Health System Performance Research Network
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Developing a Palliative Care System: Highlights from the Champlain Region

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- Champlain Regional Palliative Care Program
- The right number & types of Palliative Care beds
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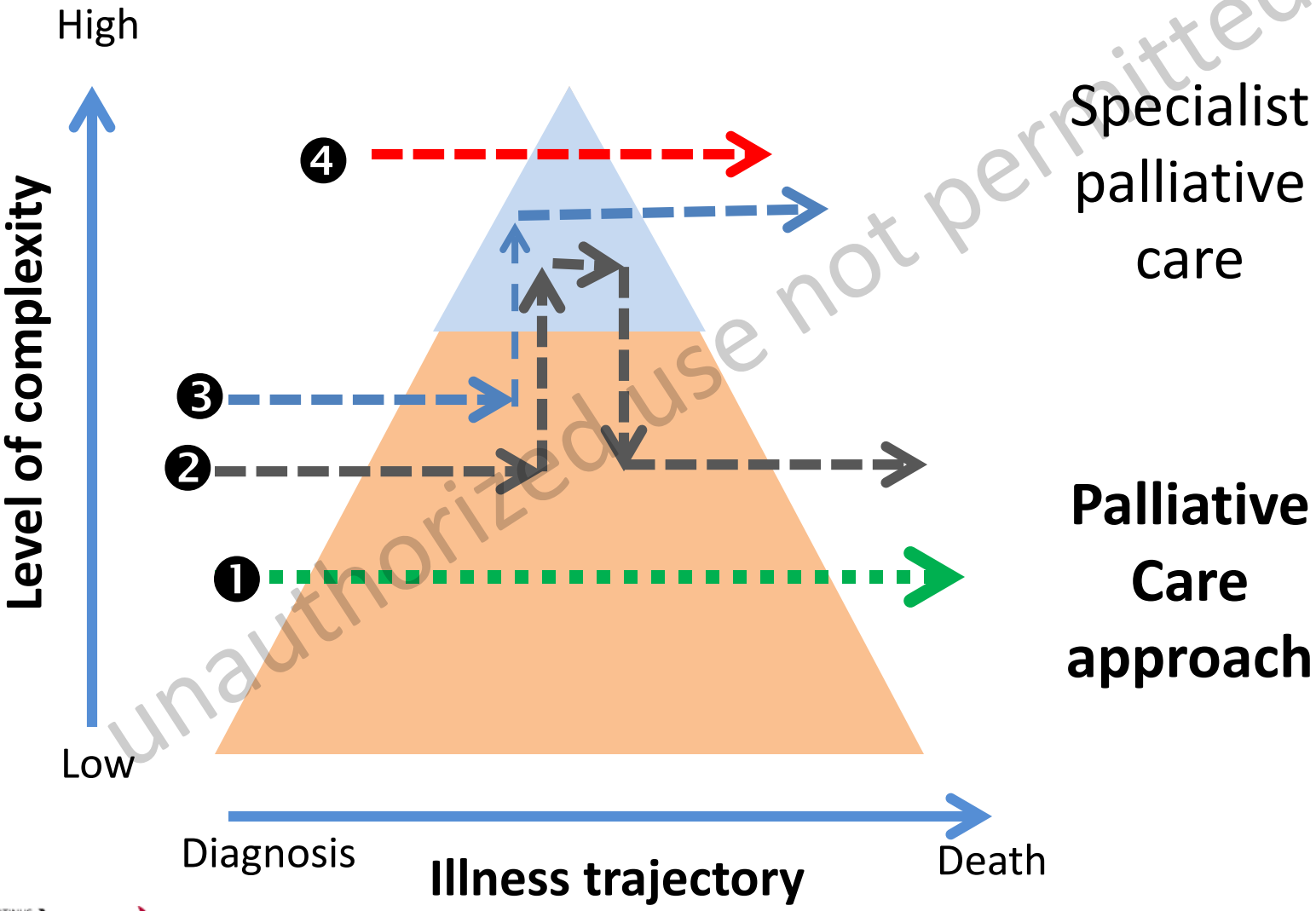
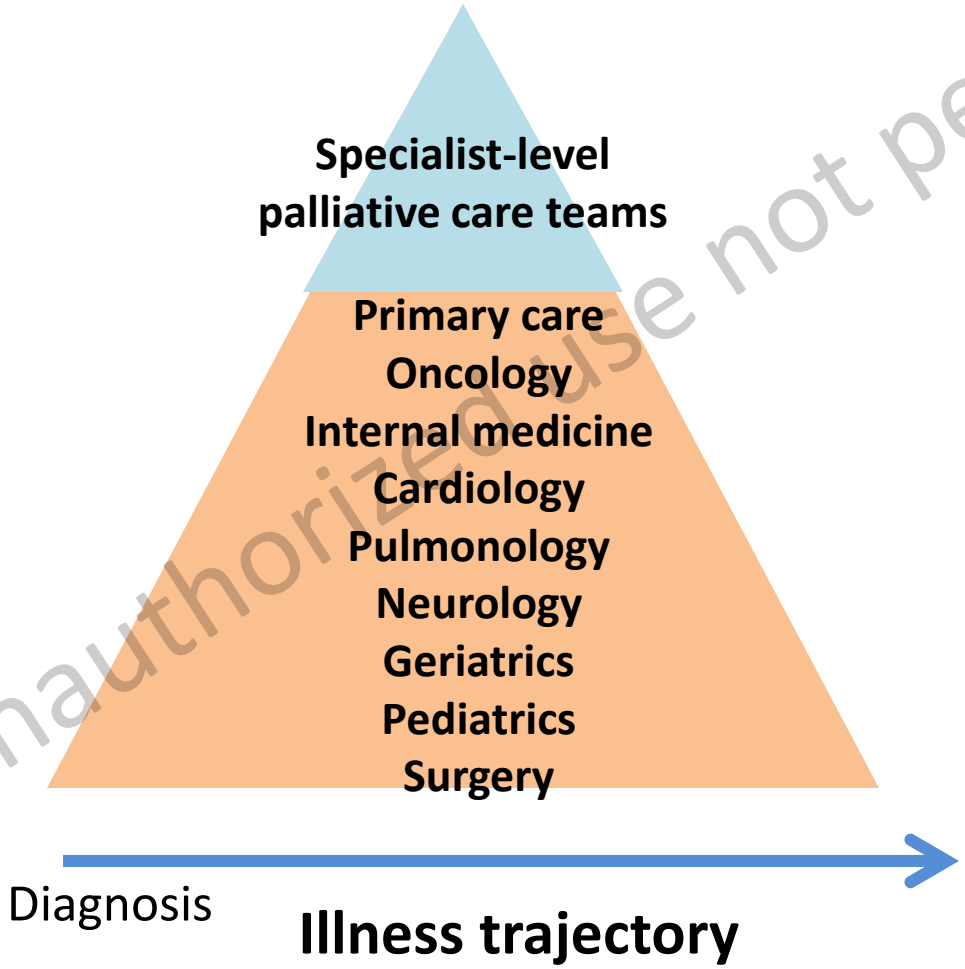
- Building community capacity
  - The Regional Palliative Consultation Team (PPSMCS & NPs)
  - FHTs Palliative Care Project
  - INTEGRATE Project
  - Regional Pallium LEAP efforts

Patients experience palliative care needs across the illness trajectory and in different settings



