Developing a Palliative Care System: Highlights from the Champlain Region

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Medical Chief, Department of Palliative Medicine, Bruyère Continuing Care & The Ottawa Hospital
Content

• 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
  – INTEGRATE Project
  – Regional Pallium LEAP efforts
Patients experience palliative care needs across the illness trajectory and in different settings

- Diagnosis
- Illness trajectory
- Death
- Level of complexity
- High
- Low

Specialist palliative care
Palliative Care approach
System Capacity:
It is everyone’s business

Specialist-level palliative care teams

Primary care
Oncology
Internal medicine
Cardiology
Pulmonology
Neurology
Geriatrics
Pediatrics
Surgery

Specialist palliative care

Palliative Care approach

Diagnosis
Illness trajectory
The right care, at the right time, at the right place

Key Palliative Care Services in Different Settings

- Palliative Care Outpatient Consult Clinics
- Palliative Specialist Support Team
- Acute Palliative Care Unit
- Home Nursing Care
- Family physicians
- Palliative Specialist Support Team
- Residential & community Hospice
- Long term care

Complex Continuing Care
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

<table>
<thead>
<tr>
<th>Activities and milestones</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008 to April 2009</td>
<td>Prepare ground, share vision, clarify needs, identify potential challenges and barriers, and solicit insights and support.</td>
</tr>
<tr>
<td>Engage champions &amp; early adopters</td>
<td></td>
</tr>
<tr>
<td>April 2009</td>
<td>Clarify mandate for change, make the case for change using systems thinking, evolve shared vision, form coalition of willing partners, get commitment and involvement</td>
</tr>
<tr>
<td>HPC EOL Network Retreat of regional stakeholders</td>
<td></td>
</tr>
<tr>
<td>May 2009 to March 2010 Planning Council and Work Groups</td>
<td>Start the design, involve early adopters as well as &quot;sceptics&quot;, form teams, promote systems thinking, do reality checks, monitor</td>
</tr>
<tr>
<td>April to May 2010 Stakeholder and External Expert Engagement and feedback</td>
<td>Get broad stakeholder engagement &amp; feedback: include users (patients, families and clinicians), administrators, policy makers. Solicit advice from experts and others who have travelled path before.</td>
</tr>
<tr>
<td>May 2010 Business Plan finalized &amp; approved by LHIN</td>
<td>Articulate vision and make case for change, explain benefits of system, demonstrate stakeholder buy-in and commitment, present bold but realistic plan.</td>
</tr>
<tr>
<td>June to October 2010 Transitional Leadership Group</td>
<td>Prepare details of change, including governance structures and processes, address legal requirements.</td>
</tr>
</tbody>
</table>
ChAMPLAIN REGIONAL PROGRAM
DEVELOPMENT PROCESS

- October 2010
  LHIN approves Start-up Plan

- November 2010
  Champlain EOL Network replaced by Champlain Regional Hospice Palliative Care Program & Board

Ongoing activities

- Celebrate past and present, Vote in new Regional Board and establish office. Start work.
- Maintain momentum, continue communicating and start addressing priorities identified during process. Achieve early successes.

HPC EOL = Hospice Palliative Care End-of-Life Network
LHIN = Local Health Integration Network
Board = Council: Governance body of Regional Program.
Champlain Regional Palliative Care Program
Initial Governance structure

Champlain LHIN

Regional Council (Board)
15 members

Host Agencies

Program Office

Committee: Education & Information

Committee: Standards & Performance Indicators

Committee: Quality

Local EOL Networks
Renfrew County (west)
Ottawa, North Lanark, North Grenville
Eastern Counties (east)

Advisory Group:
Patients and Families

Advisory Group:
Administrators

Advisory Group:
Clinicians

Work Groups
(as needed)

Supporting documents, policies, by-laws
Champlain regional HPC Program: activities completed

