



Hospice
Palliative
Care Network
Hamilton Niagara Haldimand Brant

**HNHB HPC COMMUNITY-BASED
SHARED CARE TEAMS**

Presentation Overview

- Value and Evidence for Experts Teams
- Provincial Direction
- HNHB Direction
- Collaborations and Partnerships

**Enhancing Family Physician
Capacity to Deliver Quality Palliative
Home care: *The Niagara West End of
Life, Shared-Care Model***

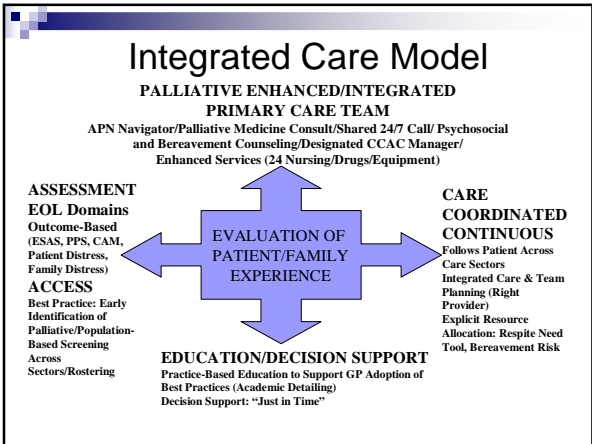
- **Project Investigators:**
 - Principals: Dr. Denise Marshall and Dr Doris Howell
 - Co-Principals: Dr. A. Taniguchi, Dr. J. Kaczorowski, Dr. K. Brazil, Dr. M. Howard.
- Funding: *MOHLTC, Primary Health Care Transition Fund Project*

Background

- Family physicians:
 - view palliative care as an inherent and important part of their role (Lehman & Daneault, 2006; Marshall, Howell, et al, 2007)
 - potential to provide effective palliative home care given adequate knowledge, skills, confidence and timely access to specialist advice (Fainsinger, et al, 2001; Higgins on, 1999).
 - family doctors and specialists often fail to develop the collaborative working relationships that would protect patient-doctor relationship and strengthen the role of the family physician (Kaperski, et al, 2006).
- Shared care between specialists and primary care physicians in mental health, maternity care, and chronic diseases have shown improvement in timely access and improved health outcomes (Rocker, 2006).

Purpose and Specific Aims

- **Purpose:** To improve quality of EOL care through implementation of a shared care model that integrated family physician care with specialist interdisciplinary palliative care.
- Specific Aims:
 - To build capacity of family physicians to provide quality palliative care 24/7 through academic detailing, role modeling and shared care.
 - Improve access to quality palliative care early in the EOL trajectory through best practice screening in GP offices .
 - Evaluate impact of model on patient/family outcomes; primary care provider outcomes; and health system outcomes.



Primary Care Interventions and Integrations

- Family Health Team practices
- 'Case finding' best practice established
- Advanced Practice Nurse as key point of contact
- APN is care settings bridge- across regions
- 'Point of care' education- using EIP model, academic detailing, Small group, case-based
- Palliative care practice lead-self selected
- Layered on-call- 1st call, 2nd call
- Shared care visits, shared care model, cross care settings with consistency

Research Questions: Patient & Family Outcomes

- Research Questions:
 - What is the effect of the enhanced team on:
 - Symptom severity and emotional distress (patient/family) from baseline to 14 days and over time?
 - Hypothesis:
 - (1) symptom severity and distress will improve from baseline to second measure (7-14 days).
 - (2) symptom severity and distress will be maintained below 6 over time.
 - What patient and disease variables are predictive of symptom and distress scores?
 - Was there concordance between preferred place of death and actual location of death?

Outcome Evaluation

- Patient/Family Outcomes
 - Reduction in symptom severity
 - Reduction in psychosocial distress for patient/family
 - Concordance between preference and place of death.
 - Patient and family perception of care quality (coordination, communication, informed decision-making, timeliness/ right services, prepared).
- Provider Outcomes
 - Satisfaction with Care Integration, Communication, Coordination, Care Planning (survey and interviews)
- Health System Outcomes
 - Reduced emergency visits, reduction in hospital days, increased home care days.
 - Cost minimization for home compared to hospital.

