Rouge Valley Health System and The Scarborough Hospital Facilitated Integration Process

Due Diligence Workbook:

Palliative Care (DRAFT)

A Facilitated Process of the Central East LHIN

Authors:	Palliative Care Working Group	**Version Number:**	2
Status:	Draft	**Version Date:**	September 5, 2013

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1. Current State Assessment & Leading Practice Review

1.1. Overview of Services/Programs

Location of Service/Program *Where are the services/ programs delivered? At both hospitals? At specific sites?*	**The Scarborough Hospital - TSH** General Campus: • Dedicated Acute Palliative Care Unit (PCU) - 18 beds in the PCU and 2 flex palliative beds in the Oncology unit; 3 rotating palliative care physicians ; interprofessional team approach to care; PCU staff receive, review, and process external applications for inpatient and outpatient palliative care services; PCU nursing staff provide phone support for community calls; palliative admission order set in use; use of standard assessment tools such as, Edmonton Symptom Assessment System (ESAS) and Palliative Performance Scale (PPS); goal is to provide 'acute' palliative care services for pain control, symptom management and end of life care. Admission criteria includes expected length of stay of 30 days or less. • Inpatient Palliative Consultation - 3 rotating palliative care physicians; Clinical Resource Leader (CRL; palliative consultants work with the interprofessional team on the referring unit; consult service is available to all hospital programs; use of standard palliative care consent form; caregiver information booklet in use. • Interprofessional Outpatient Palliative Clinic - 2 palliative care physicians, 1 Registered Nurse (RN), 1 Unit Clerk, and Social Work (SW) support. Birchmount Campus: • Inpatient palliative consultation - available to all programs; 1 Oncologist who provides palliative consultations, works with interprofessional team on referring unit, triages appropriate transfers to General Campus PCU; standard palliative consent form, and caregiver information booklet use. **Rouge Valley Health System - RVHS** • Three palliative physicians on rotation provide consults throughout the hospital • Nurse Practitioners (NP) consults in Oncology Clinic

Volume of Activity	**TSH** • Total palliative care cases admitted across both campuses with palliative as the most responsible diagnosis - is 698. • Trend showing increase in PCU admissions – 26% increase in PCU cases between 2011/12 and 2012/13. • TSH does not have palliative designated funded beds. PCU is an allocation of acute general medicine beds. • 82% of all palliative care inpatients are transferred to PCU. • PCU length of stay at 18.4 days and overall palliative cases length of stay is 12.1 days. • Has a primary post-acute palliative care partnership with Providence HealthCare (58 cases in 2012/13) • TSH General Campus has 4th highest volume of palliative care days (compared to peer hospitals with palliative care utilization) in acute care and the highest percent of medicine days used by palliative care patients (13.3%) **TSH General Campus Palliative Outpatient Clinic**: • 2012/13 (Apr to Feb) average total patient palliative clinic visits per month was 40. • Average new patient visits 14 per month. • Total average 480 visits/year (average 168 new patients per year). **RVHS** • 252 patients were identified as Palliative as the most responsible diagnosis across both sites. 163 of these patients were admitted to the Rouge Valley Centenary site. • Average length of stay; Centenary site: 14.31 days and Ajax site: 9.38 days • 75% of Palliative patients were under the care of an Oncologist
Mode of Delivery	**TSH** • Palliative Care Services are provided as inpatient and outpatient. **RVHS** • The Model of care is based on a decentralized approach with consultation services provided at both sites for any palliative inpatient. • Some patients currently seen through Outpatient Oncology clinic

Innovations Planned and/or Underway	**TSH** TSH is currently exploring the following opportunities: • Scarborough Centre for Healthy Communities (SCHC) partnership to implement Hospice Volunteer program • Expansion of interprofessional palliative consultation team across both campuses • Review of allocation of acute palliative care beds to meet community demand • Implementation of safety strategy with the initiation of revised palliative care admission order set • Initiating review of outpatient palliative care delivery models across Scarborough with community partners (in collaboration with Scarborough cluster Palliative Care interest group and Central East Hospice Palliative Care Network) **RVHS** RVHS is currently exploring the following opportunities: • Enhancing Inpatient Palliative services • Add Palliative care services to existing outpatient clinics • Strengthening community partnerships (Durham Hospice and CCAC Palliative NP access to RVHS bed boards).

