Project: Coordination of Care

Region: Lanark Leeds Grenville

Executive Sponsor: Onalee Randell

Team Lead: Ruth Dimopoulos

Project Status: March 19, 2019

South East Regional
Palliative Care
Network

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

Problem Statement

Patients, caregivers and providers experience frustration in coordinating end of life care while ensuring patient goals and wishes are met. End of life may not be identified, for several reasons and conversations about end of life care are not timely. Patients and caregivers often do not have the information they need, including the options available to them, to make informed decisions. Situations change quickly and care may not be in place or communicated within the circle of care. Cross border issues in Rideau Tay region complicate the delivery of care.

Aim Statement By March 2019, patients in the primary care practice of Dr M will be identified to benefit earlier from the palliative care approach, with a 10% increase in patients with non- cancer diagnosis identified. We will introduce standardized tools and approaches to identify and engage patients and caregivers for important conversations in the last year of life. 80% caregivers will agree/strongly agree that they were engaged in timely conversations with consistent messages that prepared them for decisions related to care and for the patient's end of life.

Project Scope

Includes:
Last year of life as identified by surprise question, with focus in the last months > > death in preferred place
Transitions in system, includes LTC
Excludes:
Bereavement services and activities
MAID

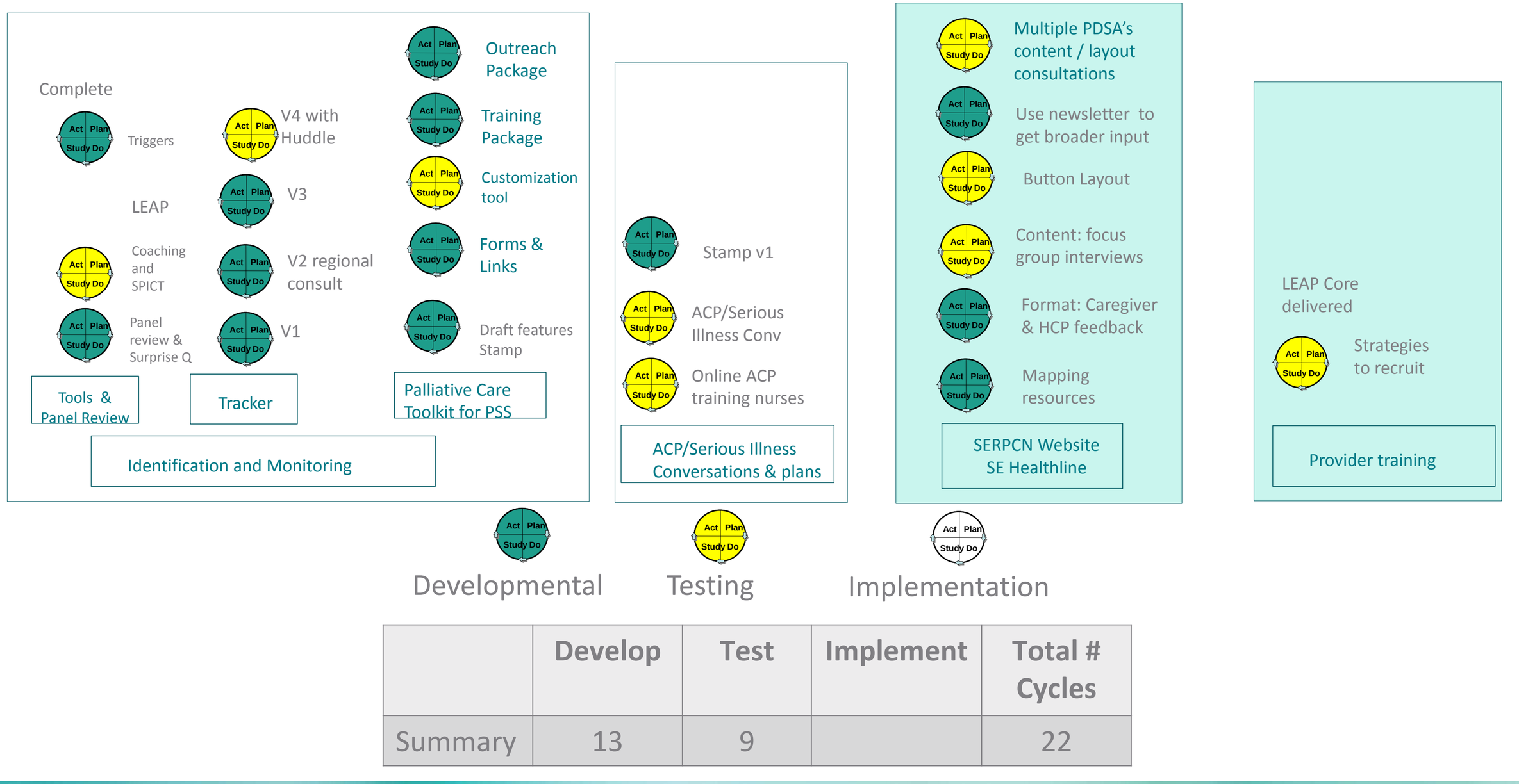
Project Team

Executive Sponsor: Onalee Randall
Director of Community Services RCHS
Team Lead: Ruth Dimopoulos

Team Members:
Anne Janssen, Caregiver
Sarah Kearney- Nolet, Care Coordinator PC, H&CC
Dzvena Krivoglavyi, NP LTC, HCC
Maureen McIntyre, Rideau Tay Health Link
Travis Wing, Manager BGH Palliative Care
Nicole Gibson, Palliative Care Consult Nurse BGH
Kelly Barry Clinical Manager RCHS

Pilot Site MDCHC
Dr Kevin Mooney, Amber Gilmour RN, Jane Doyle RN, Louise Besserer Medical Secretary, Lisa Wan Admin Manager

PDSA Status:



	Develop	Test	Implement	Total # Cycles
Summary	13	9		22

Palliative EMR Toolbar (Telus PS Suite)

e-Health Centre of Excellence www.ehealthce.ca- Waterloo Wellington LHIN

- *Assists clinicians to **earlier identify** patients who could benefit from a palliative approach to care*
- *Supports clinicians in **assessing** the palliative needs of the patient and offers a **plan** on next steps the clinician can take to participate as a member of the primary level palliative care team.*

<Insert video link and show about 15 minutes>

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Palliative Care Tracker- link to PC Toolkit

- Toolkit generate reports to inform tracker (replace manual search)
- Support coordination, coordinator role
- Need to develop and test search

VIP Tracker- Palliative Care v4 draft Primary Care Provider: Date last updated: Click on highlighted field for drop down list- click arrow -make selection

Patient Information					Key Discussions with Patient	Referrals in place			Key Contacts		
Patient	PPS	Date Last Seen by PCP	Special Monitoring Required (specify)	Preferred Place of Death	Illness Trajectory ACP - Goals of Care End of Life Planning PPS<70	Home and Community Care Assessment, Palliative Care NP, Community Supports Spiritual care, Pharm SW, OT-PT, Hospice service	PPS < 50%		SDM	Care Coordinator	Other Provider(s)
							SRK ordered	yes			
							PC Standing orders	yes			
							Nurse Pronouncement				
	70			Home			DNR-c				
							SRK ordered				
							PC Standing orders				
							Nurse Pronouncement				
							DNR-c				
							SRK ordered				
							PC Standing orders				
							Nurse Pronouncement				
							DNR-c				
							SRK ordered				
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							Nurse Pronouncement				
							DNR-c				
							SRK ordered				
							PC Standing orders				
							Nurse Pronouncement				
							DNR-c				
							SRK ordered				
							PC Standing orders				
							Nurse Pronouncement				
							DNR-c				

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CHANGE IDEA: Palliative Care Toolkit in the EMR

Enables prepared proactive Care Team through triggers, prompts, decision supports and evidence based tools

