



,Charter

Erie St. Clair Palliative Care Consultation Team Program Project Charter for Year 2

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REVISION HISTORY

WHO	DATE	DETAILS / CHANGE	VERSION #
Beth Lambie	July 23, 2009	First draft – distributed to CCAC “charter preparation group”	1
Norma Unsworth Betty Kuchta Beth Lambie	July 28 th , 29 th 30 th	Change patient to client; remove appendices; remove section “what this team is not funded to do”; add resources & stakeholders; wordsmithing, formatting	2,3,4
Beth Lambie	July 30 th	Cost/Benefit revisions, Formatting, wordsmithing	5
EC EOLCN	August 1 st -24 th	typos, wordsmithing, eligibility criteria, volume targets & pop based \$ distribution, clarify ER avoidance indicators, clarify budget including W/E planning \$, clarify Planning for W/E yet to establish model/clarify section 4-2-rewording	6
Beth Lambie, Project Team Subcommittee, Dr Maddison	August 19 th , August 27 th	adapt cost/benefit – section 3 based on OCDM costs from LHIN and ER visits/admission data from CCO/ formatting re: functions/clarification of consultation vs. care/ budget clarification/metric clarification	7,8,9
EC EOLCN	Sept 30 th	Enhance comments re. role with non- cancer clients / add comment re source of background information / remove comment re. ‘no formalized process’ by way of acknowledging previous work in WE re team from Hospice / formatting./add comment re. CTAS 1&2	10
PPSMCP	Nov. 11 th	Clarify PPSMCP role; augment goals, follow-up on feedback from ECT, clarify client/patient/resident	11

Table of Contents

Section 1: Project Description..... 1

Project Overview..... 1

Program Goals..... 5

Project Activities 7

Expected Project Deliverables 8

Milestones 8

Prerequisites and Dependencies 8

Section 2: People..... 9

Project Team..... 9

Escalation Points..... 9

Key Stakeholders..... 10

Section 3: Business Case..... 13

Expected Benefits and Cost Benefit Analysis 13

Proposed Budgets..... 16

Section 4: Risk Assessment..... 20

Risk Matrix..... 20

Section 5: Environmental Analysis..... 22

Environmental Analysis..... 22

Appendix One – Cost Benefits Calculations

Section 1: Description of Palliative Care Consultation Program and "Next Steps" Project

Charter Scope: This project charter seeks to address the following questions:

1. How do we move forward with the next phases of implementation of the Aging at Home (A @ H) Palliative Care Consultation Team (PCCT) Program for Erie St. Clair (ESC)?
What are the next steps?
2. What *is* the PCCT Program and why do we need this program?

Note –This charter is a follow-up document. Original information sources and references are cited in a number of previous reports completed by the Erie St. Clair End of Life Care Network (ESC EOLCN) (1) (2) (3) (4).

1. How do we move forward with the next phases of implementation of the Aging at Home Palliative Care Consultation Team (PCCT) Program for Erie St. Clair? What are the next steps?

Planning, Implementation and Evaluation: This project charter describes year two (2009/2010) "next steps" related to the Palliative Care Consultation Team Program (PCCT) funded through the Aging at Home (A@H) funding in Erie St. Clair (ESC). These "next steps" include:

- Evaluation of key elements of the Sarnia Lambton PCCT (established in 2008/2009) and recommendations for enhancement
- Planning and execution of key activities for implementation of the Chatham Kent PCCT in 2009/2010
- Planning for 2010/2011 implementation of Windsor Essex PCCT

The next steps are described through citing: project activities, expected deliverables and milestones, prerequisites and dependences etc.

2. What is the Palliative Care Consultation Team and why do we need it?

This project charter provides high level summary information about the rationale for the PCCT program and the operational elements of the program across the Erie St. Clair service area. The program description is provided below in a Question & Answer format followed by a summary of program goals.

Description of Program -Summary Description of Palliative Care Consultation Team

Why do we need a Palliative Care Consultation Team?

Access to specialist level Palliative Care is required in all settings where clients die. A Palliative Care Consultation Team (PCCT) is the preferred way to provide specialist level care. There is a significant body of literature supporting the value of Palliative Care Consultation Teams. Experience across the country and internationally supports this model of care as a fundamental component of a high quality "Palliative Care Program". Prior to implementation of PCCTs in Erie St. Clair there was no funded process for providing clients, living in their own homes, with specialist level direct care. As more and more clients choose to die at home, access to specialist level care is imperative.

Population-based calculations indicate that more than 3000 people per year in Erie St. Clair require access to a specialized program of Palliative Care. (This number includes clients in all sectors not just clients in their own homes). Due to physician shortages and other Human Resource issues access to specialist level Palliative Care in Erie St. Clair is limited across all sectors. This team will help address this issue for clients in the community and will facilitate integration across sectors.

What is this team funded to do?

Key functions and interventions include:

1. **Consultation** by expert clinicians for advanced pain and symptom management and other issues.-

Follow-up includes:

- consultation report (rapid turnaround time),
- formalizing "shared care model" for each specific client (e.g. determining Most Responsible Physician and facilitating working relationship between primary care physician and consultant, building capacity through mentoring, etc.),
- follow-up consultation and care as required

Consultation venues may include:

- in client's own home
 - in a clinic setting (for transportable clients)
 - in other venues as requested
2. **Co-ordination of care planning** for individual clients - This co-ordination is facilitated by cross-sector client care rounds (2x/month), by ready access to consultation reports, and by expediting testing/interventions/consultations with other specialist/service as required for symptom management. This co-ordination is enhanced specialized case management for this specific population and works symbiotically with the CCAC case managers.
 3. Provision of **On-Call Expertise 24/7**. - This expertise is provided by a team of resource nurses developed from existing contracted ESC nursing service providers. These resource nurses have additional training in Palliative Care. The Palliative Pain and Symptom Management Consultation Program (PPSMCP) consultant is an expert resource for team members.
 4. **Client/Family Education and Counselling** related to End-of-Life Care issues (including assistance with Advance Care Planning, Expected Death in the Home processes, etc.)
 5. Service delivery of **services not currently funded** by home care system in Ontario (e.g. Spiritual care, laboratory (in-home) service, etc.)
 6. **Augmentation of services** currently funded by home care system but limited - These services may include:
 - extra social work visits (provided by Social Worker with expertise in Palliative Care)
 - extra equipment rental (e.g. to extend bed rentals beyond 30 days)
 7. Formalization of **Symptom Response process** relating to ESAS (Edmonton Symptom Assessment Scale) & PPS (Palliative Performance Scale) Scores.
 8. Ongoing **evaluation of and improvements to** this new PCCT program.
 9. Provision of consultation and direct service for clients who are now cared for in the community, but who otherwise **would have been cared for in Emergency or in Acute Care**. (Direct care costs are covered by CCAC)
 10. Facilitate integration of the system as a whole. This team is expected to serve a key system integration function linking sectors and services including acute care, complex continuing care, hospices, cancer programs, community, PPSMCP, volunteer hospice programs, etc.

Who receives this care?

Eligibility Criteria:

Seniors are the largest proportion of clients who require Palliative Care.

This team will see all clients requiring palliative care – any diagnosis and any age. (It is expected that approximately 80% of clients will have a primary diagnosis of cancer with 20 % of clients demonstrating other chronic diseases as their primary diagnosis. Examples of non-cancer diagnoses include: Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Chronic Obstructive Pulmonary Disease, Stroke etc.).

Clients must have a valid OHIP number.

The following three questions are used to determine who will be seen by this expert team:

- Would you be surprised if this client died in the next 6 months?
- Does the client have symptoms and/or support needs?
- Do these symptoms and/or support needs require specialist level interventions?

Priority access will be given to any client requiring Palliative Care Services who is:

- at risk of being admitted to hospital
- at risk of presenting at the Emergency Room
- in hospital bed or Emergency Room and could be discharged home if the right kind of support was available
- in crisis
- requiring more (enhanced) service than the existing health care system can provide (on a short term basis) to enable them to stay in their own home longer

Most clients cared for by this team will be eligible for CCAC services. However any client may be seen by this team even if he/she is not currently a client of CCAC.

Who comprises the team?

- Physicians – not eligible for funding under this program
- Nurse Practitioners/Expert Nurses
- Social Workers
- Spiritual Care Providers
- Co-ordinator
- Other allied health providers as required (over and above CCAC's allocation for these services)
- Team Assistant
- Resource Nurses (providing 24/7 on call)
- PPSMCP Consultant (not funded under this program)

What agency has operational responsibility?

CCAC has operational responsibility for the PCCT in Sarnia Lambton and Chatham Kent. This includes administrative, financial, human resource and accountability roles. The Windsor Essex operational framework is yet to be developed.

What is the Advisory Role of the End-of-Life Care Network (EOLCN) ?

