

Annual Report 2008-2009

Improved Patient Flow (e.g., ED diversion, ALC alleviation, community supports, reduced wait times)

The Network submitted its first consolidated HPC proposal under the year two Aging at Home Strategy. This consortium proposal received consensus approval by the membership for the development of 9 Shared Care Teams in the Community. 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. The process of care would include standardized clinical assessment tools, team meetings for care planning with continuity and shared learning, along with common patient records and mechanisms to support communication. The proposal received approval in principle by the LHIN.

The Network, in conjunction with the Division of Palliative Care, Department of Family Medicine, McMaster University, and the Juravinski Cancer Centre developed an education tool kit for Family Physicians in the community for the implementation of common assessment tools, collaborative care plans and symptom management guidelines.

The Network also works in conjunction with the Palliative Care Consultants and hired two additional Consultants last year for Niagara and Hamilton to ensure equitable access across the LHIN area. The Consultants deliver case-based consultation, education, training and mentorship to staff providing palliative care in a variety of care settings. They also work with the Network to build community capacity in their designated areas within the HNHB.

The Network has been working with the Hamilton Health Sciences' Quality End-of-Life Care Task Force over the last 18 months to develop a corporate wide quality End-of-Life Care policy and procedures for EOL care plans for high-risk patients. The outcomes of this work includes:

- Holistic and consistent care at end-of-life;
- Treatments aligned with patient wishes, best interests, best practices;
- Seamless transitions between care settings for patients at end-of-life;
- Clear documentation of end-of-life care plan;
- Interprofessional collaboration in providing quality end-of-life care;
- Staff capacity to support patients/families through end-of-life care planning process; and
- Community awareness of the importance end-of-life care planning.

The Network will continue to work in partnership with HHS to support this knowledge transfer to the other hospitals across the HNHB LHIN area, with the hope of creating one standardized shared practice.

Education and Training

The Network was successful in delivering across the LHIN area:

- 19 Fundamental courses (interdisciplinary introduction to HPC);
- 1 AHPCE course (advanced HPC education for PSWs and Volunteers);

- 2 community education refresher days in Haldimand Norfolk and Niagara;

The Network, in conjunction with the Division of Palliative Care, Department of Family Medicine, McMaster University, was also successful in delivering across the LHIN area:

- 3 – three day LEAP courses (Learning Essential Approaches to Palliative and End of Life Care for Physicians and interdisciplinary team development);
- The Annual Fall Innovations Conference entitled “Fostering Uninterrupted Care – Sharing Vital Information”

New Relationships (e.g., memorandum of understanding, partnerships,)

The Network established a new memorandum of understanding or organizational participation agreement with stakeholder organizations across the continuum of care settings within the HNHB LHIN area. To date 17 organizations have signed on as formal partners with the Network with a commitment to work together to improve care for patients/families in the HNHB LHIN area and to influence the system to ensure that HPC services and supports are available to everyone throughout the HNHB LHIN area. These partners currently include hospitals and residential hospices, with next steps focused on partnering with the LTC Homes and the community.

The Network, in conjunction with the Provincial End-of-Life Care Network partnered with Cancer Care Ontario, the Ontario College of Family Physicians and the Ontario Association of Community Care Access Centres in planning a spring 2009 HPC Provincial Think Tank that will gather key stakeholders to:

- Present the evidence and pilot experience;
- Engage momentum and facilitate agreement to work towards a vision/’gold standard’ of a fully functioning integrated service delivery model; and,
- Discuss the roll out of a provincial Palliative/EOL shared care delivery model

The Network, in conjunction with the Provincial End-of-Life Care Network partnered with the Seniors Health Research Transfer Network to develop a Provincial EOL Community of Practice (CoP). The purpose of this CoP is to give palliative care providers mechanisms to work collaboratively to facilitate the exchange of information; identify and recommend areas of common interest for shared project planning and implementation; facilitate system coordination, decrease duplication and increase efficiencies. The EOL CoP also works across other CoPs including Alzheimer’s and Congestive Heart Failure on joint initiatives.

Planning Outcomes for Future Action

In August 2008 the Network published phase one of the HNHB HPC system design to provide an HNHB framework that the Network and its membership can use to help guide the development of an integrated hospice palliative care service delivery model in our LHIN area. It will support hospice palliative care organizations in their own decision-making and in the development of their own internal hospice palliative care strategic plans. It will also help inform the LHIN about priority requirements and support a multi-staged implementation plan for hospice palliative/end-of-life care in the HNHB LHIN.

Phase II of the HNHB HPC system design will be complete by fall 2009.