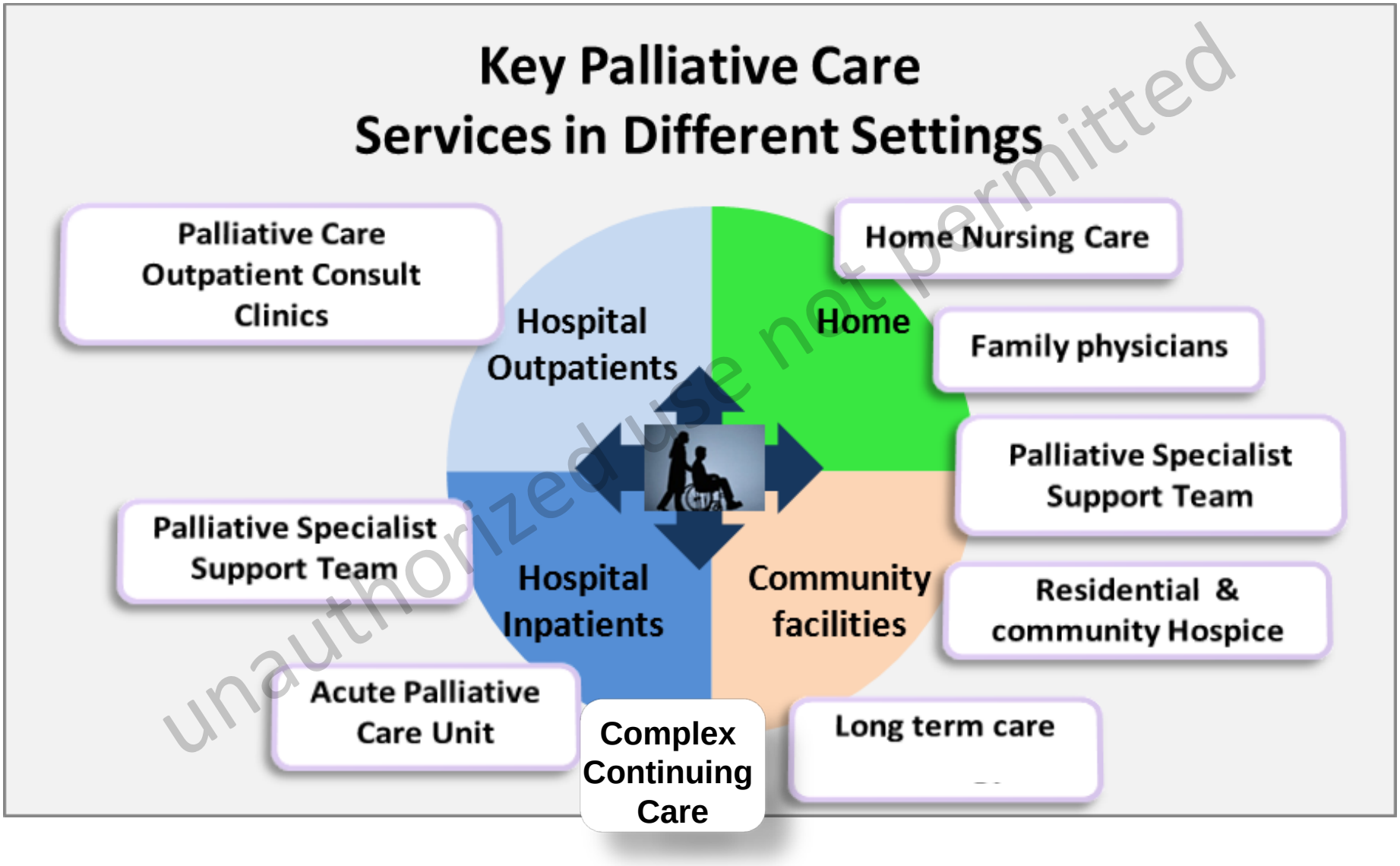
System Capacity:
It is everyone's business



Specialist palliative care

Palliative Care approach

The right care, at the right time, at the right place

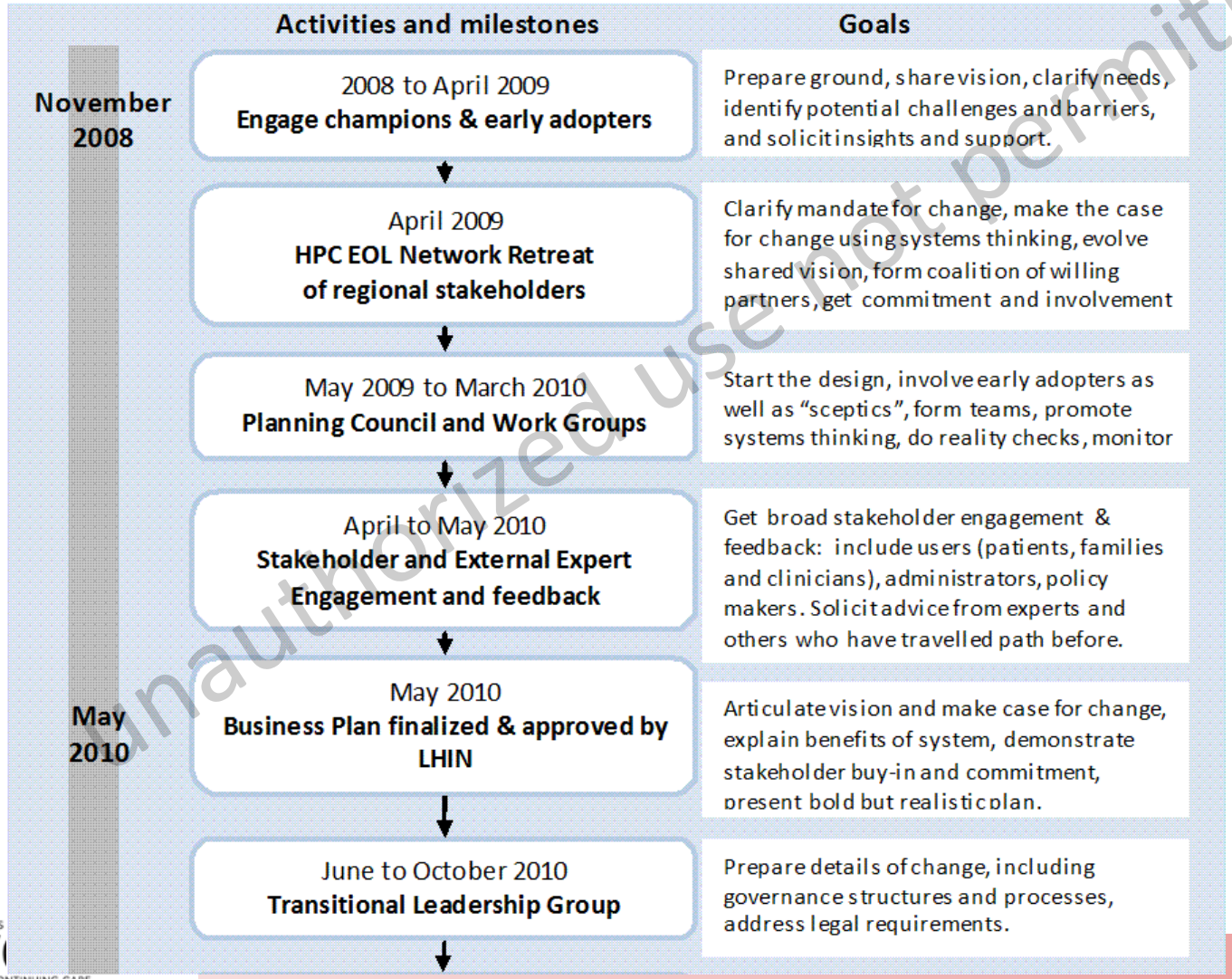


Champlain Regional Palliative Care Program

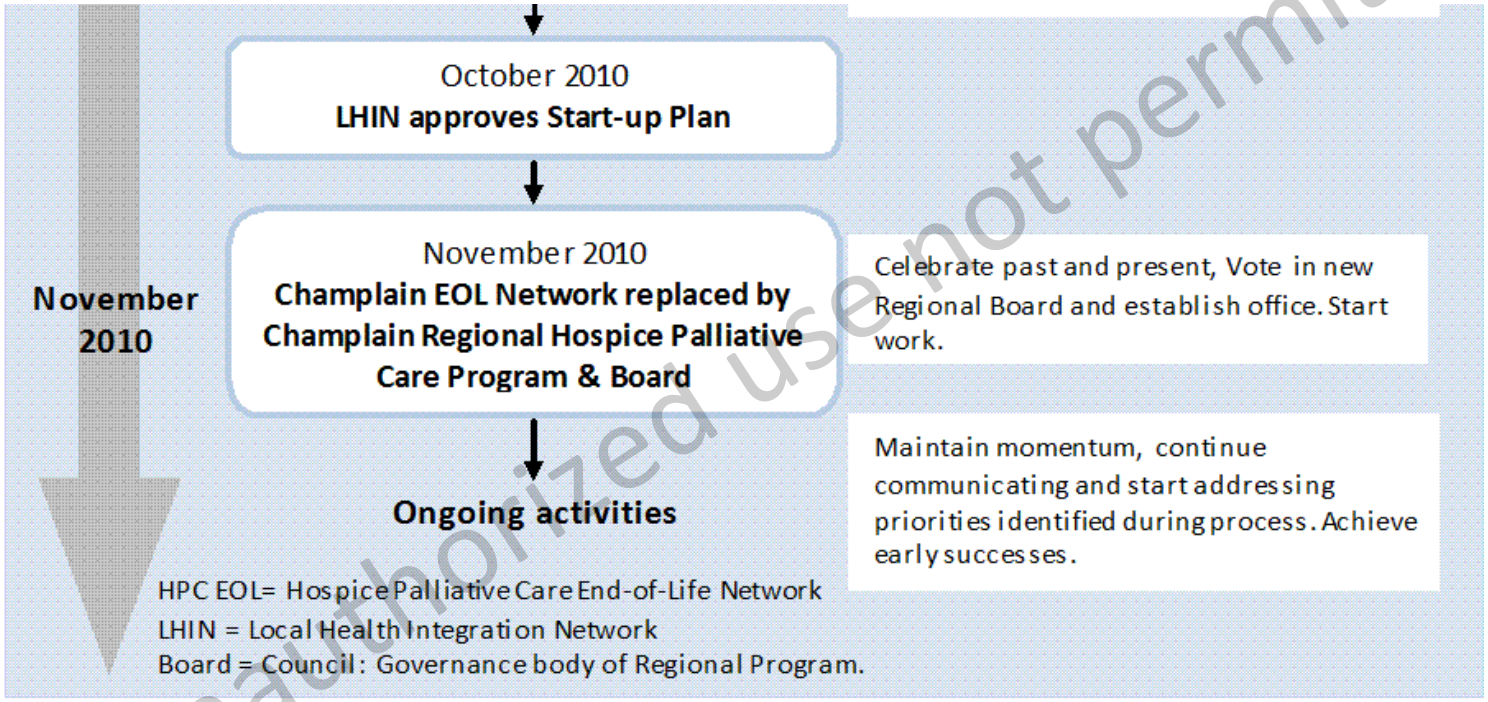
Champlain Region: State in 2009

- 26 HPC Service Providers
- LHIN
  - Multiple HSIP applications by various HPC service providers
  - Easy to say “no”
- No single vision or voice
- No prioritization of services