Key Metrics	**Both TSH and RVHS recognize these metrics:** • Average Length of stay (ALOS) • Alternate Level of Care (ALC) cases for palliative care and number of days waiting for placement • Monitoring of fall frequency and restraint use • Readmission rate to the hospital within 28 days • Discharge destination • Patient Satisfaction • Number of patients admitted to hospital with a palliative diagnosis **TSH** • Frequency of Outpatient Palliative care visits and number of new patients • PCU occupancy rate • PCU admission rate • Providence Healthcare admissions
Other Information	• TSH has membership representation on the Central East Hospice Palliative Care Network (CEHPCN) • Both TSH and RVHS palliative care programs have membership representation on the Scarborough Cluster Palliative Care interest group - which is exploring options for improved integration of palliative care services in Scarborough • TSH has identified that cancer care is one of their foundational programs. Palliative care is recognized as an essential component of the cancer care continuum. • TSH sites and RVHS combined hospital data demonstrates that both hospitals use 7.3% of their medicine beds for palliative care, with more than two thirds of the palliative care activity at The Scarborough Hospital General campus. • TSH is the only provider of acute palliative care in a PCU setting in Scarborough

1.2. Patient Profile

Patient Value Statement	Patients and families receiving Palliative Care have shared with us that they value the following treatment and interactions:
	
	• Professional and personal attention – "I am not a diagnosis"
	• Preparation for death (End of Life Decisions)
	  ○ Provide information
	  ○ Encourage Decision making
	  ○ Informed Choices
	  ○ Advance care planning
	• Continuity of care promotes support and trust
	• Pain and Symptom Management
	• Cultural sensitivity
	• Emotional support
	• Good communication
	• Acceptance
	• A sense of peace
	• Supporting religious/spiritual practices
	• Quality of life
	• Dignity
	• Compassion
	• Respect
	• Privacy
	• Comfort
	• Promote independence
	• Timely access to their health care team

Patient Characteristics	**Both RVHS and TSH provide palliative care services to patients with either cancer or non-cancer (advanced chronic illness) palliative diagnosis:**
	
	Patients with a Cancer Diagnosis:
	
	• 75% of patients are over the age of 65 with the average age 78
	• Equal mix of males and females
	• Mix of cultural beliefs
	• Majority with English as a second language
	• Financial barriers for transportation, services and drug coverage
	• Require inpatient and outpatient services
	• Varied symptom needs
	
	Patients with Advanced Chronic Illness:
	
	• Neurodegenerative
	  o Majority over the age of 65 and require supportive care in long term care
	  o Require hospital admission for acute illnesses
	• Need enhanced support regarding care planning and decision making
	• Organ failure
	• Majority of the population is under the age of 65
	• Living in their homes throughout the majority of their illness
	For all Palliative patients:
	• Majority of care is delivered by family and friends
	• 20% of Scarborough residents live on their own
	• Family members need ongoing support
	• Living with a life threatening illness impacts all aspect of the person's life
	• In Scarborough the top three languages spoken are English, Cantonese, and Tamil
	• 40% of the Central East Local Health Integration Network (CELHIN's) population resides in Scarborough.

Population Need	• 926,994 Scarborough residents live within the TSH catchment area
	• 612,022 live within the RVHS catchment area
	• Central East LHIN growth in all inpatient volumes (all patient clusters) is anticipated to be 13.3% over next 5 years and 27.7% over next 10 years
	  ➢ Acute inpatient care, emergency, cardiac cath, oncology and renal dialysis are all expected to grow by more than 20% over ten years
	• 13.6% Scarborough population is 65 years of age or older
	• Some Scarborough residents seek treatment from outside of the Central East LHIN border.
	  ○ Majority of these patients choose to return to the Central East LHIN for their palliative care.
	• Percentage of residence of our LHIN that receive Palliative Care, do so at the following:
	  ○ TSH (General Campus) – 22.5%
	  ○ TSH (Grace Campus) – 3%
	  ○ RVHS (Centenary Site) – 6.8%
	  ○ RVHS (Ajax Site) – 3.8%
	• There are no residential hospice beds
	• Families need to work, limited funds and resources
	• Projected increase of 33% for oncology services

1.3. SWOT Analysis

	RVHS	TSH
Strengths		
• Robust coordinated inpatient acute palliative care unit		X
• Partnership with Providence HealthCare to optimize continuity of care and seamless transitions for palliative patients post-acute		X
• Strong group of specialized palliative care practitioners with interprofessional approach to care (i.e. Palliative Physicians as the Most Responsible Physician (MRP)		X
• Outpatient Palliative Clinic		X
• Inpatient Palliative Consult Services	X	X