<table>
<thead>
<tr>
<th>Activities Completed</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ottawa Hospice Plan Phases 1 &amp; 2</td>
<td>Supported Ottawa Hospice groups o develop a plan to increase hospice beds in Ottawa</td>
</tr>
<tr>
<td>Service Agreements between the LHIN &amp; HPC Service Providers (entities providing HPC services)</td>
<td>Ensure standards &amp; coordination</td>
</tr>
<tr>
<td>Vetting of Proposals for HPC Services to the LHIN</td>
<td>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.</td>
</tr>
<tr>
<td>Standards for HPC services across different settings</td>
<td></td>
</tr>
<tr>
<td>Performance Indicators for the Region</td>
<td>22 Priority performance indicators have been identify for the region, as well 40 other micro indicators for individual service providers.</td>
</tr>
<tr>
<td>Central Referral and Triage System for referrals to Hospices and the Palliative Care Unit (PCU) in Ottawa</td>
<td>One single referral point for patients being referred to Ottawa’s hospices and PCU; can be done online.</td>
</tr>
<tr>
<td>Merger of PPSMCS &amp; NPs to establish strong regional community-based consultation and support team.</td>
<td>(The only region in province to do this)</td>
</tr>
<tr>
<td>Expected Death in the Home (EDITH) Protocol</td>
<td>Protocol that allows funeral homes to collect bodies of 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</td>
</tr>
<tr>
<td>Madawaska Rural Program Plan</td>
<td>Rural Hospice Palliative Program in rural and remote south western part of region.</td>
</tr>
</tbody>
</table>
Champlain Regional Program: Developing Regional Standards

## Hospices: Residential

<table>
<thead>
<tr>
<th>Standards</th>
<th>Criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>2. Clinical Policies and Procedures: Hospices will maintain up-to-date clinical care policies and procedures.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>4. RN &amp; RPN Training: All hospice RNs &amp; RPNs will have completed the Pallium LEAP 2/3 day course.</td>
<td></td>
</tr>
<tr>
<td>5. Volunteer Training: All hospice volunteers will have completed Hospice Volunteer Education Program.</td>
<td></td>
</tr>
<tr>
<td>6. PSW Training: All hospice PSWs will have completed a program (delivered jointly between PPSMCS &amp; Hospice).</td>
<td></td>
</tr>
</tbody>
</table>

## Acute Care Hospitals

<table>
<thead>
<tr>
<th>Standard</th>
<th>Criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access to Palliative Consult Services: All acute care hospitals in the region will have access to 24/7 Palliative Care Consultation support services.</td>
<td></td>
</tr>
<tr>
<td>2. In-house Palliative Consultation Service: Teaching and large community hospitals will have Palliative Care Consultation support teams.</td>
<td></td>
</tr>
<tr>
<td>3. 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.</td>
<td></td>
</tr>
<tr>
<td>4. Earlier Palliative Care: Oncology Clinics will initiate palliative care earlier in the illness trajectory, particularly lung cancer clinics.</td>
<td></td>
</tr>
<tr>
<td>5. 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) FPS or ECOS; c) Case Finding (GSF); and d) Palliative Triggers.</td>
<td></td>
</tr>
<tr>
<td>6. Information for Oncology Teams: Information on how to initiate and access hospice palliative care services will be made available to oncology teams and patients.</td>
<td></td>
</tr>
<tr>
<td>7. Palliative Care Visibility and Integration: Palliative Care will be visible for patients, families, and health professionals through signage, and information pamphlets.</td>
<td></td>
</tr>
<tr>
<td>8. 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).</td>
<td></td>
</tr>
<tr>
<td>9. Access to Palliative Consult Services: All acute care hospitals in the region will have access to 24/7 Palliative Care Consultation support services.</td>
<td></td>
</tr>
<tr>
<td>10. In-house Palliative Consultation Service: Teaching and large community hospitals will have Palliative Care Consultation support teams.</td>
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<tr>
<td>11. 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.</td>
<td></td>
</tr>
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<td>12. Earlier Palliative Care: Oncology Clinics will initiate palliative care earlier in the illness trajectory, particularly lung cancer clinics.</td>
<td></td>
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</tr>
<tr>
<td>16. 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).</td>
<td></td>
</tr>
</tbody>
</table>
### Champlain Hospice Palliative Care

