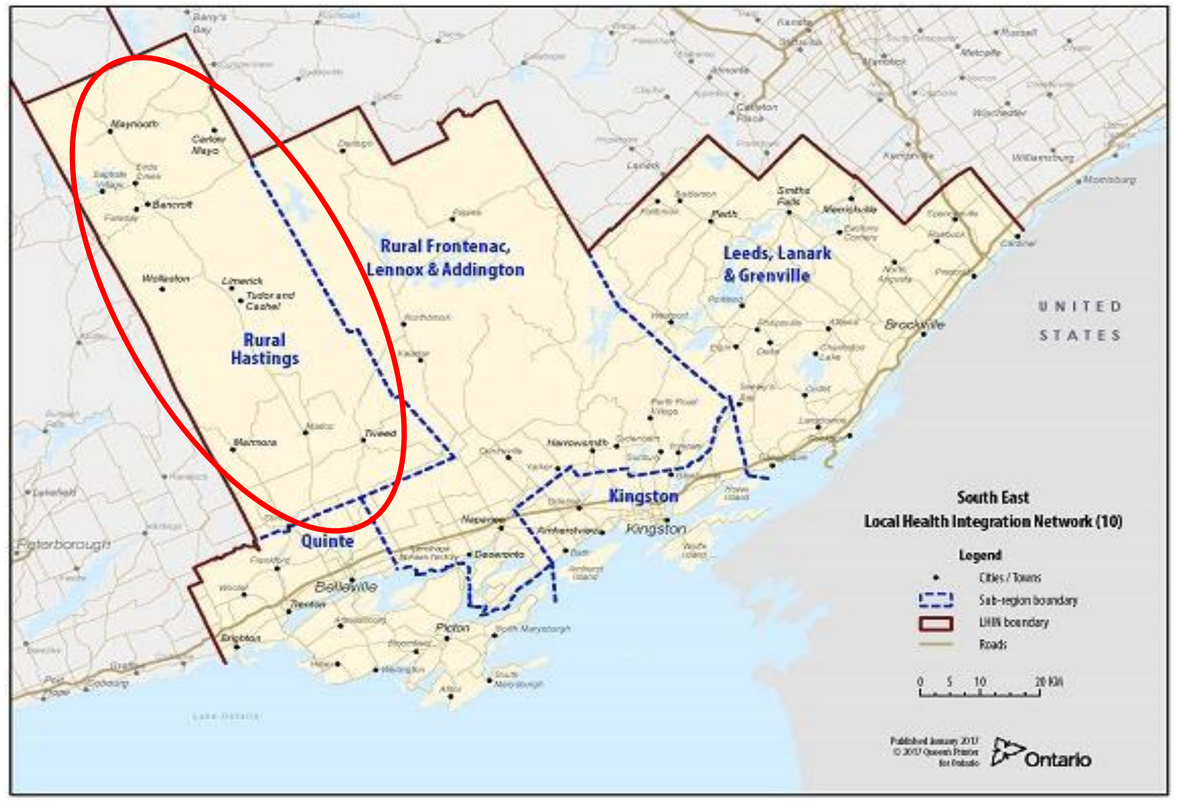
Project: Better Communication within the Circle of Care

Region: Rural Hastings

Executive Sponsor: Dr. Janet Webb

Team Lead: Alicia McCullam

Project Status: Master (Revised April 2019)



South East Regional
Palliative Care
Network

Problem & Aim Statements: Two sides of the same coin…

Problem Statement

There is a lack of access to time sensitive communication for patients/families and between providers that limits the quality of care patients receive and the efficiency of the care delivered which creates a negative experience for providers, patients and their families.

Aim Statement

We will improve the patient/caregiver experience in receiving timely and accurate communication of relevant information at end of life. We will increase positive patient/caregiver emotions by 10%. We will improve provider satisfaction with the communication they receive in the circle of care by 10% as measured by positive responses reflected in a survey relating to access and timeliness of pertinent information received. We aim to improve these experiences by March 2019.

Project Scope

Improve communication in the last 90 days of life between primary care, SE H&CC Care Coordinators, front line staff, community support services and hospice

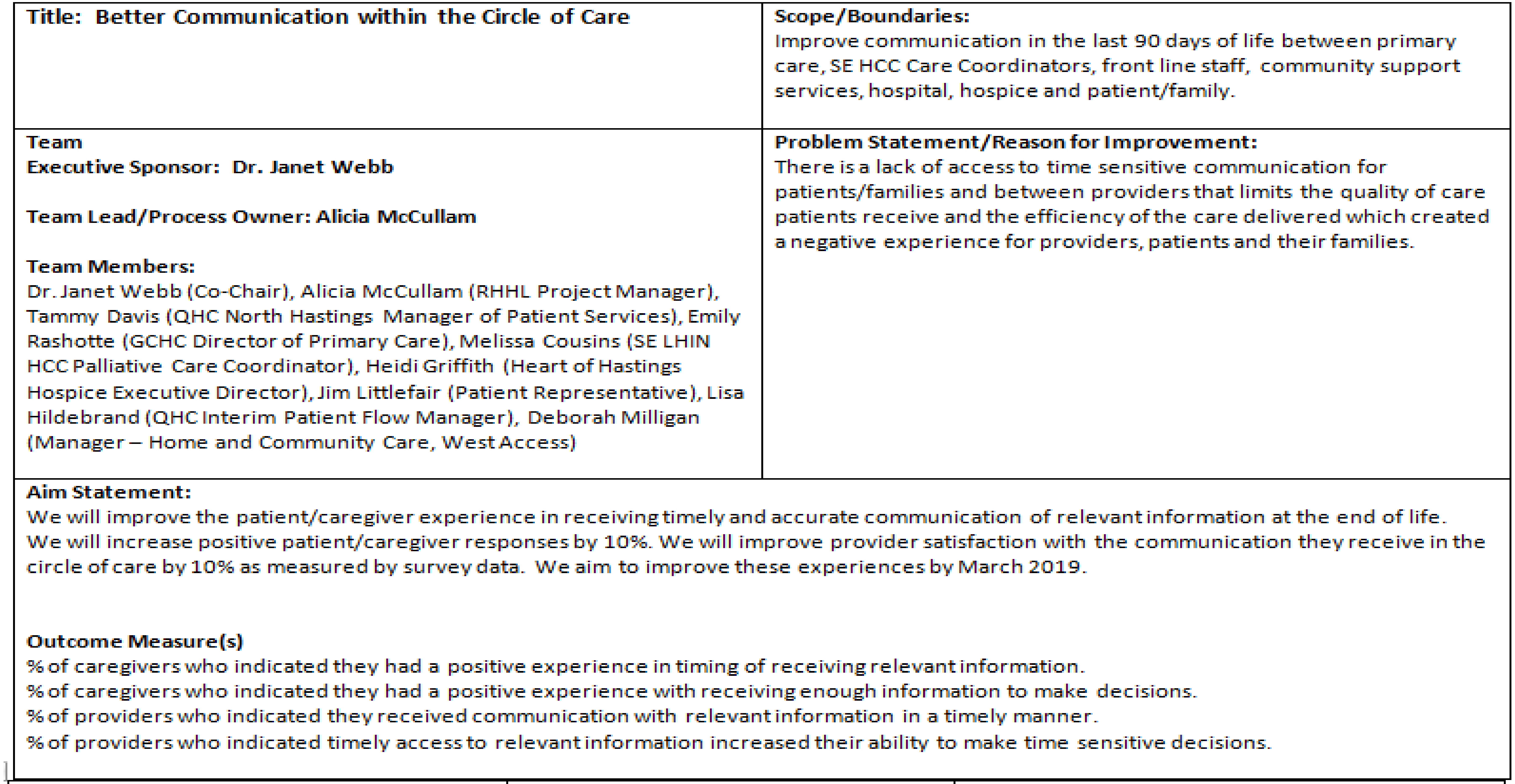
Project Team

Executive Sponsor: **Dr. Janet Webb**

Team Lead: **Alicia McCullam**

Other Team Members:

Tammy Davis (QHC North Hastings Manager of Patient Services), Emily Rashotte (GCHC Director of Primary Care), Melissa Cousins (SE LHIN HCC Palliative Care Coordinator), Heidi Griffith (Heart of Hastings Hospice Executive Director), Jim Littlefair (Patient Representative), Lisa Hildebrand (QHC Interim Patient Flow Manager), Deborah Milligan (Manager – Home and Community Care, West Access), Kelly Norris (RN Bayshore Home Health), Cris Fransky (QHC North Hastings Patient Care Leads)

<table>
<tr><td>Title: Better Communication within the Circle of Care</td><td>Scope/Boundaries:
Improve communication in the last 90 days of life between primary care, SE HCC Care Coordinators, front line staff, community support services, hospital, hospice and patient/family.</td></tr>
<tr><td>Team
Executive Sponsor: Dr. Janet Webb

Team Lead/Process Owner: Alicia McCullam

Team Members:
Dr. Janet Webb (Co-Chair), Alicia McCullam (RHHL Project Manager), Tammy Davis (QHC North Hastings Manager of Patient Services), Emily Rashotte (GCHC Director of Primary Care), Melissa Cousins (SE LHIN HCC Palliative Care Coordinator), Heidi Griffith (Heart of Hastings Hospice Executive Director), Jim Littlefair (Patient Representative), Lisa Hildebrand (QHC Interim Patient Flow Manager), Deborah Milligan (Manager – Home and Community Care, West Access)</td><td>Problem Statement/Reason for Improvement:
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Outcome Measure(s)
% of caregivers who indicated they had a positive experience in timing of receiving relevant information.
% of caregivers who indicated they had a positive experience with receiving enough information to make decisions.
% of providers who indicated they received communication with relevant information in a timely manner.
% of providers who indicated timely access to relevant information increased their ability to make time sensitive decisions.</td></tr>
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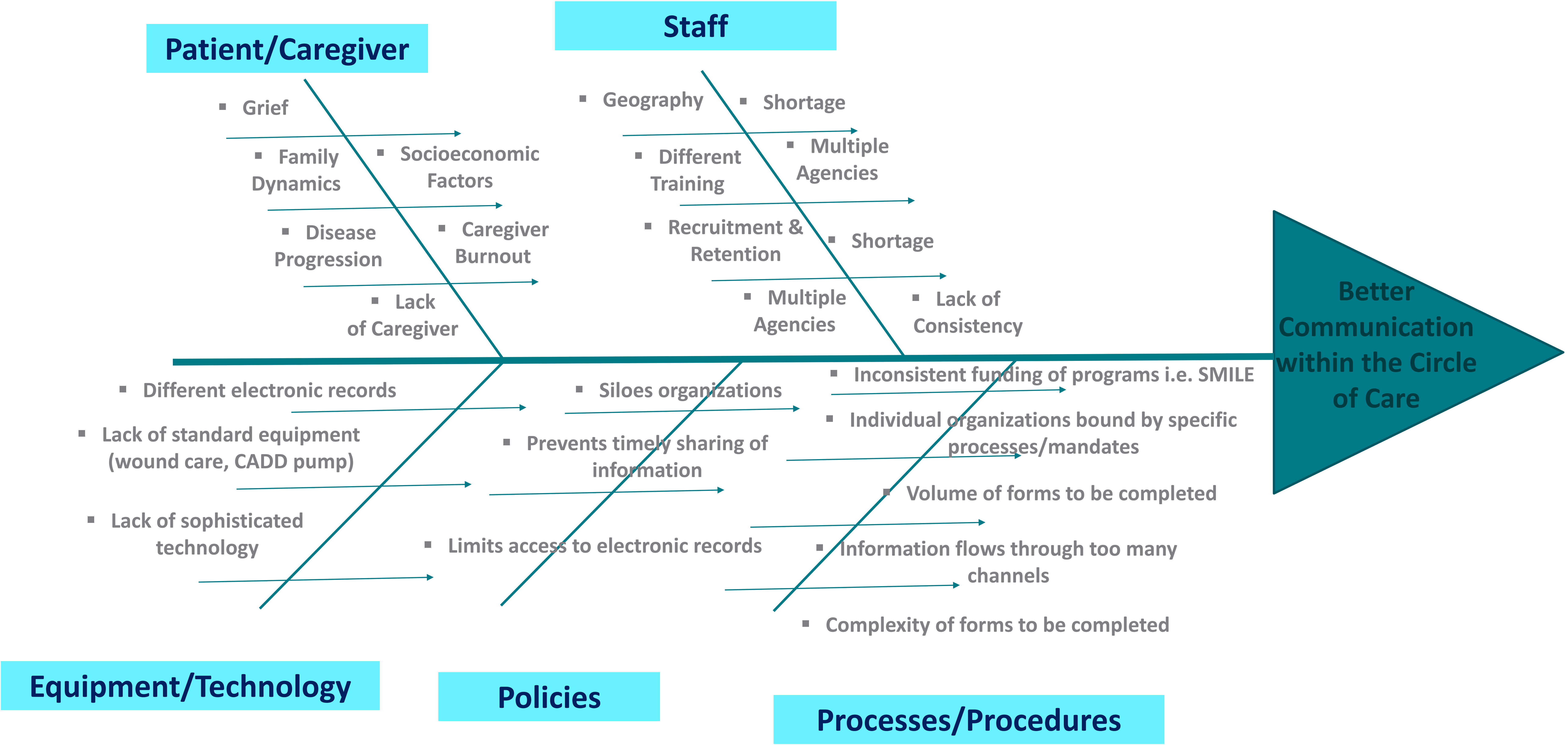
Root Cause Tools Used

