## End of Life Care (EOLC)/Hospice Palliative Care (HPC)  
### Key Projects

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<th>Explanation</th>
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| 1. Pursue priorities as outlined in the provincial document “Declaration of Partnership and Commitment to Action”, including formalizing the EOLC accountabilities and evaluative framework. | Provincial alignment:  
ESC EOLC work is in sync with that of the province as a whole.  
This Declaration document clearly links CDM and Palliative Care. (pg. 15)  
Copy of Declaration document at: [http://www.esceolcn.ca/Reports/Vision&DeclarationPartnership_v6_08Dec2011D2.pdf](http://www.esceolcn.ca/Reports/Vision&DeclarationPartnership_v6_08Dec2011D2.pdf)  
Re. Declaration Document:  
“Commitment from 14 LHINs:  
•To improve the quality of palliative delivery across Ontario, LHINs have agreed to use the Declaration of Partnership as the basis for broader regional consultation and planning discussions.”  
“Common LHIN Deliverables by 2015:  
•Established regional palliative structure with specialized palliative and advanced chronic disease resources coordinated at the regional level  
•Implementation of a palliative MLPA indicator and Balanced Scorecard  
•Care coordination role implemented through collaboration with all palliative care Health Service Providers (HSPs) across the continuum of care  
•Outreach processes established across all palliative care HSPs across the continuum of care to identify individuals with advanced chronic disease and connect them with an extended inter-professional team.”  
(For further information and references see: Attachment #1 - 1 IHSP-EOLC Provincial Initiative - backgrounder)  
ESC EOLCN work has been systematically and consistently guided by its strategic plan and updated integrated planning/implementation activities:  
**Strategic Plan:** [http://www.esceolcn.ca/AboutUs/documents/CurrentServicesRecommend.pdf](http://www.esceolcn.ca/AboutUs/documents/CurrentServicesRecommend.pdf)  
**Updated integrated planning/implementation:** [http://www.esceolcn.ca/AboutUs/IntegratedSysPlanning.htm](http://www.esceolcn.ca/AboutUs/IntegratedSysPlanning.htm) |
| 2. Continue to initiate Education Collaborative coordinated with other educational activities in Hospice Palliative Care with emphasis on best practice uptake in all care settings, (this one tactic connects with and subsumes a | Background re. HPC/EOLC Education in ESC:  
HPC/EOLC education in ESC is organized to foster best practice, common messaging and to maximize the current funds available for education. To this end the Education Subcommittee (which reports to the EOLC LHIN Advisory Network and is chaired by Julie Johnston) provides direction for cross sector, cross geography HPC education. The work of the Education Collaborative (coordinated by Maura Purdon) is directed by this committee.  
Based on a multi-year plan, each year the Education Collaborative work focuses on specific identified needs/ gaps. This year’s work includes (but is not limited to):  
1. Learning Essential Approaches to Palliative and End-of-Life Care (LEAP) Education program – Palliative Pain & |
| Lot of activities) | Symptom Management Program Southwestern Ontario & Bluewater Health
2. HPC in Hospitals (1 day) education – Windsor Regional, CKHA, Leamington,
3. Tri County PCCT community team education,
4. Pilot HPC education for PSWs – S/L or C/K lead Pilot
5. Tri County HPC Volunteer
6. Share the Care Stations – Windsor & Sarnia Hospices
7. Pilot Advance Care Planning workshop/s – CKHA Lead
8. Advanced Hospice Palliative Care Education (AHPCE) for Personal Support Workers (PSWs)
9. ‘Last Hours and Days’ – practical, hands-on education for First Nation PSWs.

(For further information and references for above see: Attachment #2 - ESC Hospice Palliative Care Education Collaborative, Year 5 Overview).