The Executive Council of the EOLCN, with input from the three Local EOLCN Committees and Steering Committee, submitted the original Business Case to the LHIN. (Feb. 8 '08)

The LHIN requested that the EOLCN serve in an "advisory capacity" for these teams.

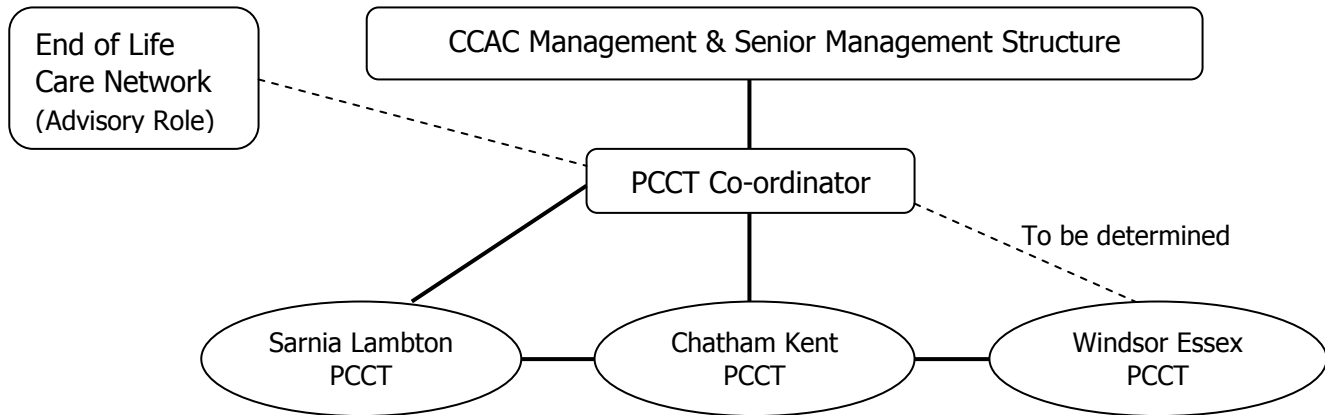
This advisory capacity does not include operational responsibility for human resources or day-to-day operations.

The current understanding of functions related to this "advisory capacity" includes:

- review of project plans and project charters
- quarterly review of budget and budget variances
 - make recommendations to address variances
- quarterly review of program targets and variances
 - make recommendations to address variances

Quarterly and year end reports will be presented to the Executive Council & Steering Committee of the EOLCN by the PCCT coordinator or designate. A summary report will be given at each local EOLCN by the PCCT Nurse Practitioner/ Expert Nurse in each county. At the request of the CCAC Senior Management the Director of the EOLCN has assumed an interim role related to project clarification/ initiation/ management for year two PCCT activities.

What does the organizational chart look like for this PCCT program?



How many new clients do we expect to see in the first full year of this program in each county?
(i.e. what are the targets?)

Sarnia Lambton – 150 new clients

Chatham Kent – 100 new clients

Windsor Essex – 300 new clients

Note – these numbers above assume that a population based methodology is used for fund distribution and that the funding for Windsor Essex is at least twice that of Sarnia Lambton

Will the teams be configured identically in each county?

It is expected that each county will develop a slightly different model of care. Variation exists, among the three counties, in terms of: current levels of funded service provision, available expertise, health status ratings, demographics, health care utilization, cultural profile etc. It is expected that these variables will be factored into the development of a unique model for each county. Part of the evaluation process is to assess the relative effectiveness of each model, Once each model is established there should be opportunity to incorporate key learnings for each and migrate practices so that eventually there is a standardized area-wide model with the best taken from each. This process is evolving and developmental.

How much extra service will be required in the community due to this team's success at hospital avoidance and how will this be funded?

One of the explicit goals of this team is to decrease dependence on hospitals (Refer to 'Program Goals' next page). Access to specialized palliative care and symptom management has been shown to reduce ED visits and subsequent inpatient admissions by up to 80%(refer to Section 3 – Business Case). Based on early experience from the team in Sarnia Lambton it is estimated that at least one third of the clients cared for by the PCCT would have had an ER visit and/or hospital admission prior to team inception.

The PCCT provides specialist level consultation and follow-up for these clients (who would previously have been hospitalized), but the provision of direct care must now be assumed by CCAC and its provider agencies rather than by the hospital.

It is generally assumed that care in the home is less expensive than care in the hospital, however costs to provide palliative care in the home are not negligible.

CCAC must fund this additional workload from its global budget. While additional funding for enhanced service provision, in the community, was provided through Ontario's End-of-Life Care Strategy (announced Oct. 2005); this funding is viewed by CCACs across Ontario as being inadequate to cover additional needs for EOL Care in the community. Concern has been expressed that service to non-palliative CCAC clients (e.g. frail elderly etc.) may need to be decreased if the EOLC team continues to be successful in its goal to decrease hospital use by EOLC clients.

This *additional service burden* needs to be more fully evaluated in Year 2 with resultant tracking and reporting to the LHIN and the EOLC Network. It is not possible to quantify this additional service burden at this time.

Why is program evaluation so important?

The Palliative Care Consultation Team is a new way of delivering care in ESC. We want to ensure that this team approach to care is enhancing care in the community and is cost effective. Additionally, as health care leaders and front-line staff we want to continually improve services for clients in Erie St. Clair. Key indicators, criteria and tracking mechanisms need to be refined, particularly those related to hospital avoidance and client outcomes.

Program Goals – Summary of Goals/Outcomes/Metrics

Table One: Summarizes Key Goals, Outcomes & Metrics for Year One & Two Team Outcomes.

Table Two: Provides more comprehensive Program Overview (using a Program Logic Framework)

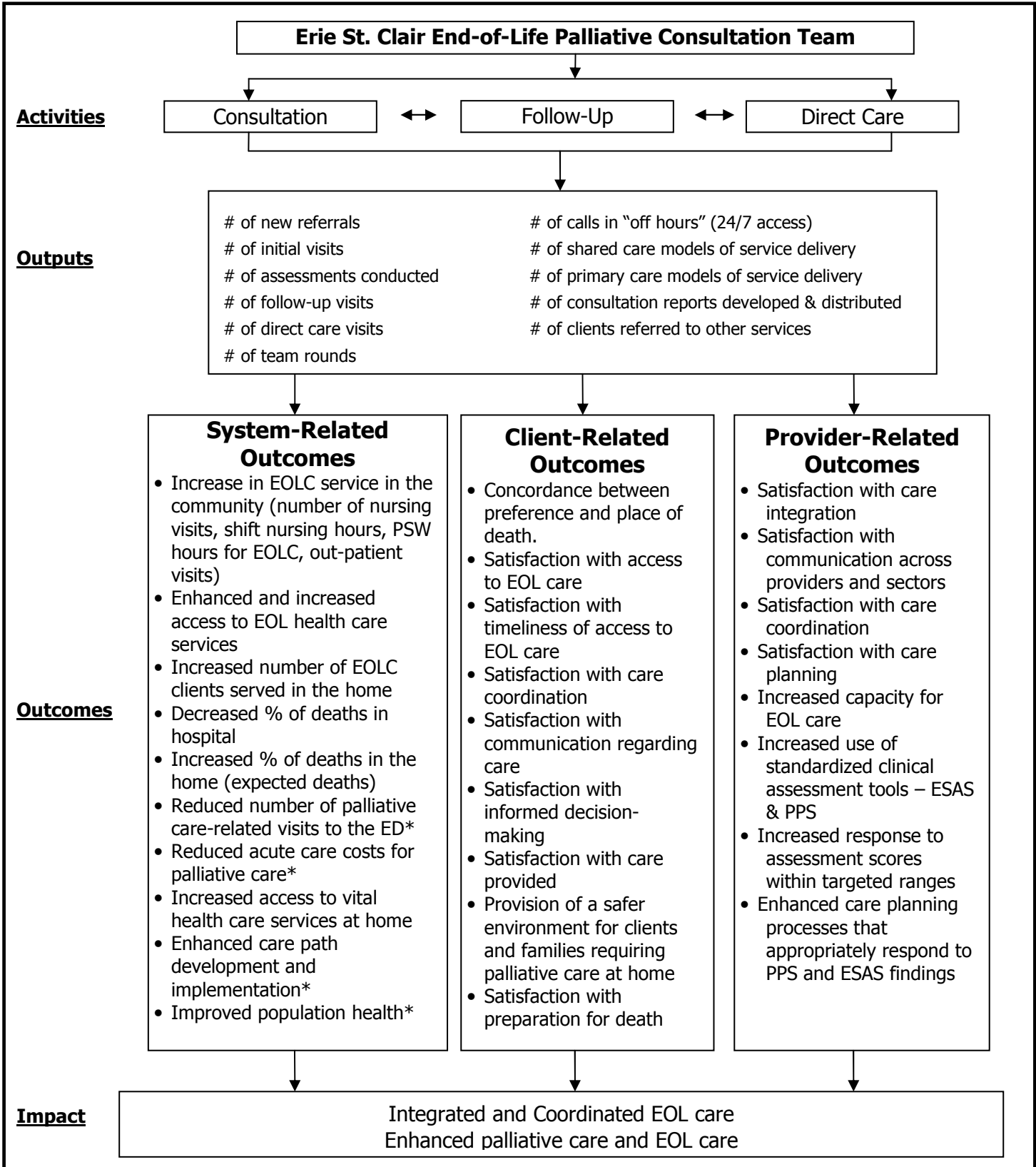
Appendix A: is an excerpt from the year one evaluation and shows a more detailed evaluation framework.