- ✓ Fishbone diagram
- ✓ 5 Why's
- ✓ Health Care Provider Survey feedback (n=36)
- ✓ Experience Based Design Interviews (10 caregivers, 10 health care providers)

Root Causes:

-Informal relationships
-Inconsistency in providers
-Do not know who is on the ‘team’
-No common tool to communicate
-Too many providers involved
-Information flowing through too many channels
-Training/competency



Patient/Caregiver

- Grief
- Family Dynamics
- Socioeconomic Factors
- Disease Progression
- Caregiver Burnout
- Lack of Caregiver

Staff

- Geography
- Shortage
- Different Training
- Multiple Agencies
- Recruitment & Retention
- Shortage
- Multiple Agencies
- Lack of Consistency

Better Communication within the Circle of Care

- Different electronic records
- Lack of standard equipment (wound care, CADD pump)
- Lack of sophisticated technology

Equipment/Technology

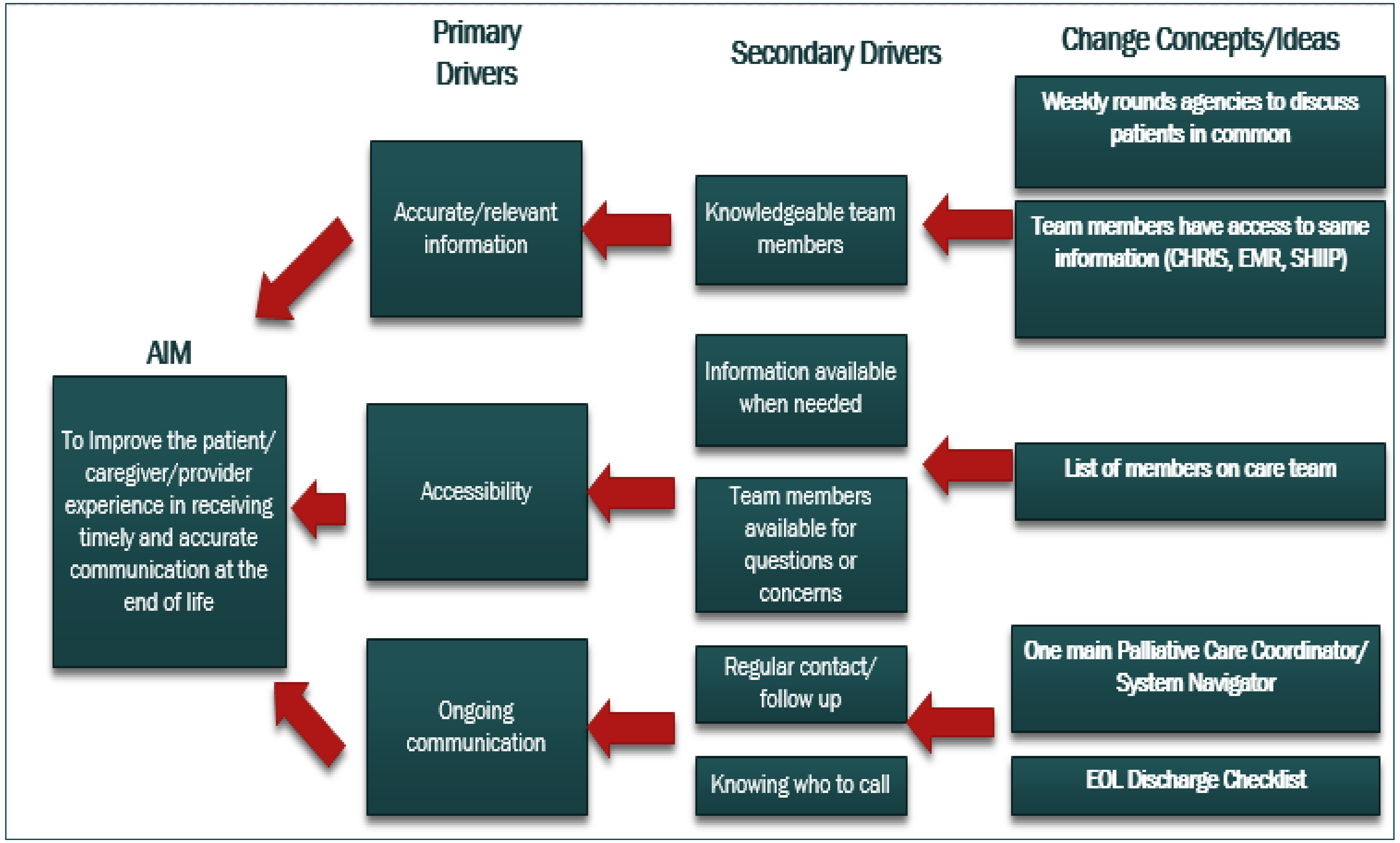
- Siloes organizations
- Prevents timely sharing of information
- Limits access to electronic records

Policies

- Inconsistent funding of programs i.e. SMILE
- Individual organizations bound by specific processes/mandates
- Volume of forms to be completed
- Information flows through too many channels
- Complexity of forms to be completed

Processes/Procedures

Generation of Change Ideas: Driver Diagram



Primary Drivers

Secondary Drivers

Change Concepts/Ideas

AIM

To Improve the patient/ caregiver/provider experience in receiving timely and accurate communication at the end of life

Accurate/relevant information

Accessibility

Ongoing communication

Knowledgeable team members

Information available when needed

Team members available for questions or concerns

Regular contact/ follow up

Knowing who to call

Weekly rounds agencies to discuss patients in common

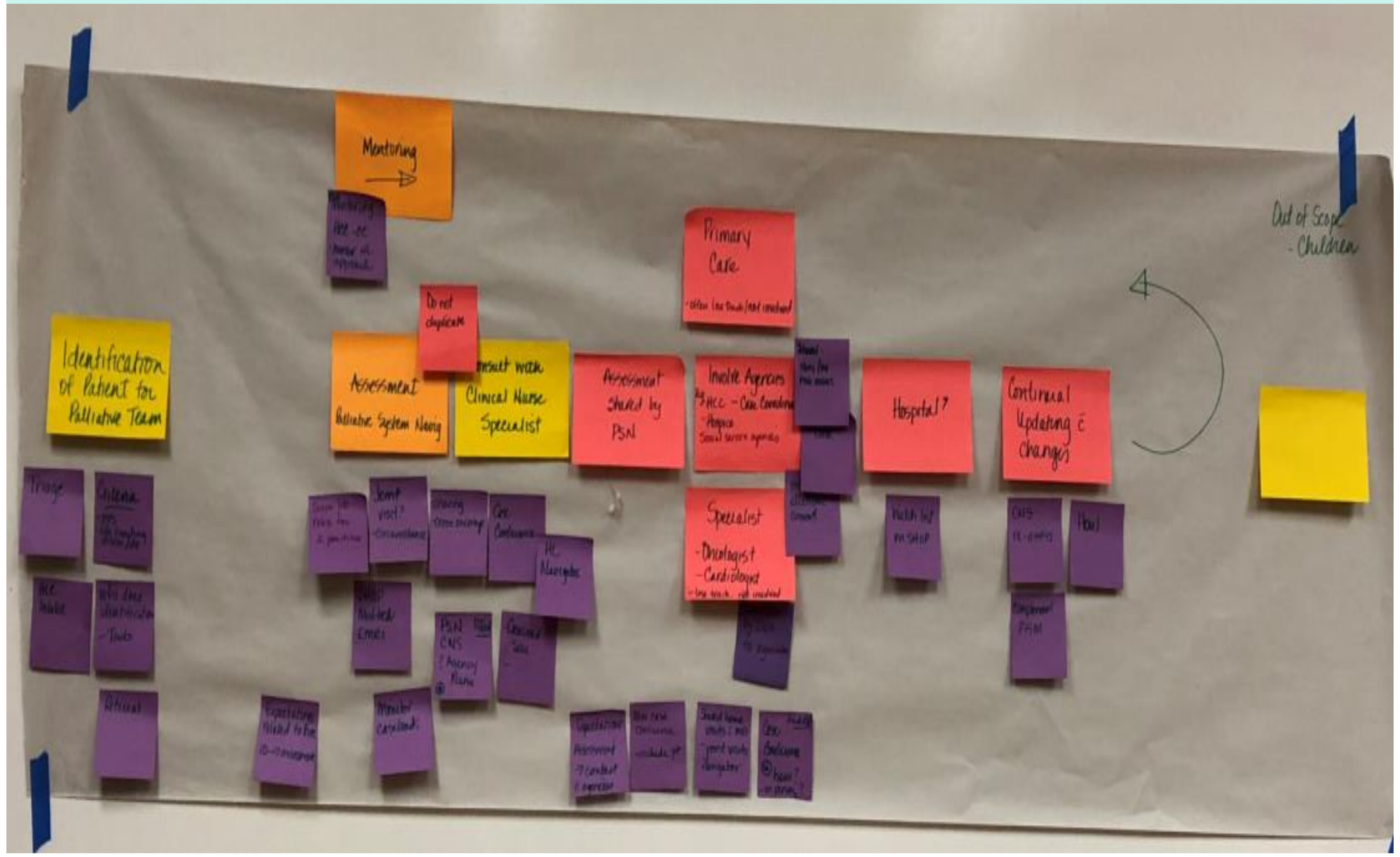
Team members have access to same information (CHRIS, EMR, SHIIP)

List of members on care team

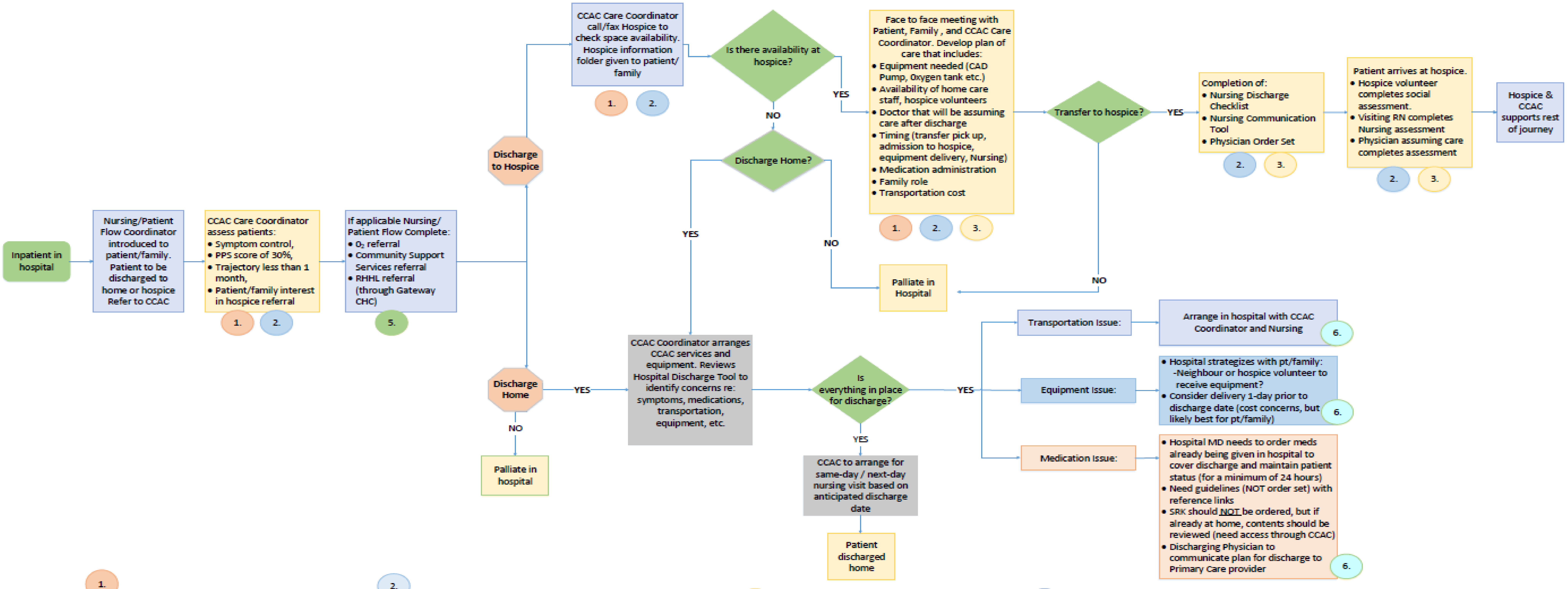
One main Palliative Care Coordinator/ System Navigator

EOL Discharge Checklist

Mapping ideal future state for communication within the circle of care to identify tests of change



RHHL Transition in Care: Hospital to Hospice or Home Process Map



Inpatient in hospital

Nursing/Patient Flow Coordinator introduced to patient/family. Patient to be discharged to home or hospice Refer to CCAC

CCAC Care Coordinator assess patients:
- Symptom control,
- PPS score of 30%,
- Trajectory less than 1 month,
- Patient/family interest in hospice referral

1. 2.