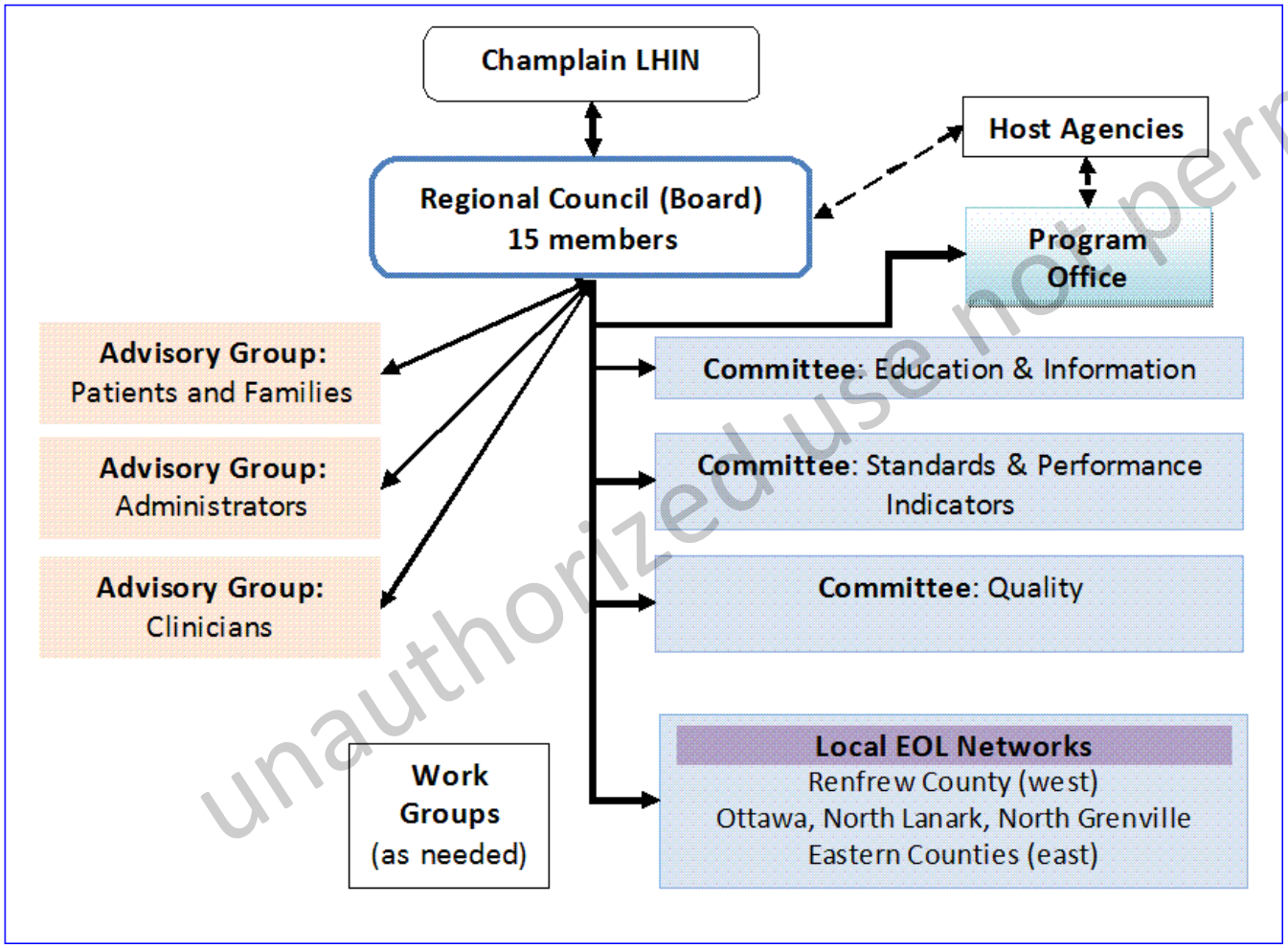
CHAMPLAIN REGIONAL PROGRAM DEVELOPMENT PROCESS



ChAMPLAIN REGIONAL PROGRAM DEVELOPMENT PROCESS



Champlain Regional Palliative Care Program
Initial Governance structure



Supporting documents, policies, by-laws

Champlain regional HPC Program:
activities completed

Activities	Description
Activities Completed	
Ottawa Hospice Plan Phases 1 & 2	Supported Ottawa Hospice groups o develop a plan to increase hospice beds in Ottawa
Service Agreements between the LHIN & HPC Service Providers (entities providing HPC services)	Ensure standards & coordination
Vetting of Proposals for HPC Services to the LHIN	All proposals related to HPC services submitted to the LHIN by various service providers have to be first vette by the Regional HPC Program Board.
Standards for HPC services across different settings	
Performance Indicators for the Region	22 Priority performance indicators have been identifie for the region, as well 40 other micro indicators for individual service providers.
Central Referral and Triage System for referrals to Hospices and the Palliative Care Unit (PCU) in Ottawa	One single referral point for patients being referred to Ottawa's hospices and PCU; can be done online.
Merger of PPSMCS & NPs to establish strong regional community-based consultation and support team.	(The only region in province to do this)
Expected Death in the Home (EDITH) Protocol	Protocol that allows funeral homes to collect bodies o deceased patients who die at home (expected deaths) without requiring a death certificate to move the body the death certificate is then completed within 24 hour
Madawaska Rural Program Plan	Rural Hospice Palliative Program in rural and remote south western part of region.

Champlain Regional Program: Developing

HOSPICES: RESIDENTIAL

STANDARDS	CRITERION
1. **EOL Care**: Residential Hospices will primarily provide End-of-Life Care (last days and weeks of life) as well as some respite care and longer-term hospice care when beds are available	
2. **Clinical Policies and Procedures**: Hospices will maintain up-to-date clinical care policies and procedures	
3. **Central Referral and Triage**: All patients being referred for residential hospice care need to be referred to and triaged by the Central Referral and Triage Process.	
4. **RN & RPN training**: All hospice RNs & RPNs will have completed the Pallium LEAP 2/3 day course	
5. **Volunteer Training**: All hospice volunteers will have c Volunteer Education Program	
6. **PSW training**: All hospice PSWs will have completed a program (delivered jointly between PPSMCS & Hospi	

ACUTE CARE HOSPITALS

STANDARD	CRITERION
1. **Access to Palliative Consult Services**: All acute care hospitals in the region will have access to 24/7 Palliative Care Consultation support services	
2. **In-house Palliative Consultation Service**: Teaching and large community hospitals will have e Care Consultation support teams	
ait time from referral to the palliative care consultation pital should be less than 24 hours for urgent cases	
staff must have easy access to information regarding the e care consult service and information on access to he region.	
s in teaching hospitals will include supervision and mandate.	
ll conduct annual Palliative and End-of-Life Care-related	
ls will use the following instruments in their daily practice o could benefit from a palliative care approach and ESAS; b)PPS; c) Case Finding (GSF); and d) Palliative Care	
ith an increased one-year mortality risk will be offered ete advance care planning.	

CANCER CENTRE

STANDARD	CRITERION
1. **Palliative Care outpatient clinics**: Cancer Centres will provide interprofessional out-patient palliative care clinics.	
2. **Quick response and triage service**: Oncology teams will have access to a Quick response and triage palliative care service, during office hours, for patients requiring urgent palliative care support.	
3. **Earlier Palliative Care**: Oncology clinics will initiate palliative care earlier in the illness trajectory, particularly lung cancer clinics.	
4. **Standardize instruments**: All outpatient clinics (oncology and palliative care) will regularly, as part of daily practice, use the following standardized clinical tools: a) ESAS; b) PPS or ECOG; c) Case Finding (GSF); and d) Palliative Triggers.	
5. **Information for Oncology teams**: Information on how to when and how to access hospice palliative care services will be made available to oncology teams and patients and families	
6. **Palliative Care visibility and integration**: Palliative Care will be visible for patients, families and health professionals through signage, and information pamphlets	
7. **Earlier transfer of care to primary care**: Patients should be encouraged to maintain contact with their family physicians throughout illness trajectory and care be transferred earlier into community for EOL care (last 3 months of life)	

Champlain Hospice Palliative Care Program Priority Indicators

Standards (N = 40); Priority Indicators (N = 23)