Costs Vary by Patient Need and Less than Hospital Day (2007)					
	Case 1	Case 2	Case 3	Case 4	Case 5
LOS	65	125	163	16	83
Home Care Days	57	125	159	15	49
Hospital Days	8	0	4	1	34
Total cost per direct home care day.	\$316.25	\$215.17	\$254.83	\$406.13	\$195.36
MOHLTC Acute care per diem rate	\$674				

- ### Provider Outcomes Physician and nurse focus groups
- Most valued components;
 - Access to the team and on call support
 - Impact on role and practice
 - Confidence in decision making
 - Better anticipation of patient needs
 - Care coordination
 - Comprehensiveness, quality of communication, nurse/md trust and respect
 - Impact on Care Quality
 - Enabling home death, averting crisis, reduced fears of suffering

- ### Primary Care Outcomes
- Family physician uptake -100%
 - Non physician practice leads emerged from each Family Health Team
 - 3/4 MD leads continuing with role
 - Education became practice-lead
 - Improvements made in non- pain symptoms, and patient communication and confidence in providing care
 - High acceptability of the APN
 - Increases perception of ability to manage and feel capable to take on care (nurse and MD)

Demonstration Project Summary

- A shared-care, population based model that integrates specialty PC supports with primary care:
 - Is efficient, effective and sustainable care
 - Increases capacity to achieve preference for place of care and death
 - Enhances the capacity of the Family Physician to provide geographically based Palliative care
 - Underscores the vital role of Palliative care Advance Practice Nurse as “ patient navigator”

HNHB Direction

- Consultant- engaged in Palliative care System design for the HNHB HPC Network
- HNHB HPC Network Service Delivery- priority focus on community teams
- January 27, 2009- preliminary approval , Aging at Home Strategy Funding
 - Yr 1 - \$729,006
 - Yr 2 - \$1,129,878
 - Yr 3 - \$1,552,750
 - Ongoing annual operating - \$837,550
- Awaits final LHIN/ MOHLTC approval

Proposal Overview

- The establishment of Community-Based, Shared-Care, Palliative Care Teams to assist seniors with EOL care throughout the HNHB LHIN area.
- These teams would shift the care of the dying from the acute setting to a home setting, whether this is an individual's home, long term care residence, rest and retirement home or residential hospice.

Proposal Overview

- These teams are based on a proven evidence based best-practice model.
- Shared care involves primary care providers in a team partnership of care with expert clinicians who together share the care of the patient in an integrated and seamless manner.

Proposal Overview

- This model would be part of an integrated service delivery approach
- This model fosters inter-professional collaborative, patient-centred practice.
- This community team model would be the first piece of a larger service delivery model and system design for HNHB LHIN

Components of the Model

- Defined population /geography
- Consultation/education by specialist to primary care, building community capacity
- 24/7 access to specialist clinician support
- Crosses continuum of patient care settings
- Coordinated system navigation

Components of the Model

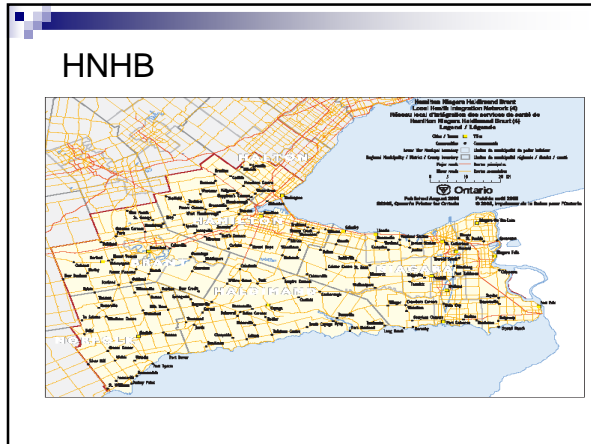
- Standardized assessment, processes of referral, patient records, evaluation and documentation
- Locally driven partnerships with a consortium based governance model
- Customization at the local level with overall adherence to iterations of a shared care, consultative model

Team Complement

- HPC Physician Specialist
- Primary Care Physicians
- Advanced Practice Nurse/Expert Nurse Clinician
- Psychospiritual Clinician
- Bereavement Support Clinician
- Dedicated CCAC Case Manager
- Administrative Support

HNHB

- The Hamilton Niagara Haldimand Brant (HNHB) LHIN covers 7,000 km²,
- Encompasses Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk.
- With approximately 1.4 million people, it is the second-largest LHIN in Ontario in terms of population size.
- The HNHB LHIN is characterized by small rural communities and large urban centres, with a resident population that displays cultural and linguistic diversity.



