Central East **LHIN**

Central East LHIN Residential Hospice Strategy

July 2016

Ontario
Local Health Integration Network

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Purpose

The purpose of this document is to provide a framework for stakeholders who are interested in the planning, development and implementation of residential hospice in the Central East Local Health Integration Network (Central East LHIN). This document was developed from evidence based documentation including research, recommendations and standards from the *Strengthening Ontario's End-of-Life Continuum: Advice Regarding the Role of Residential Hospices,* Provincial Residential Hospices Working Group (March 2015) and the *Standards for Community Residential Hospices*, Hospice Palliative Care Ontario (September 2012).

Central East LHIN Residential Hospice Strategic Aim

To expand options available to palliative patients in the Central East LHIN by increasing the number of operational residential hospice beds to 56 by 2019, by:

- Pursuing development of beds across LHIN sub-regions;
- Advancing collaborative multi-sector partnerships to make best use of public investment; and
- Recognizing residential hospice as a key element to advancing *Hospice as Hubs* strategy.

Background

A residential hospice is a healthcare facility and registered charity that provides palliative care services by an inter-disciplinary team with palliative care expertise 24 hours a day, 7 days a week in a home-like setting for the individual and their significant others at no cost to the user. A residential hospice provides an option for adults and children with life-limiting illnesses to receive end-of-life services where death is imminent and a home death is not possible or preferred but hospital level care is not required.

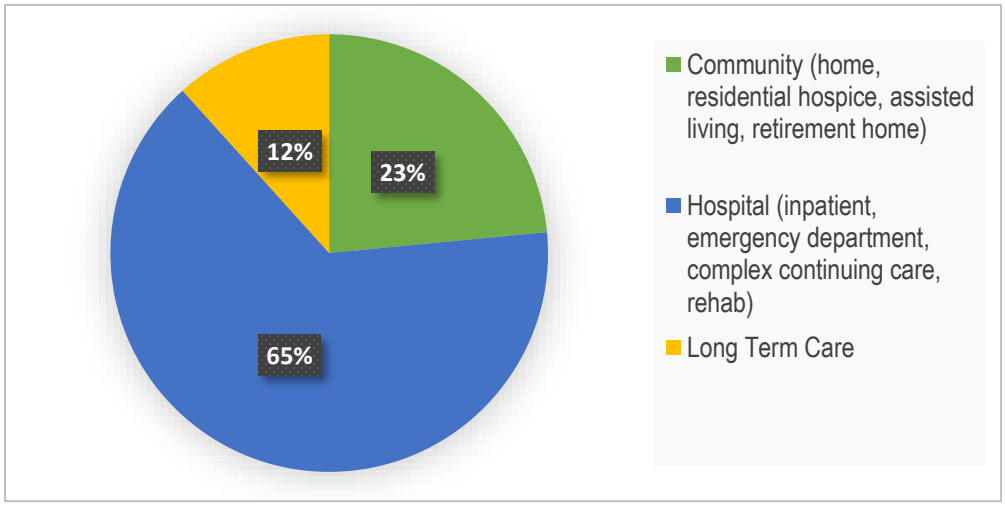
There are expected to be 100,000 deaths annually in Ontario in 2016 and beyond[1]. Approximately 10% of deaths are sudden or unexpected, most of which occur in hospital[1]. Of the non-sudden deaths in Ontario, less than 5% of people are expected to experience an acute complication or have need for specialized tertiary services at the end of life that could only be delivered in an acute care setting[1].

The table below provides an overview of the expected 100,000 deaths in Ontario by age and typology[1].

Age breakdown	75,000 seniors 25,000 children and adults
Typology - Trajectory of death	30,000 cancer 27,000 frailty/dementia 27,000 organ failure 17,000 other

Based on survey data, approximately 2/3 of Ontarians indicate they would prefer to die at home but approximately 65% of Ontarians die in hospital[2]. In Central East LHIN, 73.4% of patients receiving palliative care services died in hospital (2014/15) which is the 2nd highest rate in the province[2]. The figure below provides a breakdown of location of death in Ontario.

Figure 1. Percentage of deaths, by location of death, in Ontario, 2014/15[5]



The cost of dying in Canada has been estimated to range from $10,000 for a sudden death to approximately $40,000 for individuals with a chronic/terminal disease[3]. In Ontario, the total annual end-of-life cost of $4.7 billion represents more than 10% of all government-funded health care (not including hospices, some physician services, and community services)[3].

