### 2.6 End-of-Life Care / Hospice Palliative Care

**TEMPLATE A:**

**PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY**

<table>
<thead>
<tr>
<th>Integrated Health Services Plan Priority:</th>
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<tr>
<td>End-of-Life Care (EOLC) / Hospice Palliative Care (HPC)</td>
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**IHSP Priority Description:**

The overarching priority is to create a formalized system of HPC Service delivery in each of the three counties in Erie St. Clair, rather than a collection of disconnected services. HPC is needed for all disease categories, (including chronic diseases), and is required in all care settings where patients die.

HPC has been shown to:
- Improve patient and caregiver quality of life
- Save money for the health care system (when patients are cared for in the appropriately setting)

Despite the demonstrated benefits of HPC programs there are still far too many:
- Needlessly unpleasant deaths
- Procedures conducted on patients at the EOL which neither prolong nor improve life
- Inappropriate admissions to acute care
- Patients dying in inappropriate locations e.g. of the patients who died of cancer, the % that died in acute care hospital in Erie St. Clair is higher than the provincial average (55.7% vs. 52.1%)
- Unnecessary visits to the ED e.g. % of lung cancer patients who visited the ED in the last 2 weeks of life is higher than the provincial average (48.1% vs. 45.8%)

The need for HPC is increasing. It is projected that in the Erie St. Clair region in 2011/2012 over 3000 people (and their families) will require a specialized program of palliative care, with many more requiring primary care palliative care services. The Erie St. Clair region shows significant trends, such as aging population, rates of cancer, and residents' behaviours, such as smoking and lack of exercise, which indicate an even greater need for palliative care than is the case across the province (e.g. higher lung and bronchus cancer incidence rates, colon and rectum cancer incidence rates, chronic diseases).

Previously efforts related to enhancing HPC service delivery in Erie St. Clair have been sector specific / program specific. A cross sector, system-level approach is now required.

**Current Status**

Recent progress has been made to advance system development in Erie St. Clair, with pockets of palliative care excellence emerging. However, gaps persist and integration is incomplete, including:
- Key care settings and services lacking in specific catchment areas (e.g. Bereavement Programs for complex grief management in two counties; residential hospice in one county)
- Palliative Care Programs are established in fewer than 40% of care settings where patients die
- Specific integration essentials are needed in each county (e.g. cross sector access to documentation)
- More trained HPC professionals are needed (e.g. using a simple population based calculation and comparison with Toronto Central LHIN, Erie St. Clair has 67% fewer palliative care Physicians for patients in this community)
- Improved system-level accountability, evaluation, monitoring and reporting is needed (e.g. monitoring, evaluation and reporting at a program specific and / or facility specific level has been enhanced, however, this has not been rolled up into a system level evaluation framework or process)
- Provincial / federal policy / guidelines / funding issues continue to impact service delivery at the local Erie St. Clair LHIN level
**PART 2: GOALS and ACTION PLANS**

**Goal(s)**

**EOLC / HPC Overall Goals:**
- To ensure a full continuum of HPC care settings and services is available in each county
- To increase the number of HPC programs within care settings where patients die
- To improve integration across sectors through common regional processes, structures, education and personnel that connect the sectors
- To increase the number of specialist level HPC experts and to improve primary care providers’ knowledge, skills and confidence in reducing the severity and distress associated with end-of-life symptoms
- To enhance the current cross sector accountability mechanism for HPC in Erie St. Clair. (This accountability mechanism will include cross sector / system level planning, evaluation and reporting)
- To identify provincial and federal policy / funding / guideline issues that impact HPC service delivery and work towards improved integration

The action plans will focus on the following priority populations for EOLC / HPC:

Any patient with any diagnosis who is *deemed to require palliative care services in:*

- **Community settings as well as LTC Home and CCC and Residential Hospice settings with priority given to:**
  - Pre-empting or managing crisis situations that would otherwise lead to emergency department visits and / or hospital admissions
  - Enhancing care provision and patient family experience

- **Acute care settings with priority given to:**
  - Facilitating earlier and clearer prognostication of patient outcomes
  - Helping reduce the provision of aggressive, expensive medical treatments which neither prolong or improve life
  - Providing more timely symptom response for tertiary level HPC crisis intervention thereby facilitating earlier discharge and decreased ALC days
  - Enhancing care provision and patient family experience

- **Additional priority populations within these care settings include:**
  - “Orphan” patients – no primary care provider
  - Seniors
  - First Nations people
  - Rural or geographically isolated people
  - Minority ethnic populations
  - Frequently readmitted chronic disease patients who are nearing end of life or for whom advance care planning needs to be completed

*Note: Criteria used in Erie St. Clair for determining the need for palliative care services includes using the following questions:

1. **Would you be surprised if this client died in the next 6 months?** (If the answer is “no” - ask question 2)
2. **Does the client have unmet symptoms and / or support needs?** (If the answer is “yes” some type of palliative care assistance may be required)
Consistency with Government Priorities:
The above goals are consistent with the government’s priorities to enhance care in the community (reduce wait times), and to reduce inappropriate acute care hospital utilization (admissions, ALC days, ED visits etc.).

