Toronto Central **LHIN**

Advancing Community Integrated Palliative Care

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Russell Goldman
Director, Temmy Latner Centre for Palliative Care, Sinai Health System
Medical Advisor, Toronto Central LHIN, Home and Community Care

Jennifer Boucher
Manager Client Services, Palliative Program
Toronto Central LHIN,
Home and Community Care

Ontario
Local Health Integration Network

The Context in Ontario: Patients First

Patients First:
Action Plan for Health Care
February 2015

Feb 2015

May 2015

Patients First
A Roadmap to Strengthen Home and Community Care

PATIENTS FIRST A PROPOSAL TO STRENGTHEN PATIENT-CENTRED HEALTH CARE IN ONTARIO

DISCUSSION PAPER
December 17, 2015

Dec 2015

Bill 210, Patients First Act, 2016
Hoskins, Hon Eric *Minister of Health and Long-Term Care*
Current Status: First Reading Carried

An Act to amend various Acts in the interest of patient-centred care

June 2016

What is the Toronto Central LHIN?

WE PLAN, FUND, COORDINATE AND DELIVER SERVICES TO CITIZENS ACROSS THE CITY, INCLUDING:

services delivered by a large number of providers, including:

- 17 HOSPITALS
- 59 COMMUNITY SUPPORT SERVICE AGENCIES
- 36 LONG-TERM CARE HOMES
- 22 SERVICES PROVIDERS ORGANIZATIONS (SPOS)
- 17 COMMUNITY HEALTH CENTRES
- 75 COMMUNITY MENTAL HEALTH AND ADDICTIONS AGENCIES