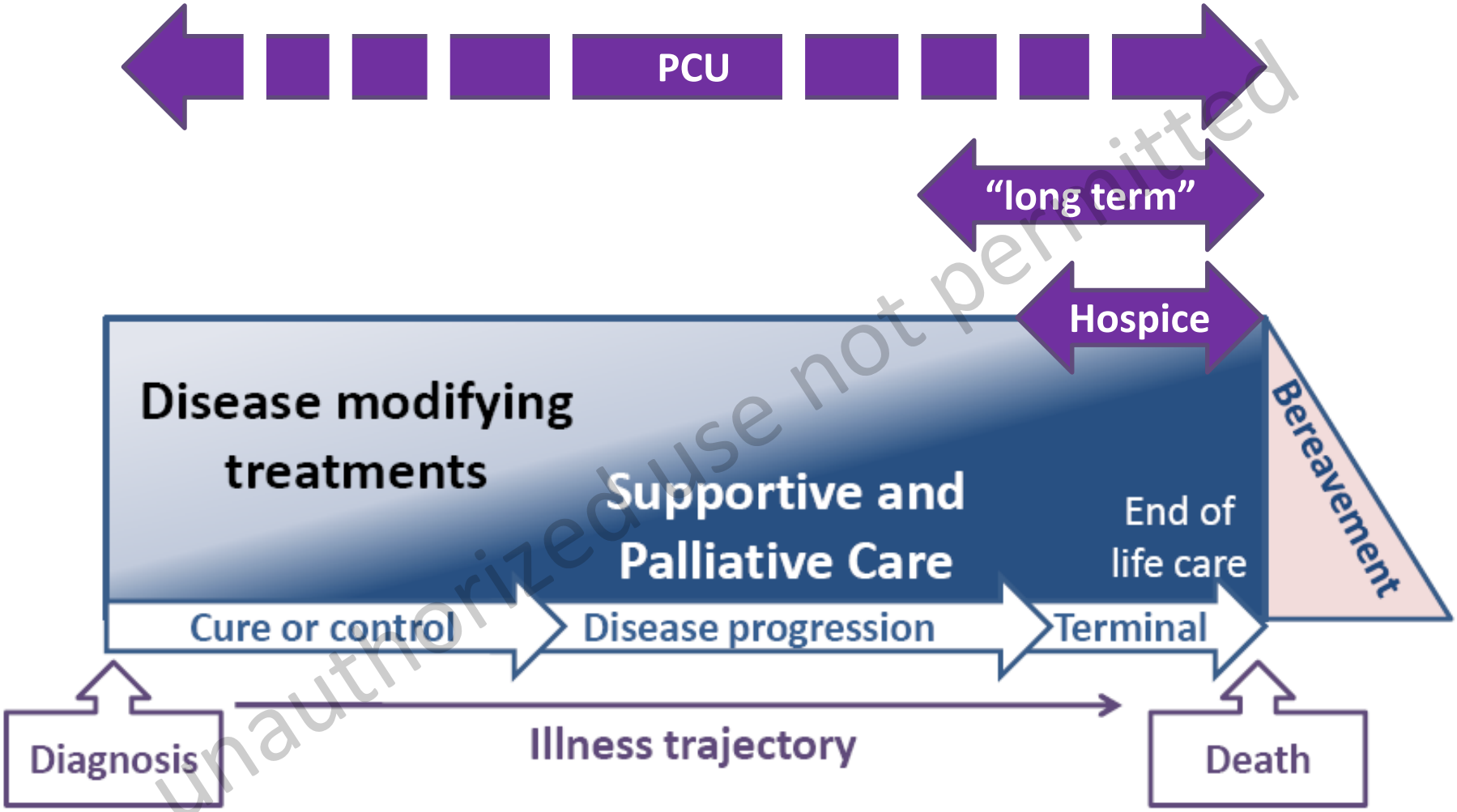
INDICATORS

Category:	Level:	Purpose:	Sector:	Benchmark:
Capacity N = 8	Macro (N = 4)	• Accountability (N = 9)	• Acute Care	N = 21
Access N = 8	Meso (N = 4)	• Quality Improvement (N = 14)	• PCUs	
Co-ordination N = 4	Micro (N = 0)	• Research	• CCAC	
Quality/ Outcomes N = 3	Macro (N = 3)		• Home	
	Meso (N = 5)		• Hospice	
	Micro (N = 0)		• LTC	
	Macro (N = 2)		• Retirement Homes	
	Meso (N = 2)		• Cancer Centres	
	Micro (N = 0)		• Family Physicians	
	Macro (N = 2)		• Nursing Agencies	
	Meso (N = 0)		• PSMCS/NPs	
	Micro (N = 1)			

The right number and types of Palliative Care beds

The Regional Palliative Care Unit and the Ottawa Hospices

In-patient palliative care beds



How many Palliative Care Beds are needed?

- **10 Palliative care beds for every 100 000 inhabitants**
  - **1/3 acute palliative care beds**
  - **2/3 “continuing care” & hospice type beds**

1. Gómez-Batiste X, Porta-Sales J, Pascual A, Nabal M, Espinosa J, et al. Catalonia WHO Palliative Care Demonstration Project at 15 Years (2005). J Pain Symptom Manage 2007;33:584-590
2. Xavier Gomez-Batiste, Josep Porta, Albert Tuca, Jan Stjensward. Organización de Servicios y programas de Cuidados Paliativos. Arán Edicones SL. Madrid, Spain. 2005:54-79
3. Gómez-Batiste X et al. Diseno, implementazion y evaluacion de programas publicos de cuidados paliativos. Medicina Clinica 2010;135(4):179-185

Situation in 2008

	Calgary	Ottawa
Population:	± 1 million	± 900 000
PCU:	28 beds	36 beds (24 +12)
Hospice:	± 80 beds	9 beds

2008 to 2015: Bruyère Palliative Care Unit
Changing from an EOL unit to more acute PCU

	2008 36 beds		**2013/2014** 36 beds	**2014/2015** 31 beds (24 + 7)
# of admissions	401		534	492
Referral sites	85% hospitals		75% hospitals	75% hospitals
Alive discharge rate:	4%	→	20%	20% (18%-28%)
Mean LOS	28 days		19.7 days	21 days
Median LOS	17 days		13 days	13 days
Wait time for admission:	9.7 days	→	2.8 days	3 days (0.5-3.5)
Occupancy rate:	90%		87.4%	92%
Admissions:	During weekdays, before 2pm	→	7 days a week	

Most are high complex
$800 per day

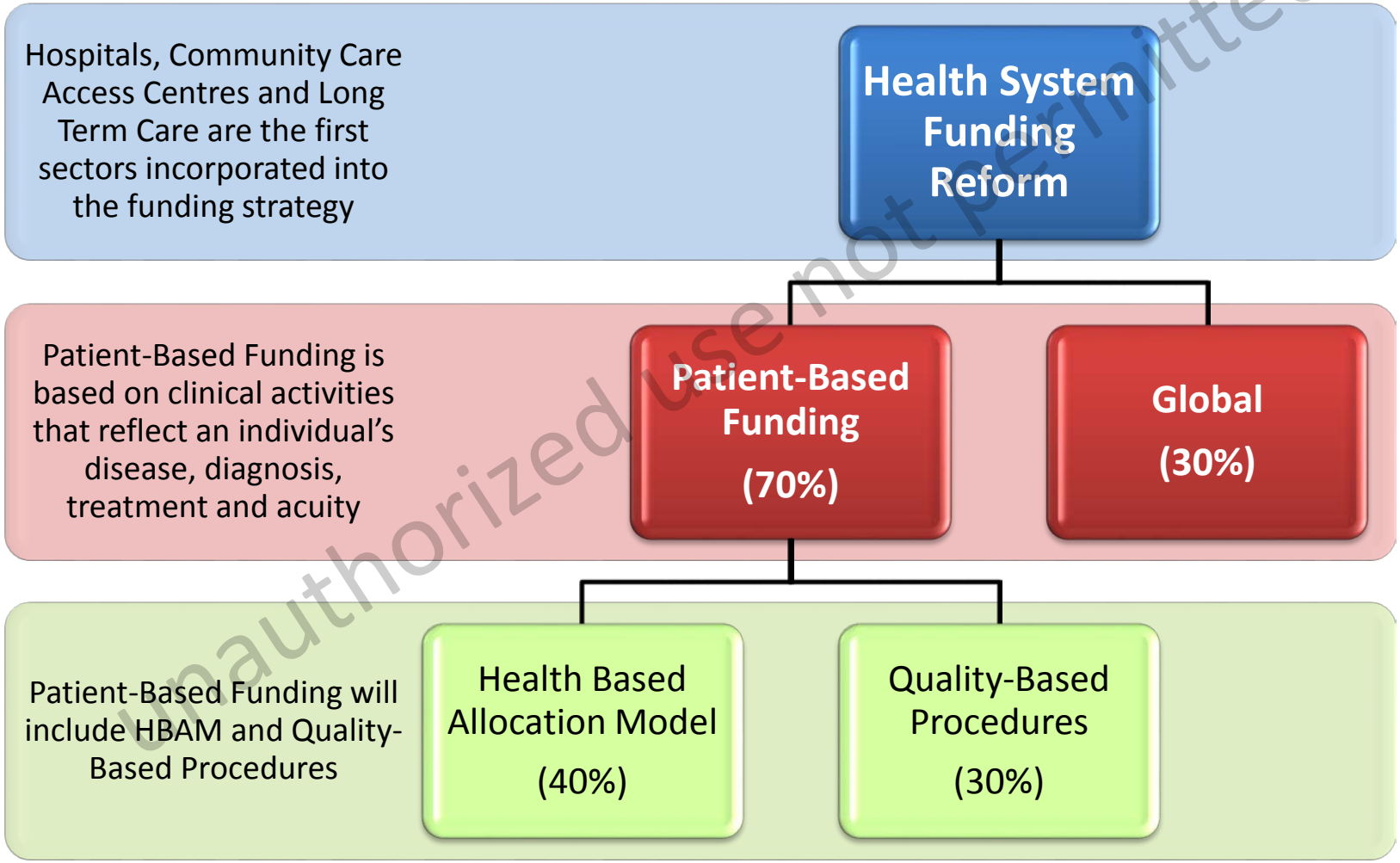
Hospice beds in Ottawa

2011	2015	In progress
3 different organizations	One organization	
1 Residential hospice:	2 Hospices	New hospice being built
Beds: 10	19 beds	Target: 35 beds
Community programs: 1 site	Community programs: 3 sites	
60% of operations funded by charity	30% of operations funded by charity	? Awaiting Ministry announcement