#### Program Priority Indicators

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Level:</th>
<th>Purpose:</th>
<th>Sector:</th>
<th>Benchmark:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity</strong></td>
<td>Macro (N = 4)</td>
<td>• Accountability (N = 9)</td>
<td>• Acute Care</td>
<td>N = 21</td>
</tr>
<tr>
<td></td>
<td>Meso (N = 4)</td>
<td>• Quality Improvement (N = 14)</td>
<td>• PCUs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Micro (N = 0)</td>
<td>• Research</td>
<td>• CCAC</td>
<td></td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>Macro (N = 3)</td>
<td></td>
<td>• Home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meso (N = 5)</td>
<td></td>
<td>• Hospice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Micro (N = 0)</td>
<td></td>
<td>• LTC</td>
<td></td>
</tr>
<tr>
<td><strong>Co-ordination</strong></td>
<td>Macro (N = 2)</td>
<td></td>
<td>• Retirement Homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meso (N = 2)</td>
<td></td>
<td>• Cancer Centres</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Micro (N = 0)</td>
<td></td>
<td>• Family Physicians</td>
<td></td>
</tr>
<tr>
<td><strong>Quality/Outcomes</strong></td>
<td>Macro (N = 2)</td>
<td></td>
<td>• Nursing Agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meso (N = 0)</td>
<td></td>
<td>• PSMCS/NPs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Micro (N = 1)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The right number and types of Palliative Care beds
The Regional Palliative Care Unit and the Ottawa Hospices
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

## Situation in 2008

<table>
<thead>
<tr>
<th></th>
<th>Calgary</th>
<th>Ottawa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population:</td>
<td>± 1 million</td>
<td>± 900 000</td>
</tr>
<tr>
<td>PCU:</td>
<td>28 beds</td>
<td>36 beds (24 +12)</td>
</tr>
<tr>
<td>Hospice:</td>
<td>± 80 beds</td>
<td>9 beds</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td>36 beds</td>
<td>36 beds</td>
</tr>
<tr>
<td># of admissions</td>
<td>401</td>
<td>534</td>
</tr>
<tr>
<td>Referral sites</td>
<td>85% hospitals</td>
<td>75% hospitals</td>
</tr>
<tr>
<td>Alive discharge rate</td>
<td>4%</td>
<td>20%</td>
</tr>
<tr>
<td>Mean LOS</td>
<td>28 days</td>
<td>19.7 days</td>
</tr>
<tr>
<td>Median LOS</td>
<td>17 days</td>
<td>13 days</td>
</tr>
<tr>
<td>Wait time for admission</td>
<td>9.7 days</td>
<td>2.8 days</td>
</tr>
<tr>
<td>Occupancy rate</td>
<td>90%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Admissions:</td>
<td>During weekdays, before 2pm</td>
<td></td>
</tr>
</tbody>
</table>

Most are high complex

$800 per day
# Hospice beds in Ottawa

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

Hospitals, Community Care Access Centres and Long Term Care are the first sectors incorporated into the funding strategy.

Patient-Based Funding is based on clinical activities that reflect an individual’s disease, diagnosis, treatment and acuity.

Patient-Based Funding will include HBAM and Quality-Based Procedures.

Health System Funding Reform

Patient-Based Funding (70%)

Global (30%)

Health Based Allocation Model (40%)

Quality-Based Procedures (30%)
### Staff mixes and ratios (in FTEs per 10 beds)

<table>
<thead>
<tr>
<th></th>
<th>Bruyère PCU</th>
<th>Edmonton PCU</th>
<th>Calgary PCU</th>
<th>Hospice Ottawa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong># of beds</strong></td>
<td>31</td>
<td>20</td>
<td>20 (27)</td>
<td>10</td>
</tr>
<tr>
<td><strong>Nursing (RN/RPNs)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days</td>
<td>2.3 (1.3/1)</td>
<td>3.5 (2/1.5) + 1 HCA</td>
<td>3.4 (2.6/0.8)</td>
<td>3 (2/1)</td>
</tr>
<tr>
<td>Eve</td>
<td>1.9 (1/1)</td>
<td>2.5 (1.5/1) + 1 HCA</td>
<td>3.4 (2.6/0.8)</td>
<td>3 (2/1)</td>
</tr>
<tr>
<td>nights</td>
<td>1.3</td>
<td>2.5 (1.5 + 1 HCA)</td>
<td>2.5 (2/0.5)</td>
<td>3 (1/2)</td>
</tr>
<tr>
<td>Social worker</td>
<td>0.26</td>
<td>0.5</td>
<td>0.5</td>
<td>Part time</td>
</tr>
<tr>
<td>Spiritual care</td>
<td>0.13</td>
<td>0.5</td>
<td>0.25</td>
<td>Part time</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0.32</td>
<td>0.4</td>
<td>0.3</td>
<td>Part time</td>
</tr>
<tr>
<td>Psychology</td>
<td>0</td>
<td>0.3</td>
<td>Access to</td>
<td>-</td>
</tr>
<tr>
<td>PT/OT</td>
<td>0.13/0</td>
<td>0.4</td>
<td>0.5 /0.25</td>
<td>Not needed</td>
</tr>
<tr>
<td>Dietician</td>
<td>0</td>
<td>0.2</td>
<td>0.25</td>
<td>Not needed</td>
</tr>
<tr>
<td>MDs</td>
<td>1</td>
<td>1</td>
<td>1.5</td>
<td>Different MRPs</td>
</tr>
<tr>
<td>Clerk</td>
<td>Part time</td>
<td>Full time day</td>
<td>Full time day</td>
<td>Volunteers day</td>
</tr>
</tbody>
</table>
### Staff mix and ratios in Ontario PCUs