	RVHS	TSH
• Strong continuum of services from inpatient to outpatient palliative services		X
• Strong safety initiative with implementation of electronic documentation for nursing and allied health		X
• Support from Oncology and Internal Medicine Specialties	X	X
• Allied Health Experience	X	X
• Nursing Experience	X	X
• Health care provider point of contact for Palliative Patients		X
• Standardized Palliative Admission Order Sets	X	X
• Direct Admission to PCU		X
• Physician Experience in palliative care as a specialty	X	X
• Use of validated palliative assessment tools		X
• Board of Directors / Senior Management Team Interest	X	X
• Palliative Care is recognized by Cancer Care Ontario (CCO) and the Regional Renal program as a specialty service (CCO directive to involve palliative care earlier to improve the patient experience).	X	X
• RVHS partnership with Toronto Hospital for Sick Children re: delivery of peadiatric oncology services • Ethicist available for consultation	X X	X
Weaknesses		
• Limited in home visiting palliative physicians in Scarborough	X	X
• Lack of dedicated palliative bed funding	X	X
• Lack of coordinated community palliative outreach services across Scarborough	X	
• Lack of community linkages	X	
• Limited weekend support and access to services	X	X
• No seamless access from and to the community	X	
• PCU and Outpatient Palliative Clinic Wait lists		X
• No dedicated Palliative unit in hospital	X	

	RVHS	TSH
• No outreach Paediatric Palliative Care		X
Opportunities		
• Coordination of inpatient palliative services between hospitals and community providers	X	X
• Development of palliative services beyond the primary source of oncology to other diseases/conditions	X	X
• Opportunities to link consult teams	X	X
• Funding from external organizations (i.e. Cancer Care Ontario, CELHIN)	X	X
• Educational opportunities for health care professionals	X	X
• Greater coordination with Scarborough Centre for Healthy Communities	X	X
• Monthly Palliative Community rounds	X	X
• Increase outpatient clinic days and availability at RVHS	X	X
• Building community capacity with specialization in palliative care	X	X
• Increase in Palliative Nurse Practitioner availability in the community	X	X
• CELHIN interest	X	X
Threats		
• New funding model	X	X
• Recruitment of human resources specialized in palliative care	X	X
• Budgetary constraints	X	X
• Demographic increased needs	X	X
• Competing priorities	X	X
• Political loss of interest in palliative care	X	X

1.4. Environmental Scan

Political	• Central East LHIN Community First Integrated Health Service Plan 2013-16: one of four of their strategic aims is to increase the number of palliative care patients who die at home by choice and spend 12 000 more days in their communities by 2016. • Available funding for physician training/education (ministry incentives) • No lobby groups for palliative care • Limited funding • Impact of what political party is in power and what they see as a priority • Funding available from government for residential Hospice beds but funding not support a sustainable model • Divide between Primary, Secondary and Tertiary Care
Economical	• New funding model • Right patient in the right bed –Health Based Allocation Model (HBAM) funding • Cost savings to families and system if care available at home • Increased aging population – increased dependence on healthcare = increased costs • Misalignment of compensation to support community care (misalignment incentives) • Compassionate Care Leave available to palliative patient primary family caregiver • Cost of Medications
Social	• Decreased number of physicians who make house calls in Scarborough ○ Why – safety, language barriers, funding, limited support • No access to Residential Hospice • Increased aging population • Language/multicultural challenges • Decrease in volunteers / family supports • Decrease in education/ media attention for end of life issues / resources • Decreased socioeconomic status

Technological	• Connecting GTA is a future resource - will integrate and securely share electronic patient information across the Greater Toronto Area (GTA) and North Simcoe Muskoka Local Health Integration Networks (LHINs) so that clinicians can deliver better, faster and more coordinated patient care • Current lack of common electronic health record between hospitals and community • Some patients and family members have limited computer/internet experience • Phone Translation Services are available (cost per minute) • Dependency/Stability of computer/electronic infrastructure • Ability to leverage communications technology
Legal	• Euthanasia is not legal in Canada and is not supported by the palliative care community (i.e. Canadian Hospice Palliative Care Association) • Important for patients to designate in advance their Power of Attorney (POA) for medical decision making • Substitute Decision Maker (SDM) when there is no POA for medical decision making • Decision making regarding Do Not Resuscitate
Environmental	• Artificial geographic boundaries to service delivery (i.e. Community Care Access Centres, home visiting palliative physician groups) • Transportation • Seasonal impact on patients' ability to travel to health care appointments or health care providers traveling to patients' homes to deliver care • Variability of community services available (level of care or services available change from one geographic area to another))