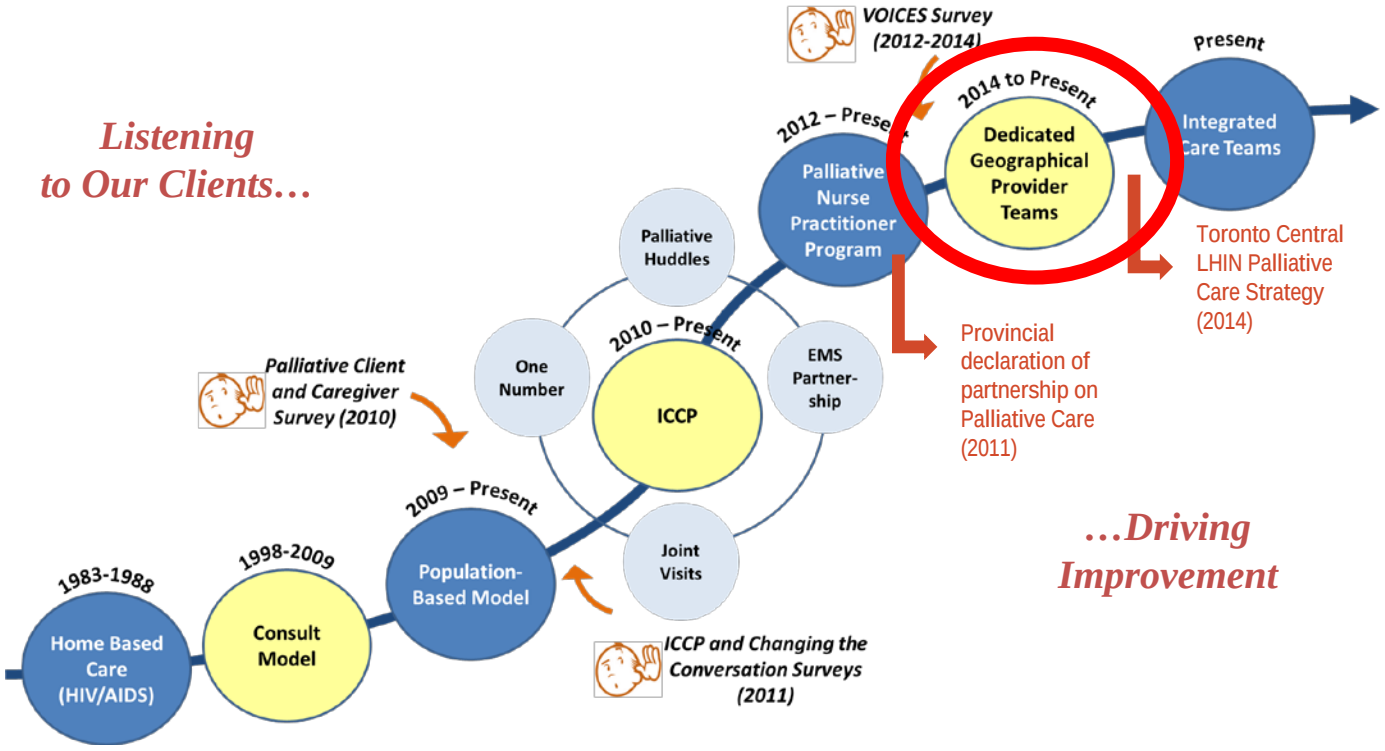
WE PARTNER

with many organizations that may not be considered part of the health care system, but nonetheless have a significant impact on a person's health and well-being.

TOGETHER WE:

- **Support** you and your family in your community to be as healthy as possible
- **Improve** your experience in the health care system; and,
- **Ensure** that we are using our health care dollars wisely so our system is strong for many generations to come

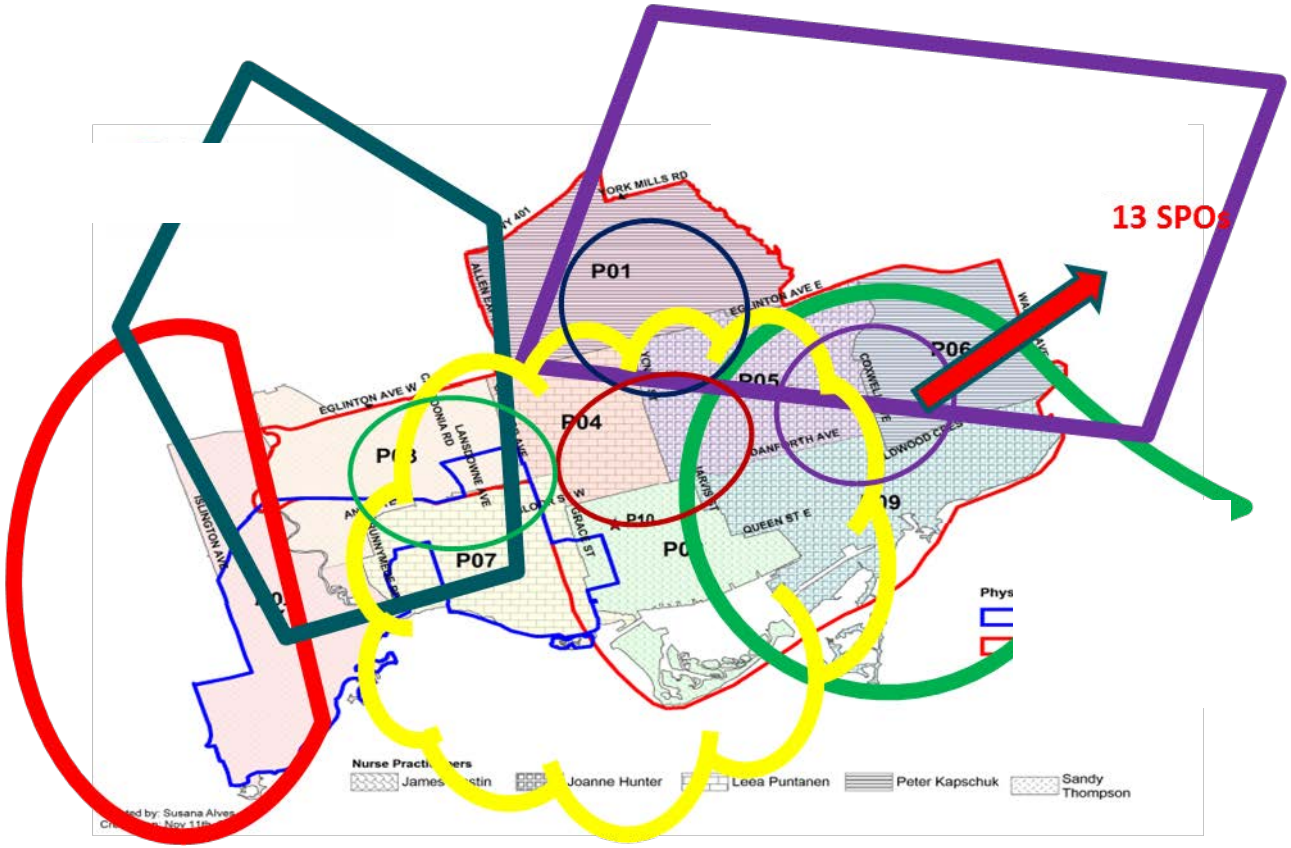
Evolution of the Palliative Care Program