In Central East LHIN, 67% of patients receiving palliative care services had at least one unplanned emergency department visit in their last 30 days of life (2014/15) and 68.1% of patients receiving palliative care services had at least one hospital admission in their last 30 days of life (2014/15) both of which are the highest rates in the province[4]. Only 22.2% of patients receiving palliative care services had at least one home visit from a doctor in their last 30 days of life in the Central East LHIN (2014/15) which is the 2nd lowest in the province[4]. There is some evidence that home visits by doctors can lead to fewer unplanned trips to the emergency department for patients nearing the end of life[4]. People who receive home visits by a doctor may also be less likely to die in hospital[5]. It is estimated that a residential hospice bed costs $439 per day to operate vs. at least $850 per day for an acute care bed[6].

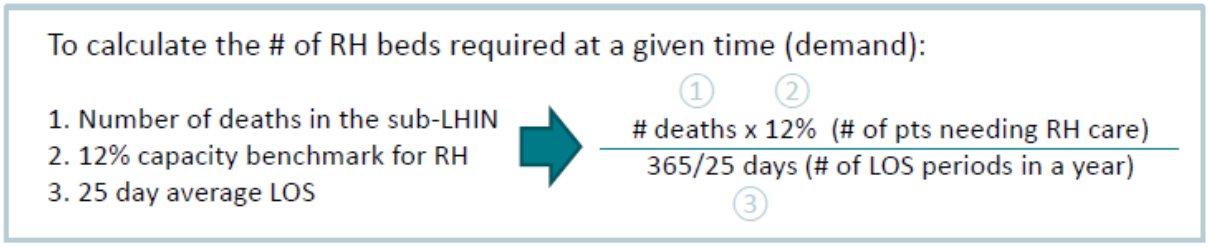
Residential Hospice Demand in Central East LHIN

There is estimated to be a demand for 94 residential hospice beds in the Central East LHIN by 2018/19. This demand is based on projected number of deaths, residential hospice utilization and average length of stay as calculated by the Ontario Palliative Care Network (OPCN). The table below breaks down the projected number of deaths and demand for residential hospice beds by LHIN sub-regions (which match Central East LHIN clusters) as calculated by the OPCN.

Demand for RH beds in 2018/19

Sub-LHIN	Projected deaths in 2018/19	# of RH beds
Durham North/Central, Durham West, Durham East	4,044	33
Scarborough Agincourt-Rouge, Scarborough Cliffs – Scarborough Centre	4,064	33
Haliburton Highlands, Kawartha Lakes, Peterborough City and County, Northumberland-Havelock	3,365	28
Total		**94**

The average length of stay (LOS) in a residential hospice bed in Ontario is 21 to 28 days[1]. A LOS of 25 days and a provincial capacity planning benchmark of 12% were used by OPCN to determine demand[1] (see footnote). The figure below details the equation used to determine estimated demand.



Current State: Residential Hospice in Central East LHIN

The Ministry of Health and Long Term Care's (MOHLTC) 2005 End-of-Life Care Strategy provided funding for nursing and personal support services for the provision of palliative care services anticipated to be available through the opening of 10-bed residential hospices. The MOHLTC identified the following 3 health service providers for allocation of 10-bed residential hospices:

- Hospice Peterborough
- VON/Durham Hospice (previously had been Durham Access to Care)
- Yee Hong Centre for Geriatric Care

To date, the above announced residential hospices remain unopened. In the meantime, this funding resides with the Central East Community Care Access Centre (CECCAC) to provide palliative care services in the community.

In April 2016, the OPCN made the recommendation to the MOHTLC to provide operational funding to support 26 additional residential hospice beds in the Central East LHIN (in addition to the 30-beds allocated in 2005). Final decision on allocation is to be made by the MOHTLC.

In 2011, the MOHTLC announced an additional $7,000,000 provincially in base funding, increasing MOHLTC support to $90,000 per adult bed annually. Once again in 2016, the MOHLTC allocated additional funding, increasing base funding to $105,000 per adult bed annually. The operational funding provided by the MOHLTC results in total funding of, for example, $315,000 annually for a 3-bed residential hospice (3 x $105,000) and $1,050,000 for a 10-bed residential hospice (10 x $105,000).