1.5. Leading Practices

Additional Leading Practices for Consideration	**Central East Local Health Integrated Network – Integrated Health Service Plan 2013-2016:** Population of Ontario is getting older and as they age they require more health care. Central East LHIN has the largest number of seniors. Central East LHIN residents have the right to die with dignity, to have access to physical, psychological, bereavement, and spiritual care, and to be granted the respect consistent with other phases of life. Ensuring timely access to quality palliative care and end of life is not only an ethical imperative but a vital component of our health care system. ***"Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016"*** **Journal of Palliative Medicine Vol. 11, #9, 2008. M.A. Liebert, Inc.DOI: 10.1089/jpm.2008.0149:** Prominent Recommendations re: preferred practices: • Provide Palliative Care by an interdisciplinary team • Provide Palliative Care that is responsive to the patient and family 24 hrs, 7 days a week • Ensure continuity of care and seamless follow-up • Ensure measurement and documentation of patient's symptoms (including psychological). • Develop and offer grief and bereavement care plan • Conduct regular patient and family care conferences **Arch Intern Med. 2008; 168(16):1783-1790:** Hospital Palliative Care consultation teams are associated with improved clinical care, patient/family/physician satisfaction, and significant hospital cost savings. **Journal of Palliative Med. Vol 12, #1, 2011. M.A.Liebert, Inc. DOI: 10.1089/jpm/2010.0347:** Identifying patients in need of palliative care assessment in Hospital setting – outlines primary and secondary criteria at time of admission. **Arch Intern Med. 2011; 171(7):649-655:** Both PCUs and palliative care consultations can improve quality of life, but PCUs offer an even greater advantage than palliative consultations alone. **Benefits of Palliative Care:** dedicated PCU offers control over roll out of clinical recommendations, presence of skilled interdisciplinary staff, and a care setting designed for the needs of seriously ill patients. Under circumstances of difficult symptom distress, family exhaustion, or lack of adequate community support services, a PCU may provide the safest and highest quality of care. Drawbacks of a PCU might include limited bed availability and decreased opportunity to promote palliative care practices throughout the hospital. **Barazzetti et al. BMC Palliative Care 2010, 9:1:** **Consensus in literature of factors that contribute to a "good" death include:**

	Symptom control; Consideration of social and relational factors; Preparation for death; Existential well-being **"Best" practice framework for providing palliative care:** Symptom Management**:** Relational and Social support interventions (cultural sensitivity, emotional support, good communication, acceptance); Preparation (advance care planning)**;** Existential Condition (being at peace, supporting religious/spiritual practices)**;** End-of-life decisions (death as natural/normal – not hastened nor postponed, participate in decision making process)**;** Quality of life**;** Dignity. **At-home palliative physician models of care examples:** Tammy Latner; Freeman Centre; Bowmanville
Leading Practices Already Implemented *Based on the Leading Practice Summary and the additional leading practices listed above, identify those that are already in place at RVHS and/or TSH.*	• **Central East LHIN Key Accomplishments to Date:** Central East Hospice Palliative Care Network (CEHPCN); Palliative Care identified as an Integrated Health Service Plan (IHSP) Strategic Aim for 2013 – 2016; Palliative Pain and Symptom Management Consultation (PPSMC); Community Palliative Nurse Practitioner Program; Standardization of Palliative Education Services; Strengthened Community Hospice Services; Expected Death At Home Package; community palliative care rounds; Interprofessional and Primary Physician Palliative Education • **TSH:** Membership with CEHPCN; Palliative Common Referral Form; Palliative Care Consent Form; Standard assessment tools (ESAS, PPS); Palliative Admission Order Set; PCU; inpatient palliative consultation services; outpatient palliative clinic; interdisciplinary care team;

Benefits of a Potential Merger *Identify the leading practices that could be adopted and/or enhanced through a potential merger of the two hospitals?*	•

2. Opportunity Assessment

2.1. Overview of Opportunities

Reference	Opportunity
1	Develop a Palliative Care Centre of Excellence in Scarborough that is supported by a division of Palliative Care.
2	Develop a Centralized Palliative Care Resource Centre for the residents of Scarborough.
3	Develop and implement a shared philosophy for the delivery of Palliative Care in Scarborough.
4	Provide cost savings and efficiencies through a robust palliative care model.
5	Provide equitable access to palliative care beds.

