



Toronto Central CCAC Palliative Care Program

Kim Pearson

Manager, Client Services
Palliative Program and
Princess Margaret Hospital

What we do in a nutshell...

Care Connections

*Helping people
find the services
they need in
their community*

Navigating & Transitions

*Working within
the system to get
people to the right
place of care*

Supportive Care Programs

*Integrated
programs of
support for key
populations*



Community Update

Successful Implementation of our Population Based Model

Acute & Rehab Transitional Care

Providing 2200 clients a month with post acute & rehab care

Child and Family

1500 kids in schools, 60 medically complex and 400 with post acute & rehab needs

Mental Health

Supporting 1000 clients with mental health issues to live in the community

Palliative Care

We help 600 clients to die with dignity

Urban Health

Access to services for homeless, under-housed and marginalized clients

Seniors Enhanced Care

Supporting 2000 seniors & their caregivers to age at home with dignity

Adult Supportive Care

Supporting 1200 adults & their caregivers to manage their long term conditions

Community Independence

Maintaining 7000 clients in the Community



Palliative Program - Team

- One Team across Toronto Central LHIN
- 9 Care Coordinators and 1 Team Resource
- 1 Manager
- Caseload 40-50 clients

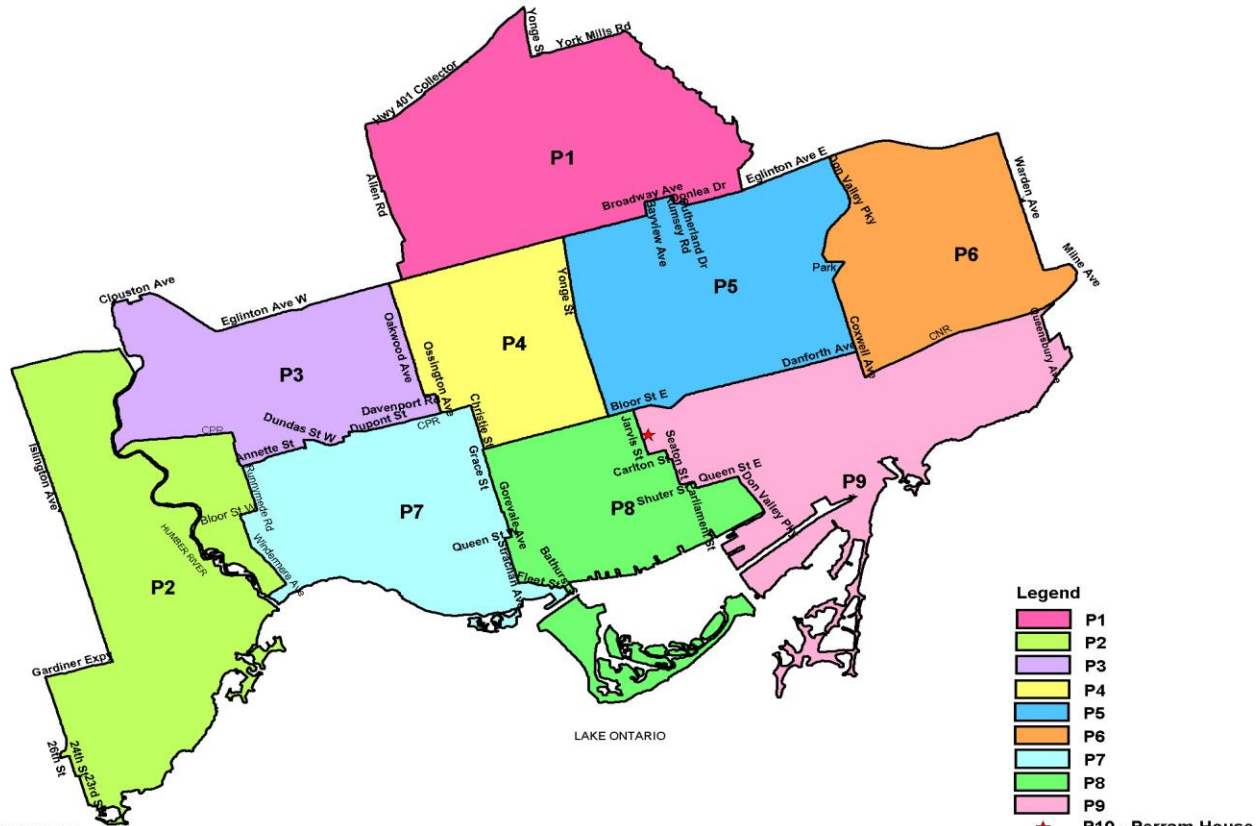


ccac casc
 Community Care Access Centre
 Centre d'accès aux soins communautaires

Palliative Map



Palliative Care Team



Created by: Olga Arguelles
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Goals & Objectives

- **Goal:** To provide quality client-centred care to individuals, who are living with or dying of an advanced illness, and their families and to ease suffering in order to provide the highest quality of life possible throughout the illness trajectory
- **Objectives:**
 - Relief from suffering, treatment for pain and other distressing symptoms
 - Support families/caregivers and prevent caregiver burden
 - Support clients and the system by reducing ER visits and hospitalization
 - Support clients to die at home or to live at home as long as possible



Client Population

- Adults* who are living with or dying of an advanced illness
- Expected life span of twelve (12) months or less
- Life limiting condition that the client and/or the family are aware of
- Client/decision maker desires a palliative approach rather than curative focus

*Consultants to Child and Family and Mental Health teams



Program Components – Care Coordination

- Responsive Palliative Team