If applicable Nursing/ Patient Flow Complete:
- O_2 referral
- Community Support Services referral
- RHHL referral (through Gateway CHC)

5.

Discharge to Hospice

CCAC Care Coordinator call/fax Hospice to check space availability. Hospice information folder given to patient/ family

1. 2.

Is there availability at hospice?

YES

Face to face meeting with Patient, Family , and CCAC Care Coordinator. Develop plan of care that includes:
- Equipment needed (CAD Pump, Oxygen tank etc.)
- Availability of home care staff, hospice volunteers
- Doctor that will be assuming care after discharge
- Timing (transfer pick up, admission to hospice, equipment delivery, Nursing)
- Medication administration
- Family role
- Transportation cost

1. 2. 3.

Transfer to hospice?

YES

Completion of:
- Nursing Discharge Checklist
- Nursing Communication Tool
- Physician Order Set

2. 3.

Patient arrives at hospice.
- Hospice volunteer completes social assessment.
- Visiting RN completes Nursing assessment
- Physician assuming care completes assessment

2. 3.

Hospice & CCAC supports rest of journey

NO

Palliate in Hospital

NO

Discharge Home?

YES

NO

Palliate in Hospital

Discharge Home

NO

Palliate in hospital

YES

CCAC Coordinator arranges CCAC services and equipment. Reviews Hospital Discharge Tool to identify concerns re: symptoms, medications, transportation, equipment, etc.

Is everything in place for discharge?

YES

CCAC to arrange for same-day / next-day nursing visit based on anticipated discharge date

Patient discharged home

YES

Transportation Issue:

Arrange in hospital with CCAC Coordinator and Nursing

6.

Equipment Issue:

- Hospital strategizes with pt/family:
  -Neighbour or hospice volunteer to receive equipment?
- Consider delivery 1-day prior to discharge date (cost concerns, but likely best for pt/family)

6.

Medication Issue:

- Hospital MD needs to order meds already being given in hospital to cover discharge and maintain patient status (for a minimum of 24 hours)
- Need guidelines (NOT order set) with reference links
- SRK should NOT be ordered, but if already at home, contents should be reviewed (need access through CCAC)
- Discharging Physician to communicate plan for discharge to Primary Care provider

6.

1.

Criteria Barriers
- Hospital Assessment required for referral: Can result in 1-2 day turnaround for assessment to referral (may be too late to transfer by then)
- PPS of 30% or less: Sometimes arriving too late from hospital, but if too early safety risks at hospice increase related to transfers/ambulation
- Family Education: want patient to stay on Sills 5

2.

Timing Barriers

Hospice Conversation
1. Can't happen for first time at hospital bedside
2. ER doctors not versed in EOLPC assessments, language, etc.
3. Family role at hospice needs to be clearly defined
4. Day of the week – same day admits very difficult, Fridays take ++ pre-planning to coordinate.
5. ++ Paperwork required, phone/multiple faxes to different organizations, lack of consistent referral process between sites

Transfer of Care
1. Need MD to assume care at hospice
2. Up to date Rx list
3. CADD pump switch over (return to QHC)

Transportation to Hospice
1. Timing of transfer challenging/ who transfers (may need multiple vehicles)
2. Family incurs cost (min $85, or $165 from BGH to Hastings)

Arrival at Hospice
1. CCAC nurse must be present at intake, not always easy to line up arrival with RN availability
2. Equipment must be present for intake
3. Need additional professional support for first 24h (to give family time to adjust)

3.

Medication Management

Symptom Response Kits
1. Patient specific – QHC told not to order for clients due to wastage
2. Kits can be ordered by hospice MD, but also result in wastage. Challenges with storage/disposal of narcotics?
3. Do not arrive until next business day

Family Administering Meds
1. Volunteers currently not able to administer any meds
2. Family need to be trained and comfortable in administering meds

CADD Pumps
1. Hospital and Community pumps not interchangeable.
2. Hospital not supposed to allow pumps out into community
3. Takes 24 h for meds to arrive for pump – if ordered as "urgent or same day" can arrive within 4 hours, but @ 3-10x normal cost.

4.

Equipment

Ordering
1. CCAC Care Coordinator cannot order equipment with wheels without Physiotherapist/Occupational Therapist recommendation
2. Same day order increases cost for delivery

Receiving Equipment
1. Patient or family must be present to receive delivery
2. Drop off time dependent on delivery route
3. Drop off may not be same day as discharge
4. Education on equipment use not provided in the home

5.

Meditech Tracker at QHC
1. Only works if patient enters through ED
2. Follows patients to floor
3. Can see CCAC services (OT/PT/Nrsg) – are we able to SRK?
4. QHC working on getting RHHL and QHL as well as Palliative NP, etc. added to tracker.

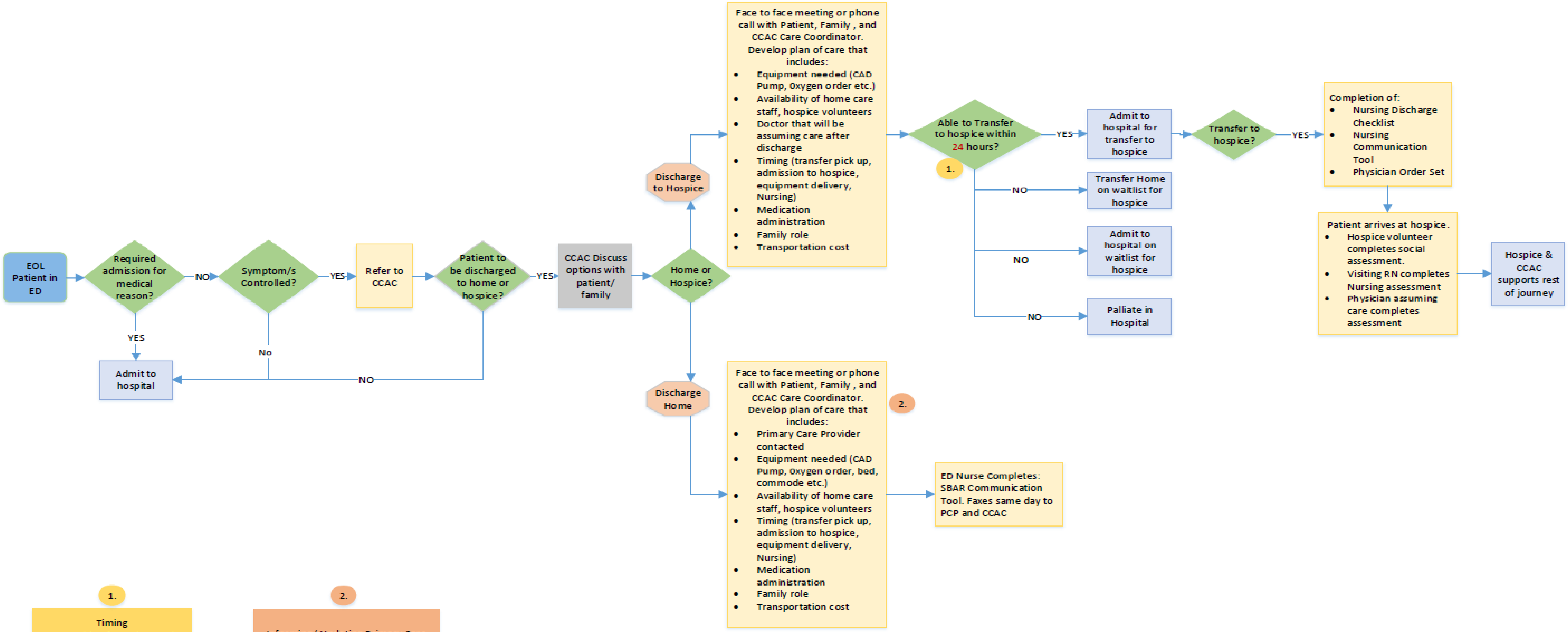
6.

Discharge Home Checklist

Support seamless discharge home
1. Transportation Issue
2. Equipment Issue
3. Medication Issue

March 4, 2016

RHHL Transition in Care: Emergency Department to Hospice or Home Process Map



EOL Patient in ED

Required admission for medical reason?

Admit to hospital

Symptom/s Controlled?

Refer to CCAC

Patient to be discharged to home or hospice?

CCAC Discuss options with patient/ family

Home or Hospice?

Discharge to Hospice

Face to face meeting or phone call with Patient, Family , and CCAC Care Coordinator. Develop plan of care that includes:
- Equipment needed (CAD Pump, Oxygen order etc.)
- Availability of home care staff, hospice volunteers
- Doctor that will be assuming care after discharge
- Timing (transfer pick up, admission to hospice, equipment delivery, Nursing)
- Medication administration
- Family role
- Transportation cost

Able to Transfer to hospice within 24 hours?

Admit to hospital for transfer to hospice

Transfer to hospice?

Completion of:
- Nursing Discharge Checklist
- Nursing Communication Tool
- Physician Order Set

Patient arrives at hospice.
- Hospice volunteer completes social assessment.
- Visiting RN completes Nursing assessment
- Physician assuming care completes assessment

Hospice & CCAC supports rest of journey

Transfer Home on waitlist for hospice

Admit to hospital on waitlist for hospice

Palliate in Hospital

Discharge Home

Face to face meeting or phone call with Patient, Family , and CCAC Care Coordinator. Develop plan of care that includes:
- Primary Care Provider contacted
- Equipment needed (CAD Pump, Oxygen order, bed, commode etc.)
- Availability of home care staff, hospice volunteers
- Timing (transfer pick up, admission to hospice, equipment delivery, Nursing)
- Medication administration
- Family role
- Transportation cost

ED Nurse Completes: SBAR Communication Tool. Faxes same day to PCP and CCAC

1.

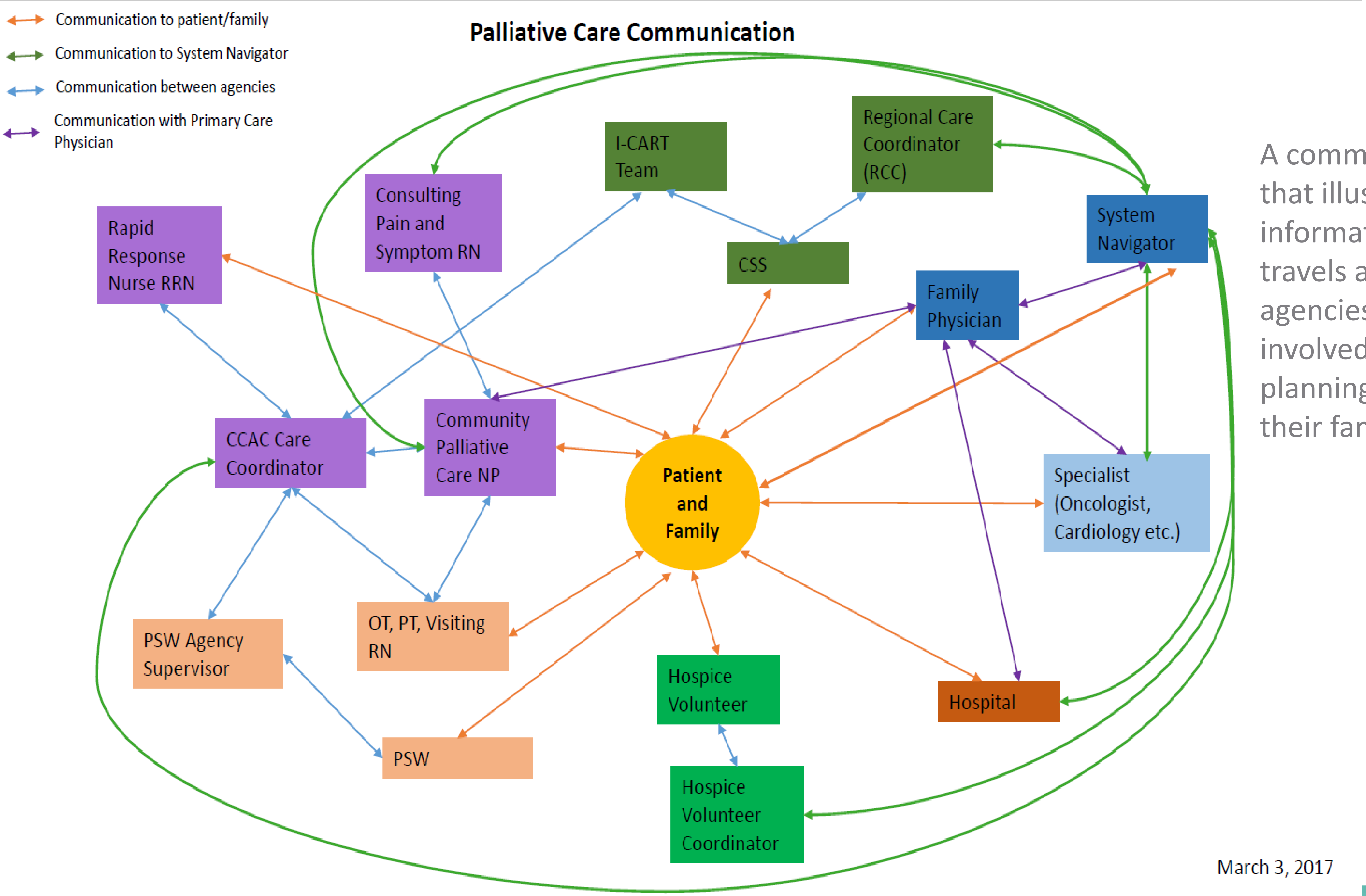
Timing
- Outside of Regular Day/ Time M-F 8:30 -4:00
- Patient could go home to wait for hospice
- Hold in ED while CCAC arranges services
- CCAC "priority" to arrange discharge plan as soon as possible
- Friday at noon deadline – CCAC pre plan for discharge Monday, hospital could "hold" patient until then

2.