How Patient Experience will be improved

Earlier Identification of Patient for Palliative Care

- Earlier and more frequent conversations for patient to discuss their values, goals and wishes.
- Patient receives earlier assessment and identification of needs to plan supports
- Fewer crises with proactive approach to meet patient needs

Evidence: Identification of palliative care needs earlier in the disease trajectory has been recognized as a significant success factor in positive patient/family and system outcomes [1]

Facilitation of Palliative Care Competencies

- Prompts in Toolkit increase likelihood of getting right service at right time
- Discussion tools facilitate difficult conversations about illness trajectory and goals of care

Increased Awareness & Access to Resources

- Links to SE Palliative Care Website/Healthline within EMR can be reviewed with patient
- Tools and resources can be discussed with patient, printed from EMR and given to patient
- Patients will feel more prepared and aware of resources

Improved Communication and Coordination

- Standard searchable data entry making information more available to care team and patient/family
- Information can be printed and efaxed to others in circle of care and provided to patient

Caregiver approved

1. Baidoobonso S. Patient care planning discussions for patients at the end of life: an evidence-based analysis. Ont Health Technol Assess Ser [Internet]. 2014 December; 14(19):1–72.

CHANGE IDEA: Palliative Care Toolkit in the EMR

From a Caregiver: How would my experience and that of my family member have been improved had EMR with palliative care triggers been in place?

If a Dr is triggered will s/he spend the time to follow the triggers?

IF our doctor had access to it and IF he knew how to use it and how to properly insert the information, then, would he have been triggered to:
- tell us and print out what services exist in the community ?
- tell us how to contact the Care Coordinator?
- tell us that there is a palliative care nurse practitioner available to support us at home?
- ask if my family member had any personal care wishes?
- send an immediate request to HCC ?
- provide us with immediate 24/7 access to himself or a nurse or a professional who had our files?
- give us an idea of what we might expect over the next few months of tests, etc and who/how we can phone to follow up? what hospitals might be involved, etc.

High Level Overview of Work plan for EMR Toolkit

Engage Senior Leaders, Influencers, Early Adopters	Link to 2019-20 Quality Improvement Plans Liaise with Sub-regional Directors and link to plans (e.g. COPD initiative) Identify small group of pilot sites sub-region, and possibly across LHIN sub-regions where there is already interest to try the tool
Customize Toolkit for Testing	**Customization Tool-** inventory of custom forms, documents and links, identify standard tools for SE and highlight areas for local customization **Training by eHealthCE-** virtual training sessions purchased, training sessions recorded for future use, training manual, draft workflow for tool to support testing and spread Create Version 1 of LLG Tool for testing
Testing Tool	Communication to pilot site organizations- all staff, emails, presentations, use stories Increase awareness of early identification and benefits: culture and values of community, HCP's Identify 1-2 testers per site, provide training, workflow Initiate Rapid Cycle PDSA cycles to collect feedback, adjust content Scale up within pilot sites
Thinking about Sustainability	Feedback mechanisms- huddles for pilot sites Visual Management in pilot site Onsite Provider Champions
Thinking about Spread	Dropbox for sharing most recent version of EMR Tool Spread Plan: Customization package, Training Package, SE PC Toolkit for local customization Spread Leads/Champions by Sub-region, give champions a voice to promote early identification