Variability in client experience

- 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

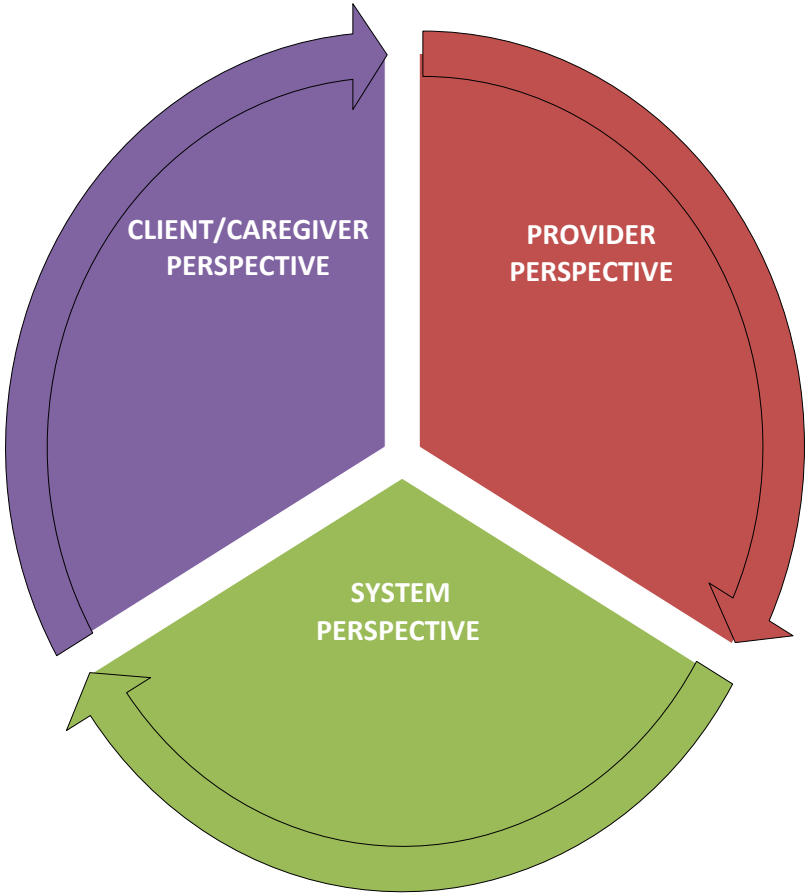
Where we started



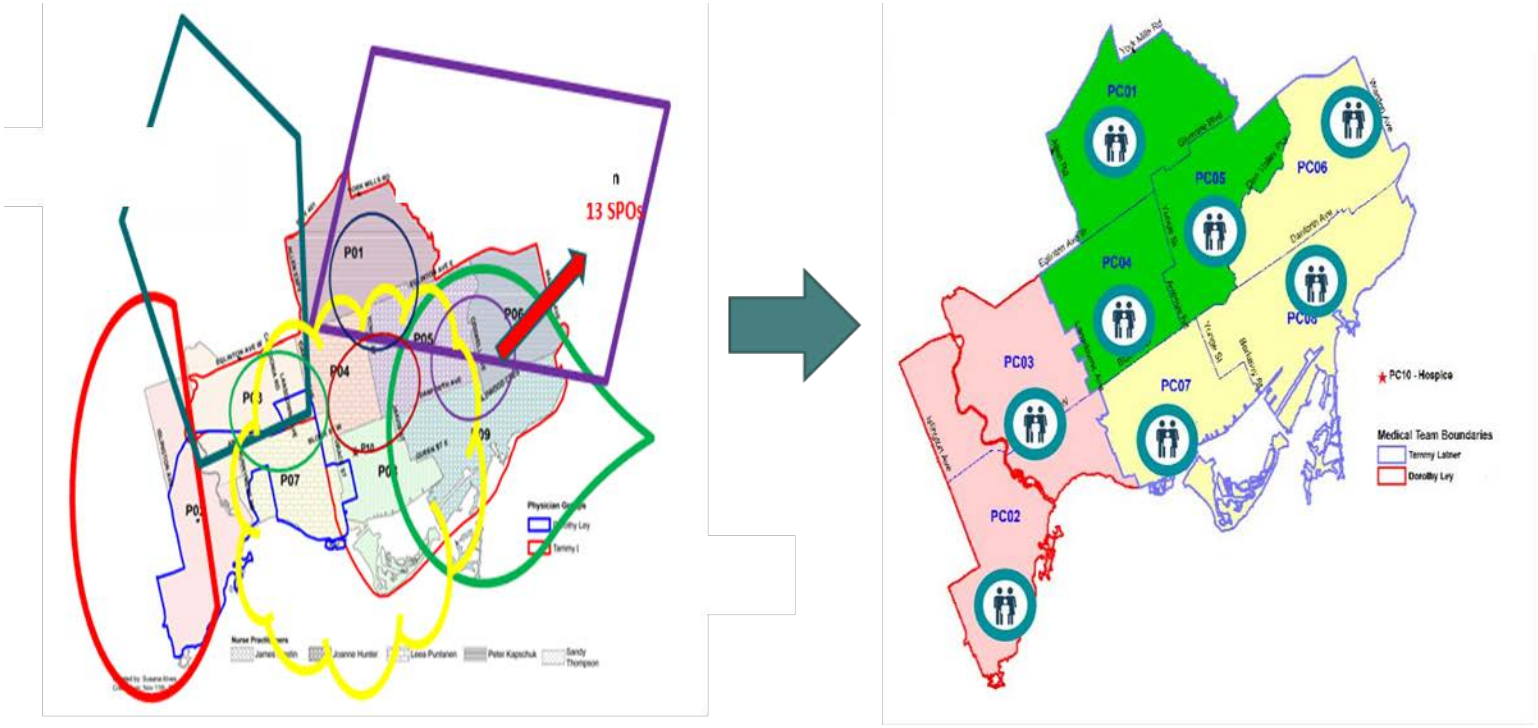
What Did We Envision?