Hospice Care Ottawa Growth: Strategies

- Merged hospice groups into one (2012)
- Got hospitals to provide some funding to hospices
  - Hospital bed $1000/day; Hospice $450/day
- Use existing facilities to host hospice
- New hospice plan: 15 beds
- Site for Family Medicine engagement

Ministry Health Services Funding Reform



Staff mixes and ratios (in FTEs per 10 beds)

	Bruyère PCU	Edmonton PCU	Calgary PCU	Hospice Ottawa
# of beds	31	20	20 (27)	10
Nursing (RNs/RPNs)				
Days	**2.3** (1.3/1)	**3.5** (2/1.5) + 1 HCA	**3.4** (2.6/0.8)	**3** (2/1)
Eve	**1.9** (1/1)	**2.5** (1.5/1) + 1 HCA	**3.4** (2.6/0.8)	**3** (2/1)
nights	**1.3**	**2.5** (1.5 +1 HCA)	**2.5** (2/0.5)	**3** (1/2)
Social worker	0.26	0.5	0.5	Part time
Spiritual care	0.13	0.5	0.25	Part time
Pharmacy	0.32	0.4	0.3	Part time
Psychology	0	0.3	Access to	-
PT/OT	0.13/0	0.4	0.5 /0.25	Not needed
Dietician	0	0.2	0.25	Not needed
MDs	1	1	1.5	Different MRPs
Clerk	Part time	Full time day	Full time day	Volunteers day

Staff mix and ratios in Ontario PCUs

	RN/RPN/PSW**	Pharm	SW	Chaplain	PT	OT	
PCUs in acute hospitals (n)	**9**	**0.36 [0.1-1.0]**	**0.44** [0-1.6]	**0.26** [0.1-0.7]	**0.28** [0.1-1.0]	**0-0.2**	**Some facing cuts & downsizing**
Day: mean [range]	**2.9** [2.5-3.3]						
Eve: mean [range]	**2.39** [1.7-3.3]						
Night: mean [range]	**1.86** [1.3-2.6]						
PCUs in CCC (n)	**6***	**0.16 [0-0.3]**	**0.26** [0-0.7]	**0.18** [0.14-0.25]	**0.21** [0.1-0.5]	**0.25** [0-0.5]	**All facing significant funding cuts. Changing role**
Day: mean [range]:	**2.46** [2-3]						
Eve: mean [range]	**2** [1.6-2.9]						
Night: mean [range]	**1.14** [0.6-1.5]						

Challenges

- PCU cuts
- Where will complex patients be cared for?
- Where will “long term palliative care” patients requiring in-patient care be cared for?
  - LTC
  - Complex Continuing Care

Getting the right patient to the right bed

The System for Managing Access, Referrals and Triaging (SMART)

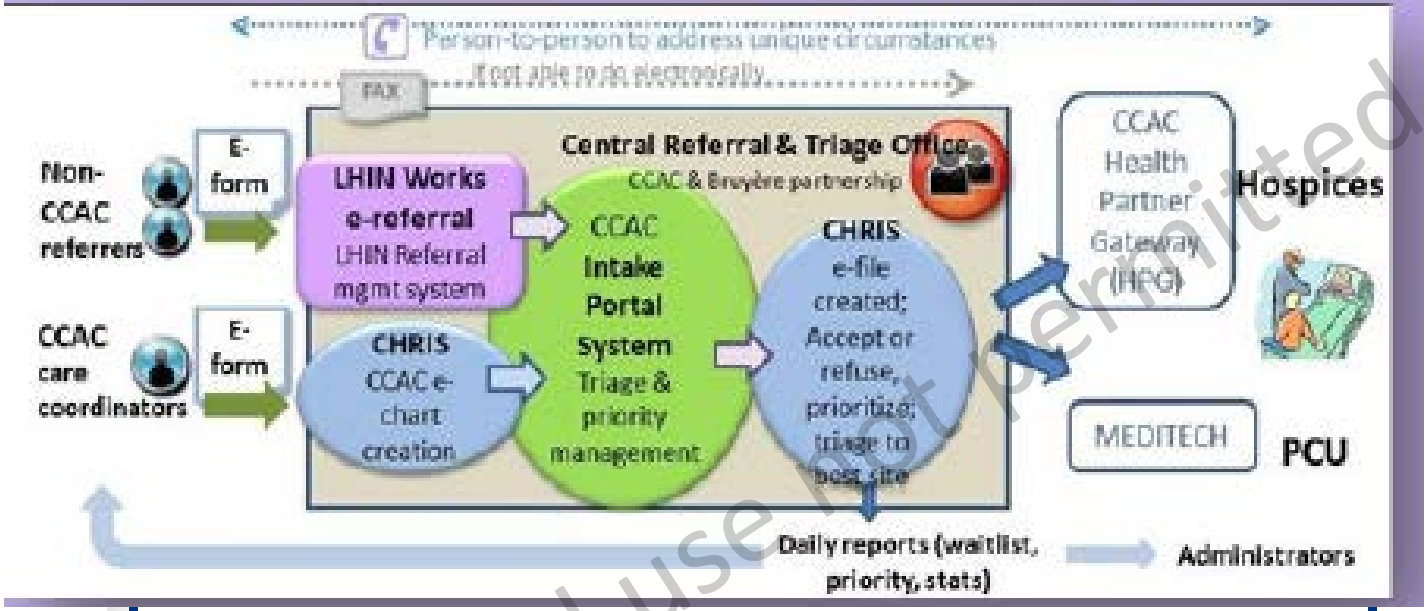
System to Manage Access, Referrals and Triage (SMART) to PCU and Hospice beds

- Before 2012
  - 2 separate referral systems for PCU & hospice
  - Duplication of referrals
  - Duplication of triage process
  - Inappropriate admissions
  - No clear admission and discharge criteria for PCU and Hospices
  - Lack of systems thinking

SMART single Referral and Triage (SMART) Process

- Funded by Ministry Innovation Fund
  - Bruyère Medical Organization
- 2 components:
  - Single referral & triage process
  - Single online platform
- Established admission & discharge criteria together
- Central triage process
  - 2 coordinators: Bruyere & CCAC
  - Oversight committee meets quarterly (Bruyère, Hospice, CCAC, Hospitals)

SMART e-Referral System



SMART SYSTEM FUNCTIONS	CURRENT STATUS
LHIN Works e-referral system to communicate with CCAC's CHRIS system	Complete
Training of referral sources	Complete
SMART referrals sent and received	Complete
Real-time statistics for administrators	Started
Automated reports to referral sources on status of referral: patient's place on the waitlist	Date TBD
Real-time reporting to system users on bed availability and bed location	Date TBD

SMART

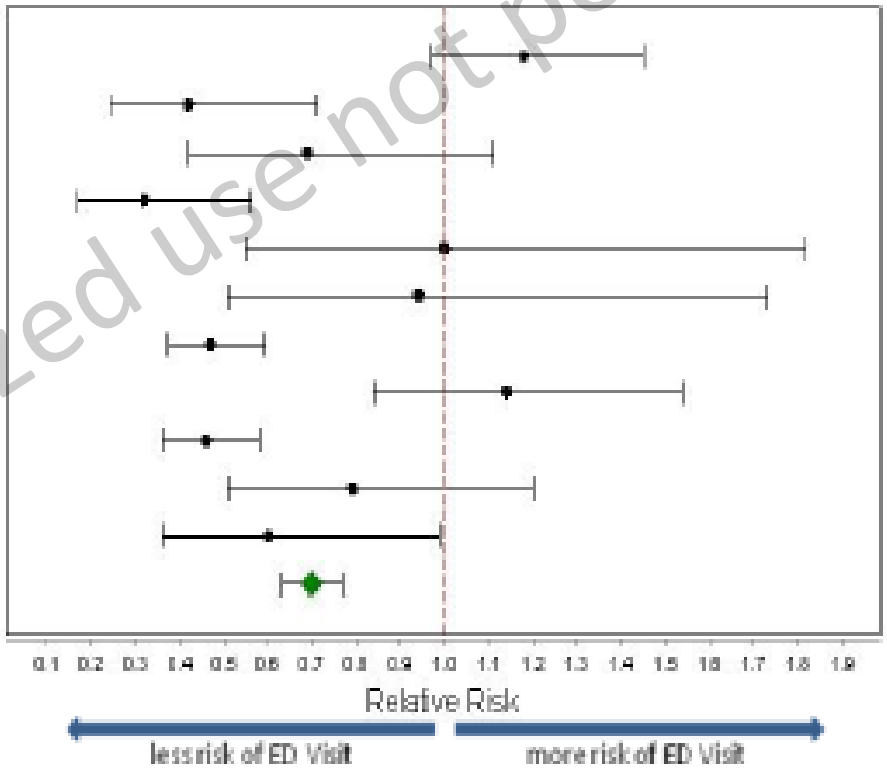
- Over 1500 referrals processed by the system to date
- Ongoing education
- Ongoing software development
- Ongoing indicator monitoring and reporting
- Interest from other sectors

