



Hospice Palliative Care (HPC) in Windsor Essex

Right Patient in the Right
Place at the Right Time

Palliative Care across the
Continuum
February 2010

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Handouts adapted from:

*'Report on Current Services & Recommendations for Future
Systems - Hospice Palliative Care in Erie St. Clair'*

B. Lambie & ESC EOLCN December 2008.



Windsor Essex Table 1
Description of Hospice Palliative Care Sectors/Care Settings Locations below are 24/7 care settings

Description	In Home- CCAC & CSPA	Residential Hospice -Hospice of W/E	Acute Care (AC)			Complex Continuing Care		Long Term Care Homes
			LDMH	HDGH	WRH	LDMH	WRH	
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. .	Dedicated Palliative Care beds in a stand-alone setting - 8 beds. Non –residential support programs are provided at adjacent Resource Centre for outpatients.	No designated HPC beds.	No designated beds.. Several private rooms with special amenities are used for palliative care when available.	Oncology unit is an integrated unit with cancer patients requiring palliative care interspersed with cancer patients receiving curative intent treatments. -28 beds plus 2 flex beds and 2 emerg.- hold beds. Non- cancer patients requiring HPC are dispersed throughout med/surg/ICU beds.	No dedicated beds.	Dedicated unit at Malden Park location. 20 beds	Models of Palliative Care vary significantly. Beds typically not dedicated to Palliative Care only – some specialty areas/rooms available for EOL care
Volumes (2006/2007)	MIS code 95 220 clients (2006/07)	-105 admissions - 92 deaths (2009)	Z51.5 code - 23 discharges - 112 days of care	Z51.5 code -255 discharges - 3975 days of care	Z51.5 code - 96 discharges - 998 days of care	34 deaths	Deaths – 237- in all CCC beds not just the 20 HPC beds	Approximately 738 deaths in LTC beds (2006/07)
Access to Physician Specialist (for Hospice Palliative Care)	Consults by a Palliative Care Physician from Hospice as requested by MRP..	Consults and care by a Palliative Care Physician. .	One hospitalist with HPC expertise provides consultation .	Several hospitalists have HPC expertise.	No identified on site expert HPC physician. Care provided by MRP (oncologist, hospitalists etc.) with some consultation from Windsor Hospice Physician. On site Pall. Care physician to start in Oct.2010	One hospitalist with HPC expertise provides consultation .	Expert HPC physician consults/cares for all patients.	Variable by home
Access to: Non-physician specialist expertise (for Hospice Palliative Care)	-Hospice Team nurses provide consultation within the community settings- team to be augmented with A@H funding 2010. -Dedicated CCAC Case Managers typically have specialist level of expertise. -CSPA have varying levels of secondary level expertise (e.g. fundamentals/CAPCE etc.). -CCAC employed NP.	-Expectation is that I staff will have secondary level HPC expertise within their own professional scope of practice (e.g. CAPCE or AHPCE). -Clinical Director as specialist level nursing expertise.	One NP with additional expertise in HPC. NP covers all patients (AC &CCC) not just HPC..	One Expert NP with extensive training, experience and expertise in HPC.	-Expert nurse from WRCC provides consultation (with MRP referral). Expert NP to start Feb. 2010.	One NP with additional expertise in HPC. NP covers all patients (AC &CCC) not just HPC.	-Charge nurse is HPC expert (CAPCE trained with much - experience). -many staff have advanced training (fundamentals, CAPCE etc).	-Wide variation in expertise. Many LTCHs have Fundamentals, CAPCE & AHPCE trained staff. -PPSMC (Carole Gill) available to providers in all LTCHs.
Consultation	Consultation to Care Providers is available from 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.). Hospice W/E has funding to provide education to Care Providers.							
Vol. Hospice program	Potential to assist with volunteer training and recruitment across sectors.							

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	Residential Hospice	Acute Care	Complex Continuing Care	Long Term Care Homes
*Tertiary Care Interventions	N	N	Y	N	N
Paracentesis/Thoracentesis	N	N	Y	Y	N
Initiation of Intraspinal pain management	N	N	Y	Y	N
Initiation of Ventilator/Respirator Care	N	N	Y	N	N
Management of Ventilator/Respirator Care (Bipap)	Y	N	Y	Y	S
Blood transfusions	N	N	Y	N	N
IV therapy – fluid replacement	Y	Y	Y	Y	S – with CCAC teaching
IV therapy – antibiotic therapy	Y	Y	Y	Y	N
Initiation of Central Line	N	N	Y	S	N
Management of Central Line	Y	Y	Y	Y	S – with CCAC teaching
Palliative Chemotherapy	Y-oral meds and monitoring pumps	N	Y	Y	N
Diagnostic Imaging	N	N	Y	N	N
Diagnostic Lab	Lab pick up with cost	Lab pick up with cost	Y	Y	Lab pick up 1x per week
Surgical & Anesthesiology Intervention	N	N	Y	N	N
Palliative Radiotherapy	N	N	RCP locations only	N	N
PCA Pumps	Y	Y	Y	Y	N

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. –Dec. 2008.

***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 regimes 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	Residential Hospice	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.	- EOL predicted on admission - Would be appropriate for in home care if family / informal care provider support & resources were available	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	Yes – DNR on admission	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 supportive care -advanced skill level in EOL care -sub-acute level of care requirement	-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	-PPS < 60 - approx 3 months -ALOS Hospice -21 days	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	-Use of diverse pharmacology requires frequent Physician intervention	- 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.- Dec. 2008.

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Flow Chart

EOLC in the Home—Decision Points