3. Enhance hospice palliative care programming in all hospitals (including ICUs) to facilitate better care, earlier identification, appropriate placement within hospital (e.g. avoid ICU admission when possible) and optimal discharge planning from hospital,

| A key standard articulated in the Provincial HPC System Design Framework and reiterated in the Declaration document is: “In each care setting where patients die there is a clearly defined Palliative Care Program”. (pg. 12 - http://www.esceolcn.ca/Reports/ProvSysDesFramework.pdf).
It has been estimated that fewer than 40% of care settings can meet this standard.

The following hospitals in ESC have committed to enhancing their Hospice Palliative Care Programming in the next year:
- HDGH
- WRH
- CKHA
- LDMH
- BWH

The focus and approach of each organization differs, however all have committed to a collaborative approach with partners.
(Work plans and strategies for each site are under development. One upcoming key collaborative activity in W/E involves a process mapping workshop – sponsored by the RCP).

4. Quality improvement in LTC with respect to HPC. (In addition to building capacity through education, there is also effort in attaining quantitative and qualitative data to support outcome measures.)

| Each year over 750 people die in Long Term Care Homes (LTCHs) in Erie St. Clair (ESC). With efforts to conserve acute care system resources increasing, more people are remaining in long-term care (LTC) through to the end of their lives, resulting in an increase in the complexity of palliative care required in LTC settings. Yet many of our LTCHs report being poorly equipped to deal with these complex needs. One of the challenges often cited is the limited availability of capacity building; education and training in palliative and end-of-life care for staff working in LTC.

In ESC one of the activities undertaken to help address this was a pilot project where a nationally recognized palliative care education program, Learning Essential Approaches to Palliative and End-of-Life Care (LEAP) was used to provide education. This project included partner collaboration with a “job shadowing” opportunity that brought LTCH staff to St.
Joseph’s Hospice.
Successful evaluations of this pilot project resulted in a second round of education offered to LTCHs in another county.
(For additional information refer to newsletter pg. 5

The success of this has led to further recognition and:
• A request for our PPSMCP to lead the upgrading of LEAP curriculum for LTCHs (Canada-wide),
• An offer to partner with NW LHIN with SKTN (which is formerly SHTRN and ORC [Ontario Research Centres on
Aging]) where a knowledge broker would work with us to implement framework for PC and LTC and the tools
for change.

This current quality improvement activity builds on the above work.

5. Enhanced primary care role in managing EOL patients

The need to enhance the role of Primary care in managing EOL patients is articulated in the Declaration document:
“Ensure primary and secondary providers in each community have timely and appropriate access to specialized
palliative expertise (e.g. inter-professional palliative consult teams available to all care settings as well as other
processes (for education, mentorship and specialized consultation)
• Provide expert palliative care (when it is needed) through an inter-professional team approach that includes
skilled palliative care service providers becoming a part of the core team of primary providers,
• Determine what resources are needed within each community to ensure access to palliative consult team(s),
• Avoid duplication of consultation level services in any one region.”

Action commitments include:
• “LHINs via their Regional Networks/Programs will examine ways to strengthen and leverage access to palliative
care expertise at all levels (primary, secondary, tertiary).
• MOHLTC to consider in context of policy development” (pp. 32, 33).

ESC LHIN and ESC EOLCN are undertaking tactics and activities to support the role of primary care providers in managing
EOLC. These include:
• LEAP education (several sessions throughout the region),
• Increasing physician involvement at collaborative tables (e.g. ESC EOLCN LHIN Advisory Network),
• Supporting role of RCP physician lead at a regional level,
• Clarifying referral criteria for each provider level,
• Supporting implementation of 5 new Palliative Care Nurse Practitioners in ESC.

A key issue in terms of physician primary care involvement in EOL care is related to physician remuneration.
-Under the topic of PHYSICIAN ENGAGEMENT, the Declaration document (pg. 37). states:
“Ensure the right financial incentives and delivery supports are in place to broaden and optimize physician
6. **Virtual Team – advanced access to EOL specialists/other**

The concept of Virtual Teams spanning all sectors is articulated in the *Declaration document*.