 - Contact with clients within 24-48 hours of being referred to the program
 - Home visit with client and family within 5 days and earlier if needed
 - Frequent home visits and contacts
 - Support from a coordinated care team with 24/7 day responsiveness
- Assessment and development of comprehensive plans to support palliative clients to remain at home as long as possible or transition to an appropriate care setting
- Linkage with community palliative physicians, medical, social, community and hospice based services
- Follow clients and family across the care continuum ensuring palliative clients have supported transitions from hospital to home and from home to palliative care units or hospices.
- Facilitate regular team meetings/rounds and care conferences as needed
- *Consult at Home* – Consultative support by Palliative Care team to CS teams and partners



Program Components - Tools

- TCPCN Palliative Common Referral Form
- Palliative Performance Score (PPS)
- Edmonton Symptom Assessment Scale (ESAS)
- CSR – Palliative
- Record of Care
- Preferred Practice Guidelines for Community Palliative Care Nursing



Program Partners

- Palliative Care Physician teams
- Service Providers – (e.g. Nursing, Personal Support, Social Work, Occupational Therapy, Medical Supplies and Equipment)
- Hospices
- Family Health Teams and/or Primary Care Physician
- Community Health Centres
- Pharmacy
- Regional Cancer Centres – Odette and Princess Margaret Hospital
- Acute Care Hospitals
- Palliative Care Units and Residential Hospices



Inter-Professional Team Approach

- **Teams include:**

- Palliative Care Coordinator
- Physician (Temmy Latner Centre for Palliative Care, Toronto Grace Hospital and St Joseph's Health Centre)
- Nursing
- Social Work
- Hospice

- **Team Goals**

- Care Planning
- Education
- Support



Moving Forward

- Development of Service Commitments for our clients
- Mapping the experiences of our clients & caregivers
- Engaging clients & caregivers in program design and improvement
 - Surveying clients in April 2010
- Working with key partners to improve transitions & integration at the point of care
- Formalize inter-professional care team
- Develop program indicators



Mapping the experiences of our clients & caregivers

Understanding the needs of our clients with cancer

- 10-11 – Map clients in the community living with cancer
- Gather data – quantitative and qualitative
- Work with RCCs – Odette and PMH - to improve transitions and integration
- Determine best program to support this population



Questions & Comments