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<thead>
<tr>
<th>Action Plans / Interventions</th>
<th>Target - % completed by year</th>
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<tbody>
<tr>
<td></td>
<td>2011-12</td>
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<tr>
<td>Advance a full continuum of care settings and services for EOLC / HPC in all 3 counties –</td>
<td>40%</td>
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<td>specific focus on addition of Bereavement Services and Residential Hospice.</td>
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<tr>
<td>Support building and integration of HPC programs in all care settings where patients die –</td>
<td>30%</td>
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<tr>
<td>specific focus on community (education and Palliative Care Consultation Team) and other</td>
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<tr>
<td>care settings (education).</td>
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<tr>
<td>Continue with integration activities and projects – specific focus on Education Blueprint /</td>
<td>40%</td>
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<td>Strategy and Communication Strategy (refer to specific strategy documents for details).</td>
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<td>This includes education in First Nations and other culturally diverse populations and emphasis on enhancing best practice in all care settings.</td>
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<tr>
<td>Enhance human resources for HPC by: advancing the use of team based care, providing education</td>
<td>20%</td>
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<td>to primary care providers, recruiting specialist level HPC providers etc.</td>
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<td>Strengthen system-level accountabilities – including the EOLC Erie St. Clair LHIN Advisory</td>
<td>45%</td>
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<td>Network role in system level: data collection, evaluation, outcomes and overall performance</td>
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<td>of the HPC system.</td>
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<td>Participate in development of provincial / federal level policy / guidelines / strategies.</td>
<td>40%</td>
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<td>Develop mitigating strategies to work around current imposed limitations.</td>
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Expected Impacts of Key Action Items

- Expanded PCCT
  - To all three counties to serve an additional 550 new community-based clients
- Reduced avoidable ED visits, avoidable admissions and ALC days
  - Avoidance of ED visits / admissions in 70% of PCCT clients who might have otherwise visited the ED
- Increased options in care settings for dying patients and increased prevalence of concordance between client preference and place of death
  - At least 60% of PCCT clients will achieve concordance between preference and place of death
- Increased percentage of non-hospital deaths
  - At least 50% of PCCT clients will die in non-hospital locations
- Improved patient flow
  - At least 75% of stakeholders will report an improvement in patient flow as a result of the action plans / interventions
- Enhanced Palliative Care Programs within acute care settings facilitating earlier identification and treatment of patients requiring palliative care thereby:
  - Reducing the numbers of procedures (which neither prolong nor improve life) conducted on patients at the end of life
  - Reducing length of stay
- Enhanced Palliative Care Programs in all settings where patients die so that within three years at least 70% of these care settings have a definable and viable HPC Program for their clients
- 10% increase in number of providers who receive training in HPC
- Increased use of informal care givers by 10% to support the current volunteer complement through Share the Care™ training
- Enhanced system level accountability for Hospice Palliative Care service delivery with publication of first Erie St. Clair HPC system-level report card in 2011/2012
- Increased access to comprehensive, quality HPC Services across the Erie St. Clair region
- Improved symptom management and quality of life for patient and family / care providers resulting in improved patient / family and provider satisfaction with EOLC and quality of dying
- Decreased likelihood of major depression, poor health and premature death for family members / caregivers
- Creation of a sustainable, innovative regional model of care and accountability that synergistically leverages current provider systems and strengths and is robust and flexible enough to be maintained in the event of changes in personnel, changes in priorities etc.

What are the risks / barriers to successful implementation?

- Public (and health care provider) misconception that palliative care means abandoning hope and just “doing nothing”, resulting in delayed referrals and continued acute care approach
- Sector specific priorities that may not support a system-wide approach to Palliative Care Service Delivery.
- Recruitment issues – Specialist level Palliative Care Physicians, NP as well as other team members
- Improve data collection methodologies to allow HPC evaluation at a system level (e.g. National Ambulatory Care Reporting System (NACRS) to capture increased use of ED by patients who require palliative care)
- Few resources in LTC homes to support increased staffing requirements that may be needed to handle complex palliative care needs
- Need to clarify policy directions regarding the role of residential hospices within the HPC system