“Provide care through an inter-professional care team approach:

Teams will be fluid in their members as defined by individual / family need throughout the illness journey and inclusive of palliative care specialists (e.g. including palliative consult teams) when appropriate. The person and family are at the centre of the care. Providers in each care setting are part of a “virtual team” that spans all the care settings and sectors through which the person may pass.” (*Declaration document* pg. 39)

In ESC two key steps are required to advance this vision of a virtual team:

1. Each care setting needs to have basic elements of a HPC program. (refer to 3 & 4 above),
2. The individual silos (care settings) need to work together as a system. This requires intentional collaboration.

As part of this IHSP work, specific collaboration essentials are being pursued, led by a variety of partners. These activities include:

- advancing use of best practice common tools and processes (including CCO Symptom Management Guides)
- Strengthening/creating collaborative structures (including patient specific cross sector rounds, enhancing EOLCN regional and local tables etc.)
- Common understanding of service delivery models
7. Advance Care Planning Strategy for Uptake

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<th>Draft plan re. ESC ‘ACP for ALL Program’</th>
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<td>• 3 year ESC wide program directed at having people of all ages, including the seriously ill, complete advance care plans</td>
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<td>• Goal is to encourage earlier conversations &amp; development of plans so conversations are not having to be managed in a crisis</td>
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<td>• Proposed program to involve collaboration &amp; partnership between the ESC LHIN, ESC EOLC Network, EOLCN Education Collaborative, SW PPSMCP, ESC hospitals, ESC CCAC, Community Service Providers, Primary care providers, Hospices, LTCHs &amp; Volunteer organizations</td>
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<td>• Year 1 proposed:</td>
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<td>o One hospital facility in partnership with the ESC EOLCN, Education Collaborative, SW PPSMCP &amp; ESC CCAC to develop Pilot education sessions &amp; resources that are open/available to other sectors &amp; geographies in years 1-3.</td>
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<td>o Explicitly link with COPD work to insure ACP included in process and clinical care paths.</td>
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<td>o Explicitly link with provincial level work.</td>
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For further information see:

- “Speak Up” campaign at: [http://www.advancecareplanning.ca/](http://www.advancecareplanning.ca/)
- information in Declaration document related to ACP (e.g. pg. 39)

Note – ESC ACP work plan is under development awaiting approvals from partner agencies.

8. Supporting residential hospice development in Chatham-Kent and in Leamington

| The importance of Residential Hospices as a shared priority is articulated in the Declaration document: |
| “OPTIMIZE RESIDENTIAL HOSPICES TO SUPPORT INDIVIDUALS WHO CANNOT BE CARED FOR AT HOME BUT WHO DO NOT REQUIRE CARE IN A HOSPITAL” (pg. 37). |

Action commitments, articulated in the Declaration document, that the ESC region has already embraced as part of the business plans prepared by both Chatham-Kent and Leamington include:

- “Review client population (e.g. profile and needs) and care delivery models within existing free-standing residential hospices to understand any existing variations (delivery and cost and outcomes) |
- Consider innovative approaches to reduce capital costs (e.g. using existing spaces)”,(pg. 37)

Other action commitments in the Declaration document require a provincial level impetus. These include:

- “HPCO and PEOlCN in collaboration with MOHLTC, LHINS, to launch a residential hospice action group to further explore issues (including policy and delivery) and develop a business case for change |
- Ensure Ontario residents have equitable access to this resource, where care in this setting is the most appropriate and cost effective based on individual and family preferences and level of need,
Establish an appropriate level of consistency across regions,” (pg. 37).

As provincial level action is undertaken the ESC EOLCN/LHIN will continue to:
- support alternatives to Residential Hospice care,
- seek possible regional funding opportunities,
- work with/encourage grass-level groups as opportunities arise,
- actively advance provincial level work.