FOR HOSPICE CARE

HOSPICE TORONTO

The Dorothy Ley Hospice

Hazel Burns Hospice
Empowering individuals to live one moment at a time
We believe in dignity
We believe in compassion
We believe in autonomy
We believe in support

BetterLiving
Health and Community Services

Community-Based Palliative Physicians

MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Temmy Latner Centre for Palliative Care
Max and Beatrice Wolfe Children's Centre

The Dorothy Ley Hospice

TC CCAC Palliative Program

Toronto Central CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires du Centre-Toronto

50 years of caring for Toronto

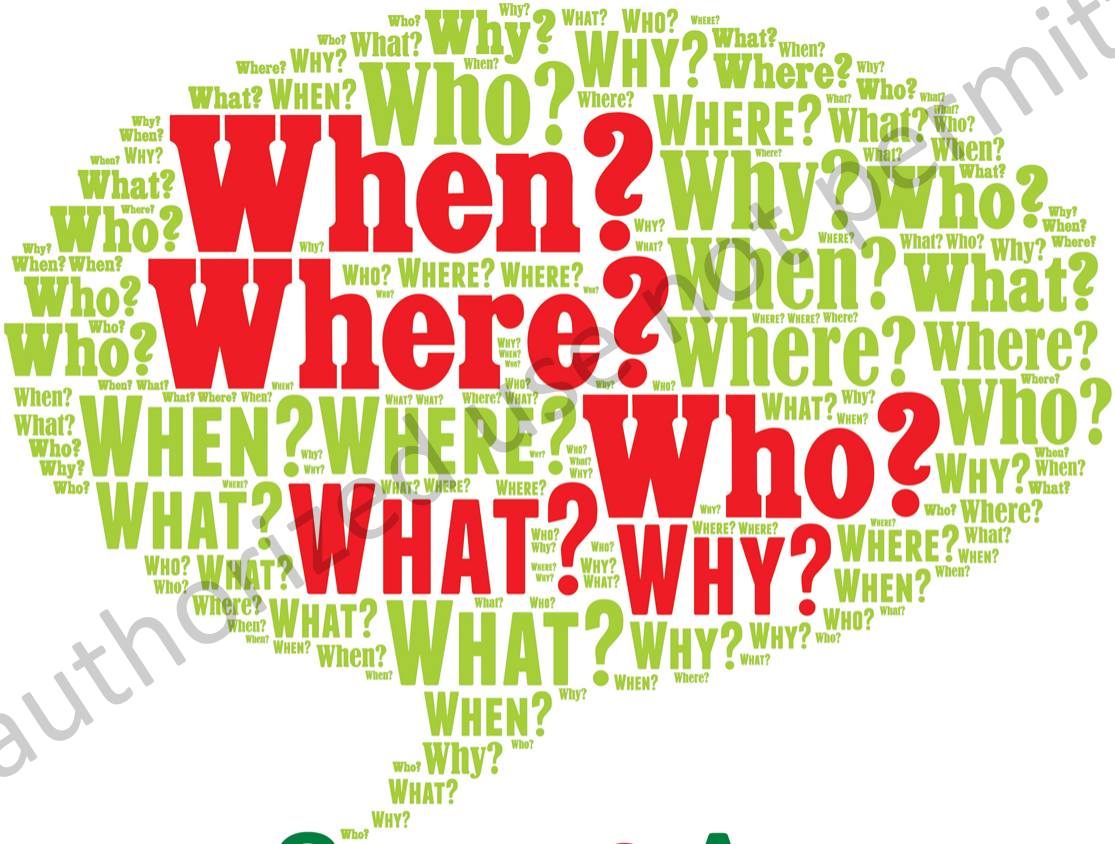
Spectrum HEALTH CARE
Always with you.

S·R·T MED-STAFF

Saint Elizabeth
Well beyond health care

Palliative Care Units and Residential Hospices

8 Palliative Care Units
2 Residential Hospices



Questions & Answers