The Bridge Hospice

The Bridge Hospice is a three-bed free-standing residential hospice situated in rural Northumberland County in Warkworth, Ontario. Through the support of their Board and community volunteers, the Bridge Hospice began taking residents in June 2013. In September 2015, the Bridge Hospice and Saint Elizabeth Community Enterprise entered into a partnership agreement. The partnership includes annualized funding to support a revised service delivery model. Under this agreement, Saint Elizabeth Community Enterprise provides the Bridge Hospice with $300,000 in annualized funding for 5 years. Key highlights include:

- Delivery of 24/7 personal support worker (PSW) and on-call registered nurse (RN) services for admissions, specialty treatments and other services offered outside of CCAC support;

[1] As a planning guide, approximately 12% of the 1% of patients approaching end-of-life within the community may need access to a residential hospice care setting during their last weeks of life (i.e. cannot or prefer not to be cared for at home), but do not need hospital level care.

- Access to a 24/7 on-call infrastructure;
- Additional oversight for PSW, RN and volunteer hospice staff;
- Development and completion of administrative reporting requirements;
- Annual measurable outcomes and evaluation; and
- Ongoing professional development - access to online education programs.

The operation of the Bridge Hospice is also supported by the visiting services of the CECCAC. Residential Hospice patients are eligible to receive services through CECCAC and other LHIN funded health service providers (e.g. Community Care Northumberland visiting hospice or Meals on Wheels) as would be available to an individual who is residing in their own home.

Haliburton Highlands Health Services

Haliburton Highlands Health Services (HHHS) provides an integrated system of health care in Haliburton, including ambulatory/emergency care, long-term care and community support services. Within the 14-bed hospital, a dedicated palliative care room has been renovated to reflect a home-like setting, while providing medical/nursing staff expertise. Hospice volunteers provide patient and family supports on-site while policies and procedures, roles and responsibilities were created to introduce a hospice philosophy in an acute setting. Patients are admitted to the room from the hospital as well as directly from the community. Program delivery began in October 2011 and in April 2016, HHHS received approval from the MOHLTC to expand their service from 1-bed to 2-beds. HHHS is solely responsible for capital and operating costs.

Figure 2 provides a timeline for residential hospice in Ontario and the Central East LHIN.

Figure 2. Residential Hospice Strategy and Implementation Timeline in Ontario and Central East LHIN

Based on the Central East LHIN Residential Hospice Strategic Aim, the 2005 End-of-Life Care Strategy allocation (30 beds) and recommendations made by the OPCN to the MOHLTC (26 additional beds), the LHIN is recommending the 26 additional beds be allocated as follows:

- 10 additional beds be implemented in Scarborough;
- 10 additional beds be implemented in Durham;
- 3-bed funding be allocated to the Bridge Hospice; and
- 3 additional beds be implemented in the Northeast cluster (City of Kawartha Lakes or Northumberland).

The HHHS 2-bed residential hospice is not included in the allocation above or table below as the beds are funded through HHHS operating dollars and not through separate residential hospice operational funding.