Building Community Capacity :
The Regional Palliative Care Consultation Team (RPCT)

Community Palliative Care Teams in Ontario

Figure 2. Relative Risk of Having a Late-Life ED Visit for Exposed vs. Unexposed

Region	n/team	RR	(95% CI)
1	828	1.18	[0.97-1.45]
2	107	0.42	[0.24-0.71]
3	124	0.69	[0.42-1.11]
4	117	0.32	[0.17-0.56]
5	99	1.00	[0.55-1.82]
6	76	0.94	[0.51-1.73]
7	663	0.47	[0.37-0.59]
8	448	1.14	[0.84-1.54]
9	739	0.46	[0.36-0.58]
10	167	0.79	[0.51-1.20]
11	115	0.60	[0.36-0.99]
Pooled	3109	0.70	[0.63-0.77]



Seow H et al. BMJ 2014

Models of Care provided by Specialist Teams

	Consultation Model		Shared Care Model			Substitution Model
Palliative Care Specialist (PCS) involvement	Limited Consultation (CL)	Broader Consultation (CB)	Shared tending to Consultation (S-C)	Shared Equal (SE)	Shared tending to Substitution (S-S)	**Substitution (Sub)**
Scope of intervention by PCS	Limited to one or a few problems, provides recommendations to MRP; may sometimes initiate treatment	PCS explores all the palliative needs of the patient, makes recommendations to MRP	PCS explores all the palliative needs of the patient	PCS manages all the palliative needs of the patient	PCS manages all the palliative care needs of the patient as well as some other health issues (e.g. hypertension medication)	PCS takes care of all aspects of care, not only palliative care related ones
Prescribing and orders	Seldom if at all provides repeat prescriptions or orders	Orders or prescribes treatments only until situation stable and then withdraws.	Continues to order or prescribe treatment related to palliative care needs	Continues to order or prescribe only treatments related to palliative care	Provides most of the follow-up orders and prescriptions for the patient	Provides all the follow-up orders and prescriptions for the patient
Final decision-making	Most Responsible Physician (MRP)	MRP	Shared by PCS & MRP, but largely delegated to MRP	Shared equally between MRP & PCS	Shared by PCS & MRP, but largely delegated to PCS	PCS
Extent of visits by PCS	Limited number of visits, usually only one	Continues visiting until situation stable & then withdraws	Regular ongoing visits, plus regular visits by MRP (may or may not be jointly with PCS)	Regular ongoing visits, plus regular visits by MRP (may or may not be jointly with PCS)	Regular ongoing visits. Occasional visits by MRP	Regular ongoing visits. MRP seldom if at all visits

Palliative Community Consultation Teams
Champlain vs Edmonton Zone 2012

	Champlain	Edmonton Zone
Population:	1.2 million	1.2 million
Team:	2 APNs 1.4 doctors	5 doctors 5 nurses
Sector covered:	Community	Community & Community Hospitals
Family physician involvement:	The exception	The rule
Role of team:	Clinical support (Mainly consultation, some shared care) Education, QI, System leadership	

Regional Palliative Care Consultation Team (RPCT)- implemented in March 2012

Bruyère-based PPSMCS

- Since 1996
- 2.5 Advance Practice Nurses
- 1.4 FTE Palliative Physician
- 1 FTE admin support

CCAC Palliative NPs

- 2012
- 5 NPs

Regional Palliative Care Consultation Team

- Mainly consultation support
- Education & QI
- Collaboration: Bruyère, CCAC, Bruyère AFP & Regional Palliative Care Program

Champlain RPCT

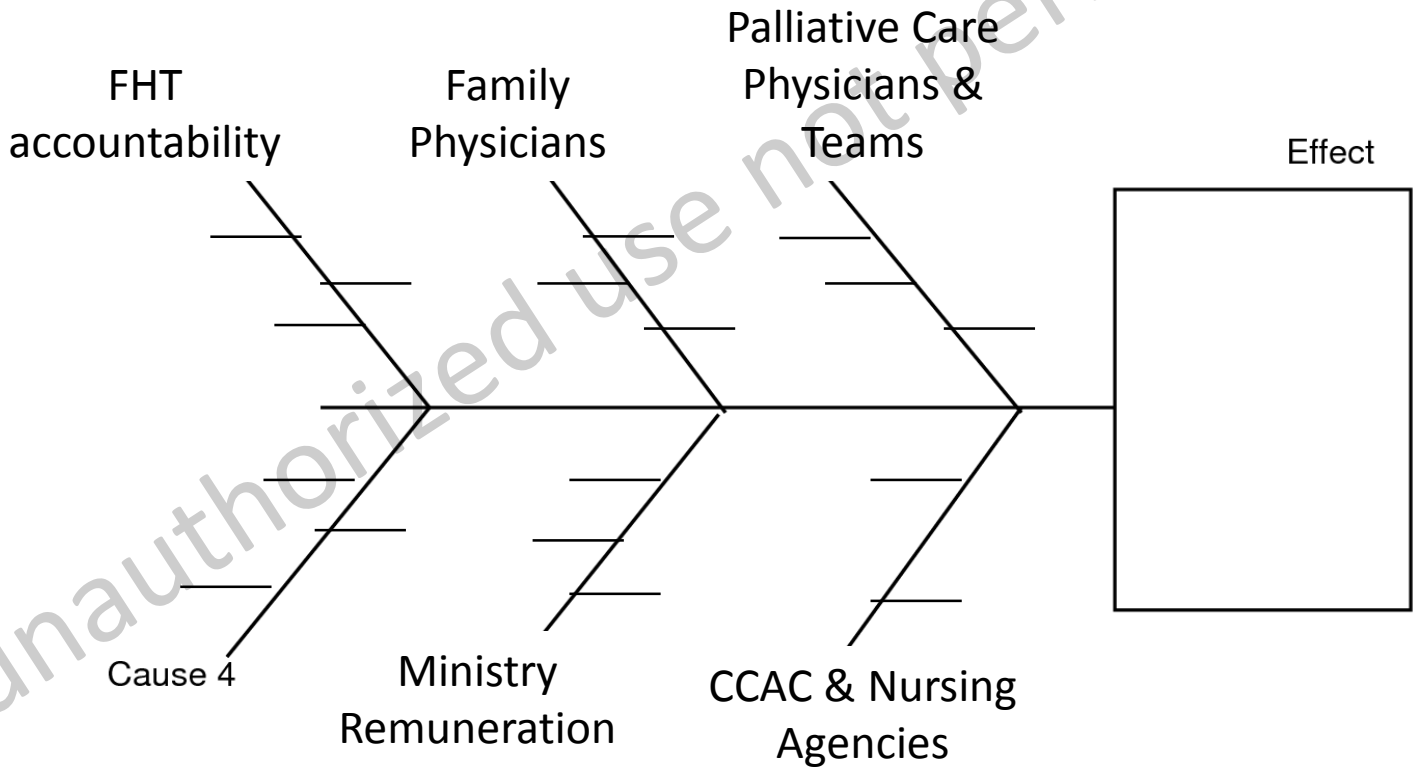
		2012-2013	2013-2014	2014-2015
Total New Referrals		601	744	899
Referral Source:				
	Hospitals	39.6%	31.7%	28.1%
	Long-Term Care	6.5%	10.4%	7.6%
	Primary Care Offices (GPs)	20.5%	19.8%	15.7%
	CCAC/ Community Nursing	12%	19.6%	27.9%
Diagnoses %	**Cancer**	68%	67%	66%
	Non cancer	32%	33%	34%
Total # of visits		714	841	1,047
Total # of telephone consultations & case management calls		4,778	5,796	6,003
Total Education Sessions Provided		63	90	106
	# of hours	149.50	258.75	368
	# of participants	1,908	3,116	2,573

RPCT Challenges

- Performance indicators for NPs focus on quantity in MRP role, rather than capacity building
- Remuneration discrepancies between NPs & APNs
- NP after hours costs

Building Community Capacity :
The FHTs Palliative Care Project

Why do so few family physicians in Ontario urban centres provide palliative care and EOL care to their own patients?