Informing/ Updating Primary Care Provider (PCP)
- PCP not aware patient has been to ED
- ED providers not completing or changing medication orders
- Who should notify the PCP that patient is in ED being discharged?

Discharging provider to call PCP
CCAC CC call PCP – CCAC not always aware of hospital visit discharge
Hospital Palliative NP – could they facilitate orders and discharge plan with PCP?

April 8, 2016

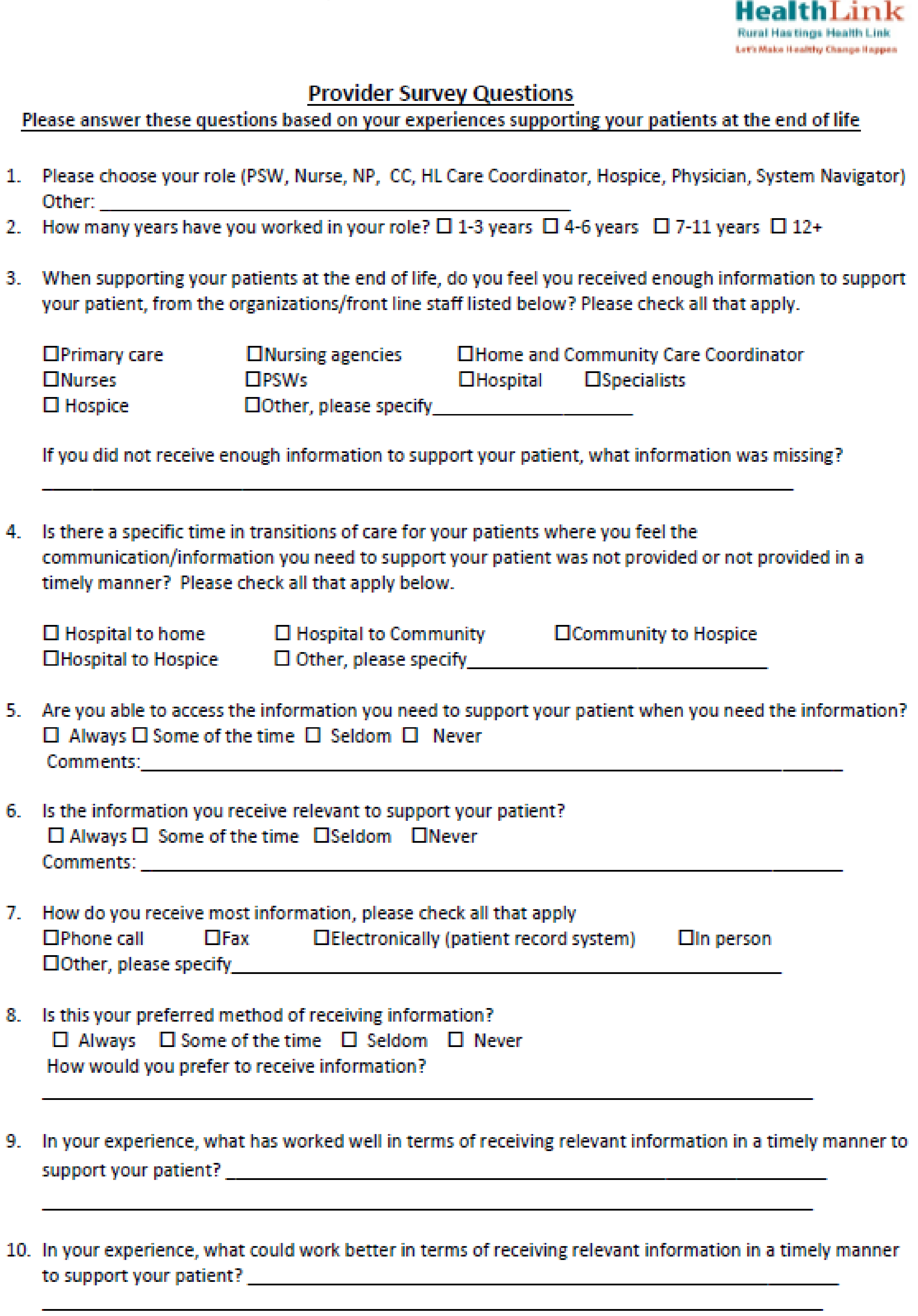


Palliative Care Communication

A communication exercise that illustrates how information/communication travels amongst multiple agencies, and providers involved in end of life care planning with patients and their family/caregivers.

March 3, 2017

Survey and Experience Based Design for provider and caregiver feedback



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Rural Hastings Health Link
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Provider Survey Questions

Please answer these questions based on your experiences supporting your patients at the end of life

1. Please choose your role (PSW, Nurse, NP, CC, HL Care Coordinator, Hospice, Physician, System Navigator) Other: ______________________________
2. How many years have you worked in your role? ☐ 1-3 years ☐ 4-6 years ☐ 7-11 years ☐ 12+

3. When supporting your patients at the end of life, do you feel you received enough information to support your patient, from the organizations/front line staff listed below? Please check all that apply.

   ☐Primary care ☐Nursing agencies ☐Home and Community Care Coordinator
   ☐Nurses ☐PSWs ☐Hospital ☐Specialists
   ☐ Hospice ☐Other, please specify____________________

   If you did not receive enough information to support your patient, what information was missing?
   ____

4. Is there a specific time in transitions of care for your patients where you feel the communication/information you need to support your patient was not provided or not provided in a timely manner? Please check all that apply below.

   ☐ Hospital to home ☐ Hospital to Community ☐Community to Hospice
   ☐Hospital to Hospice ☐ Other, please specify______________________________

5. Are you able to access the information you need to support your patient when you need the information?
   ☐ Always ☐ Some of the time ☐ Seldom ☐ Never
   Comments:____

6. Is the information you receive relevant to support your patient?
   ☐ Always ☐ Some of the time ☐Seldom ☐Never
   Comments: ____

7. How do you receive most information, please check all that apply
   ☐Phone call ☐Fax ☐Electronically (patient record system) ☐In person
   ☐Other, please specify____

8. Is this your preferred method of receiving information?
   ☐ Always ☐ Some of the time ☐ Seldom ☐ Never
   How would you prefer to receive information?
   ____

9. In your experience, what has worked well in terms of receiving relevant information in a timely manner to support your patient? ____
   ____

10. In your experience, what could work better in terms of receiving relevant information in a timely manner to support your patient? ____
    ____

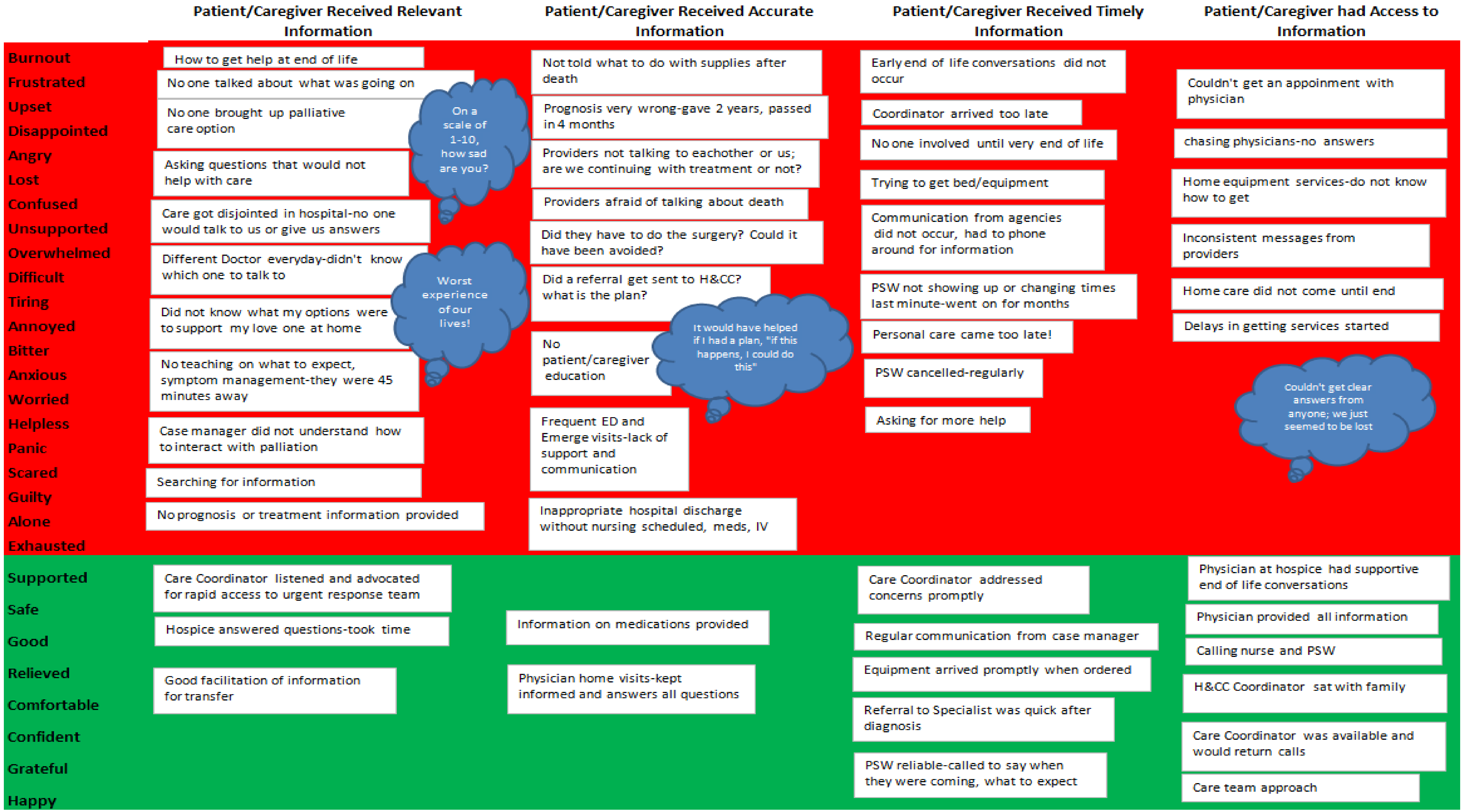
Experience Based Design for Providers (End of Life)

1. What is your role?
2. How long have you been in your role?
3. Have you had any palliative care training? If so, what training have you received?
4. Can you share with me an experience that stands out where things went really well?
5. Can you share with me an experience where things really didn't go so well?
6. How is information communicated to you for the client you are supporting at end of life?
7. Could you describe your experiences in receiving the information that is required to support your client at the end of life when the information is needed?
8. Could you describe your experience in not receiving the information you need to support your client at the end of life in a timely manner?
9. Do you ever worry you don't have all of the information you need to support your clients at the end of life? What information is required?
10. Related to transitions in care
    a. Can you describe how you receive information during those transitions specifically related to the timing of information received
    b. Can you describe the amount of information you receive in terms of was it enough to support your client, and was the information relevant?
11. As you know, many providers are involved in end of life health care delivery (PSWs, nurses, physicians, etc.); how do you feel the communication works?