<table>
<thead>
<tr>
<th></th>
<th>RN/RPN/P SW**</th>
<th>Pharm [0.1-1.0]</th>
<th>SW [0.1-1.6]</th>
<th>Chaplain [0.1-0.7]</th>
<th>PT [0.1-1.0]</th>
<th>OT [0]</th>
<th>PCUs in acute hospitals (n)</th>
<th>Day: mean [2.5-3.3]</th>
<th>Eve: mean [1.7-3.3]</th>
<th>Night: mean [1.3-2.6]</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCUs in acute hospitals (n)</td>
<td>9</td>
<td>0.36 [0.1-1.0]</td>
<td>0.44 [0-1.6]</td>
<td>0.26 [0.1-0.7]</td>
<td>0.28 [0.1-1.0]</td>
<td>0-0.2</td>
<td></td>
<td>2.9 [2.5-3.3]</td>
<td>2.39 [1.7-3.3]</td>
<td>1.86 [1.3-2.6]</td>
</tr>
<tr>
<td>PCUs in CCC (n)</td>
<td>6*</td>
<td>0.16 [0-0.3]</td>
<td>0.26 [0-0.7]</td>
<td>0.18 [0.14-0.25]</td>
<td>0.21 [0.1-0.5]</td>
<td>0.25 [0-0.5]</td>
<td>All facing significant funding cuts. Changing role</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Some facing cuts & downsizing

All facing significant funding cuts. Changing role

Note: PCUs in CCC are not facing significant funding cuts. Changing role. Some are facing cuts & downsizing.
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

Central Referral & Triage Office
CCAC & Bruyère partnership

CCAC Health Partner Gateway (HPG)

Hospices

Non-CCAC referrals
LHIN Works e-referral LHIN Referral mgmt system

CHRIS
E-form

E-form

CCAC care coordinators

CHRIS e-file created; Accept or refuse; prioritize; triage to best site

Daily reports (waitlist, priority, stats)

Administrators

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

<table>
<thead>
<tr>
<th>Region</th>
<th>n/team</th>
<th>RR</th>
<th>(95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>828</td>
<td>1.18</td>
<td>(0.97-1.45)</td>
</tr>
<tr>
<td>2</td>
<td>107</td>
<td>0.42</td>
<td>(0.24-0.71)</td>
</tr>
<tr>
<td>3</td>
<td>124</td>
<td>0.69</td>
<td>(0.42-1.11)</td>
</tr>
<tr>
<td>4</td>
<td>117</td>
<td>0.32</td>
<td>(0.17-0.66)</td>
</tr>
<tr>
<td>5</td>
<td>99</td>
<td>1.00</td>
<td>(0.58-1.82)</td>
</tr>
<tr>
<td>6</td>
<td>76</td>
<td>0.94</td>
<td>(0.51-1.73)</td>
</tr>
<tr>
<td>7</td>
<td>663</td>
<td>0.47</td>
<td>(0.27-0.89)</td>
</tr>
<tr>
<td>8</td>
<td>448</td>
<td>1.14</td>
<td>(0.64-1.94)</td>
</tr>
<tr>
<td>9</td>
<td>739</td>
<td>0.46</td>
<td>(0.26-0.83)</td>
</tr>
<tr>
<td>10</td>
<td>167</td>
<td>0.79</td>
<td>(0.49-1.30)</td>
</tr>
<tr>
<td>11</td>
<td>415</td>
<td>0.80</td>
<td>(0.48-1.36)</td>
</tr>
<tr>
<td>Pooled</td>
<td>8,009</td>
<td>0.70</td>
<td>(0.63-0.77)</td>
</tr>
</tbody>
</table>