2.2. Opportunity Assessment

Opportunity 1: Develop a Palliative Care Centre of Excellence in Scarborough that is supported by a division of Palliative Care

Overview:

Description	• To leverage critical mass in order to deliver best practice Palliative Care across the continuum of inpatient, outpatient, and outreach services. • To create a division of Palliative Care to develop and coordinate palliative care services in alignment with a program vision with administrative and physician leadership. • Building the scope of palliative care services to meet the community need in collaboration with community partners.
Anticipated Alignment to Guiding Principles	• Collaboration • Accessibility • Sustainability • Excellence

Potential Benefits and Risks:

Potential Benefits	
Patient	• Seamless service • Accessible and consistent high quality care • Care delivered where needed
Community	• Care in your community • Increased support services • Consistent high standard of care across Scarborough
Organization	• Specialized skills / attracting expertise • Recognition • Academic opportunities for research and training • Greater efficiency • Better utilization of services
Clinicians & Staff	• Enhance staff / clinician satisfaction through specialty professional

	development • Flexibility to work across continuum • Availability of support by palliative team (for other specialties)

Potential Risks	
Risk	**Mitigation Strategy**
• Community readiness / capacity to support the continuum of care (i.e. increase demand for CCAC, family physician interest in practicing palliative care, residential and volunteer hospice services)	• Shared care model with community palliative care providers • Strong anchor of support from in-patient Palliative Care Unit(s)
• Funding to support the continuum of care	• Ensure efficiency across shared delivery model, strengthening fund raising strategy, and reallocation of funds

Benefit Realization:

Estimated Timeline	• Medium-term (1-2 years)

Key Metrics to Measure Benefits	• Patient / Family satisfaction • Staff / physician / clinician satisfaction • Referral and patient service volumes • Wait times (inpatient and outreach consultation / Palliative Care Clinic / PCU admission etc.) • Alternate Level of Care (ALC) days • Research generated • Use of validated tools (i.e. ESAS, PPS) • Quality-based procedures funding (QBP)

Feasibility Assessment:

Key Metrics to Estimate High-Level Financial Impact	•

Required Investments – Operating and Capital (if applicable) *Identify the key financial investments (e.g. one-time costs) required to realize the benefits.*	•

Analysis	•

Anticipated Financial Impact *Indicate the order or magnitude financial impact (stated in the $100,000).* *Is this opportunity a financial investment or savings?*	•

Opportunity 2: Develop Centralized Palliative Care Resource Centre for the residents of Scarborough

Overview:

Description	• Expertise in Hospice Palliative Care resources • Resource centre in one location • "One stop shop" resource service that facilitates the coordination and navigation of palliative care services for Scarborough residents. • Promotes seamless integration of inpatient, outpatient, outreach, and community palliative care services. Team approach involving interprofessional hospice palliative care providers from all Scarborough hospice palliative care services. • Education and support centre for community members and health care providers
Anticipated Alignment to Guiding Principles	• Accessibility • Excellence

Potential Benefits and Risks:

Potential Benefits	
Patient	• Timely and seamless access to care for patients, family and caregivers • Easy access to information and enhanced supportive compassionate care • Holistic approach to care and access to a wider range of services • Move to a patient centred model of care
Community	• One central point of entry to initiate / obtain hospice palliative care support
Organization	• Streamline care and less duplication of services • Improved efficiencies and cost savings / pooled resources
Clinicians & Staff	• Ease of access for health care providers / primary care providers • Enhanced health care provider support

Potential Risks	
Risk	**Mitigation Strategy**
• Lack of funding	• Mitigate by leveraging new revenue streams, partnerships & existing resources
• Duplication of service	• Develop shared partnership(s)
• Community confusion regarding change in services	• Develop education, marketing, and consultation plans
• One point of entry into palliative care system can slow down access, therefore resulting in increased wait lists	• Set standard timelines, Quality improvement assessments, and monitor performance • Identify levels of patient priority and triage on intake of referrals i.e.

	CTAS (Emergency triage identification) •

Benefit Realization:

Estimated Timeline	• Phase One: Medium-term (1-2 years) • Phase Two: Long-term (3-5 years)

Key Metrics to Measure Benefits	• Wait time from referral to service seen • Wait time from referral to first contact • Survey satisfaction – Patient Family & Provider • Decrease in emergency visits • Inpatient Palliative care length of stay • Palliative patient days at home by choice (should see an increase in number of palliative patient days in their home) • Pre and Post ESAS with service activation (should see an improvement in ESAS with service activation) • Employee retention

Feasibility Assessment:

Key Metrics to Estimate High-Level Financial Impact	•

Required Investments – Operating and Capital (if applicable) *Identify the key financial investments (e.g. one-time costs) required to realize the benefits.*	•

Analysis	•

Anticipated Financial Impact *Indicate the order or magnitude financial impact (stated in the $100,000).* *Is this opportunity a financial investment or savings?*	•

Opportunity 3: Develop and implement a shared philosophy for the delivery of Palliative Care services in Scarborough

Overview:

Description	• A shared vision, mission, and values will positively influence the service delivery model and provide continuity of care in Scarborough.
Anticipated Alignment to Guiding Principles *Shade the relevant guiding principle(s)*	• Collaboration • Accessibility • Sustainability • Excellence

Potential Benefits and Risks:

Potential Benefits	
Patient	• Standardization of palliative care services • Consistent care delivery
Community	• Equitable access to quality palliative care services • Cohesive program delivery – seamless care
Organization	• Focus and coordination of services • Clarity of expectations for service delivery
Clinicians & Staff	• Clear focus and direction for palliative care • Provide consistent goals for palliative care among disciplines • Enhance quality based care delivery by providing a consistent message for health care providers on how to deliver care

Potential Risks	
Risk	**Mitigation Strategy**
• Diverging opinions or ideas on what the shared philosophy should be.	• Use best practices to guide the development of a shared philosophy.