Experience Based Design Questions for Caregivers

1. Can you tell me about your story from start to finish?
2. Can you talk about the different transitions in care you experienced as a caregiver?
3. What transitions seemed the most difficult?
   a. Can you describe how you were feeling?
4. How did you receive the communication you needed to guide your decision making in supporting your loved one?
5. What information did you receive that allowed you to support your loved one?
6. What information could have been helpful but was not received?
7. Can you give an example of when you felt you received the information at the right time?
8. Can you give me an example of when you needed more information or communication but it was not communicated?
9. As many providers are involved in supporting a patient at the end of life, how do you feel the care team provided the same message?
10. What is the most important message you want to share?
11. Any additional insights/perspective to share?

Qualitative Analysis of *Caregiver Experience* Based Co-Design Interviews (n=10)



Patient/Caregiver Received Relevant Information | **Patient/Caregiver Received Accurate Information** | **Patient/Caregiver Received Timely Information** | **Patient/Caregiver had Access to Information**

Burnout
Frustrated
Upset
Disappointed
Angry
Lost
Confused
Unsupported
Overwhelmed
Difficult
Tiring
Annoyed
Bitter
Anxious
Worried
Helpless
Panic
Scared
Guilty
Alone
Exhausted

Patient/Caregiver Received Relevant Information

- How to get help at end of life
- No one talked about what was going on
- No one brought up palliative care option
- Asking questions that would not help with care
- Care got disjointed in hospital-no one would talk to us or give us answers
- Different Doctor everyday-didn't know which one to talk to
- Did not know what my options were to support my love one at home
- No teaching on what to expect, symptom management-they were 45 minutes away
- Case manager did not understand how to interact with palliation
- Searching for information
- No prognosis or treatment information provided

On a scale of 1-10, how sad are you?

Worst experience of our lives!

Patient/Caregiver Received Accurate Information

- Not told what to do with supplies after death
- Prognosis very wrong-gave 2 years, passed in 4 months
- Providers not talking to eachother or us; are we continuing with treatment or not?
- Providers afraid of talking about death
- Did they have to do the surgery? Could it have been avoided?
- Did a referral get sent to H&CC? what is the plan?
- No patient/caregiver education
- Frequent ED and Emerge visits-lack of support and communication
- Inappropriate hospital discharge without nursing scheduled, meds, IV

It would have helped if I had a plan, "if this happens, I could do this"

Patient/Caregiver Received Timely Information

- Early end of life conversations did not occur
- Coordinator arrived too late
- No one involved until very end of life
- Trying to get bed/equipment
- Communication from agencies did not occur, had to phone around for information
- PSW not showing up or changing times last minute-went on for months
- Personal care came too late!
- PSW cancelled-regularly
- Asking for more help

Patient/Caregiver had Access to Information

- Couldn't get an appoinment with physician
- chasing physicians-no answers
- Home equipment services-do not know how to get
- Inconsistent messages from providers
- Home care did not come until end
- Delays in getting services started

Couldn't get clear answers from anyone; we just seemed to be lost

Supported
Safe
Good
Relieved
Comfortable
Confident
Grateful
Happy

Patient/Caregiver Received Relevant Information

- Care Coordinator listened and advocated for rapid access to urgent response team
- Hospice answered questions-took time
- Good facilitation of information for transfer

Patient/Caregiver Received Accurate Information

- Information on medications provided
- Physician home visits-kept informed and answers all questions

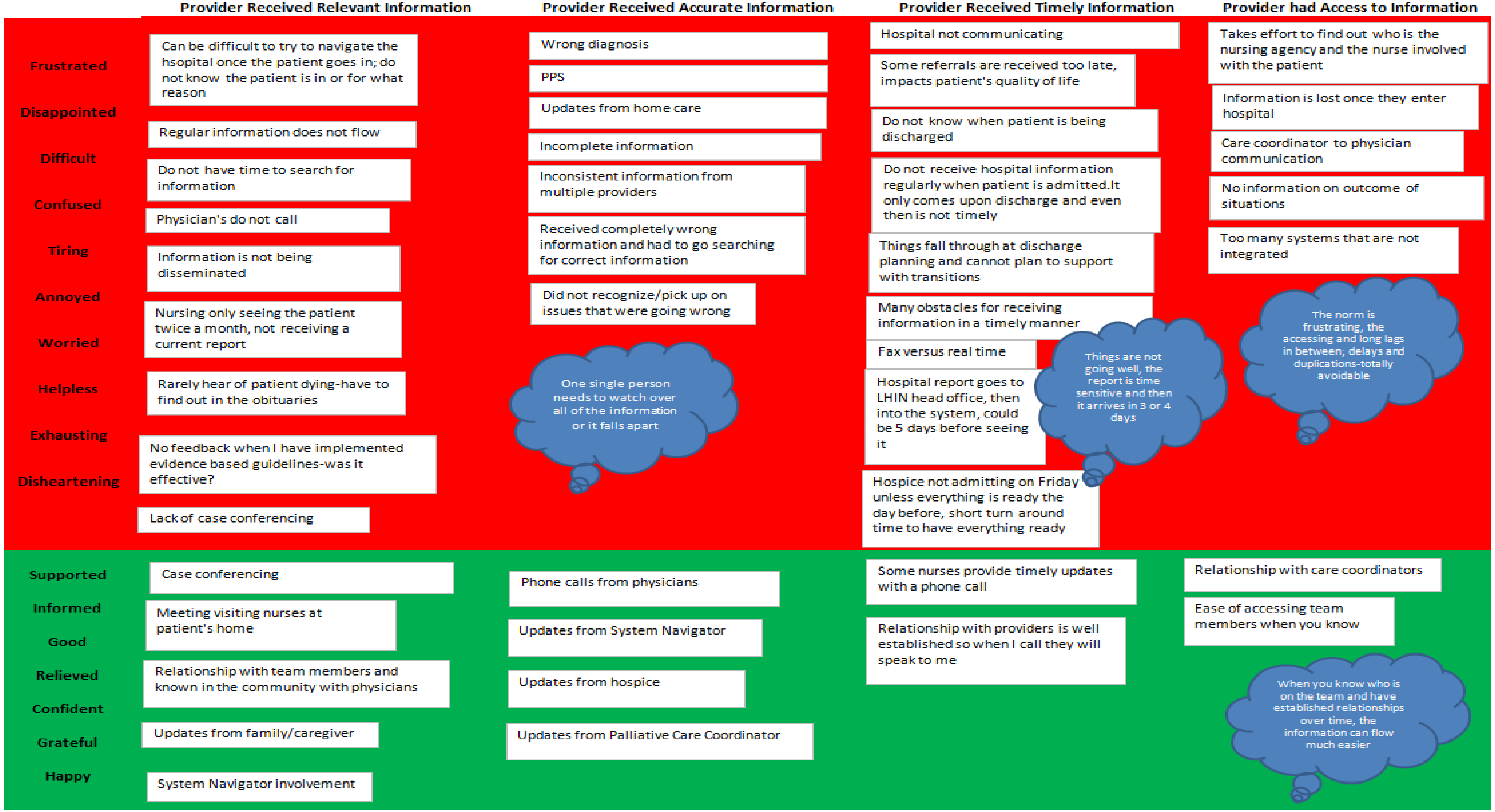
Patient/Caregiver Received Timely Information

- Care Coordinator addressed concerns promptly
- Regular communication from case manager
- Equipment arrived promptly when ordered
- Referral to Specialist was quick after diagnosis
- PSW reliable-called to say when they were coming, what to expect

Patient/Caregiver had Access to Information

- Physician at hospice had supportive end of life conversations
- Physician provided all information
- Calling nurse and PSW
- H&CC Coordinator sat with family
- Care Coordinator was available and would return calls
- Care team approach

Qualitative Analysis of *Provider Experience* Based Co-Design Interviews (n=10)



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Frustrated
Disappointed
Difficult
Confused
Tiring
Annoyed
Worried
Helpless
Exhausting
Disheartening

Provider Received Relevant Information

- Can be difficult to try to navigate the hsopital once the patient goes in; do not know the patient is in or for what reason
- Regular information does not flow
- Do not have time to search for information
- Physician's do not call
- Information is not being disseminated
- Nursing only seeing the patient twice a month, not receiving a current report
- Rarely hear of patient dying-have to find out in the obituaries
- No feedback when I have implemented evidence based guidelines-was it effective?
- Lack of case conferencing

Provider Received Accurate Information

- Wrong diagnosis
- PPS
- Updates from home care
- Incomplete information
- Inconsistent information from multiple providers
- Received completely wrong information and had to go searching for correct information
- Did not recognize/pick up on issues that were going wrong

One single person needs to watch over all of the information or it falls apart

Provider Received Timely Information

- Hospital not communicating
- Some referrals are received too late, impacts patient's quality of life
- Do not know when patient is being discharged
- Do not receive hospital information regularly when patient is admitted.It only comes upon discharge and even then is not timely
- Things fall through at discharge planning and cannot plan to support with transitions
- Many obstacles for receiving information in a timely manner
- Fax versus real time
- Hospital report goes to LHIN head office, then into the system, could be 5 days before seeing it
- Hospice not admitting on Friday unless everything is ready the day before, short turn around time to have everything ready

Things are not going well, the report is time sensitive and then it arrives in 3 or 4 days

Provider had Access to Information

- Takes effort to find out who is the nursing agency and the nurse involved with the patient
- Information is lost once they enter hospital
- Care coordinator to physician communication
- No information on outcome of situations
- Too many systems that are not integrated

The norm is frustrating, the accessing and long lags in between; delays and duplications-totally avoidable

🟩

Supported
Informed
Good
Relieved
Confident
Grateful
Happy

Provider Received Relevant Information

- Case conferencing
- Meeting visiting nurses at patient's home
- Relationship with team members and known in the community with physicians
- Updates from family/caregiver
- System Navigator involvement

Provider Received Accurate Information

- Phone calls from physicians
- Updates from System Navigator
- Updates from hospice
- Updates from Palliative Care Coordinator

Provider Received Timely Information

- Some nurses provide timely updates with a phone call
- Relationship with providers is well established so when I call they will speak to me

Provider had Access to Information

- Relationship with care coordinators
- Ease of accessing team members when you know

When you know who is on the team and have established relationships over time, the information can flow much easier

Caregiver Impact Statements

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- The hospice people were great and transitioning into the hospice was great
- I was so grateful for the Doctor at hospice
- One care coordinator was remarkable and she took the time and listened to everything I had to say
- I didn’t have to go chasing, she (care coordinator) did that.
- Those final pieces were comforting, that is 24-36 hours of compassion and support.
- It takes a team of people to provide that kind of care
- She talked to both of us, she treated us with respect
- Hospice made it easier for me, to love my mother opposed to being there with all the stress
- Hospice allowed us to support our loved one while they supported us and that provided peace

−

- It can be described as a battle rather instead of a moment to grieve
- I feel like I am losing my sensation, is that what dying is like? (Patient) .Supportive conversations, education, what to expect are not occurring
- You don’t realize you’re burning out until it happens
- They were discharging her regardless, where do you want us to send her; in other words we don’t want her here
- The room (hospital) was small and hot, we had to go begging for ice chips and water
- I was a basket case; I didn’t know what to do
- Couldn’t get clear answers from anyone, we just seemed to be lost
- This felt like I am always battling-for any kind of help
- Getting access to palliative care and that transition from hospital to palliative care gets a little rough because it’s a lot to put on a person when their spouse is dying and sometimes they are not equipped to make the best decisions.
- Hugely frustrating
- When they say they can provide things, they need to be held accountable and ready at the times stated.
- When you are reaching out to ask for help and then told you don’t need it-it is devastating.
- Final times of life deserve better

Provider Impact Statements

+

- The right people in the role can make the difference
- Hospice communication is streamlined and effective
- Communication is easier between patient and care team as point person is established
- Small team allows close working relationships with professional agencies
- Sharing of information requires building relationships with key players
- Communication is often relationship based
- Relationships drive best practice
- Most of the time I can get the information—if I have a close relationship with them, they call me
- Nurse may pass but the PSW has the information.
- I make sure that the PSW know they are valuable. They may not even realize the information they hold.

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- In healthcare, we don’t talk to each other; we fill out forms…that are mandated…that no one looks at.
- As a healthcare provider, I was disappointed, we could do it so much better
- Too many loop holes to jump through, silos to jump through, people hiding behind privacy laws preventing flow of communication
- Guarding information
- They need to have one single person who is watching over all of the pieces of care, it all falls apart.
- When you get to palliation there seems to be this gap between everything from physicians, to Home and Community Care, Hospital, Hospice or whatever. Every single one of those situations families are getting irate or giving up.
- So many things get missed; it is unbelievable; these are significant health consequences
- There are so many referrals that someone can say ‘hey, something is going on’ and you shouldn’t have to wait for critical and crisis situations before catching-you can’t catch 100%-many instances, yes.
- You know the system, until you are living in it, then you realize how broken it can be.
- Labour is required to get information
- The norm is frustrating, the accessing and long lags in between; delays and duplications. - Totally avoidable.
- Person dependent (if communication is timely)

What was Important to Patient/Caregiver

Opportunity to express their wishes and have them be heard and respected

Receive quality care at end of life because only 1-2 nurses providing care were involved

Have honest conversations about death

Receive communication, updates; someone talk to us

Resources-too late

Know what the options are if I take my spouse home vs. hospice? Will I have support?