(For more comprehensive listing and description of Program Goals refer to original business case and team advancement documents submitted to the LHIN as well as evaluation documentation from year 1)

Table One

Program Goal	Outcomes or Benefits	Metrics
To increase access to specialized Palliative Care for clients in the community including expertise in: <ul style="list-style-type: none"> • symptom management • disease progression / prognosis • all domains of care 	Enhanced quality of care for client and family including a decrease in compassion fatigue with resultant improvement in bereavement recovery. Decreased stress on primary care providers who may be dealing with situations beyond their level of expertise thereby reducing burn out and staff turnover.	Number of clients accessing specialist level consultation will increase by the following in the first year of team implementation: <ul style="list-style-type: none"> • Sarnia Lambton – 150 • Chatham Kent – 100 • Windsor Essex – 300
To make it possible for clients to die with dignity at home, if that is their location of choice	Concordance between client preference and place of death	<ul style="list-style-type: none"> • 100% of PCCT clients will be asked about preference related to place of death • at least 60% of PCCT clients will achieve concordance between preference and place of death in first year of PCCT in each county • at least 50% of PCCT clients in Sarnia Lambton will die in non-hospital locations in the second year of team operation • At least 30% of PCCT clients in Chatham Kent will die in non-hospital locations (in the first year of team operation).
To decrease dependence on hospital through: <ul style="list-style-type: none"> • ER avoidance • admission avoidance • ↓ ALC days • ↓ acute care LOS 	<u>Financial</u> Net savings for health care system <u>Client/Family Care</u> Enhanced options and interventions on issues which may cause hospital admissions/ER visits.	<ul style="list-style-type: none"> • Case reviews on 100% of PCCT clients who had an ER visit or an admission (documentation of rationale and remedial action) • Avoidance of ER visits/ admissions in at least 30% of PCCT clients (note -more specific criteria need to be developed against which to measure ER avoidance)
To improve patient flow/co-ordination/integration across the care continuum	Optimization of scarce health resources; care gaps addressed, duplication reduced	<ul style="list-style-type: none"> • At least 75% of stakeholders will report an improvement in client flow as a result of the PCCT intervention

Table Two



EOL = End of Life

EOLC = End of Life Care

ED = Emergency Department

*long-term outcomes that require > 2 years for clear evidence of achievement

Source: Adapted from Evaluation Report ESC PCCT – Appendix B

Project Activities

Project Activities for Year 2:

- enhancing Sarnia Lambton Program
- initiating Chatham Kent Program
- planning for Windsor Essex Program
- overarching activities that relate to all three programs

The listing below is at a high level. Tasks related to each activity will be delineated once consensus is achieved relating to overall charter and high level activities.

1) Sarnia Lambton

Continue to enhance program as follows using Plan Do Study Act (PDSA) cycles:

- 24/7 On Call Resource Team – evaluation and recommendations
- Completion of hiring
- Refine financial accounting and supporting data
- Define budget line expenses and process to monitor & report variances
- Refine evaluation process and tracking of indicators with particular emphasis on developing criteria for evaluating ER avoidance/hospital admissions
- Clarification of criteria for “augmented services”
- Stakeholder consultation and ongoing communication

2) Chatham Kent

Recruit Physician and staff

- Confirm logistics – (location of team within CCAC, etc.)
- Team development and training
- Stakeholder consultation and ongoing communication

3) Windsor Essex

- Define model
- Define operational agency/personnel issues
- Initiate stakeholder consultation
- Initiate work on Project Charter for Year 3

4) Overarching Activities

Distribute Project Charter to EOLCN Executive Council and incorporate feedback

- Endorsement of Project Charter by LHIN
- Establish ongoing reporting requirements for accountability to LHIN
- Formalize format for information flow to EOLCN Executive Council, the ESC LHIN and other stakeholders
- Initiate Evaluation Process
- Develop Communication Plan

Expected Project Deliverables

Overarching Deliverables

- Project Charter endorsed by EOLCN Executive Council & LHIN Finalization of reporting mechanism to LHIN
- Finalization of format and process for information flow to EOLCN

Sarnia Lambton:

- Format for indicator tracking completed
- Financial tracking format and budget revised and finalized
- Resource Team evaluation with recommendations completed

Chatham Kent:

- First client seen 2 weeks after hiring/orientation completed
- Physician recruitment and staff hiring process activated as soon as written notice of Year 2 funding received
- Consultation with First Nations communities to identify and initiate resolution to unique needs

Windsor Essex:

- Identify and meet with key stakeholders to define model and initiate discussion relating to operational agency and personnel issues

Project Milestones (*denotes gated milestone)

- *Project Charter approval
- *Receipt of funding letter Year 2
- *Physician recruited for Chatham Kent
- *Hiring of NP/Expert Nurse/Support Staff - Chatham Kent
- *Team hired/contracted
- First client seen Chatham Kent
- Determination of Windsor Essex model of care and operational agency

Prerequisites

Prior to initiation of the PCCT in Chatham Kent:

- Assessment of physician interest and availability
- Development of communication plan

Early planning for PCCT in Windsor Essex will address:

- clarity on scope and sustainability of consultation service currently provided by Hospice of Windsor/Essex
- impact of cessation of current on-call physician stipend for community care and review of alternatives (e.g. agencies that may be willing to contribute to stipend)
- co-ordination of physician/team education (LEAP training)

Dependencies

- LEAP training
- Education Blueprint
- Financial Resources for Physician on-call stipend
- Other initiatives currently underway within the EOLCN (e.g. right patient/right place/right time, system design, etc. etc.)

Section 2: People

Project Team

Below is a listing of the project implementation team. The program team is described in section 1.

Project Role	Position	Name
Project Sponsor	CCAC Administration	Norma Unsworth
Project Manager	Director EOLCN – ESC	Beth Lambie
Project Resources	CCAC Executive Assistant	Rose Whelen
	CCAC Senior Manager	Andrew Ward
	CCAC Finance	Glenda Mailloux, Aaron Ryan
	CCAC – Human Resources	Kelley Ilisevic
	CCAC - Communication	Caen Suni
Project Oversight	Members EOLCN Executive Council	Kathy Bresett, Brenda Carter, Carol Derbyshire, Julie Johnston, Betty Kuchta (Chair), Beth Lambie, Lucie Lombardo, Dr. Glen Maddison, Monica Robson, Nancy Snobelen, Pat Somers.

Escalation Points

<i>Issue Type</i>	<i>Escalation Point</i>
Budget: Process for tracking actual & variances	CCAC Senior Management
Schedule: Recruitment/Hiring of staff	CCAC Senior Management
Scope: Project Scope/Charter Issues	CCAC Senior Management/EOLCN/LHIN
Staffing: Training & Orientation	CCAC Senior Management
Technical: IT Issues	CCAC Senior Management
Privacy/Policy: Internal CCAC policy issues	CCAC Senior Management
Other: Sector issues relating to implementation	Specific Partner Agency Management Staff
Physician: Clinical issues	Dr. G. Maddison – CCAC Senior Management
Public Relations/Communication: PR issues	CCAC Senior Management/EOLCN

Key Stakeholders

Stakeholder <i>(Identify the Stakeholder group)</i>	Description of Interest in the Project <i>(brief overview of each group's interest in project or its outcomes..What is current level of awareness and buy in?)</i>		
	RACI*	Drivers <i>(note current drivers which would cause the group to support the project)</i>	Barriers <i>(note obstacles which would prevent the group from supporting the project)</i>
Clients/Family	Clients & Family want compassionate, competent, accessible Palliative Care		
	I	<ul style="list-style-type: none"> Awareness; positive experience; recognized as responsive quality service 	<ul style="list-style-type: none"> No consistency and poor communication among providers; negative experience; non-responsive team
ESC CCAC	CCAC has primary responsibility for care of clients in the community		
	R, A	<ul style="list-style-type: none"> Desire to provide better outcomes through specialist care; to increase the ability of front-line providers to respond to client needs 	<ul style="list-style-type: none"> Extra "service burden" generated from Team's success
ESC LHIN	ESC LHIN supported original business case as the goal is to help individuals remain at home (aging at home); LHIN is interested in new models of care & positive impact on hospital use and client care		
	R, A	<ul style="list-style-type: none"> Transparency, accountability & consensus among stakeholders; positive outcomes 	<ul style="list-style-type: none"> Lack of consensus among EOLCN members; targets inconsistent with investment
Hospitals	Hospitals support initiatives related to ↓ LOS, ER avoidance, etc.		
	C, I	<ul style="list-style-type: none"> Inclusion as stakeholder; effective in ER avoidance, reducing hospital admissions and length of stay; improves client flow 	<ul style="list-style-type: none"> Failed communication between PCCT and hospital team in case of admission; inconsistency in treatment between community and hospital; funding limited to community
Hospices	Residential hospices work closely with community to provide alternative to hospital		
	C, I	<ul style="list-style-type: none"> Inclusion as key stakeholder; recognized as part of community care continuum; improves client flow 	<ul style="list-style-type: none"> Failed communication between PCCT and hospice team in case of admission; inconsistency in treatment between sectors; funding limited to non-residential