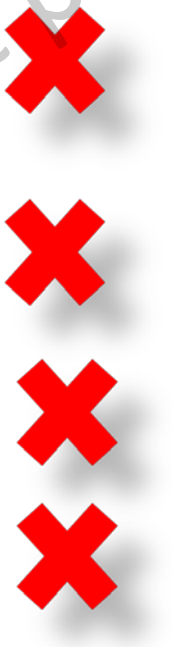


Ottawa Academic Family Health Teams
Palliative Care Project

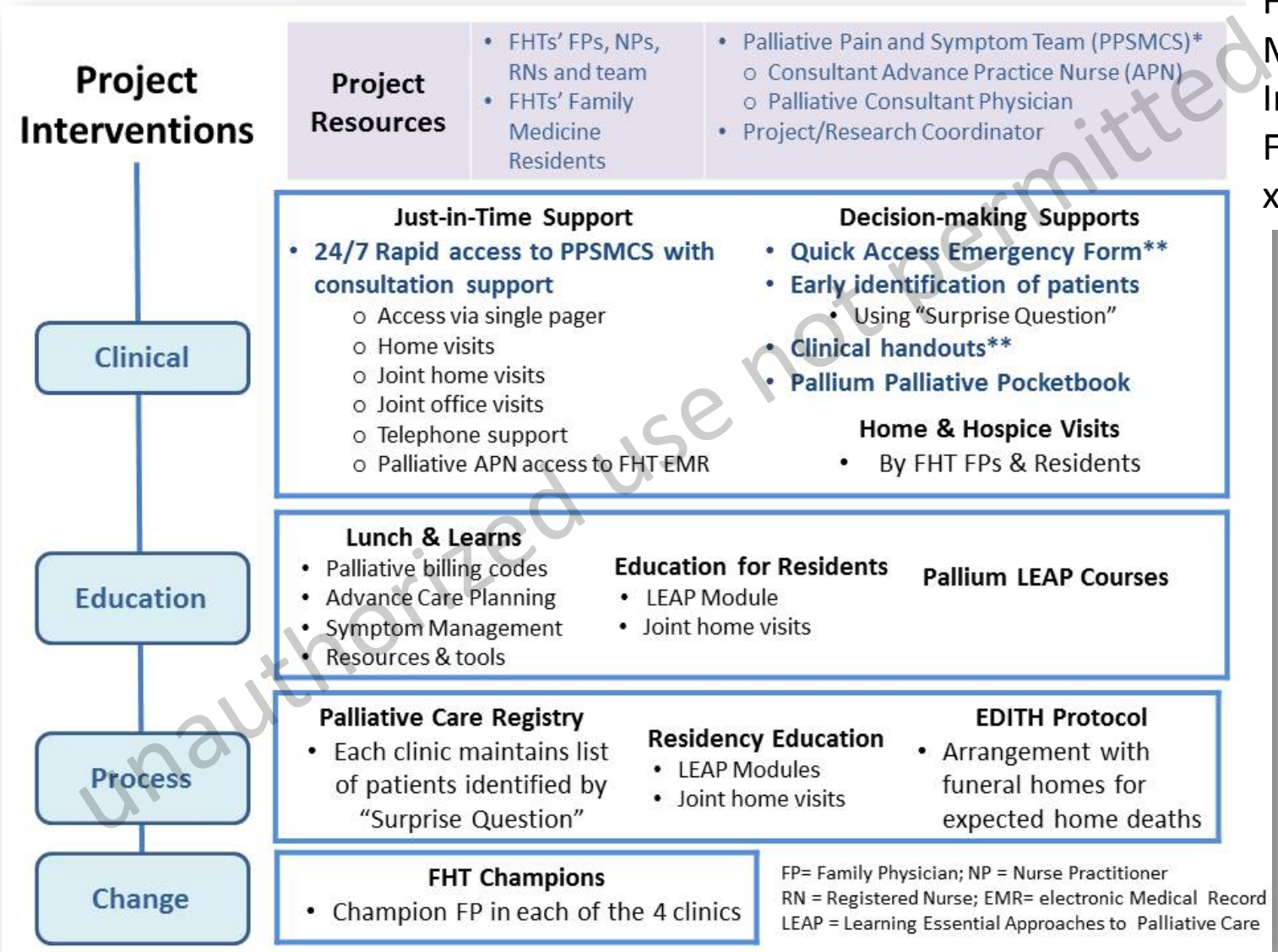
Doing palliative care?

2011

CLINIC A	**17 FPs, 1 NP, 3 RNs, 1 Pharm, ±30 residents**
CLINIC B	8 FPs, 2 NPs, 3 RNs, 1 Pharm, ± 9 residents
CLINIC C	12 FPs, 1 NP, 2RNs, ± 30 residents
CLINIC D	7 FPs, 1 NP, 2 RNs, ± 8 residents