Someone to listen to our story

Respite hours to support caregiver-not enough

On call hospital physician took the time, sat down listened to the patient's wishes, explained the process of receiving treatment vs. not,

Asked the patient their preferred place of death and facilitated that transfer

To be able to support their loved one without all the stress

To have all the information to make decisions

Receive support and services without battle

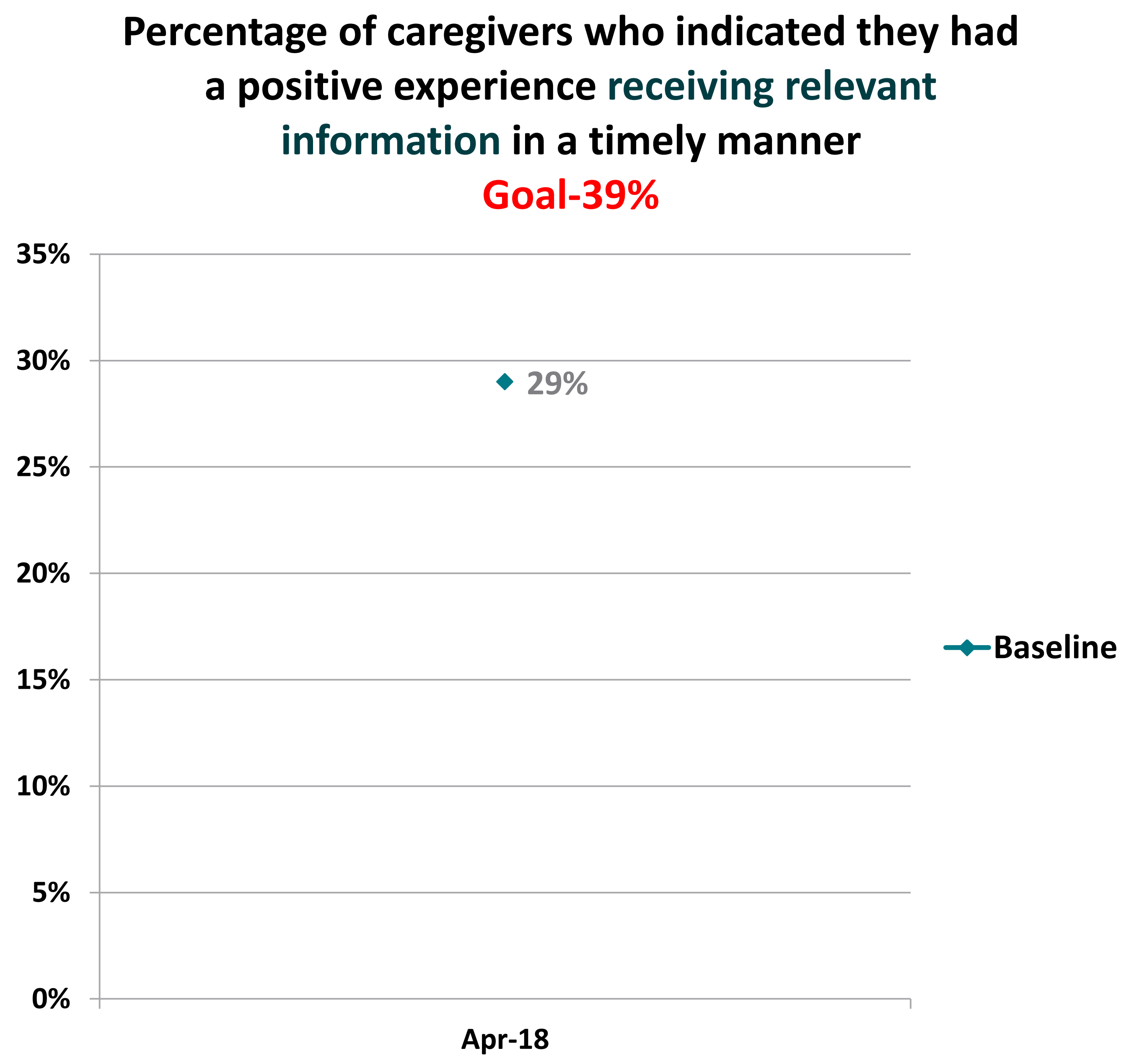
To be treated with respect

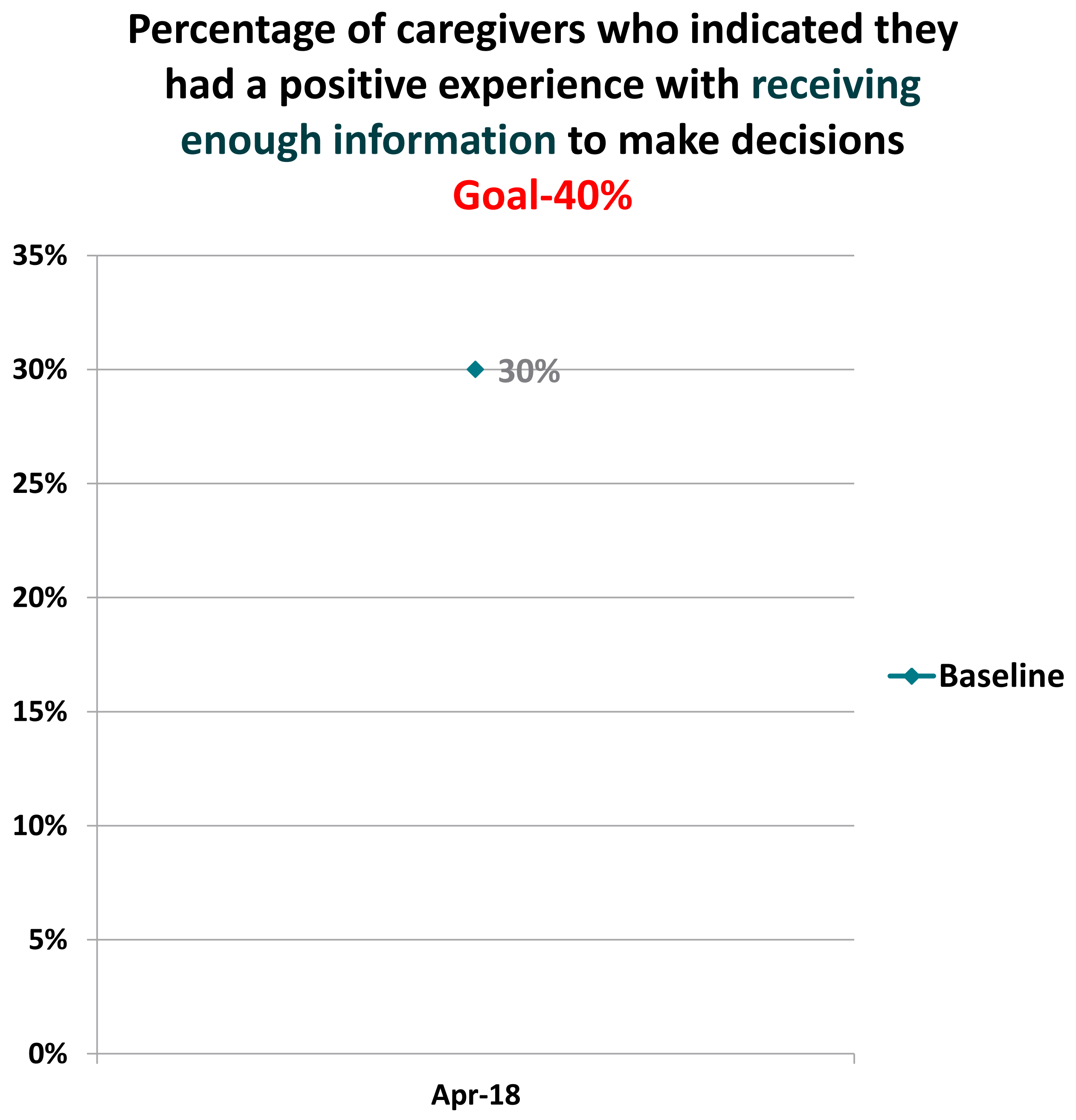
South East Regional
Palliative Care
Network

Out of Scope – Additional feedback from provider and caregiver interviews that is out of scope for our project but requires noting

- Accessing dietician services
- Financial burdens-could not take time off to provide care, take to appointments, etc.
- Cost of drugs (some samples)
- Fee for foot care services (for home visit)
- Competency (unnecessary treatments, inconsistent information, wrong medications, different levels of care, basic care, etc)
- Nursing not spending enough time for care
- Basic care did not happen
- Staffing issues-no coverage
- Hours for Nursing/PSW needs increasing
- Eligibility-did not quality for personal care so daughter had to miss school to take care
- No family support
- Lifeline not funded (patient had to be left home all day unsupported as caregiver had no choice but to work. Patient would be falling constantly).
- Coverage of geography for Palliative NP-limited in number of patients can see
- Inconsistent excellence in nursing and PSW staff
- Education is not covered nor is time to upgrade skills, or cannot attend due to coverage issues
- Inexperienced newer PSWs or nursing-inconsistent care
- Community nurses are not paid well
- Lack of social work/spiritual support across QHC
- Last minute revoking of DNRs-hospital
- Geography of agency nurses having to cover (for example: to restart a line)

Run Charts for Outcome Measures



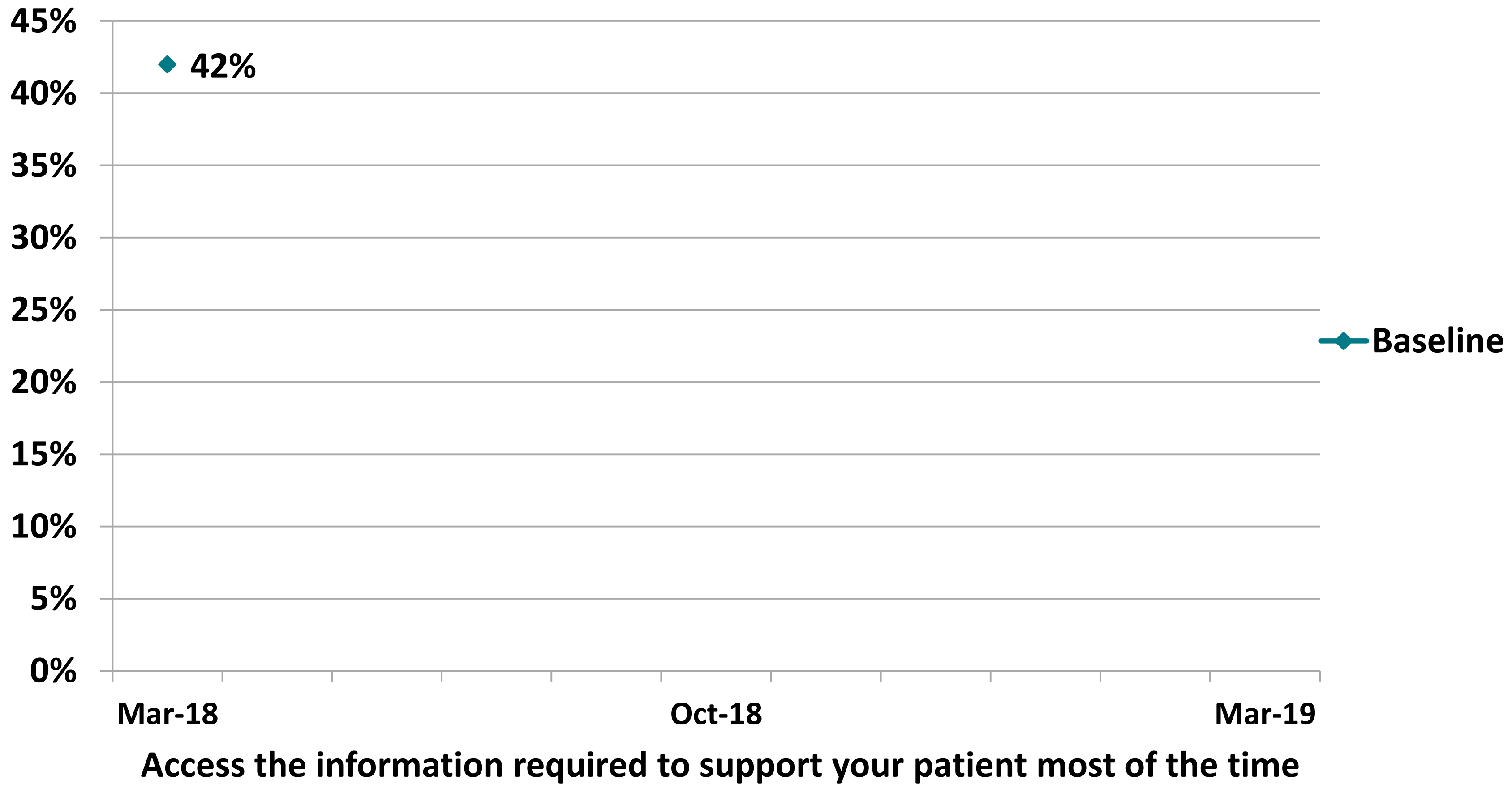


Caregiver responses from Experience Based Design Interviews conducted within the Rural Hastings Sub Region