Community Service Provider Agencies	Community Service Provider Agencies are the front-line providers of care in the community. They recognize the need for enhanced access to specialist level consultation and care		
	R, A, C, I	<ul style="list-style-type: none"> • Desire for better client outcomes; recognize need for enhanced clinical expertise ; meets contract obligations set out by the Community Care Access Centre 	<ul style="list-style-type: none"> • Insufficient resources to support PCCT and knowledge transfer; failed communication between PCCT and front-line providers of care
Physicians	The role of specialist physician & interaction with other primary care physicians is critical		
	R, A, C, I	<ul style="list-style-type: none"> • Desire for better client outcomes ; recognition of physician as key partner in client care 	<ul style="list-style-type: none"> • Funding not available for physicians; failed communication between PCCT and physician
Cancer Care Ontario/ Provincial EOLCN	Provincial organizations have endorsed the concept of PCCTs and are following ESC progress with interest		
	C	<ul style="list-style-type: none"> • Consistent with best practice; successful implementation can migrate to other areas in the Province 	<ul style="list-style-type: none"> • Poor outcomes
All people in Network	Network comprised of providers and all care sectors – much interest in Hospice Palliative Care delivery		
	C, I	<ul style="list-style-type: none"> • Desire for better client outcomes, consistency in practice across the continuum, knowledge transfer, service accessibility 	<ul style="list-style-type: none"> • Lack of information on progress of program; funding not available to all sectors and organizations; limitations on eligibility for program
EOLCN Executive Council	The Executive Council supported the initial proposal and continues to serve in an advisory capacity		
	A, C, I	<ul style="list-style-type: none"> • Evidence of positive outcomes 	<ul style="list-style-type: none"> • Poor outcomes, lack of transparency and accountability

Windsor Regional Cancer Program	WRCP is a co-sponsor of the EOLCN and has MOHLTC mandated accountability for regional cancer outcomes including palliative care outcomes		
	C, I, A	<ul style="list-style-type: none"> Evidence of positive outcomes; consistency in practice; knowledge transfer 	<ul style="list-style-type: none"> Poor outcomes, lack of transparency and accountability; funding limited to community Lack of competency of PCCT
Primary Care Providers i.e. CHC, FHT, Nurse Practitioner-led clinics	Primary care providers collaborate with specialists & providers in a shared care model		
	R, A, C, I	<ul style="list-style-type: none"> Desire for better client outcomes ; recognition of role of new primary care models to provide “wrap-around” care; knowledge transfer; consistency in practice 	<ul style="list-style-type: none"> Funding not available to all sectors and organizations; failed communication between PCCT and primary care team Lack of competency of PCCT
Long Term Care Homes	LTCHs care for many dying residents. Liaison between the PCCT and providers in LTCHs will evolve		
	C, I	<ul style="list-style-type: none"> Desire for better resident outcomes, consistency in practice across the continuum, knowledge transfer, service accessibility 	<ul style="list-style-type: none"> Lack of information on progress of program; funding not available to all sectors and organizations; limitations on eligibility for program
Palliative Pain and Symptom Management Consultation Program (PPSMCP)	PPSMCP is funded to provide palliative pain and symptom management consultation, education and mentorship to health care providers , which includes to PCCT(s). PPSMCP is the lead for Aging at Home funded education strategy (blueprint).		
	C,I,A	<ul style="list-style-type: none"> Shared goals for client care (best practice and consistency); promotion and utilization of education programs throughout ESC; common interest in success of education and mentorship resources Consultation Expertise available to PCCT 	<ul style="list-style-type: none"> Lack of transparency and accountability; failure of PCCT to promote and support education programs, mentorship and consultation offered by PPSMCP Lack of competency of PCCT

* **RACI – Responsible, Accountable, Consulted, Involved**

Section 3: Business Case

Expected Benefits, Costs and System Savings

1) Overall benefits of Palliative Care

Palliative Care is beneficial to clients, families and to the system. Palliative care is:

- Client-centred and family-centred.
- Beneficial in reducing symptom burden and enhancing client and family satisfaction.
- Cost-saving in terms of reducing hospital and ICU length of stay while providing compassionate care.
- Cost saving for the system as a whole when programs are in place to foster Emergency Room (ER) avoidance and hospital admission avoidance. Programs which foster these system savings include community based teams such as PCCT.

2) Benefits of a Community Based Palliative Care Consultation Team

- Access to specialist level Palliative Care is required in all settings where clients die
 - A Palliative Care Consultation Team (PCCT) is the preferred way to provide specialist level care.
 - This team will provide ESC clients at home with access to specialist level care.
- By providing needed expertise in the clients' homes this team will enhance the clients' options for location of death and end of life care.
- The PCCT model in ESC is a key step in creating a comprehensive system of palliative care in the ESC region. This team is a vehicle for integration.
- PCCTs increase client and family satisfaction with care and provide an increased comfort level with care in the home setting.
- Evaluations of PCCTs report increased levels of satisfaction and confidence from formal primary care providers when they have the expert team as back up.
- Significant cost savings can be realized for the system as a whole as a result of the introduction of a PCCT serving the community.
- Decreased chronic disease of bereaved because of better recovery for family (informal) care provider survivors

3) Discussion of Cost Saving Benefits

System level savings can be realized through the implementation of Palliative Care Consultation Teams serving community based clients in each County in Erie St. Clair.

Potential savings come from 3 key sources:

- a. Decreased hospital dependence.
- b. Decreased use of prolonged "curative" interventions .
- c. Enhanced efficiencies in home care delivery.

a. Decreased hospital dependence

Savings will result from decreased hospital dependence specifically:

- Emergency Department avoidance
- Admission avoidance
- Decreased ALC days
- Decreased Acute Length of Stay.

Access to specialized palliative care and symptom management has been shown to reduce ED visits and subsequent inpatient admissions by up to 80% in other jurisdictions (e.g. Victoria BC). Given our limited experience with the model in Ontario we may not achieve 80% reduction initially, but a significant impact can be made.

We have attempted to estimate potential system level savings that may be possible with the introduction of a community based palliative care consultation team. These estimates illustrate possible "order of magnitude" benefits. Currently there are not system-wide tracking systems to definitively track these system wide savings as they correlate to the PCCT. Thus these estimates must be viewed as points for discussion and not as outcomes that can be definitely measured. Despite the difficulty in tracking system-wide savings, the PCCT *is* tracking indicators that reflect the PCCT impact on ER/admission avoidance.

For the purposes of estimating potential reduction in hospital volumes and costs we have used 3 scenarios:

- Scenario 1 – Maximum – 80% reduction with estimated savings of **\$8,845,341**
- Scenario 2 – Mid range – 60% reduction with estimated savings of **\$6231,272**
- Scenario 3 - Minimum – 40 % reduction with estimated savings of **\$4,008,204**

Information Sources:

Costs:

Hospital costs used in this estimate are Ontario Cost Distribution Methodology (OCDM) averages for ESC (provided by LHIN staff).

Volumes:

1. Cancer clients' potentially avoidable ER visits and admissions
 - *CIHI National Ambulatory Reporting System, 2007/08: Total cancer visits linkage to Ontario Cancer Registry –ESC averages*

CTAS 3, 4 or 5-categories were used for ER visits and admissions related to cancer palliative care. These volumes are conservative because only visits/ admissions related to palliative care were used. If the client had received treatments (radiation, systemic or surgery) in the previous 4 weeks they were excluded from this calculation. An additional comment related to the use of only CTAS 3,4 &5 is that in many palliative care situations even CTAS 1 and 2 could be avoided if timely expertise was available in the community and if proactive measures have been taken.(comment source is Dr. Glen Maddison –ESC Palliative Care Expert and ER Physician).
2. Non-cancer clients potentially avoidable ER visits and admissions
 - estimated using 20% of the cancer volumes
3. Length of stay data –
 - *CIHI National Ambulatory Reporting System, 2007/08: Total cancer visits linkage to Ontario Cancer Registry – ESC averages*
4. Hospital volumes used for calculation of savings from decrease LOS
 - based on ESC Z51.5 numbers (07/08)

(Refer to Appendix One for details of calculation methodology.)