One Client, One Team

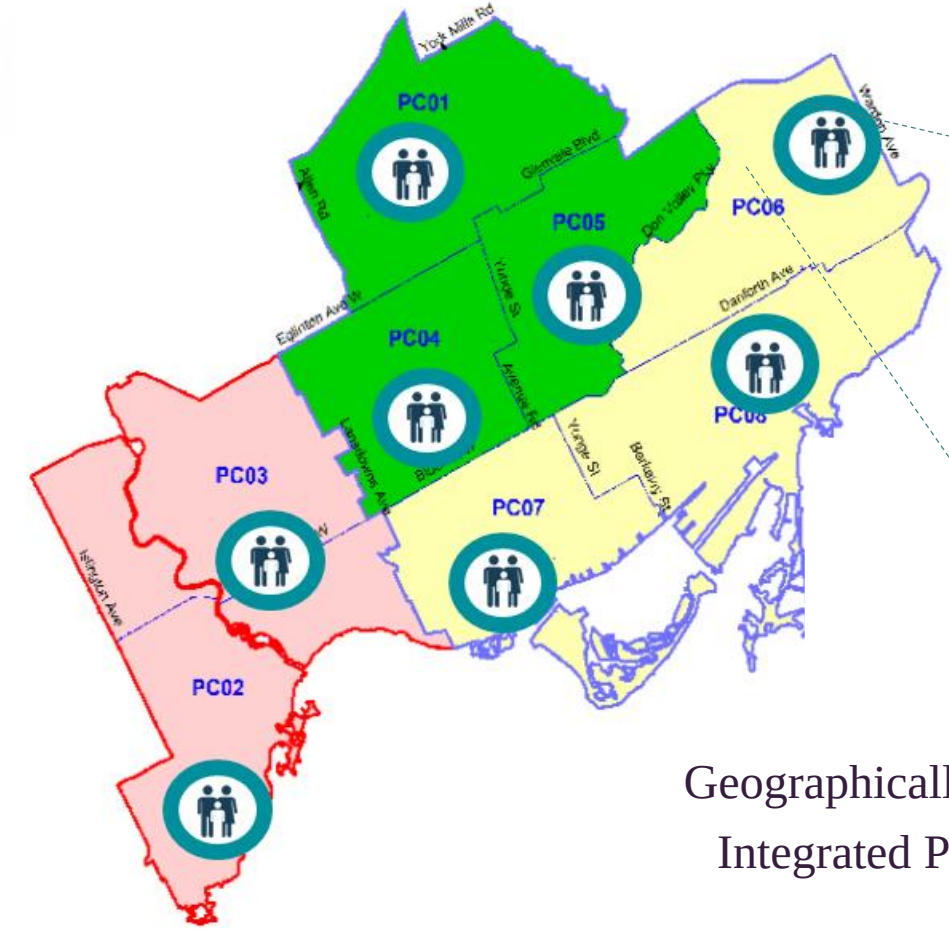
- An integrated,
- inter-professional,
- specialized
- palliative care team that works together to meet the needs of clients and their families
- in a community setting.