Seow H et al. BMJ 2014
# Models of Care provided by Specialist Teams

<table>
<thead>
<tr>
<th>Consultation Model</th>
<th>Shared Care Model</th>
<th>Substitution Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Palliative Care Specialist (PCS) involvement</strong></td>
<td><strong>Shared tending to Consultation (S-C)</strong></td>
<td><strong>Shared tending to Substitution (S-S)</strong></td>
</tr>
<tr>
<td>Limited Consultation (CL)</td>
<td>Shared Equal (SE)</td>
<td>Substitution (Sub)</td>
</tr>
</tbody>
</table>

**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 manages all the palliative needs of the patient
- 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
- Provides most of the follow-up orders and prescriptions for the patient

**Final decision-making**
- Most Responsible Physician (MRP)
- MRP
- Shared equally between MRP & PCS
- Shared by PCS & MRP, but largely delegated to MRP & 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

<table>
<thead>
<tr>
<th></th>
<th>Champlain</th>
<th>Edmonton Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population:</td>
<td>1.2 million</td>
<td>1.2 million</td>
</tr>
<tr>
<td>Team:</td>
<td>2 APNs, 1.4 doctors</td>
<td>5 doctors, 5 nurses</td>
</tr>
<tr>
<td>Sector covered:</td>
<td>Community</td>
<td>Community &amp; Community Hospitals</td>
</tr>
<tr>
<td>Family physician involvement:</td>
<td>The exception</td>
<td>The rule</td>
</tr>
<tr>
<td>Role of team:</td>
<td>Clinical support (Mainly consultation, some shared care) Education, QI, System leadership</td>
<td></td>
</tr>
</tbody>
</table>
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

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

CCAC Palliative NPs
• 2012
• 5 NPs
# Champlain RPCT

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

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, 2 RNs, ±30 residents |
| CLINIC D | 7 FPs, 1 NP, 2 RNs, ±8 residents |
FHTs Palliative Care Project interventions

Funding: Ministry Innovation Fund x 3 yrs

### Project Interventions

#### Project Resources
- FHTs’ FPs, NPs, RNs and team
- FHTs’ Family Medicine Residents

#### Just-in-Time Support
- 24/7 Rapid access to PPSMCS with consultation support
  - Access via single pager
  - Home visits
  - Joint home visits
  - Joint office visits
  - Telephone support
  - Palliative APN access to FHT EMR

#### Decision-making Supports
- Quick Access Emergency Form**
- Early identification of patients
  - Using “Surprise Question”
- Clinical handouts**
- Pallium Palliative Pocketbook

#### Home & Hospice Visits
- By FHT FPs & Residents

---

#### Clinical

##### Lunch & Learns
- Palliative billing codes
- Advance Care Planning
- Symptom Management
- Resources & tools

##### Education for Residents
- LEAP Module
- Joint home visits

##### Pallium LEAP Courses
- Residency Education
  - LEAP Modules
  - Joint home visits

##### EDITH Protocol
- Arrangement with funeral homes for expected home deaths

---

#### Process

##### Palliative Care Registry
- Each clinic maintains list of patients identified by “Surprise Question”

##### FHT Champions
- Champion FP in each of the 4 clinics

---

#### Education

##### Education for Residents
- LEAP Module
- Joint home visits

---

#### Change

##### FHT Champions
- Champion FP in each of the 4 clinics

---

FP = Family Physician; NP = Nurse Practitioner
RN = Registered Nurse; EMR = electronic Medical Record
LEAP = Learning Essential Approaches to Palliative Care

---

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### Ottawa Academic Family Health Teams Palliative Care Project

**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, 2 RNs, ±30 residents

**CLINIC D**
- 7 FPs, 1 NP, 2 RNs, ±8 residents

#### Doing palliative care?

<table>
<thead>
<tr>
<th>Year</th>
<th>CLINIC A</th>
<th>CLINIC B</th>
<th>CLINIC C</th>
<th>CLINIC D</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>[x]</td>
<td>[x]</td>
<td>[x]</td>
<td>[x]</td>
</tr>
<tr>
<td>2015</td>
<td>All FPs</td>
<td>All FPs</td>
<td>2/3 of FPs</td>
<td>[x]</td>
</tr>
</tbody>
</table>

*unauthorized use not permitted*
FHTs Project:
Palliative Care Billings and Referrals to Palliative Care Team

![Graph showing Palliative Care Billings and Referrals over time for AFHT 1 and AFHT 2. The graph displays two lines, one for Billing and one for Referrals, with data points for 2009 to 2013.](image-url)
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

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.

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.
10. The right performance indicators and funding formulae.