Note - Hospital palliative care continues to be an essential component of Palliative Care service provision. This calculation is not meant to suggest that all Palliative Care clients can, or should be, cared for only in the community throughout their entire Palliative Care journey.

b. Decreased use of prolonged “curative” interventions

Savings will be realized by reducing costs related to prolonged curative interventions and investigations. A significant body of research has demonstrated savings in hospital settings, when a Palliative Care program is introduced and care plans are adjusted to emphasize symptomatic care rather than curative care. A recent American study (Sept. 2008) showed savings of up to \$4900 per palliative admission. Savings included significant reductions in pharmacy, laboratory and intensive care costs. Few studies are available in a community setting but it is generally agreed that the same principles apply.

Currently Erie St. Clair shows a higher percentage of clients receiving chemotherapy in the last 2 weeks of life than is the case across Ontario: 6.9% vs. 6.1%. (CCO quality Index [July20, 2009]). This suggests that some opportunity for savings of this nature may be possible as programs of palliative care are enhanced in Erie St. Clair.

Methodology is not available to quantify the system savings as it relates to clients being cared for in the community, therefore an estimate of savings is not provided here. Given the costs of the more invasive “curative” interventions and investigations it can be expected that savings will be significant.

c. Enhanced efficiencies in home care delivery.

Evaluations of various PCCTs have demonstrated an increased level of satisfaction and confidence in providing care among informal care providers served by a PCCT. It is expected that this may translate into decreased calls to and dependence upon the formal care providers.

Qualitative studies have supported the increased comfort level of informal care providers in the presence of an available PCCT, however the positive financial sequelae has not been quantified in a manner that allows estimates of potential savings.

d. Summary Discussion of Potential Estimated System Level Cost Savings

Conservative calculations demonstrate that the ESC Palliative Care Consultation Teams have the potential to facilitate annual net savings of 1.9 million to 6.7 million dollars. This projected net saving is based on the assumptions related to decreasing dependence on hospitals. No information is available to quantify the savings that could be realized from the other two categories of potential savings. The table below summarizes these savings.

Comparison of Costs and Potential Savings – PCCT in ESC	
Annualized Costs of PCCT in 3 counties	Estimated potential system-level savings (note- these estimates are “order of magnitude” only and should not be viewed as definitive)
\$520,000 + \$785,000 + \$785,000(estimated) = \$2,090,000	a) Decreased hospital dependence - \$4,008,204 to \$8,845,341
	b) Decreased use of prolonged “curative” interventions – ‘significant’ (unable to estimate due to no community-based methodology)
	c) Enhanced efficiencies in home care delivery – unable to estimate
Overall net savings: Based on conservative calculations (of the few elements for which we can propose quantitative estimates), projected system-level net savings (savings minus costs) range from \$6,755,341 to 1,918,204.	
Refer to appendix one for details on methodology and calculations used to obtain above numbers.	

(Information above is adapted from: *Hospice Palliative Care in Erie St. Clair – Report on Current Services and Recommendations for Future systems – Dec. 2008- ESC EOLCN; PCCT evaluation reports from HNHB and WW; and from discussion and reports from Fraser Health*)

Refer to Tables below for details on year one and two budgets for the PCCT programs in ESC.

ESC CCAC Palliative Care Consultation Team Phase II Budget Projection

(**with** Coordinator in budget)

Annualized year one and year two funding - ongoing budget

(Note - A separate start-up budget will be prepared which will include one time expenses not included in this annualized budget)

Staffing and Benefits	Budget	Description/Rational	
PCCT Team Coordinator	\$ 133,000	If not paid for from A@H funding EC2	
PCCT Nurse Practitioner/Expert Nurse	\$ 311,600	2.53 FTE	1 NP per county plus relief (\$123,500/FTE)-S/L & C/K
Spiritual Care Provider	\$ 107,500	1.1 FTE	S/L & C/K
Social Work	\$ 130,000	1.2 FTE	S/L & C/K
Program Admin. Assistant	\$ 80,000	1.2 FTE	.6 FTE S/L & .6 FTE C/K
Support staff to Pain & Symptom Clinic S/L	\$ 35,400	S/L clinic is at St. Joseph's Hospice	
Nursing Support for P&S Clinic	\$ 50,000	Fee for service S/L & C/K	
Resource Nurse 24/7 On-call & Patient Visits	\$ 80,000	Fee for service for secondary experts from each agency - S/L & C/K	
OT or PT	\$ 107,500	1.1 FTE	.5 FTE S/L & .5 FTE C/K
Operating Costs			
Travel	\$ 24,000	Estimated travel costs for all team members to pt homes etc.	
Purchase service	\$ 20,000	eg. in-home lab costs, respiratory therapy, Pharmacy consultation etc.	
Cultural sensitivity contracts/interpreters	\$ 10,000		
10% CCAC Administration/overhead	\$ 130,000	Includes office supplies, overhead, office equipment amortization, etc.	
Rental/equipment/supplies etc.	\$ 20,000	Equipment, Bed rental, etc.-patient equipment	
Other			
Evaluation	\$ 30,000	S/L & C/K - contracted comprehensive evaluation-	
Education	\$ 30,000	Specialist level team must constantly keep abreast of best practice to continue to be "expert"	
Communication/Stakeholder engagement	\$ 6,000		
Total Cost of PCCT Program - Annualized Phase II		<u>\$ 1,305,000</u>	
Total budget for year one plus year two PCCT - \$520,000 (year one) plus \$785,000 (year two) = \$1,305,000			

ESC CCAC Palliative Care Consultation Team Phase II Budget Projection

(without Coordinator in budget)

Annualized year one and year two funding - ongoing budget

(Note - A separate start-up budget will be prepared which will include one time expenses not included in this annualized budget)

Staffing and Benefits	Budget	Description/Rational	
PCCT Team Coordinator	000,000	Coordinator position paid for from A@H funding EC2	
PCCT Nurse Practitioner/Expert Nurse	\$ 444,600	3.6FTE	1 NP per county plus relief (\$123,500/FTE)- recruitment for NP for Windsor is step one in planning for Windsor Essex team
Spiritual Care Provider	\$ 107,500	1.1 FTE	S/L & C/K
Social Work	\$ 130,000	1.2 FTE	S/L & C/K
Program Admin. Assistant	\$ 80,000	1.2 FTE	.6 FTE S/L & .6 FTE C/K
Support staff to Pain & Symptom Clinic S/L	\$ 35,400	S/L clinic is at St. Joseph's Hospice	
Nursing Support for P&S Clinic	\$ 50,000	Fee for service S/L & C/K	
Resource Nurse 24/7 On-call & Patient Visits	\$ 80,000	Fee for service for secondary experts from each agency - S/L & C/K	
OT or PT	\$ 107,500	1.1 FTE	.5 FTE S/L & .5 FTE C/K
Operating Costs			
Travel	\$ 24,000	Estimated travel costs for all team members to pt homes etc.	
Purchase service	\$ 20,000	eg. in-home lab costs, respiratory therapy, Pharmacy consultation etc.	
Cultural sensitivity contracts/interpreters	\$ 10,000		
10% CCAC Administration/Overhead	\$ 130,000	Includes office supplies, overhead, office equipment amoritization, etc.	
Rental/equipment/supplies etc.	\$ 20,000	Equipment, Bed rental, etc.-patient equipment	
Other			
Evaluation	\$ 30,000	S/L & C/K - contracted comprehensive evaluation-	
Education	\$ 30,000	Specialist level team must constantly keep abreast of best practice to continue to be "expert"	
Communication/Stakeholder engagement	\$ 6,000		
Total Cost of PCCT Program - Annualized Phase II	<u>\$ 1,305,000</u>		
Total budget for year one plus year two PCCT - \$520,000 (year one) plus \$785,000 (year two) = \$1,305,000			

ESC CCAC Palliative Care Consultation Team (PCCT) - Projected Actuals - Start up Budget (one time)

