



Hospice Palliative Care (HPC) in Chatham Kent

Right Patient in the Right Place at
the Right Time

Palliative Care across the Continuum
February 2010

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Handouts adapted from:

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Chatham Kent

Table 1

Description of Hospice Palliative Care Sectors/Care Settings

Locations below are 24/7 Care Settings

Description	In Home- CCAC & CSPA	Acute Care (AC) CKHA – 2 sites	Complex Continuing Care (CCC) CKHA – 2 sites	Long Term Care Homes
Model of Care	CCAC provides single-entry coordinating services for clients being cared for in the community. Professional homecare and home support services are contracted to the private sector. (VON, Bayshore, VHA, in Chatham)	No designated beds at either site. Several 'special rooms' for EOL care.	Clustering of 6 beds integrated unit with other CCC beds at Chatham site. 'EOL beds' at Wallaceburg site	Models of Palliative Care vary significantly Beds typically not dedicated to Palliative Care only – some specialty areas/rooms available for EOL care
Volumes (2006/07)	MIS code 95: 145 clients	Z51.5 code: 207 discharges, 2039 days of care	131 deaths	Approximately 271 deaths in LTC beds (2006/07)
Access to Physician Specialist	Currently no identified exp physician. Team will bring expertise.	No identified Palliative Care specialist physician. MRP provides care.	No identified Palliative Care specialist physician. MRP provides care.	Variable by home
Access to Specialist level HPC Expertise: Non-physician	-Team is in process of being implemented to provide specialist level expertise within the community settings. -Dedicated CCAC Case Managers typically have specialist level of expertise. -CSPAs have varying levels of secondary level expertise (e.g. fundamentals / CAPCE etc.). - CCAC employed NP	-2 FTE Supportive Care Consultation Nurses, with specialist level expertise, consult with patients in AC and CCC (via physician referral) – Chatham site. -Some nurse have CAPCE	-2 FTE Supportive Care Consultation Nurses, with specialist level expertise, consult with patients in AC and CCC (via physician referral) – Chatham site. -Some nurse have CAPCE .	-Wide variation in expertise. Some LTCHs have CAPCE trained nurses. -Some have Fundamentals and AHPCE trained staff. -PPSMC (Ann Brignell) available to providers in all LTCHs.
Consultation	Consultation to care providers is provided by the Palliative Pain and Symptom Management Consultation Program (PPSMCP).			
Education	Formalized training for staff available from Palliative Pain & Symptom Management Consultation Program (Fundamentals, CAPCE, AHPCE, and sector specific education etc.).			
VON Volunteer Hospice Program	Potential to assist with volunteer training and recruitment across sectors. Currently in C/K working with patents in community, LTCH and at CKHA.			

Table 2

Typical HPC Interventions/Procedures/Services Provided ON SITE - By Patient Location

Locations below are 24/7 care settings – Mobile/transportable patients may travel from their primary location to receive these interventions/procedures/services as outpatients at hospitals and RCPs

LEGEND: Y= Yes, most facilities provide this N= No, most facilities do not provide this ; S=A significant number of facilities provide this service/intervention/procedure;

	In Home- CCAC and CSPA	Acute Care	Complex Continuing Care	Long Term Care Homes
*Tertiary Care Interventions	N	Y	N	N
Paracentesis/ Thoracentesis	N	Y	Y	N
Initiation of Intraspinal pain management	N	Y	Y	N
Initiation of Ventilator/Respirator Care	N	Y	N	N
Management of Ventilator/Respirator Care (Bipap)	Y	Y	Y	S
Blood transfusions	N	Y	Y	N
IV therapy – fluid replacement	Y	Y	Y	S – with CCAC teaching
IV therapy – antibiotic therapy	Y	Y	Y	Some with CCAC teaching
Initiation of Central Line	N	Y	S	N
Management of Central Line	Y	Y	Y	S – with CCAC teaching
Palliative Chemotherapy	Y-oral meds and monitoring pumps	Y	Y	N
Diagnostic Imaging	N	Y	Y	N
Diagnostic Lab	Lab pick up with cost	Y	Y	Lab pick up 1x per week
Surgical & Anesthesiology Intervention	N	Y	S	N
Palliative Radiotherapy	N	RCP locations only	N	N
PCA Pumps	Y	Y	Y	A few with CCAC teaching
Services which are common to virtually all locations	Management of : tube feedings, pressure ulcers, oxygen therapy, Some degree of support from Pharmacy, Allied health, Volunteers,			