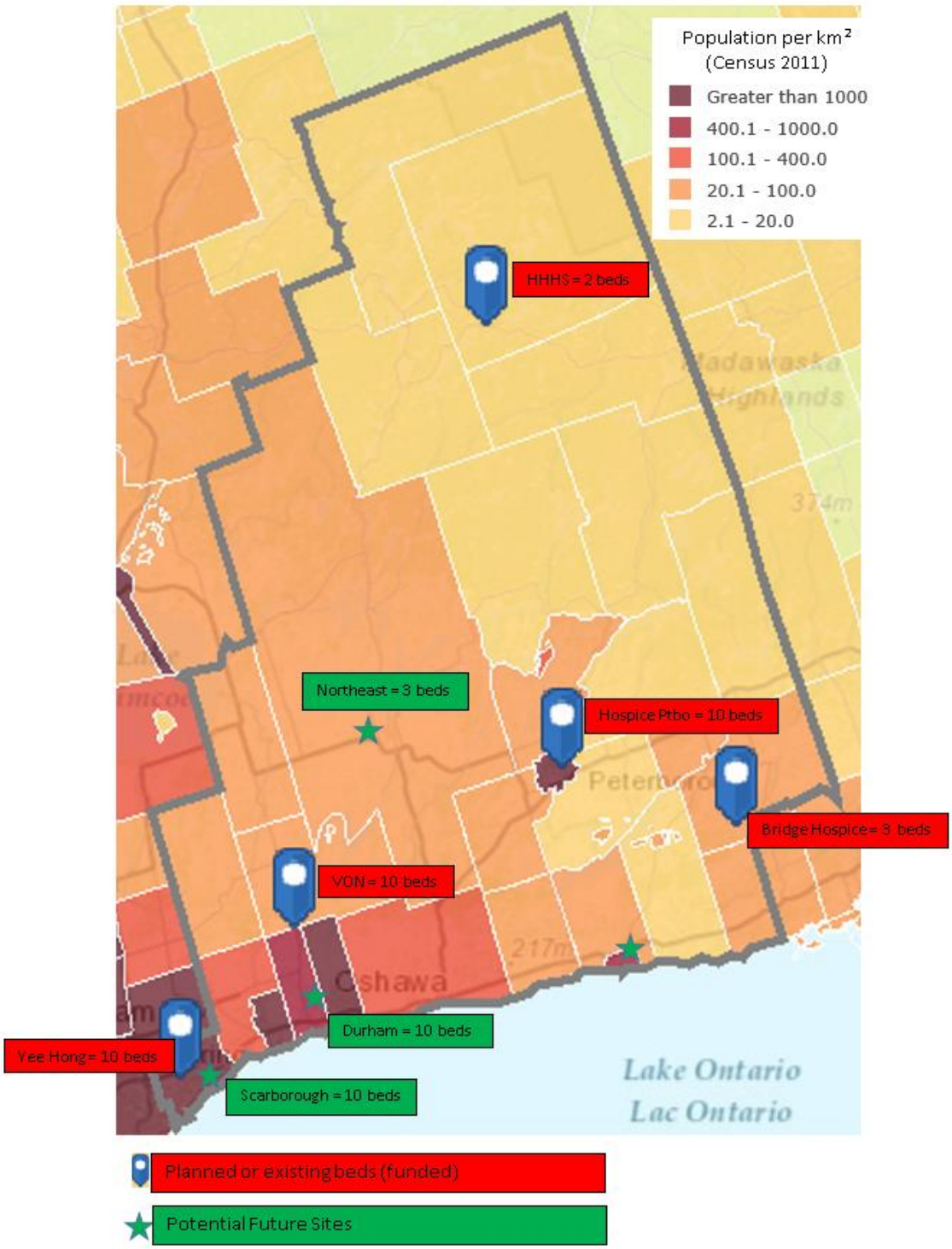
The table below summarizes residential hospice bed allocation and demand in Central East LHIN.

Table 1.

Central East LHIN cluster	Identified Demand 2018/19 (number of beds)	2005 MOHLTC allocation (number of beds)	Central East LHIN directed number of beds (based on 2016 OPCN allocation)	Total bed allocation (including 2005 and 2016 allocations)
Scarborough	33	10	10	20
Durham	33	10	10	20
Northeast	28	10	6	16
Total	**94**	**30**	**26**	**56**

The map below details current residential hospice supply and projected demand in 2018/19 as calculated by the OPCN.

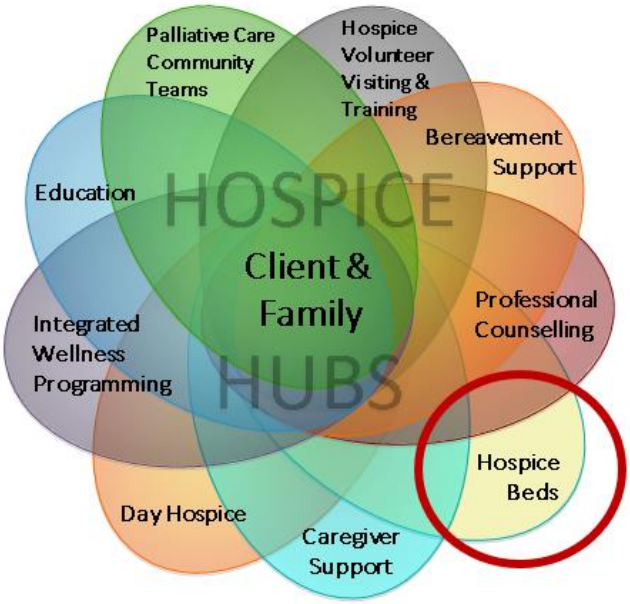
Figure 3. A map detailing residential hospice supply and Central East LHIN recommended beds