Phased-in Implementation Plan

- 9 community based palliative care teams to serve a population-based approach
- multi-phase approach with community capacity building and resource development.
- Three year period with community readiness strategy

Year One (2009-2010)

- Hamilton East (1 FTE Team) - existing
- Niagara West (.5 FTE Team) - existing
- Brantford (1 FTE Team) - existing
- Burlington (1 FTE Team) - existing
- Niagara North (.5 FTE Team) – new
- Hamilton Central (1 FTE Team) - new

Year Two (2010-2011)

- Niagara South-East (1 FTE Team) - new
- Haldimand Norfolk (1 FTE Team) - new

Year Three (2011-2012)

- Niagara North-East (1 FTE Team) -new
- Hamilton North (1 FTE Team) - new

Partnerships and Resources

- The grant is a partnership
 - HNHB LHIN
 - HNHB HPC Network
 - HNHB CCAC
 - Division of Palliative Care, Department of Family Medicine, McMaster University
 - Lakehead University
- Other local partners working collaborative on the individual (including in-kind resources)

Expected Outcomes

- Impact on Alternative Level of Care (ALC), Emergency Room (ER)
- Greater achievement of requested place of death
- Supporting Current Initiatives in the HNHB LHIN IHSP
- Building Community Capacity
- Growing Physician Capacity
- Fewer patient transitions in care

Impact on Alternative Level of Care (ALC), Emergency Room (ER)

- In 07-08 there was a total of 3,288 inpatient cases with a palliative care diagnosis (Z51.5 code) across the HNHB
- Of these cases 2,671 or 81.2% entered an inpatient bed via the emergency department
- The total number of inpatient days occupied by these patients was 88,195 days.
- The total number of ALC days occupied by these patients was 34,425 days or 39% of palliative inpatient days.
- The average ALC beds per day were 111 at 85% occupancy.

Growing Physician Capacity

- Palliative care physicians in our LHIN have formed a group with MOHLTC- the HOPE APP
- little new capacity building for HPC Physicians in this first contract
- Aging at Home Funding would provide a three year funding incentive for MD to practice Palliative care in the region
- Successful demonstration of patient need for these MD would provide evidence for growth for the second APP contract

Current Network Service Delivery Activities

- Service Delivery Committee (SDC) will help guide the roll-out, providing common tools and support
- SDC currently has membership from across the 4 current teams - now expanding to include representation from across the continuum of care as requested by the Advisory Committee
- Nursing Roles Sub-Committee
- Psychospiritual and Bereavement Roles Sub-Committee
- Evaluation Sub-Committee
- Engagement with Community Teams governance groups
- Engaging the 3 Community Committees and Membership

Provincial Direction

- To date four Network proposals have been approved within the Aging at Home Strategy across the province for community based teams, including:
 - Erie St. Clair
 - Wellington Waterloo
 - Central
 - HNHB
- distinctions within the models, but similar values, components and outcome performance measures

Provincial Direction

- Each of these LHIN areas are now working cooperatively to share resources, tools and experiences as the teams roll-out, e.g.,
 - System Designs
 - Implementation Strategies
 - Team Role Descriptions
 - Memorandums of Understanding
 - Host Agency Applications

Provincial Direction

- A provincial working group has also come together, which includes: CCO, OCFP, OACCAC and the PEOLCN
- Goal – Provincial Think Tank
 - To gather key stakeholders to discuss the roll-out of a provincial model of care and to develop an implementation strategy
 - Is there enough evidence, pilot experience and momentum to roll out a provincial palliative care delivery model?
 - Are we all in agreement about working towards a vision/‘gold standard’ of fully functioning integrated service delivery model throughout Ontario?

An Ontario Regional Model of care

- Simultaneous model across care settings
- Integration between ‘pieces’
- 4 defined levels of care
 - Primary
 - Secondary
 - Tertiary
 - Quaternary
- *The HNHB Network shared care community teams are a primary/secondary interface and thus can be part of the overall model of care*

■ ***Every system is perfectly designed to get the results it gets.***

□ P Bataldin