With Coordinator charged to this budget - Coordinator paid from EC2 budget

Staffing and Benefits	Annualized Budget	Projected Actuals as of March 31, 2010	
PCCT Team Coordinator	\$133,000.00	\$66,500.00	6 months
PCCT Nurse Practitioner/Expert Nurse	\$311,600.00	\$175,000.00	Full year S/L; 5 months C/K; 3 months W/E
Spiritual Care Provider	107,500.00	50,000.00	4 months fee for service S/L; 5 months full time S/L & C/K
Social Work	130,000.00	65,000.00	Fee for service S/L ; 5 months full time S/L & C/K
Program Admin. Assistant	80,000.00	75,000.00	Full time S/L & C/K
Support staff to Pain & Symptom Clinic-SL	35,400.00	18,000.00	6 months S/L
Nursing Support for P&S Clinic	50,000.00	35,000.00	Fee for service S/L Full year; 5 months C/K
Resource Nurse 24/7 On-call	80,000.00	46,500.00	Full year S/L; 5 months C/K
OT or PT	107,500.00	40,000.00	(4 months at full time S/L & C/K)
Operating Costs			
Travel	\$24,000.00	\$16,000.00	(Full year S/L plus 5 months C/K)
Purchase service	20,000.00	10,000.00	(Half year both counties)
Cultural sensitivity contracts	10,000.00	10,000.00	
10% CCAC Administration	130,000.00	100,000.00	(Full year S/L; 6 months C/K)
Rental/equipment/supplies etc.	20,000.00	15,000.00	(Full year S/L; 5 months C/K)
Other			
Evaluation	\$30,000.00	\$30,000.00	
Education	30,000.00	30,000.00	
Communication/Stakeholder engagement	6,000.00	6,000.00	
One Time Start Up Costs			
Clinic setup and equipment - S/L		\$75,000.00	
Clinic setup and equipment - C/K		75,000.00	
IT purchase		20,000.00	
Office set-up		20,000.00	
Pt. Equipment purchase (mattresses, oximeters, etc.)		20,000.00	
Start up training		15,000.00	
Start up communication plan		20,000.00	
Start up recruitment costs		10,000.00	
Planning for W/E		30,000.00	
Project management		22,000.00	
Total Cost of PCCT Program	<u>\$1,305,000.00</u>	<u>\$1,095,000.00</u>	*
* Total budget for year one plus year two PCCT - \$520,000 (year one) plus \$575,000 (year two pro-rated) = \$1,095,000			

ESC CCAC Palliative Care Consultation Team (PCCT) - Projected Actuals - Start up Budget (one time)

Without Coordinator charged to this budget - Coordinator paid from EC2 budget

Staffing and Benefits	Annualized Budget	Projected Actuals as of March 31, 2010	
PCCT Team Coordinator	\$0.00	Paid from EC2 Budget	
PCCT Nurse Practitioner/Expert Nurse	\$444,600.00	\$241,500.00	Full year S/L; 5 months C/K; 5 months W/E
Spiritual Care Provider	107,500.00	50,000.00	4 months fee for service S/L; 5 months full time S/L & C/K
Social Work	130,000.00	65,000.00	Fee for service S/L; 5 months full time S/L & C/K
Program Admin. Assistant	80,000.00	75,000.00	Full time S/L & C/K
Support staff to Pain & Symptom Clinic-S/L	35,400.00	18,000.00	6 months S/L
Nursing Support for P&S Clinic	50,000.00	35,000.00	Fee for service S/L Full year; 5 months C/K
Resource Nurse 24/7 On-call	80,000.00	46,500.00	Full year S/L; 5 months C/K
OT or PT	107,500.00	40,000.00	(4 months at full time S/L & C/K)
Operating Costs			
Travel	\$24,000.00	\$16,000.00	(Full year S/L plus 5 months C/K)
Purchase service	20,000.00	10,000.00	(Half year both counties)
Cultural sensitivity contracts	10,000.00	10,000.00	
10% CCAC Administration	130,000.00	100,000.00	(Full year S/L; 6 months C/K)
Rental/equipment/supplies etc.	20,000.00	15,000.00	(Full year S/L; 5 months C/K)
Other			
Evaluation	\$30,000.00	\$30,000.00	
Education	30,000.00	30,000.00	
Communication/Stakeholder engagement	6,000.00	6,000.00	
One Time Start Up Costs			
Clinic setup and equipment - S/L		\$75,000.00	
Clinic setup and equipment - C/K		75,000.00	
IT purchase		20,000.00	
Office set-up		20,000.00	
Pt. Equipment purchase (mattresses, oximeters, etc.)		20,000.00	
Start up training		15,000.00	
Start up communication plan		20,000.00	
Start up recruitment costs		10,000.00	
Planning for W/E		30,000.00	
Project management		22,000.00	
Total Cost of PCCT Program	<u>\$1,305,000.00</u>	<u>\$1,095,000.00</u>	*
* Total budget for year one plus year two PCCT - \$520,000 (year one) plus \$575,000 (year two pro-rated) = \$1,095,000			

<p>care partners and care providers. In addition, PCCT will result in case-finding and higher demand for home care service. This target population becomes a priority when others such as the frail and elderly appear to get less service. Two of the groups that feel this most are physicians and CCAC case managers, whose client populations are mixed and generic. This may result in a reluctance to refer to the PCCT.</p>		
<p>3 - Service Burden on CCAC Success of this team (in terms of hospital avoidance) results in increased demands for care from CCAC. These clients, who previously would be cared for in Emerg or Acute Care often have complex needs which require intensive and extensive interventions from CCAC in addition to the expert consultation offered by the team. While this extra service burden cannot be eliminated awareness and tracking of its impact will assist with further planning.</p>	<ul style="list-style-type: none"> • High Probability • High Impact 	<p>Establish system to track additional service burden resulting from “success” of the team and report on findings.</p>
<p>4 - Special Target Populations The culturally disenfranchised will not make use of the program and these populations will continue to have poor health outcomes and inadequate palliative care.</p>	<ul style="list-style-type: none"> • High Probability • High Impact 	<p>Identify and resolve unique population needs through consultation and involvement:</p> <ul style="list-style-type: none"> • First Nations planned in Year 2 • Culturally diverse groups in Windsor Essex to be incorporated in planning for Year 3 • Incorporate French Language Services requirements into program and planning
<p>5 - Lack of Integration Any program/service sector has a risk of becoming a “stand-alone” entity that is not integrated with other sectors. If this occurs with the PCCT, anticipated efficiencies and client care outcomes will be jeopardized.</p>	<ul style="list-style-type: none"> • High Probability • High Impact 	<p>Continue with activities currently underway within ESC EOLCN including:</p> <ul style="list-style-type: none"> • Regular meetings in each county • Education Strategy • System Design Framework • Balance Scorecard on the Palliative Care System in ESC • Work related to Right Patient/Right Place/Right Time, system design etc. • Ongoing support from PPSMCP

Section 5: Environmental Analysis

Environmental Analysis

Regional System of Palliative Care

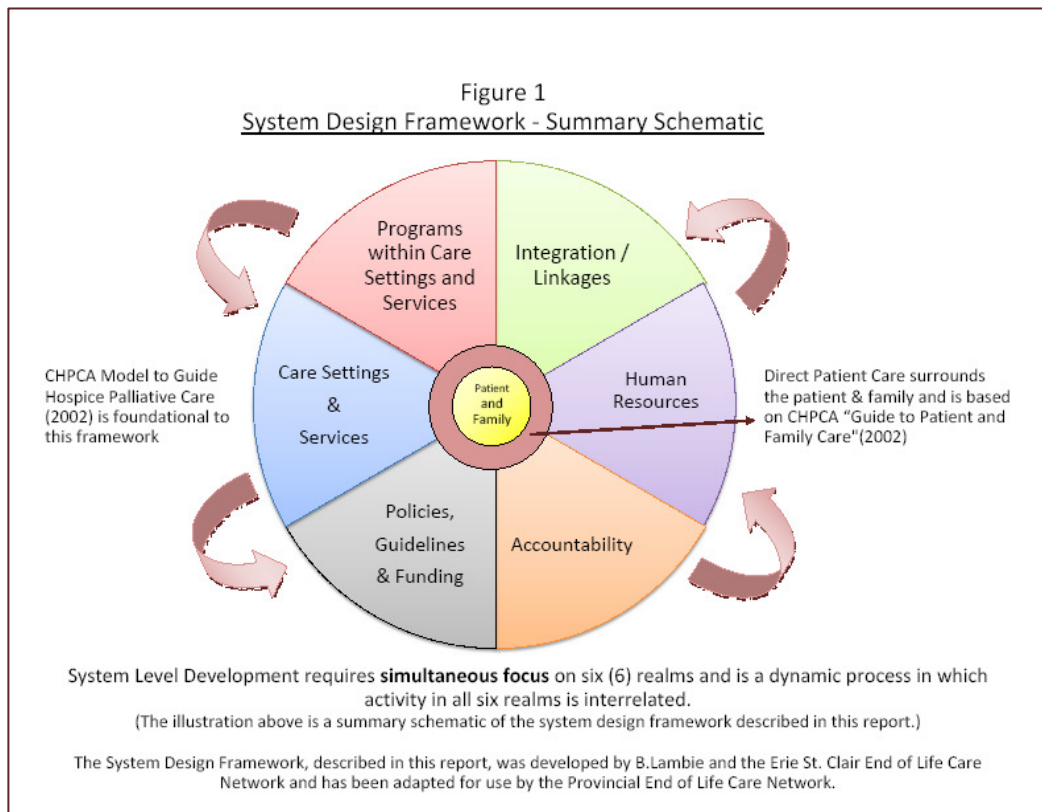
Health care in Ontario is delivered by sectors and by independent service providers, each with its own Board of Directors, individual mandate, operational imperatives and strategic directions. For most providers of Hospice Palliative Care, Palliative Care is but one of many services they deliver. A "regional system" of Hospice Palliative Care in Ontario is really a "system of systems". The same is true in Erie St. Clair. The PCCT program in Erie St. Clair is a primary vehicle for integrating our local care systems, supported by the collaboration and relationship between organizations in the continuum of care through the End-of-Life Care Network.