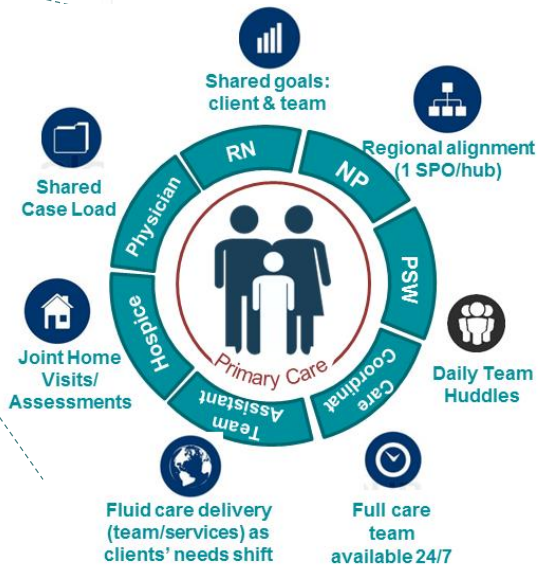


Scaling Integrated Care Teams



One Client, One Team – Current State





Geographically- Based, Dedicated Integrated Palliative Care Teams

One Client – One Team Experience

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

Palliative Team Daily Huddle:
Led by the Care Coordinator and attended by the integrated care team to discuss change in status of clients, urgent needs and adjustments in plan of care.

Caregiver Support
Support programs and support structures for caregivers and families

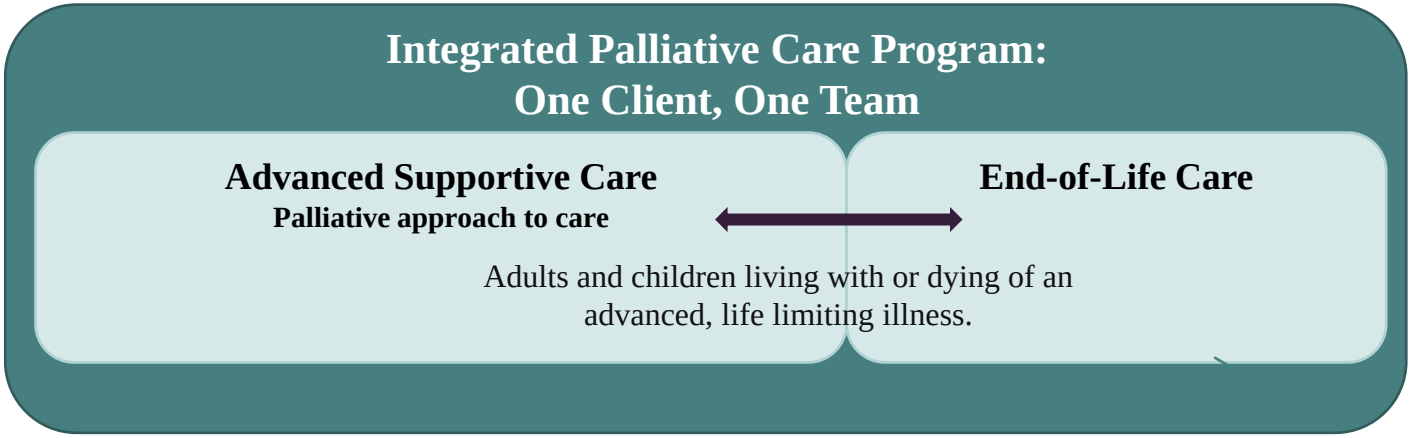
One EMR:
Enables communication and clinical documentation amongst all members of the care team and clinical