FHTs Palliative Care Project interventions

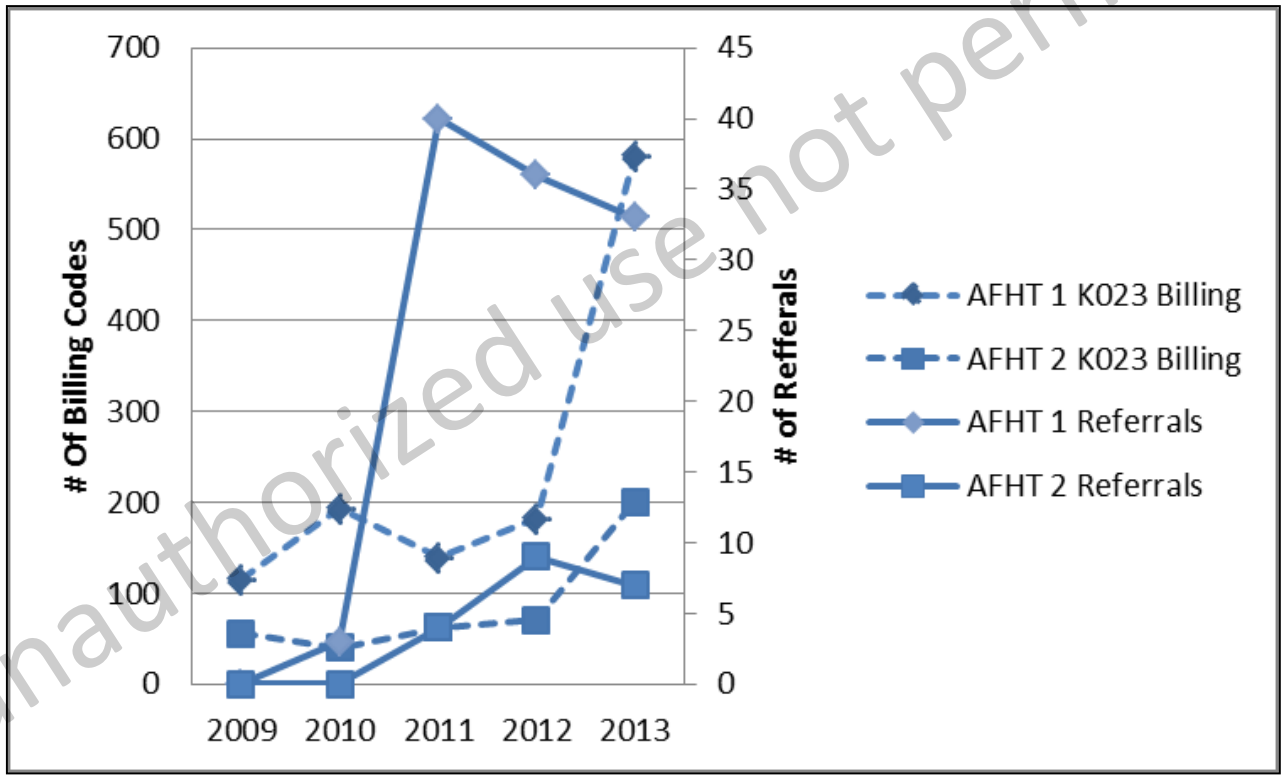


Funding:
Ministry Innovation Fund
x 3 yrs

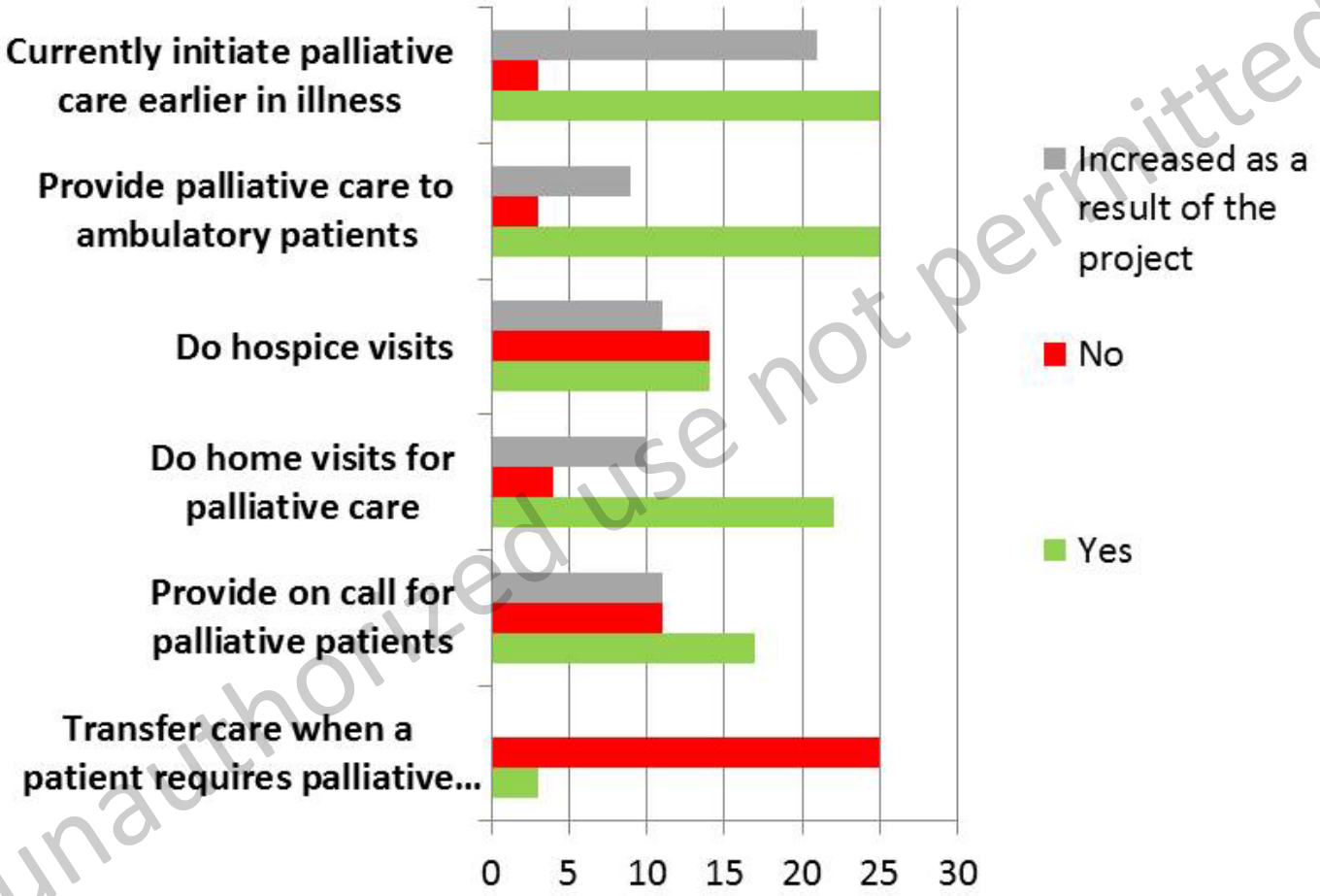
Ottawa Academic Family Health Teams
Palliative Care Project

		Doing palliative care? 2011	2015
CLINIC A	**17 FPs, 1 NP, 3 RNs, 1 Pharm, ±30 residents**	✗	All FPs
CLINIC B	8 FPs, 2 NPs, 3 RNs, 1 Pharm, ± 9 residents	✗	All FPs
CLINIC C	12 FPs, 1 NP, 2RNs, ± 30 residents	✗	2/3 of FPs
CLINIC D	7 FPs, 1 NP, 2 RNs, ± 8 residents	✗	✗

FHTs Project:
Palliative Care Billings and Referrals to Palliative Care Team



FHTs Project Exit Survey (Staff)



Residents' Survey: Significant more comfort providing palliative & EOL care, including hospice care and home visits

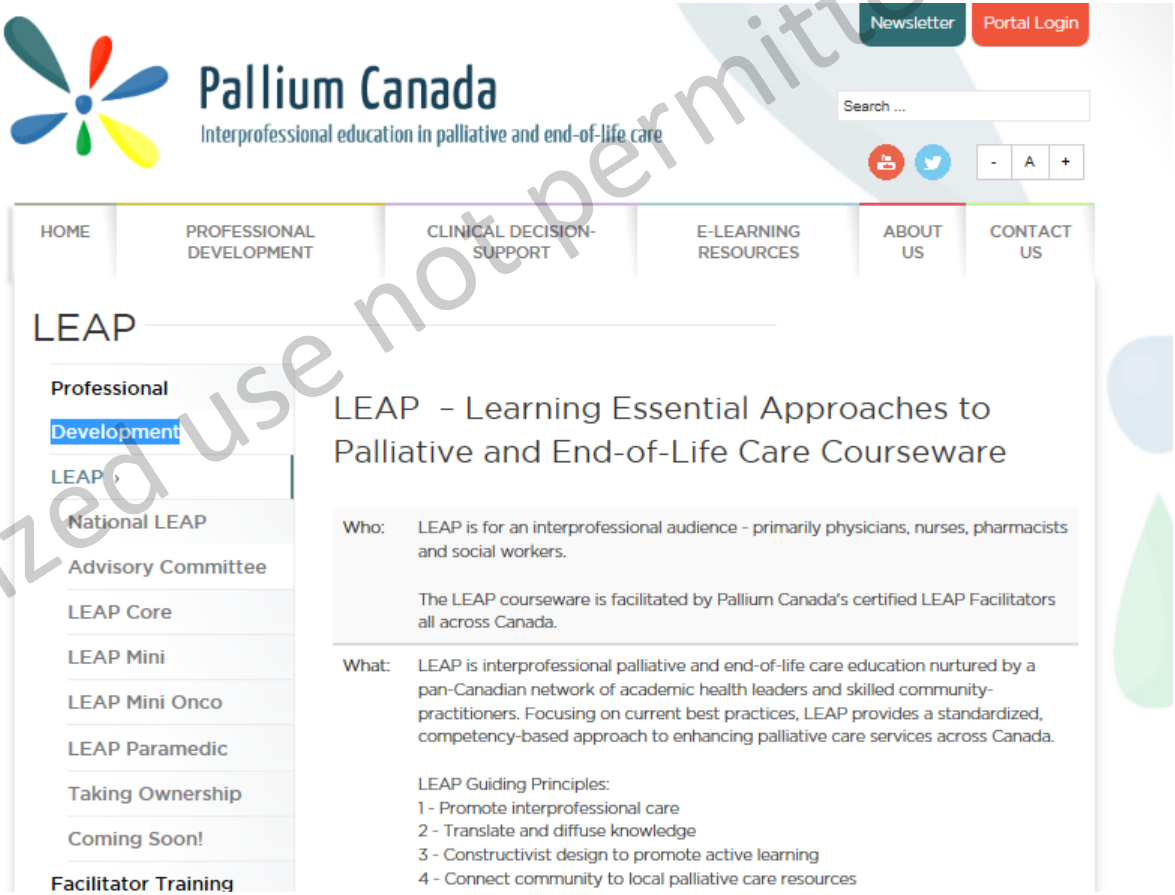
Family Physicians providing palliative care

- Ongoing work on survey of family medicine clinics & family doctor list
- Increasing number of family physicians in Champlain providing care with support of RPCT
  - Early adopters
    - e.g. Rockland, Stittsville & Orleans FHTs
  - LEAP Programs
  - INTEGRATE Project

Building Community Capacity

Building primary-level capacity across region
Regional Education Strategy

- Regional Education Coordinator
- Facilitator training
- LEAP in community, cancer centre, hospices, nursing agencies, LTC, hospitals, Eds,
- RPCT at core



Challenges

- Health Funding Reform & HBAM
- Focus on hospices by current Ontario government & HPCO
- Lack of AFP & regional AFP models for palliative care physicians
  - Insufficient positions for community
  - Lack of palliative care MDs in hospitals & Cancer Centre
- No HOC funding for TOH palliative care doctors
- No CPOC funding for RPCT MDs
- NP performance indicators that focus on quantity

Impact of hospital inpatient palliative care consultation

- Systematic review
- 10 studies included
- Improved care to patients
- Cost savings

May P, Charles N, Morrison SR. Economic impact of hospital inpatient palliative care consultation: Review of current evidence & directions for future research. J Pall Med 2014;17(9):

Conclusions

- Champlain Regional Palliative Care Program
- The right number & types of Palliative Care beds
  - Palliative Care Unit (PCU)
  - Hospice Care Ottawa
- Getting the right patient to the right bed
  - Single central referral and triage process & system
- Building community capacity
  - The Regional Palliative Consultation Team (PPSMCS & NPs)
  - FHTs Palliative Care Project
  - Regional Pallium LEAP efforts
- **Those professionals who work at the bedside have much to contribute to fix the system**
- **Address challenges before much of the good work is lost**
- **Start diffusing innovation, rather than re-inventing the wheel**

THE TOP TEN SIGNS THAT PALLIATIVE CARE IS FULLY INTEGRATED IN A HEALTH CARE SYSTEM

1. Palliative care approach is activated early.
2. The “Surprise Question” is used in daily practice.
3. Goals of care and advance care planning (ACP) discussions are routine.
4. A strong primary-level palliative care base.
5. Specialist-level interprofessional palliative care consultation and support teams in hospitals and the community with home care nursing resources.

Pereira J. In: CMA Report on Palliative & EOL Care. May 2015

THE TOP TEN SIGNS THAT PALLIATIVE CARE IS FULLY INTEGRATED IN A HEALTH CARE SYSTEM

6. Adequate numbers of acute palliative care unit and hospice beds.
7. Palliative care strategies in long term care (LTC) and nursing homes.
8. Specialist palliative care teams are adequately staffed.
9. Palliative care education: undergraduate, postgraduate and continuing professional development.
10. The right performance indicators and funding formulae.

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