Run Charts for Outcome Measures

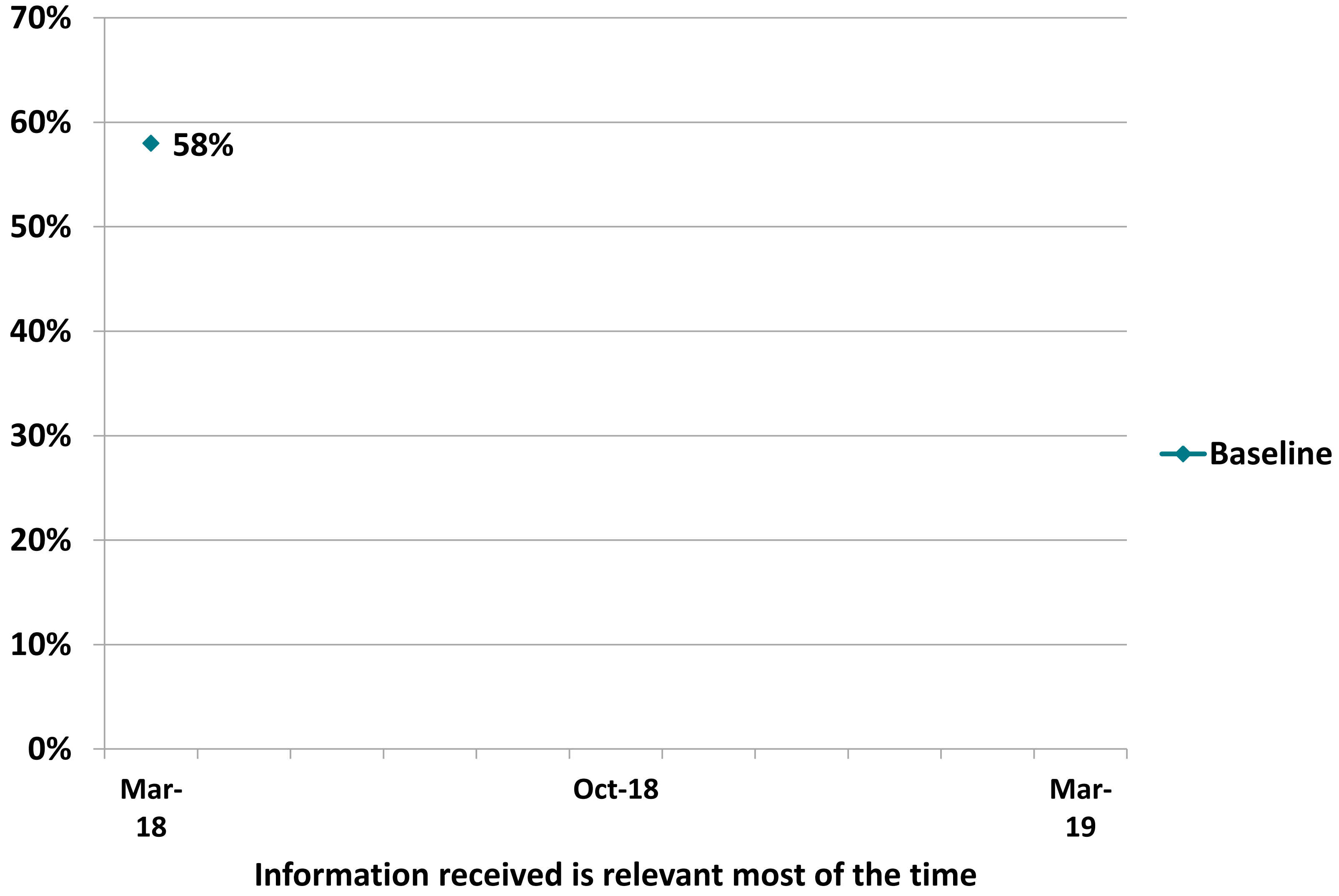
Percentage of Providers who answered they were able to access the information needed to support their patient 'most of the time' (n=36)

Goal-52%



Percentage of Providers who responded the information received was relevant 'most of the time'

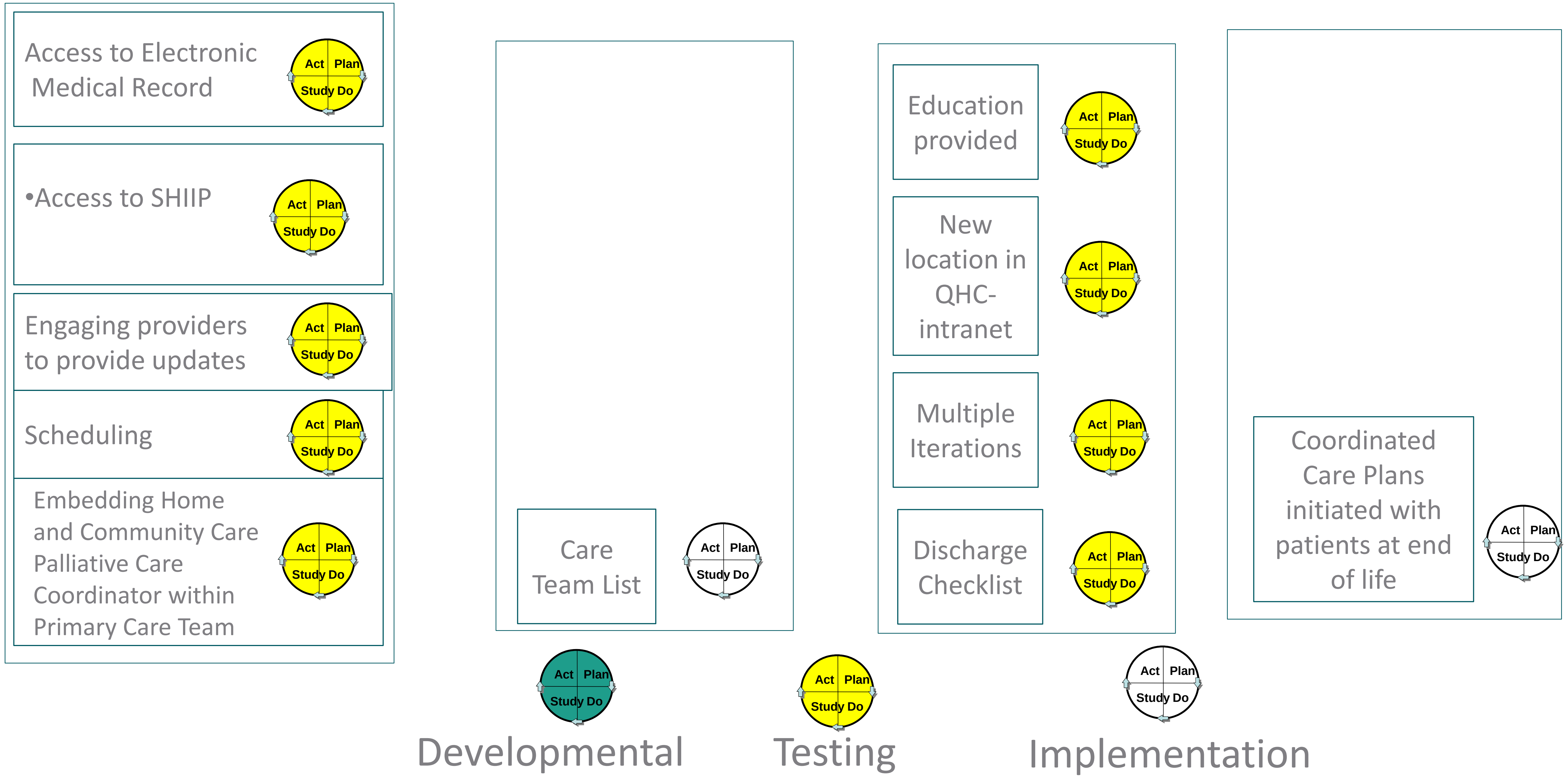
Goal-68%



Provider survey responses from completed surveys within the Rural Hastings Sub Region

PDSA Status: Developing/Testing Change Ideas

STATUS



Access to Electronic Medical Record

- Access to SHIIP

Engaging providers to provide updates

Scheduling

Embedding Home and Community Care Palliative Care Coordinator within Primary Care Team

Care Team List

Education provided

New location in QHC-intranet

Multiple Iterations

Discharge Checklist

Coordinated Care Plans initiated with patients at end of life

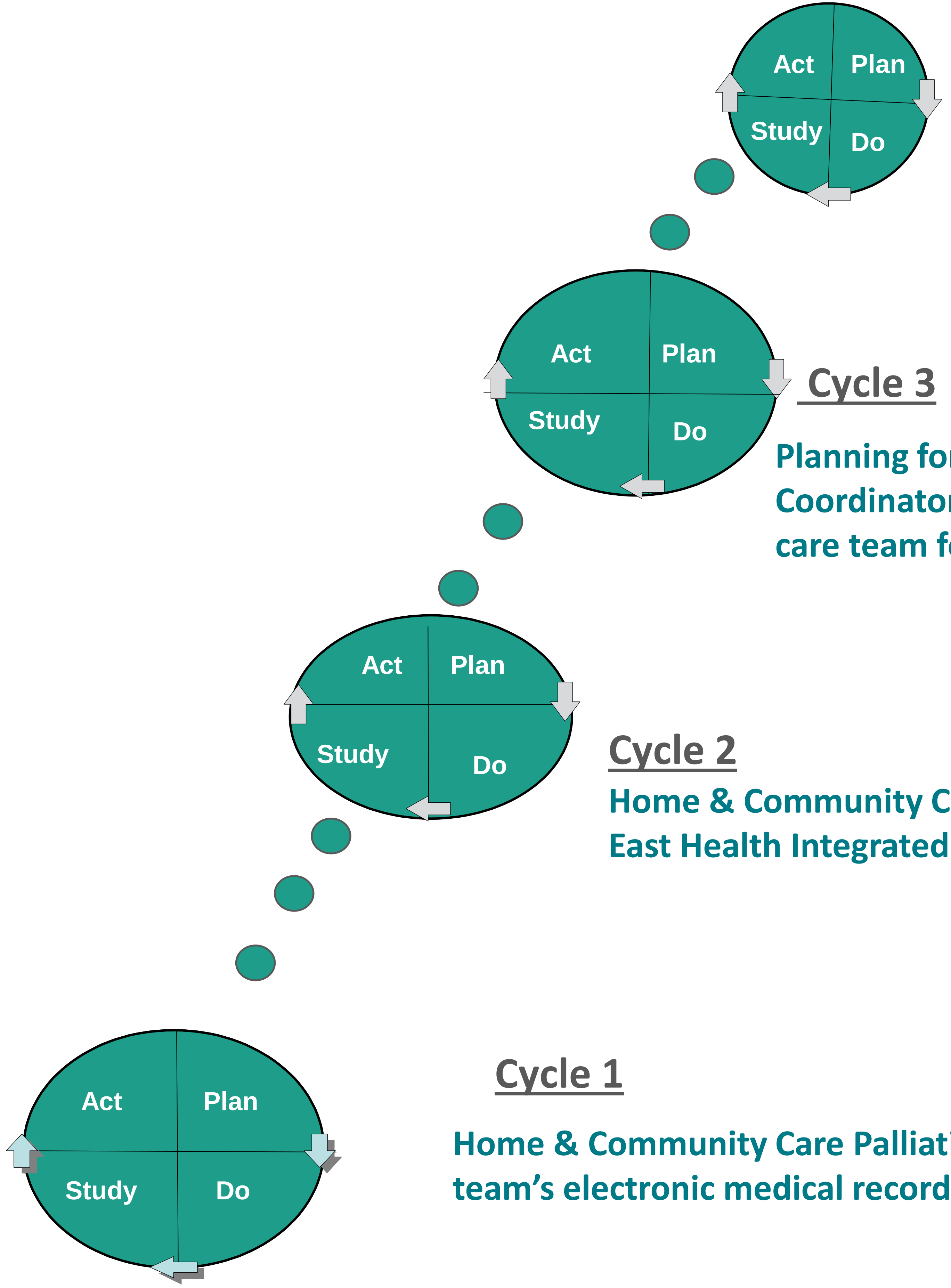
Developmental

Testing

Implementation

	Develop	Test	Implement	Total # Cycles
Summary		8	2	10

PDSA cycles to date for embedded H & CC Palliative Care Coordinator



Cycle 4

Planning for Home & Community Care Palliative to view Coordinated Care Plans in SHIIP
Planning for H&CC Coordinator to contribute to existing Coordinated Care Plans