	• Incorporate community needs into the shared philosophy
•	•
•	•

Benefit Realization:

Estimated Timeline	• Short-term (up to 1 year)

Key Metrics to Measure Benefits	• Patient and family satisfaction regarding the consistency of palliative care services received in Scarborough. • Health care provider satisfaction with working within a shared philosophy • Quality indicators such as wait times and referral volumes

Feasibility Assessment:

Key Metrics to Estimate High-Level Financial Impact	•

Required Investments – Operating and Capital (if applicable) *Identify the key financial investments (e.g. one-time costs) required to realize the benefits.*	•

Analysis	•

Anticipated Financial Impact *Indicate the order or magnitude financial impact (stated in*	•

the $100,000). *Is this opportunity a financial investment or savings?*	

Opportunity 4: Provide cost savings and efficiencies through a robust palliative care model.

Overview:

Description	• The formation of a strong and accessible palliative care model for Scarborough will enhance the utilization of services and resources to the fullest extent possible. • This will result in the proper distribution of resources and enhance the potential for funding of palliative services.
Anticipated Alignment to Guiding Principles	• Collaboration • Accessibility • Sustainability • Excellence

Potential Benefits and Risks:

Potential Benefits	
Patient	• Seamless and timely access to care • Strong formal support network available
Community	• Cohesive program delivery • Enhanced availability of services
Organization	• Collaborative opportunities to enhance funding for services • Enhanced utilization of resources • Cost savings due to shared ownership of services
Clinicians & Staff	• Ability to deliver palliative care to patients that is comprehensive and efficient in nature • Greater support network available to other specialties

Potential Risks

Risk	Mitigation Strategy
• Lack of initial investment to develop a robust palliative care model and lack of sustainable funding	• Seek and develop community partnership(s) to enhance funding opportunities in the development of a palliative care program • Identify funding resource opportunities through the Health System Funding Reform (HSFR)
• Lack of clarity on how acute palliative care is defined and when acute palliative care services should be accessed.	• Develop clear definition of acute palliative care services and service delivery model to ensure acute and post-acute palliative services respond to the community needs. • Education and promotion around distinction between acute palliative care and post-acute palliative care
•	•

Benefit Realization:

Estimated Timeline	• Medium-term (1-2 years)

Key Metrics to Measure Benefits	• Patients being cared for in their place of choice • Volumes / type of services • Wait times (i.e. consultation / service initiation) • ALC days / conservable days • Quality-based procedure funding

Feasibility Assessment:

Key Metrics to Estimate High-Level Financial Impact	•

Required Investments – Operating and Capital (if applicable) *Identify the key financial investments (e.g. one-time costs) required to realize the benefits.*	•

Analysis	•

Anticipated Financial Impact *Indicate the order or magnitude financial impact (stated in the $100,000).* *Is this opportunity a financial investment or savings?*	•

Opportunity 5: Provide equitable access to palliative care beds.

Overview:

Description	• Scarborough residents require accessible inpatient palliative care to provide symptom management, pain control and end-of-life care. • Inpatient palliative care would be integrated within a continuum of services that include outpatient and outreach care. • Inpatient care can be transitional and accessible to patients within the community who require periods of admission for acute treatment following which they can return home again. Inpatient care also supports community providers by providing access to inpatient palliative services for their patients when required.
Anticipated Alignment to Guiding Principles	• Collaboration • Accessibility • Sustainability

	• Excellence

Potential Benefits and Risks:

Potential Benefits	
Patient	• Accessing palliative services across a continuum of care that is determined by patient need • Patient can receive coordinated and focused care in a supportive environment for end of life care
Community	• Palliative care services available within local community • Supportive partnership with primary care to support acute care needs for patients within the community
Organization	• Critical mass may influence cost efficiencies • Enhanced coordination of care
Clinicians & Staff	• Enhances the specialization of care and skill set • Increased job satisfaction to provide coordinated specialized care