To move from our current system of sector-specific service provision to an integrated system of palliative care service provision requires that:

1. A full continuum of care settings and services is in place,
2. In each care setting where clients die, there is a clearly defined Palliative Care Program developed (with defined access to specialist level expertise),
3. Sectors and services are linked by common practice, processes, and structures,
4. Adequate numbers of trained professionals are available,
5. System level accountability is clearly defined and communicated,
6. Funding models, guidelines and policy directions support an integrated system.

Effective system level development requires simultaneous attention to six (6) realms, as follows:

1. Care settings and Services
2. Programs within care settings and services
3. Integration / Linkages
4. Human Resources
5. System Accountability
6. Policies, Guidelines and Funding



Regional System Design and the PCCT - The brief description below highlights how this Palliative Care Consultation Teams fits within system design work.

Care Settings and Services: Current standard and best practice literature identify expert consultation teams as one of the key services required in a Regional System of Palliative Care. This PCCT program makes this service available to clients within the ESC community.

Programs within Care Settings and Services: As the Regional System is being built, attention must be given to key elements of service delivery within each of the component parts. A key element for the delivery of quality Palliative Care, is “access to specialist level expertise”. This expertise must be available to the community sector, as more and more clients choose to die at home. This PCCT program will provide the growing numbers of community clients with access to specialist level expertise.

Integration / Linkages: Transitions between sectors are important to clients and families. The client and family perspective of the coordination, seamlessness and integration of our Hospice Palliative Care system is an important measure of our success at delivering integrated care. This PCCT program plays an integral role in implementing a number of the “integration essentials” that are required for a true system of Palliative Care.

Human Resources: Compassionate, skilled people are at the core of Palliative Care. Equipment is important, medication is vital, but without the people the right care does not reach the client. This PCCT program uses an inter-professional care model to optimize the physician specialist role by leveraging the expertise of Nurse Practitioners, Social Workers and other professionals. This inter-professional care model makes best use of scarce resources and further offers sustainability by attracting professionals interested in being part of a leading practice environment.

System Accountability: If we are to develop a well-functioning cross-sector Regional System of Palliative Care we need to develop accountability models that support and advance the care of clients across sectors, aligned with operational accountabilities within each sector. The accountability structure of this PCCT program demonstrates system level accountability, supported by the commitment of the members of the EOLC Network and the advisory role of its Executive Council. This provides an opportunity to provide a template for other integration initiatives within Erie St. Clair.

Policies, Guidelines and Funding: Policies, guidelines and funding directly impact not only client care but system design and development. This PCCT is constricted by a number of funding and policy issues, but will provide us with a testing ground for innovative approaches and resolutions.

Summary

The health care environment in Ontario is complex and constantly changing. In the Palliative Care 'world' expert teams/consultation teams are considered to be a core element of a quality regional palliative care program and are cited as an essential component of care in every benchmarked regional program (e.g. Fraser Health, Edmonton's Capital Health, Australia's model etc.). Expert teams are the preferred method of providing "tertiary level / specialist level expertise".

ESC EOLCN members have repeatedly identified the need for expert consultation teams in each county. This is a priority for our area. During the Aging at Home funding application process, over 50 EOLCN participants identified this as the number one priority issue requiring funding.

Several examples of expert teams are available in Ontario.

Frequently a team is what defines a "program" – i.e. clients referred to the team are considered to be "in the program". There is a significant body of literature to support the development of Expert Palliative Care teams.

CHPCA's Pan-Canadian Gold Standard for Palliative Home Care lists consultation teams as important for quality palliative care in a home care setting.

Consultation teams typically are multidisciplinary.

The team will serve as a catalyst for integration and enhanced cross-sector cooperation. Fraser Health of British Columbia describes a "connecting role" for such teams. "The consult teams are a key factor in working towards seamless transitions and care for clients and their families as they move from one sector to another in the healthcare system. They make decisions with clients about the best location of care at a given time in the illness trajectory. Consult team members often act as a bridge to communicate client and family needs to team members in other settings."

A regional expert team, with expertise in each county and coordination regionally, is viewed as a foundational component of an integrated system of Palliative Care within Erie St. Clair.

Information Sources

(Refer to these documents for detailed reference information)

1. **ESC EOLCN (Lambie, B.).** *Hospice Palliative Care in Erie St. Clair, Report on Current Services and Recommendations for Future Systems.* 2008.
2. —. *System Design Framework - Developing a Regional System of Hospice Palliative Care Delivery in Erie St. Clair.* Erie St. Clair Region : Erie St. Clair End of Life Care Network, 2009.
3. —. *Foundational Concepts and Definitions Related to Hospice Palliative Care Service Delivery.* s.l. : Erie St. Clair End of Life Care Network , January 2009 rev. May 2009.
4. **ESC EOLCN (Lambie B.).** *Preliminary Directional Planning Report - Hospice Palliative Care in Erie St. Clair.* s.l. : Erie St. Clair, end Of Life Care Network , 2008.
5. ESC EOLCN –Erie St Clair End-of-Life Care Network, Palliative Consultation Team Final Evaluation Report April 30, 2009. Completed by Loretta M. Hillier – Health Care Research and Evaluation

Cost / Benefits Calculations

Appendix One

Palliative Care Consultation Team - Erie St. Clair - Impacts							
Summary of Estimated Potential System-Wide Savings by Decreasing Dependence on Hospitals (to be considered "order of magnitude estimates" only)							
Savings from estimated ER Avoidable Visits Cancer & Non-Cancer (CTAS 3,4,5)	Estimated volume of Avoidable Activity			Cost per Visit or IP day	Estimated Savings		
	High 80%	Medium 60%	Low 40%		High	Medium	Minimum
	2,366	1,775	1,183	\$218	\$515,875	\$386,906	\$257,938
Savings from estimated Avoidable Admissions (from Emergency) (CTAS 3,4,5) Cancer & Non-Cancer	592	444	296	\$1,037 at a LOS of 9.6	\$5,896,664	\$4,222,498	\$2,948,332
Savings from estimated Reduced LOS using Z51.5 Discharge #'s of 782 for 07/08					\$2,432,802	\$1,621,868	\$801,934
					3 days reduced	2 days reduced	1 day reduced
Total Estimated Potential Savings					\$8,845,341	\$6,231,272	\$4,008,204

Palliative Care Consultation Team - Estimated Savings by Decreasing Dependence on Hospitals								
1) Emergency Room Estimated Potentially Avoidable Visits & Costs (Costs based on OCDM)								
ER Potential Avoidance - cancer patients	A	B	C	D	E	F	G	H
	ESC # of ER Palliative Care Related Cancer Vists (CTAS 3,4,or 5)*	Est. # of Avoidable Visits - Cancer			Cost per ER Visit**	Est. Cost of Avoidable Visits - Cancer		
		High 80% of A	Medium 60% of A	Minimum 40% of A		High	Medium	Minimum
	2,465.00	1,972.00	1,479.00	986.00	\$218.00	\$429,896.00	\$322,422.00	\$214,948.00
ER Potential Avoidance - non cancer (20% of # of cancer patient)	I	J	K	L	M	N	O	P
Est. # of Non-Cancer Palliative Care related ER visits which may be Avoidable 20% of A	Est. # of Avoidable Visits - Non-Cancer			Cost per ER visit **	Est. Cost of Avoidable Visits - Non-Cancer			
	High 80% of I	Medium 60% of I	Minimum 40% of I		High	Medium	Minimum	
	493.00	394.40	295.80	197.20	\$218.00	\$85,979.20	\$64,484.40	\$42,989.60
Total -Cancer & non-cancer potentially avoidable ER visits	A + I	B + J	C + K	D + L		F + N	G + O	H + P
	2,958.00	2,366.40	1,774.80	1,183.20		\$515,875.20	\$386,906.40	\$257,937.60
		Potentially avoidable visits				Potential Savings		

PCCT 19-08-2009

*Source: CIHI National Ambulatory Care Reporting System 2007/2008; Total cancer visits linkage to Ontario Cancer Registry - Number cited includes only cancer patients whose visit was related to palliative care and excludes patients who have received cancer treatment in the previous 4 weeks (radiation, systemic, surgical intervention) or whose dx was not related to cancer dx (e.g.injuries, trauma etc.). Thus the number used is a conservative estimate of those impacted by the PCCT since many cancer patients receiving treatment (symptom relief treatment) will be cared for by the PCCT.