Capacity barriers

Cycle 3

Planning for Home & Community Care Palliative Coordinator embedded into an additional primary health care team for further testing

No capacity to spread geographically

Cycle 2

Home & Community Care Palliative has access to the South East Health Integrated Information Portal (SHIIP)

Cycle 1

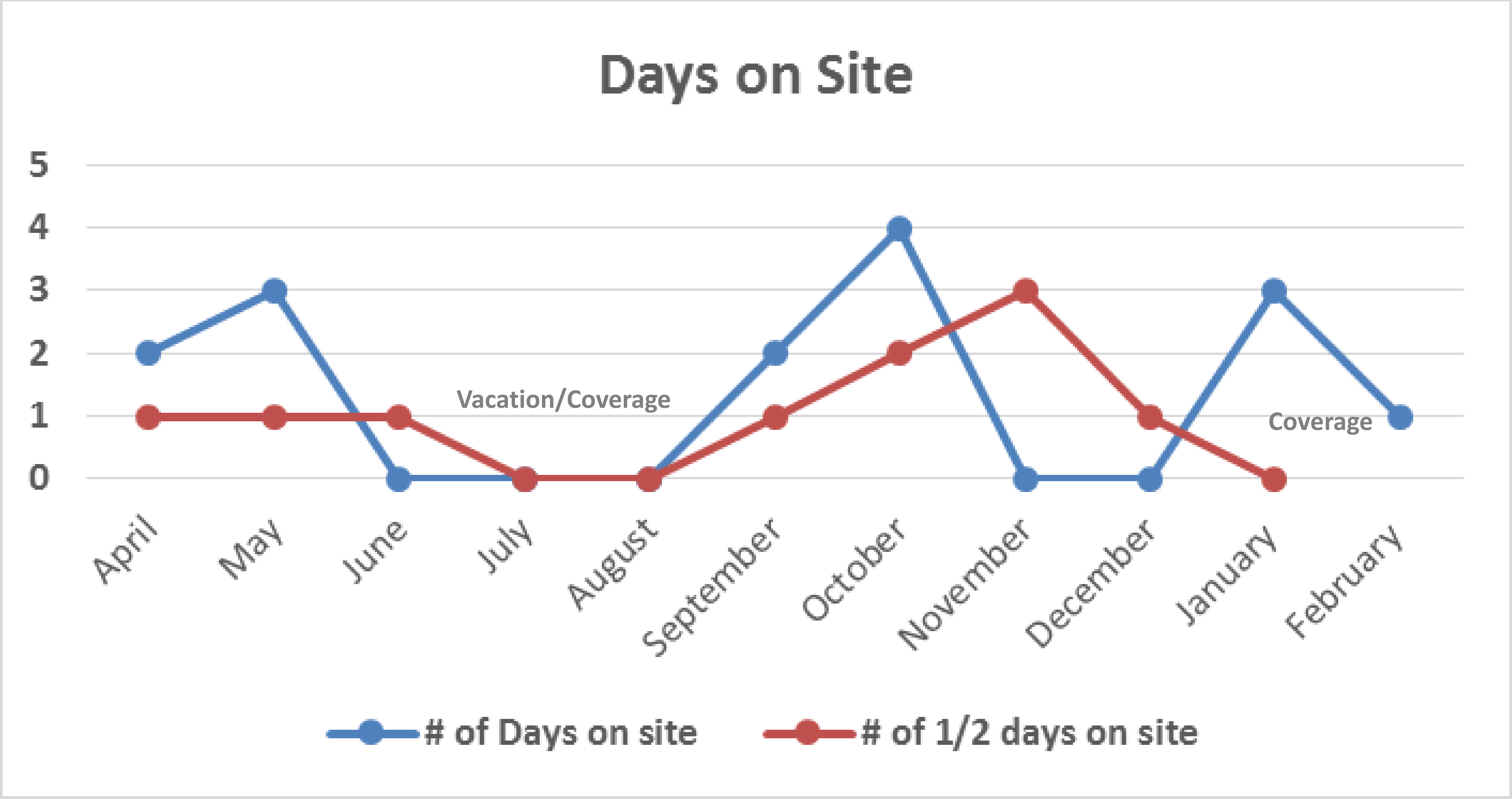
Home & Community Care Palliative Coordinator accessing primary care team's electronic medical record

Developmental

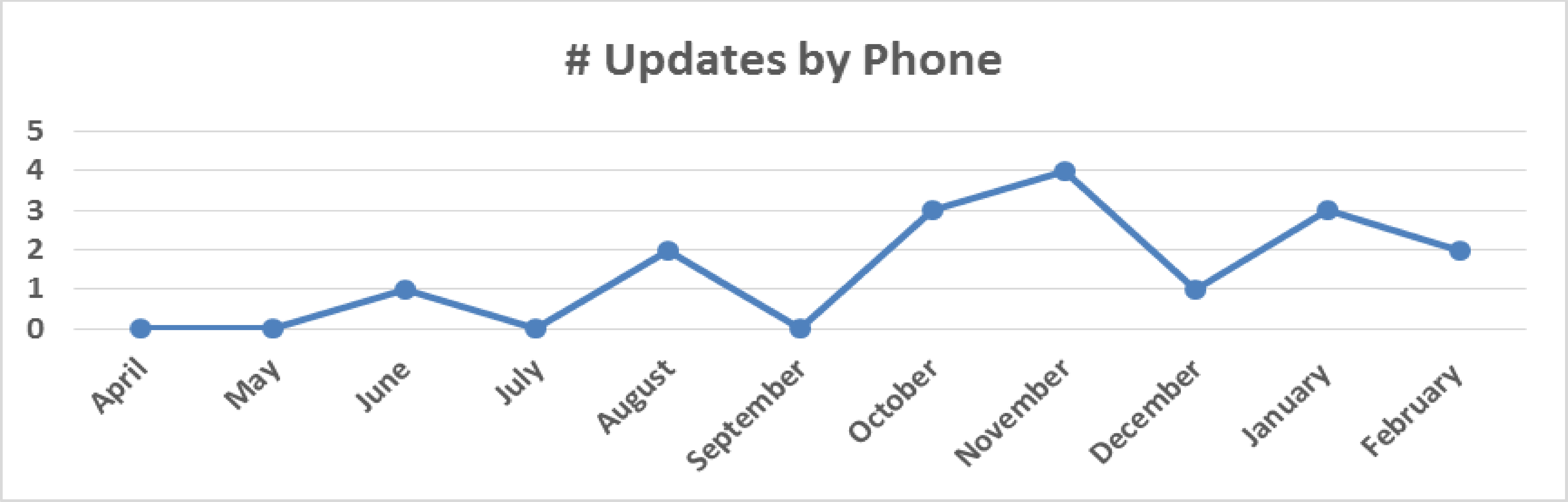
Testing

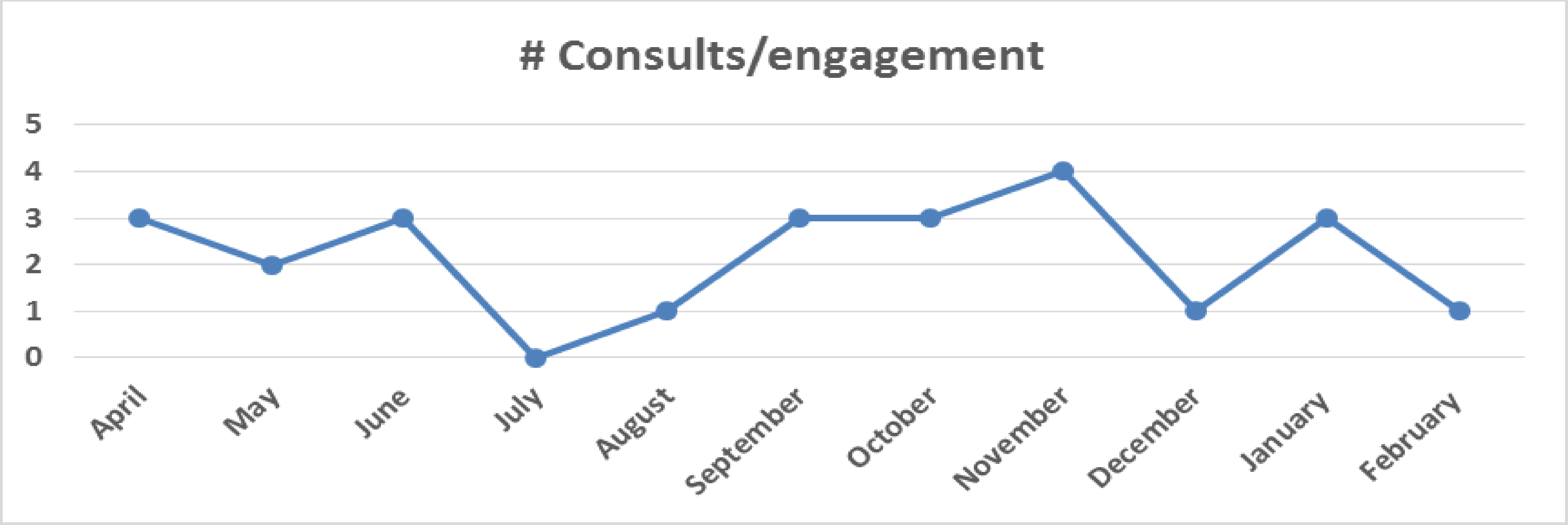
Run Charts for Process Measures

Palliative Care Coordinator
April 2018 to February 2019



Palliative Care Coordinator
April 2018 to February 2019





Feedback from Primary Care Providers on their Experience with having the H&CC Palliative Care Coordinator on site

Overall increased satisfaction with the direct access to the Palliative Care Coordinator

When Providers were asked…

"Do you know the Home & Community Care-Palliative Coordinator supporting your patients receiving palliative care?"

- **100% of providers surveyed responded, 'Yes'**

"Are you comfortable contacting the Home & Community Palliative Coordinator supporting your patients receiving palliative care?"

- **100% of providers surveyed responded, 'Yes'**

"Do you find it effortless to get a hold of your Home & Community Care Palliative Coordinator supporting your patients receiving palliative care?"

- **75% of providers responded, 'Yes'**

"Is there an ease in accessing the services that the palliative care coordinator delivers (i.e. CADD pump)?"

- **50% of providers responded 'Always', 50% responded 'Some of the time'**

When asked "what are some of the ways you contact the Palliative Care Coordinator?"

- **E-mail**
- **Phone**
- **EMR Direct Messaging**
- **Fax directly to home and community care**

> **Provider Quote:**
> **"I've found it very useful to have the palliative care coordinator onsite at our clinic intermittently."**

Feedback from Palliative Care Coordinator

Successes

- Concept is great
- Able to get information when needed
- Relationships with physicians and NPs is good
- Access to EMR has been helpful
- Knows the primary care providers
- Opportunities to provide and receive updates
- Presence in the office

Barriers

- Geography
- Caseload
- Covering for other Care Coordinators
- Shared office (patient confidentiality for patients not rostered to CHFHT)
- Engaging providers

How does Embedding a Palliative Care Coordinator within the Primary Care Team Improve the Patient/Caregiver Experience?

- ✓ Palliative Care Coordinator informs patient’s care team of any changes in status
- ✓ Accessible by members of the patient’s care team for consultation, questions, updates
- ✓ Palliative Care Coordinator has access to primary care EMR (history, consultation notes, specialist notes, medication lists, etc.)
- ✓ Palliative Care Coordinator is the conduit between care team members and patient/caregiver
- ✓ Increases patient’s confidence in members of their care team
- ✓ Presence in office builds relationship amongst primary care and Palliative Care Coordinator

Accomplishments

- ✓ Embedding Palliative Care Coordinator within CHFHT
- ✓ Discharge checklist (educating front line hospital nurses and hospital managers, increased utilization of the checklist and communication generated because of the checklist, improved transitions in care for patients)
- ✓ Completion of provider surveys and provider and caregiver interviews were valuable to the work of the project.
- ✓ Participation in the RPCN projects
- ✓ Presentation to members of the OPCN
- ✓ Dedicated Team members
- ✓ Continuing to build on relationships in the Rural Hastings Sub Region and beyond

Lessons Learned

Challenges Encountered

Resources for testing change ideas

Additional representation from H & CC, Home Care, Primary Health Care and Hospital would be beneficial

Additional care givers on project team would be ideal

Small scale change

Data collection

Lessons Learned

Factors Enabling Project Progress and Pace

- Dedicated working group members
- Champion Physician as executive sponsor
- Ruth Dimopoulos, Project Team Leads, Hilary Blair
- Regular touch points
- RPCN Steering Committee

THANK YOU

QUESTIONS??