Hospice as Hub

In April 2014, the Central East Hospice Palliative Care Network (CEHPCN) developed a Regional Palliative Care Plan detailing 5 priority recommendations. One of the recommendations was the creation of *Hospice Hubs*, with a hub being a publicly visible profile for local hospice information, services and a Centre of Excellence in hospice palliative care, grief and bereavement services. Furthermore, a common basket of core programs and services across local hospice settings, should be available to patients and caregivers based on need. Residential hospice is a component of the *Hospice Hub* model. The following diagram is a depiction of *Hospice Hub* model developed by the Central East LHIN Hospice as Hubs Working Group.

Figure 4. Hospice Hub Model



The expectation of the *Hospice Hub* model is that hospices will be part of a community-wide effort to establish well known and easily accessible public spaces for the public to have all of their questions and concerns about death, dying and loss answered. If a residential hospice is not co-located with the visiting hospice, it's expected that the residential hospice will ensure the full spectrum of services are available to, and known by, all residents as a formal, integrated and collaborative model with visiting hospice services.

Clinical palliative care stretches outside the *Hospice Hub* model through services provided by the Community Palliative Care Nurse Practitioners (CPCNP), CCAC contracted service providers, Palliative Care Community Team, primary and specialty care, and hospitals. The Palliative Care Community Team supports patients through the clinical and non-clinical components of palliative care.

Model for Residential Hospice in Central East LHIN

The model for residential hospice care in the Central East LHIN should be collaborative in nature and provide holistic palliative care through an inter-disciplinary team with palliative care expertise.

In alignment with the Provincial Residential Hospice Working Group, there is no recommended minimum size requirement (i.e. number of beds) for a residential hospice in Central East LHIN. There is recognition of the need for flexible models in smaller communities which do not have a population or service base to support the development of a 10-bed residential hospice. It is acknowledged that operating efficiencies do exist for a 10-bed residential hospice versus a residential hospice with fewer than 10 beds. Residential hospice beds may be located in a free-standing building or co-located in another healthcare setting depending on the needs of the community and available

resources. Decisions regarding the location and model of a residential hospice should be made collaboratively with the LHIN to ensure system alignment and integration.

Regional Oversight

At a LHIN level, centralized planning and oversight will be provided by the Central East LHIN through the CEHPCN to support capacity development to reduce gaps, strengthen service integration, create system efficiencies and optimize the use of resources, while ensuring regional and province-wide learning and uptake of leading practices. The LHIN will provide clarity around issues that cross boundaries, such as privacy, risk management, and shared accountability, ensuring consistency throughout the LHIN. The LHIN will also find opportunities for shared back office functions across program areas as appropriate. A Central East LHIN Residential Hospice Community of Practice will support planning, implementation and operation of residential hospice and representatives from residential hospices will be expected to participate (with support through the CEHPCN).

Ideally, through the delivery of quality hospice palliative care, access and admission to a residential hospice should not be a surprise for most patients and families, but will be planned for and organized in advance, informed by their existing needs assessment, preferences and care plan. Structured but flexible local processes will be established that would allow a patient to move into a residential hospice quickly when urgent circumstances arise and suitable arrangements cannot be made in advance.

Access and wait list management to residential hospice will be planned and coordinated through a consistent, standardized, regionally-based care coordination process and model. The access point for coordination of care should reflect the entire journey of care and leverage existing community-based models. The residential hospice will be responsible for reviewing all applications for admission and confirming the hospice's ability to safely meet the care needs of the potential client before admitting them to the hospice.

Residential hospices should have formal collaborative partnerships with hospitals, community-based services and primary care providers in their communities, recognizing that residential hospices are an important resource to support the movement of patients from acute care or alternative level of care beds into settings more appropriate to their needs, or have patients avoid hospitalization altogether.