Shared Caseload and Joint Home Visits / Assessments :
Joint visits to introduce the team based care approach, conduct coordinated assessment and care plan and reduce duplication for client/caregiver

Partnership with EMS:
Working with EMS to support clients to remain at home and communicate with the integrated team on status and transition plans

Full Care Team Available 24/7:
Access to care team 24/7

Clients who benefit the most from the program



Clients typically have the following characteristics:

- Expected life span of 12 months or less
- Identified as benefitting from, and amenable to, a palliative approach to care
- Evidence supporting advanced disease (e.g. presence of medical conditions associated with advanced disease, severe and progressive symptoms, rapid decline, or decreased functional status)*
- May have had frequent ED visits involving unmanaged pain and symptoms

*see definition of Advanced Chronic Disease in the Declaration.

Quality Improvement - Palliative Team Huddle

WHO ATTENDS:

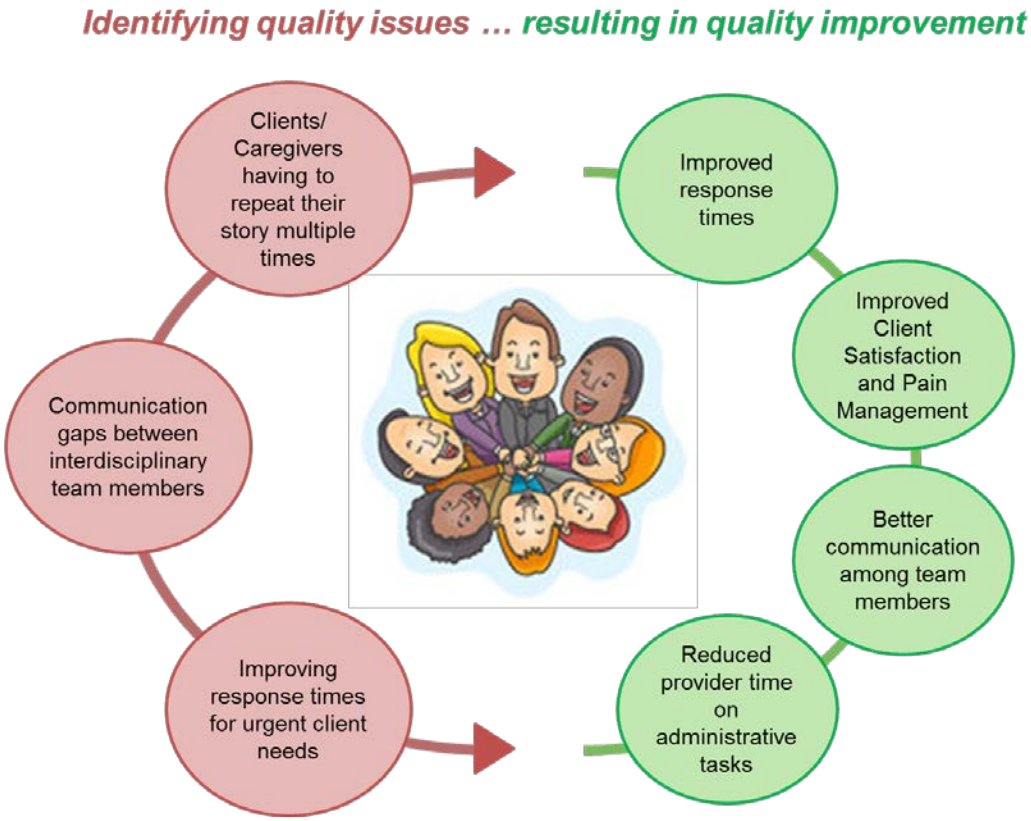
- *Care Coordinator*
- *Nurse Practitioner*
- *Service Provider Nurses*
- *Palliative Care Physician*
- *Personal Support Worker*

WHAT'S DISCUSSED:

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

HOW OFTEN:

- *Daily for 10 minutes*



Shared Electronic Medical Record

Updated medical history and notes

On call updates

Facilitates submission of PCU applications

Faster ordering of labs and medication for NPs

Reduced duplications in documentation

Better communication amongst team (shared HV letter)

Timely updates in change of status (HH, PCU admission, etc.)