Format and content adapted from work done by Windsor/ Essex End of Life Care Committee under the leadership of Sandra Kroh - validated by each county's EOLCN committee in 2008. Reviewed Jan 2011 in C/K and S/L.

***Tertiary Care includes treatment for: bowel obstructions, spinal cord compression, febrile neutropenia, hypercalcemia, acute severe symptom management (restlessness, agitation, confusion, pain crisis, and anxiety)**

Tertiary Care also includes specific treatment regimens and care co-ordination such as: palliative sedation for refractory symptoms, oncological emergency care, urgent referrals to Cancer Centre, etc.

Table 3

Typical Eligibility Criteria for Hospice Palliative Care in ESC

(Locations below are 24/7 care settings – day programs/clinics/ambulatory care services may support patients in these locations particularly patients in home)

Expert teams significantly enhance care and connections at home and across sectors.

	In Home CCAC and CSPA	Acute Care	Complex Continuing Care	Long Term Care Homes
General Description	-Patient requires in -home coordinated multidisciplinary care, -Is not eligible for other settings or chooses care in home. - Typically significant degree of family / informal care provider support & resources are required particularly in later stages.	Need for Palliative Care approach may be at time of initial diagnosis/ palliative prognosis or acute exacerbation; -Management of severe symptoms; -May require intensive *tertiary level interventions to manage symptoms.	-Provide continuing and specialized services to medically complex patients, who usually have multiple health problems and/ or functional impairments.	-Provide care to individuals who no longer are able to live independently and have fully utilized all available resources and services within the community.
DNR established on admission	DNR may or may not be established	DNR may or may not be established	-General CCC beds: DNR may or may not be established -Designated HPC units: DNR on admission	DNR may or may not be established
Level of Care / Monitoring Required and available	-Varying degrees of monitoring and care levels -24/7 professional support may be offered in last 2 weeks of life	-24/7 registered staff with patients -high degree of aggressive clinical/ medical interventions	-24/7 registered staff with patients -Care needs exceed that available in community or LTC settings	-24/7 registered staff on site -PSW 24/7 coverage -Care needs exceed that available in community
Prognosis / typical LOS/ coding	Coded MIS 95 when prognosis is approx 3 months	Coded Z51.5 when a case meets BOTH of the following criteria: -patient has a terminal illness and is receiving palliative care (“comfort care”, “supportive care”, “compassionate care” or “pain control only”)	-General CCC beds: no predetermined or typical LOS -Designated HPC beds: terminal dx. with ALOS approx. 4 months -HPC needs are not well captured with CCRS coding.	-Most patients requiring HPC are those who are already residents and enter EOL phase. -longer LOS than other setting typically
Physician Intervention	-Variable levels of Physician involvement required -House calls typically required for EOLC	- May require care from various specialists to identify & control symptoms	-Use of diverse pharmacology requires frequent Physician intervention	Variable levels of Physician involvement required
Criterion which are common to all locations	Patient: consents to care in this setting; requires professional health care; Typically requires pain and symptom management and psychosocial support; May require lab and other diagnostic testing to identify and control symptoms; has valid OHIP.			
Format and content adapted from work done by Sarnia Lambton End of Life Care Committee under the facilitation of A. Baker – validated by each county’s EOLCN committee.				

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Flow Chart

EOLC in the Home—Decision Points