** Source: Ontario Cost Distribution Methodology (OCDM) average for ESC (provided by ESC LHIN)

Palliative Care Consultation Team (PCCT) - Estimated Savings by Decreasing Dependence on Hospitals										
2. Estimated Potentially Avoidable Admissions & Costs (Costs based on OCDM)										
Potentially Avoidable Admissions from Emerg - Cancer	A	B	C	D	E	F	G	H	I	
	ESC # of Palliative Care Related Cancer admissions from ER CTAS 3,4,5 *	High	Medium	Minimum	Cost per Patient Day **	Average LOS*	High	Medium	Minimum	
	617.00	80% of A 493.60	60% of A 370.20	40% of A 246.80	\$1,037.00	9.60	E x B x F \$4,913,886.72	E x C x F \$3,685,415.04	E x D x F \$2,456,943.36	
Potentially Avoidable Admissions from Emerg - Non Cancer	J	K	L	M	N	O	P	Q	R	
	Est. # of Non-Cancer Palliative Care related admissions which may be avoidable	High	Medium	Minimum	Cost per Patient Day **	Average LOS	High	Medium	Minimum	
	20% of A 123.40	80% of J 98.72	60% of J 74.04	40% of J 49.36	\$1,037.00	9.60	O x N x K \$982,777.34	O x N x L \$737,083.01	O x N x M \$491,388.67	
Total Cancer & Non-Cancer Potentially Avoidable Admissions (from ER)	A + J 740.40	B + K 592.32	C + L 444.24	D + M 296.16			G + P \$5,896,664.06	H + Q \$4,422,498.05	I + R \$2,948,332.03	

*Source: CIHI National Ambulatory Care Reporting System 2007/2008; Total cancer visits linkage to Ontario Cancer Registry - Number cited includes only cancer patients whose visit was related to palliative care and excludes patients who have received cancer treatment in the previous 4 weeks (radiation, systemic, surgical intervention) or whose dx was not related to cancer dx (e.g.injuries, trauma etc.). Thus the number used is a conservative estimate of those impacted by the PCCT since many cancer patients receiving treatment (symptom relief treatment) will be cared for by the PCCT. This # is only for admission from ER and excludes direct admits.

** Source: Ontario Cost Distribution Methodology (OCDM) average for ESC (provided by ESC LHIN)

Palliative Care consultation Team Estimated Savings by Decreasing Dependence on Hospitals					
3. Potential Decreased Length of Stay of Admitted Patients (including ALC)					
	A	B	C	D	E
	# of Palliative coded Discharges (coded Z51.5) ESC (07/08)	Cost per Inpatient per day**	High 3 days saved per admission	Medium 2 days saved per admission	Minimum 1 day saved per admission
Potential decrease LOS	782	\$1,037	A x 3 x B \$2,432,802	A x 2 x B \$1,621,868	A x 1 x B \$810,934

Evaluation Framework

Objective 1: describe the services provided by the Palliative Consultation Team and the population served

Outcomes	Indicators	Sources of Information	Design/ Timeline
Description of services provided by the expert time	<ul style="list-style-type: none"> • Number/type of professionals on the team • # of new referrals • Referral sources • # of initial visits • # of assessments conducted • # of follow-up visits • # of direct care visits • #of team rounds • Attendees at team rounds • #of calls in "off hours" (24/7 access) • # of shared care models of service delivery • # of primary care models of service delivery • # of consultation reports developed & distributed • Providers receiving a consultation report(primary care, client, service provider agency, CCAC, acute care) • # of clients referred to other services • time per visit, per client • # of team members involved per client • # of visits per client per team member • Length of client stay on service • Response time to referrals • Response time to consultation report distribution 	Service tracking records completed the team/administrative assistant	Service tracking from January 1 to March 31, 2009

Outcomes	Indicators	Sources of Information	Design/ Timeline
	<ul style="list-style-type: none"> Place of client death 		
Description of the client population served by the PCT	<ul style="list-style-type: none"> Age Gender Place of residence Available caregiver support Location at time of assessment Diagnosis Palliative Performance Score Place of death 	Service/client tracking records completed the team/administrative assistant	Service/client tracking from January 1 to March 31, 2009

Objective 2: Identify the impacts associated with the Palliative Consultation Team

Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
<p><u>Client-related:</u></p> <ul style="list-style-type: none"> Concordance between preference and place of death. satisfaction with access to EOL care satisfaction with timeliness of access to EOL care satisfaction with care coordination satisfaction with communication regarding care satisfaction with 	Caregiver ratings of satisfaction	90% of clients/ caregivers satisfied with service	Caregiver Interview	Satisfaction interview (telephone) completed three weeks after initial visit with the team (January 1 to March 31, 2009)

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Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
informed decision-making • satisfaction with care provided • satisfaction with preparation for death				
• provision of a safer environment for clients and families requiring palliative care at home	Key stakeholder reports of safer home environments for EOL care as a result of the PCT	90% of providers reporting safer home environments for EOL care as a result of the PCT	Key stakeholder survey Key stakeholder interview	Key stakeholder surveys distributed in March 2009 Key stakeholder interviews conducted in March 2009
<u>Provider-related outcomes:</u> • satisfaction with care integration • satisfaction with communication across providers and sectors • satisfaction with care coordination • satisfaction with care planning • increased capacity for EOL care	Provider ratings of satisfaction Provider ratings of increased capacity for EOLC as a result of the PCT	90% of providers satisfied with care integration, coordination, planning and communication 90% of providers reporting increased capacity for EOLC as a result of the PCT	Key stakeholder survey Key stakeholder interview	Key stakeholder surveys distributed in March 2009 Key stakeholder interviews conducted in March 2009

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Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
<ul style="list-style-type: none"> increased use of standardized clinical assessment tools – ESAS & PPS increased response to assessment scores within targeted ranges care planning processes which appropriately responded to PPS and ESAS findings. 	<p>Documented use of ESAS & PPS in client records (e.g., reports, assessments etc)</p>	<p>90% of clients screened for symptom severity using the ESAS</p> <p>90% of clients have functional status assessed using the PPS</p> <p>Scores used to inform care planning for 90% of clients</p>	<p>Service/client tracking records completed the team/administrative assistant</p>	<p>Service/client tracking from January 1 to March 31, 2009</p>
<p><u>System-related outcomes:</u></p> <ul style="list-style-type: none"> Increase in EOLC service in the community Enhanced and increased access to EOL health care services Increase in number of EOLC clients served in the home. 	<ul style="list-style-type: none"> increase number of nursing visits increase in shift nursing hours increase in PSW hours for EOLC increase in number of visits to outpatient clinic 	<p>2% increase in MIS 95 coded volumes in Q4 08/09 compared to Q4 07/08 in the following categories:</p> <ul style="list-style-type: none"> total number of clients total number of visits/hours-nursing/PSW/ social work <p>2% increase in number of clinic visits Q4 08/09 compared to Q4 07/08</p>	<p>CCAC code 95</p>	<p>Retrospective analysis of submitted data</p>

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Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
Decrease in % of deaths in hospital* ¹⁴	Long-term outcome – unable to evaluate in the short time frame of this evaluation			
Increase in % of deaths in the home (expected deaths with EDITH protocols in place)	Proxy – location of death for clients in this program. Otherwise – unable Total number of expected home deaths between January 1 – March 31, 2009 Number of actual deaths at home between January 1 – March 31, 2009 Percent increase in home deaths compared to quarterly reports of the previous year.			
Reduction in number of palliative care-related visits to the ED*	Long-term outcome – unable to evaluate in the short time frame of this evaluation			
Reduced acute care costs for palliative care*	Long-term outcome – unable to evaluate in the short time frame of this evaluation			
Increased access to vital health care services at	Key stakeholder (Provider) reports of increased access	90% of providers reporting safer home	Key stakeholder survey Key stakeholder	Key stakeholder surveys distributed

* Although it is not possible provide evidence of these outcomes within the short-time frame of this evidence, qualitative data on potential impacts will be gathered as part of the focus group interviews with key stakeholders and the PCT/ team organizers.

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Outcomes	Indicators	Target/Benchmark	Sources of Information	Design/ Timeline
home		environments for EOL care as a result of the PCT	interview	in March 2009 Key stakeholder interviews conducted in March 2009
Enhanced care path development and implementation*	Long-term outcome – unable to evaluate in the short time frame of this evaluation			
Improved population health*	Long-term outcome – unable to evaluate in the short time frame of this evaluation			

Objective 3: Describe the development and implementation of the Palliative Consultation Team

Outcomes	Indicators	Sources of Information	Design/ Timeline
Description of the development and implementation of the PCT	<ul style="list-style-type: none"> • Factors that facilitated or enabled the development and implementation of the PCT • Challenges, or barriers, to role development and implementation • Service delivery issues • Key lessons learned • Suggestions for improvement? For sustainability? For expansion to other counties? • Next steps for the PCT? 	<p>Key stakeholder interview</p> <p>Focus Group interviews with PCT and key stakeholders (EOLC Network)</p>	<p>Individual key stakeholder interviews conducted in March 2009</p> <p>Focus group conducted in early April 2009</p>

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