Interest in PC Palliative Care Toolkit in LLG

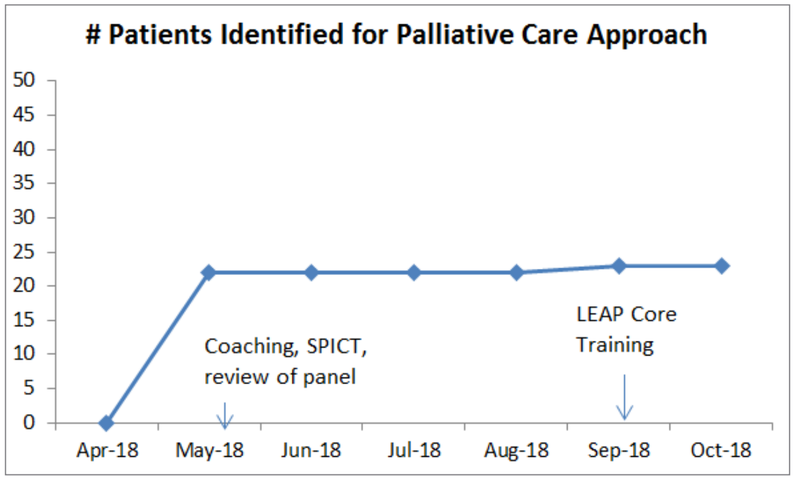
- Outreach meeting with 1 FHT – plan to include early identification indicator in their QIP, experience in using QI approach
- Outreach meeting planned with FHT- physicians who provide palliative care with BGH Palliative Care Program
- Information session requested by a second CHC

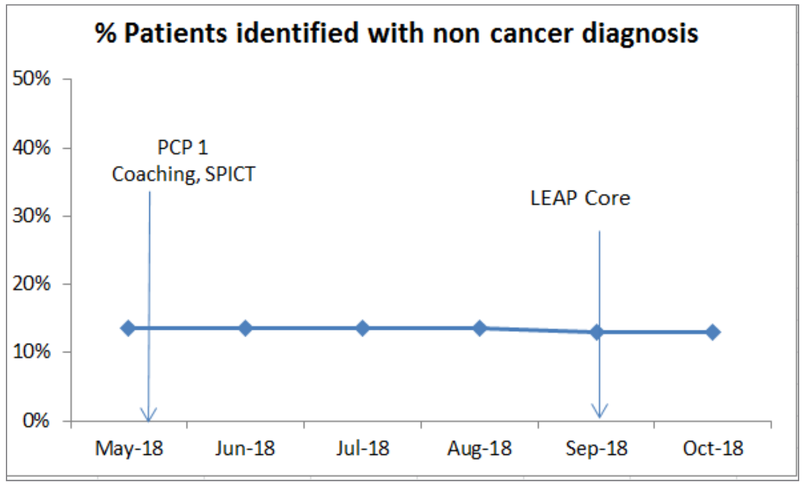
- Staying connected with two other FHTs in SE who plan to look into Toolkit

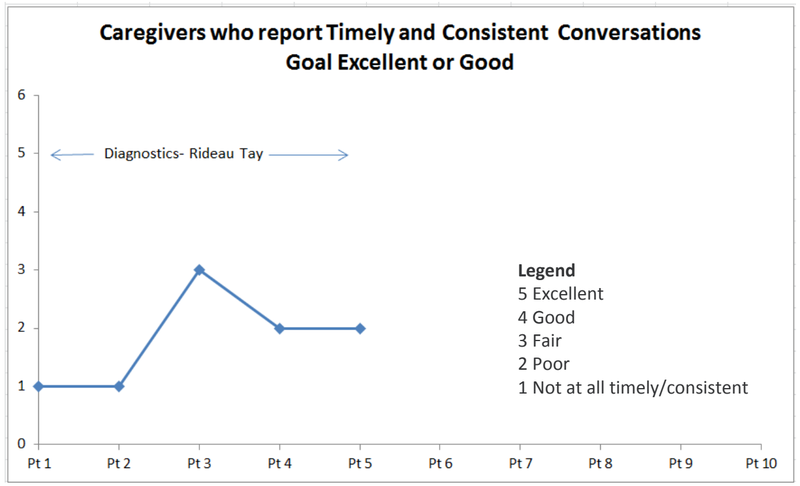
Project Data- no updates

No searchable data related to palliative care
Unable to implement manual audit, staff capacity and privacy barriers
Attempts to track manually – failed.