Provincial Residential Hospice Standards

Hospice Palliative Care Ontario (HPCO) published the first standard for residential hospices in Canada in 2005. The standards were updated in 2012, with a focus on four fundamental areas: clinical care, governance, operations and quality assurance. The Standards have been adopted into HPCO Accreditation Framework, allowing residential hospices to pursue voluntary accreditation with HPCO. It is the expectation of the LHIN that a residential hospice will pursue HPCO Accreditation within 2 years of becoming operational. The HPCO Standards are scheduled to be reviewed in 2017. Below is a list of the 15 defined standards:

- *Section A – Clinical Care*
    - Standard A1. Model of Care
    - Standard A2. Access to Hospice
    - Standard A3. Assessment
    - Standard A4. Information Sharing
    - Standard A5. Care Planning
    - Standard A6. Care Delivery
- *Section B – Governance*
    - Standard B1. Board of Directors
    - Standard B2. Financial

    - Standard B3. Fundraising
- *Section C – Operations*
    - Standard C1. Facility Design and Risk Management
    - Standard C2. Human Resources
    - Standard C3. Volunteer Involvement
- *Section D – Quality Assurance*
    - Standard D1. Operations
    - Standard D2. Individual and Provincial Sustainability
    - Standard D3. Research and Education

The Standards state that facilities incorporated in a residential hospice must consist of at a minimum:

- Private residential rooms
- Community living room
- Community kitchen and eating area
- Quiet area
- Tub/Shower room
- Public washrooms meeting accessibility regulations;
- Dirty utility area
- Supplies area
- Nursing station including secure medication room
- Administrative offices
- Children's play area

All residential hospices, regardless of care setting or size, should meet all applicable residential hospice Standards, and must operate a program which is financially sustainable. As there is recognition for flexible models in smaller communities, if a Standard is unable to be met, the residential hospice must work collaboratively with the LHIN to mitigate any risks.

Currently, the provision of nursing, personal support and other community services to residents in residential hospices must comply with the requirements of the *Home Care and Community Services Act, 1994* (HCCSA).

Metrics

Standardized process and outcome measures will be identified by the LHIN and reported quarterly. Metrics will incorporate quality of care, person-centred and community system outcomes (e.g. reducing number of Emergency Department visits in last 30 days of life).

Funding

Operational Funding

Residential hospices are not health service providers under the *Local Health System Integration Act, 2006*. Should legislative changes take place through Bill 210, a residential hospice may be considered a health service provider with opportunity to receive funding directly from the LHIN.

Currently, residential hospices are part-funded by the MOHLTC and part from charitable donations and fundraising. The MOHLTC provides funding for nursing and personal support services at a rate of $105,000 per adult bed annually. Currently, funds are flowed through the CCAC and there are two options for the flow of funding. Hospices may:

a. Receive a funding envelope to independently employ nursing and personal support services, with an accountability agreement through the CCAC; or
b. Receive nursing and personal support staff through CCAC-contracted service providers.

Capital Funding

Typical capital cost to build a 10-bed residential hospice can range from at least $3,000,000 to $5,000,000[3]. Communities must fundraise 100% of the capital planning and construction costs. All residential hospices must comply with relevant provincial and federal legislation and regulations that govern registered charities and healthcare facilities.

Health service providers should work with the LHIN and other stakeholders in the planning, implementation and operation of a residential hospice. Given the capital requirements necessary to build a residential hospice and the need for ongoing fundraising to support operational costs, communities are strongly encouraged to work in a collaborative manner to support successful implementation. Given the system impact of a residential hospice, the LHIN is prepared to facilitate partnerships with hospital, CCAC, primary care, community support services, and others as required. The LHIN will support and facilitate planning tables to enable development of integrated systems and partnerships, and is supportive of health service providers partnering with private organizations or stakeholders to enable the construction and/or operation of a residential hospice.

Barriers and Risks

There are several barriers to the establishment of residential hospice in the Central East LHIN. The large capital requirement to build a residential hospice is an often cited barrier, especially in smaller communities. Once the required capital fundraising is established, the ongoing fundraising required to sustain the operation of the residential hospice is an often cited barrier.

To mitigate these risks, as detailed previously, the LHIN is willing to work with providers in the planning, development and implementation stages, as well as facilitate partnerships to support an integrated model for residential hospice.

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