Potential Risks *Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.*	
Risk	**Mitigation Strategy**
• Lack of designated funded palliative care beds	• Community partnership to optimize utilization of funded palliative care beds within Scarborough • Clearly define acute inpatient palliative services • Enable community services to support non acute palliative care • Rely on robust interprofessional palliative consultation team to navigate patients through the continuum of services
• Demand is greater than capacity	• Establish patient flow strategy that promotes short term stay for acute symptom management • Explore partnerships with other inpatient palliative care funded beds within Scarborough

•	•

Benefit Realization:

Estimated Timeline	• Short-term (up to 1 year)

Key Metrics to Measure Benefits	• Inpatient admissions • Length of stay • ALC rates

Feasibility Assessment:

Key Metrics to Estimate High-Level Financial Impact	•

Required Investments – Operating and Capital (if applicable) *Identify the key financial investments (e.g. one-time costs) required to realize the benefits.*	•

Analysis	•

Anticipated Financial Impact *Indicate the order or magnitude financial impact (stated in the $100,000).* *Is this opportunity a financial investment or savings?*	•

2.3. Stakeholder Engagement Information

This section should summarize the input considered from stakeholder engagement activities. Content in this section should be drawn from the Working Group's ***Stakeholder Engagement Summary.*** *(Refer to the Guiding Framework for expectations).*

Note: This section will be completed before final submission of the Workbook. Working Groups are to use the Stakeholder Engagement Summary as a tool to document and consider stakeholder input/feedback collected during the due diligence process.

3. Recommended Integration Opportunities

3.1. Alignment to Guiding Principles

For each of the recommended opportunities, complete the table on the following page. Specifically, for each of the recommended integration opportunities, Working Groups must clearly articulate a rationale that describes the degree to which the integration opportunity supports each of the Guiding Principles. In building this rationale, the Working Groups will use the most relevant measures/indicators based on the service/program.

Recommendation 1: [Insert Recommendation Statement]

Description:

Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text

Alignment to Guiding Principles:

	COLLABORATION ***We believe that collaboration will lead us to better solutions.***	**ACCESSIBILITY** ***We believe in providing accessible patient care to our community.***	**SUSTAINABILITY** ***We believe that we must find new solutions to sustain our health care system.***	**EXCELLENCE** ***We believe that we must never waver from our responsibilities to provide quality patient care and to be accountable to our stakeholders.***
Rationale	•	•	•	•
Measures/ Indicators	•	•	•	•

4. Workbook Sign-Off

Identify the individuals that were involved in the completion of the Workbook.

Organization - Program	Team Member:
	Signature Print Name Date
	Signature Print Name Date
	Signature Print Name Date
	Signature Print Name Date
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Organization - Program	Team Member:
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	Signature Print Name Date
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	Signature Print Name Date

Appendix: Leading Practice Summary (KPMG)

The purpose of this section is to highlight and identify high-level leading practices themes for the purpose of assisting in the due diligence review. The themes that have been identified in this document are from several sources and are meant to provide Working Group members with a broad view of the themes related to leading practices for **Palliative Care**. These sources include KPMG's own experience, global thought leadership and external sources (where identified).

The below tables summarizes leading practices themes for Palliative Care.

Leading Practice Themes	

Hospice Palliative Care Network
 	
Hamilton Niagara Haldimand Brant LHIN (HNHB LHIN)[1]
	• The HNHB LHIN's Hospice Palliative Care Network (HPCN) was created to assist the MOHLTC in achieving their general goal of comprehensive, consistent and high quality end-of-life care.
	
	• The Network is administered by HNHB CCAC. HPCN is currently coordinating a project as a part of the LHIN IHSP by partnering with Cancer Care Ontario and the Juravinski Cancer Centre in the implementation of the Provincial Palliative Care Integration Project.
	
	• The benefits of the HPCN and their integration initiatives include, but are not limited to:
	
	  • Providing a unified forum for system-wide planning, problem solving and integration
	
	  • Better access to information and support for service providers and consumers
	
	  • More effective and efficient services and transitions between settings
	
	  • Enhanced coordination, cooperation and system improvement
	
	  • Capacity building
	
	• The needs for HPCN are assessed and addressed through the collaborative efforts of available organizations and services in partnership. The Network's partners include:
	
	  • HNHB CCAC
	
	  • Palliative Care Physicians

[1] KPMG Report: *"Hamilton Health Sciences, St. Joseph's Health System, Joseph Brant Memorial Hospital, HNHB Community Care Access Centre, Integrated Health Services Delivery Model Project"*; August 25, 2010 (confidential)