= RELEASED TIME TO CARE FOR CLIENTS

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.."*

82%

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

64%

Percent of our clients who died at home

18%

Percent of our clients who died in residential hospice

10%

More clients 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?

Enhancements to the "One Client – One Team Experience"

<u>Enhanced Caregiver Support</u>
Enhance support programs and structures for caregivers and families based on our Client Advisory Panel recommendations

<u>Expand use of one EMR to other care team partners:</u>
Enables communication and clinical documentation amongst all members of the care team and clinical

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

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

The Future of Integration Across Sectors

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

- 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
- Meeting the rising tide of those in need of palliative care
  - Primary care integration
  - Shared care models
  - Improve seamless transitions between acute care and community
  - Partnerships with LTCH: explore palliative care team support for clients in LTCH

Our Partners

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

Community-Based Palliative Physicians

- Temmy Latner Centre for Palliative Care
- Dorothy Ley Physician Group

Specialized Palliative Care Coordination and Nurse Practitioner Program

- Toronto Central LHIN

Specialized Nursing and Personal Support

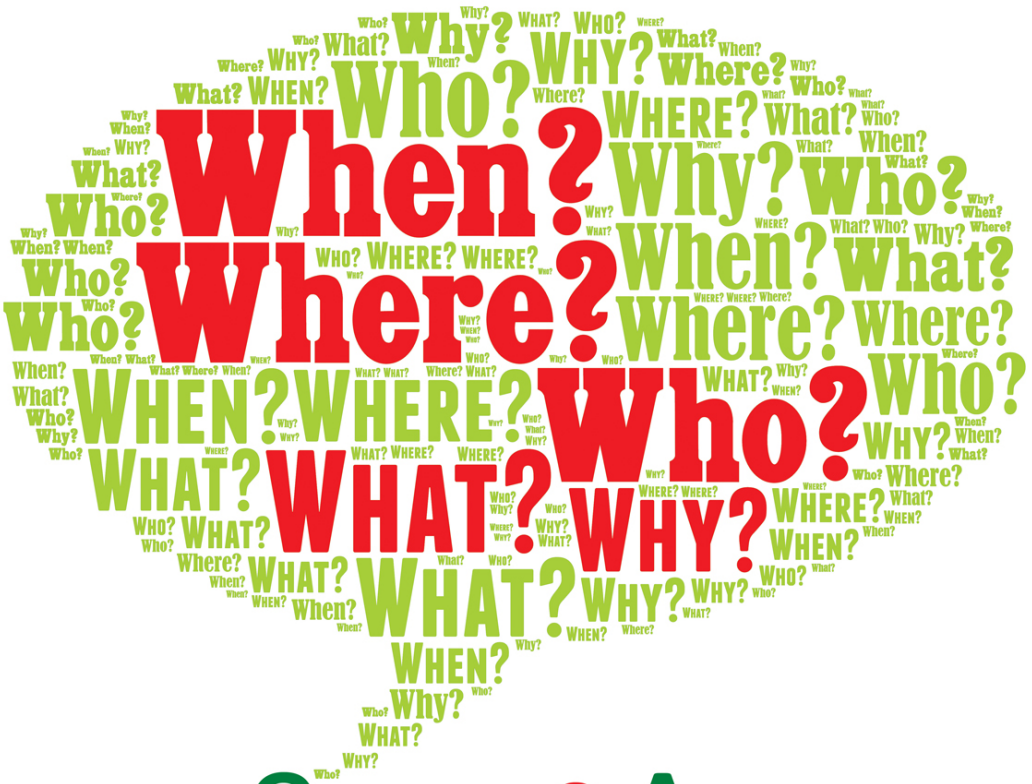
- Spectrum Health Care
- SRT Medstaff
- St. Elizabeth Health Care

Visiting Hospice Partners

- Hospice Toronto
- Hazel Burns
- Philip Aziz
- Dorothy Ley
- Better Living

Visiting Hospice: Affiliated

- Jewish Family & Child Service
- Circle of Care
- Casey House


When?
Where?
Who?
What?
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WHAT?
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Questions & Answers