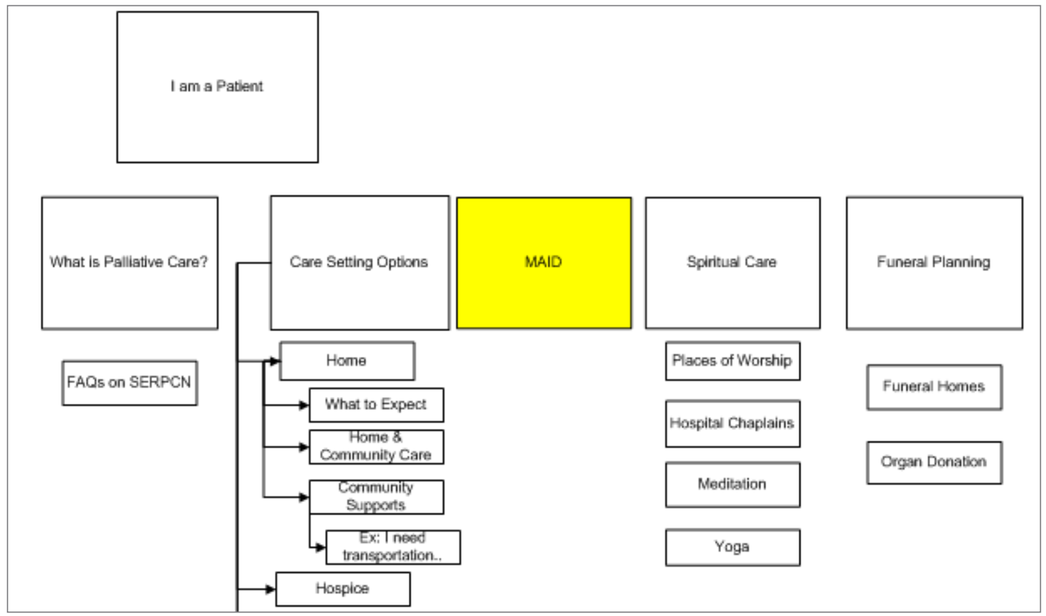
WW PC Toolkit with searchable data will provide project data going forward.


Patients Identified for Palliative Care Approach
50
45
40
35
30
25
20
15
10
5
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Coaching, SPICT, review of panel
LEAP Core Training


% Patients identified with non cancer diagnosis
50%
40%
30%
20%
10%
0%
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
PCP 1 Coaching, SPICT
LEAP Core


Caregivers who report Timely and Consistent Conversations Goal Excellent or Good
6
5
4
3
2
1
0
Diagnostics- Rideau Tay
Pt 1
Pt 2
Pt 3
Pt 4
Pt 5
Pt 6
Pt 7
Pt 8
Pt 9
Pt 10
Legend
5 Excellent
4 Good
3 Fair
2 Poor
1 Not at all timely/consistent

SERPCN website: Mini-site of Southeast Healthline (SERPCN Work Plan E2i)



Training to make revisions to website
Consultation with Healthline re: formatting

Link to Palliative Care Toolkit
Connecting Providers, Care Coordinators and Patients to website resources

Question for Steering Committee:
Do you support inclusion of MAID resources and training on the SERPCN Website?

Lessons Learned

Challenges Encountered

- Barriers for pilot site to engage in improvement work (e.g. staffing pressures, competing major change initiative for organization)- project ‘landed in their lap’
- Data collection for project- should be addressed by Toolkit
- Delays in receiving and accessing PC Toolkit

Scoping Discussions for FY 2019-20 initiated (and to be continued):

- Manageable for pilot sites
- Alignment with HSDF
- Integration- identification of coordinator, assessment, plan

Celebrating our Team- Accomplishments

"QI process worked beautifully from those early meetings using QI tools, finding root causes and coming up with ideas. And here we are today all the dots connecting with the [provincial] priorities "

" I would like to celebrate the [pilot] team, their flexibility and making it work to test ideas such as the tracker huddle"

" I'd like to acknowledge the commitment organizations working together on this project"

THANK YOU

QUESTIONS??