Leading Practice Themes	
	• Pharmacies • Residential Hospices • Hospitals • Community Support Services • Long Term Care facilities
Central Okanagan Palliative Response Team[2]	• The Central Okanagan Palliative Response Team is a multidisciplinary team that provides crisis response 24/7 for palliative care patients and families, mainly at home, but occasionally in the Emergency Room. The team consists of a nurse and social worker with physician support. All of the providers have developed new skills and competencies, and as a result of the team, changes in location of death have occurred.
Erie St. Clair System Design Framework for Regional Hospice Palliative Care[3]	• The Erie St. Clair System Design Framework for Regional Hospice Palliative Care is a system design and development model for a region of approximately 7,324 square kms which has a population of approximately 631,000 people located in three urban centres, numerous small municipalities and a large rural area. The Framework attempts to provide a picture of how the individual systems can work and plan together to create an overall Regional System of Hospice Palliative Care. The six realms identified for this model include care settings and services; programs within care settings and services; integration/linkages; human resources; system accountability; and policies, guidelines and funding.
Niagara West Shared Care Model[4]	• The Niagara West Shared Care model is a comprehensive, population based model for palliative care patients. The purpose of the model is to improve the quality of end-of-life care through the implementation of a shared care model that integrates primary care services with specialized palliative care services. The model focuses on continuity of care, provides seamless care, and reduces the need for patient transitions in care. Palliative/end-of-life clinical care is provided with an emphasis on the primary care role: what the family doctor and beside nurses provide. Consultative palliative care is provided by an expert palliative care consult team that works with the primary care team. Together they provide shared care to patients in a variety of care settings - private

[2] http://www.cancerview.ca/idc/groups/public/documents/webcontent/hhr_repo_central_ok_pall.pdf
[3] http://www.cancerview.ca/idc/groups/public/documents/webcontent/hhr_repo_erie_st_clair.pdf
[4] http://www.cancerview.ca/idc/groups/public/documents/webcontent/hhr_repo_niagara_west.pdf

Leading Practice Themes	
	homes, retirement homes, long term care facilities, hospices, hospitals, etc. • Family doctors and primary care nurses are key for the primary care aspect of the model. They receive support from the palliative care team of consultant specialists, consisting of palliative care clinicians (e.g., palliative care physician, palliative care nurse, psychospiritual clinician and bereavement counselor) and a dedicated home care manager. A key component of the model has been the introduction of a Palliative Care Nurse Clinician as an overall system and patient navigator.

Transforming End of Life Care in Acute Hospitals[5]	• The Transform Programme aims to improve end of life care within acute hospitals across England, enabling more people to be supported to live and die well in their preferred place.
	
	• To support hospital Trusts in reaching these goals, the Transform Programme encourages the use of existing tools and resources and in particular the implementation of five key enablers:
	
	  • Advance care planning
	
	  • Electronic Palliative Care Coordination Systems
	
	  • AMBER care bundle
	
	  • Rapid Discharge Home to Die Pathway
	
	  • Liverpool Care Pathway for the Dying Patient
	
	• **How hospitals benefit from the Transform Programme**
	
	  • It improves the quality of individual patient experience and quality of care
	
	  • It supports people to die in the place of their choice
	
	  • It promotes the development of a skilled workforce with improved staff morale and retention
	
	  • It allows the Trust to manage its resources effectively, including a reduction in inappropriate interventions
	
	  • It helps to manage and reduce unplanned hospital admissions

[5] http://www.endoflifecare.nhs.uk/search-resources/transforming-end-of-life-care-in-acute-hospitals.aspx

Leading Practice Themes	
	• It reduces complaints and enhances reputation of the Trust.
Electronic Palliative Care Co-ordination Systems (EPaCCS)[6]	• Enable health and social care staff to have instant access to crucial information about people approaching end of life. The development of EPaCCS was a key commitment of the End of Life Care Strategy and has been highlighted in the Department of Health's 2012 Information Strategy. An information standard for end of life care co-ordination systems was approved in March 2012. ISB 1580 sets out the key information to be recorded and shared, supporting high quality, and co-ordinated end of life care.
Palliative Alliance[7]	• The Alliance consists of 27 researchers and 38 organizational partners from around the world that have come together share their expertise in palliative care or related field in order to contribute to the development of palliative care in LTC. The researchers in the Alliance have expertise in palliative care education, pain and symptom management, organizational health etc. Organizational partners are local to the communities of the four study sites as well as are provincial and national organizations. • The overall goal of the PC-LTC Research Alliance is to improve quality of life for people who are dying in LTC homes through developing formalized palliative care programs which follows the Canadian Hospice Palliative Care Association's Square of Care.

[6] Improving End of Life Care brochure from the NHS National End of Life Care Programme. 2012
[7] http://www.palliativealliance.ca/