Early Identification for Palliative Care
Lanark Leeds Grenville

Executive Sponsor: Onalee Randell
Team Lead: Ruth Dimopoulos

Project Status: December 17, 2019

South East Regional
Palliative Care
Network

Project Scope

Includes:
Last year of life: identification> assessment
Primary care sites

Project Team

Executive Sponsor: Onalee Randell
Director of Community Services RCHS
Team Lead: Ruth Dimopoulos
QI Advisor: Megan Jaquith

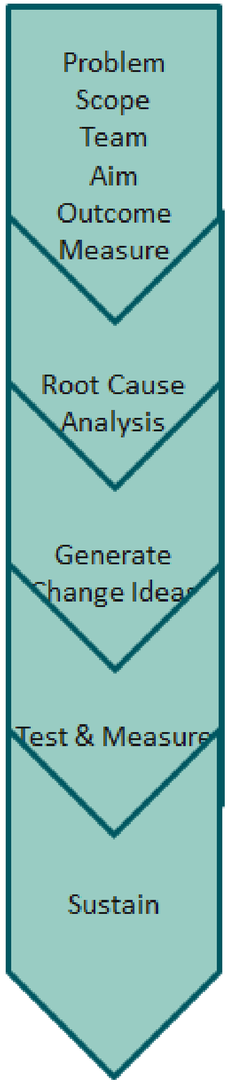
Team Members:
Anne Janssen, Caregiver
Sarah Kearney- Nolet, Care Coordinator PC, H&CC
Dzvena Krivoglavyi, NP LTC, HCC
Maureen McIntyre, Rideau Tay Health Link
Travis Wing, Manager BGH Palliative Care
Nicole Gibson, Palliative Care Consult Nurse BGH
Kelly Barry Clinical Manager RCHS
Sandy Shaw, Palliative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

Pilot Site MDCHC
Amber Gilmour
NP Nicole Roller
NP Lindsay MacDonald

Pilot Site- Perth Family Medical
Dr Stephanie Popiel

Data Support – Sue Calver RCHS

Back to the beginning November 2017



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.

Root Causes

Providers not comfortable raising palliative care and end of life discussion, messages may not be clear or consistent, occur early or often enough. Palliative Care competency, training and experience of health care providers. Some patients and caregivers not ready, don't hear or don't understand the conversation. Planning for end of life is not part of our culture, there is fear of death, & people are not aware of importance of ACP.

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Original Aim Statement 2018-2019

Aim Statement By March 2019, 30 patients will be identified in a primary care pilot site 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.

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Alignment of Project with Provincial and Regional Priorities & Recommendations

Key Document	Actions
HQO Palliative Care Standard Statement 1- Identification & Assessment of Needs Statement 3- Advanced Care Planning, Substitute Decision Maker Statement 4- Goals of Care	Search for validated tools to support earlier identification in Primary Care setting. Leverage EMR. Training
OPCN/SE RPCN Work Plan 2018-19 C. Enabling Early Identification of Patients Who Would Benefit from Hospice Palliative Care	Tool search while awaiting recommendations from OPCN Advocated for training opportunities to support early identifciation and conversations with patients (LEAP, ACP, Goals of Care, Health Care Consent)
Palliative Care Health Services Delivery Framework Recommendation 1: The patient who would benefit from palliative care will be identified early in their illness.	Review alignment with Patient Pathway Identification and assessment
OPCN Tools to Support Earlier Identification of Palliative Care	Confirmed alignment with recommended tools for primary care setting Use of e-Health Centre of Excellence Palliative Care Toolkit/Toolbar-
HQO- Quality Improvement Plan Indicator People with a progressive life-limiting illness have their palliative care needs identified early through a comprehensive and holistic assessment.	Rideau Community Health Services included Palliative Care Indicator in 2019-20 QIP Project aim statement tweaked to align with indicator Outreach and support to others working on this indicator as part of spread plan

Contributing to OPCN Big Dot Measures

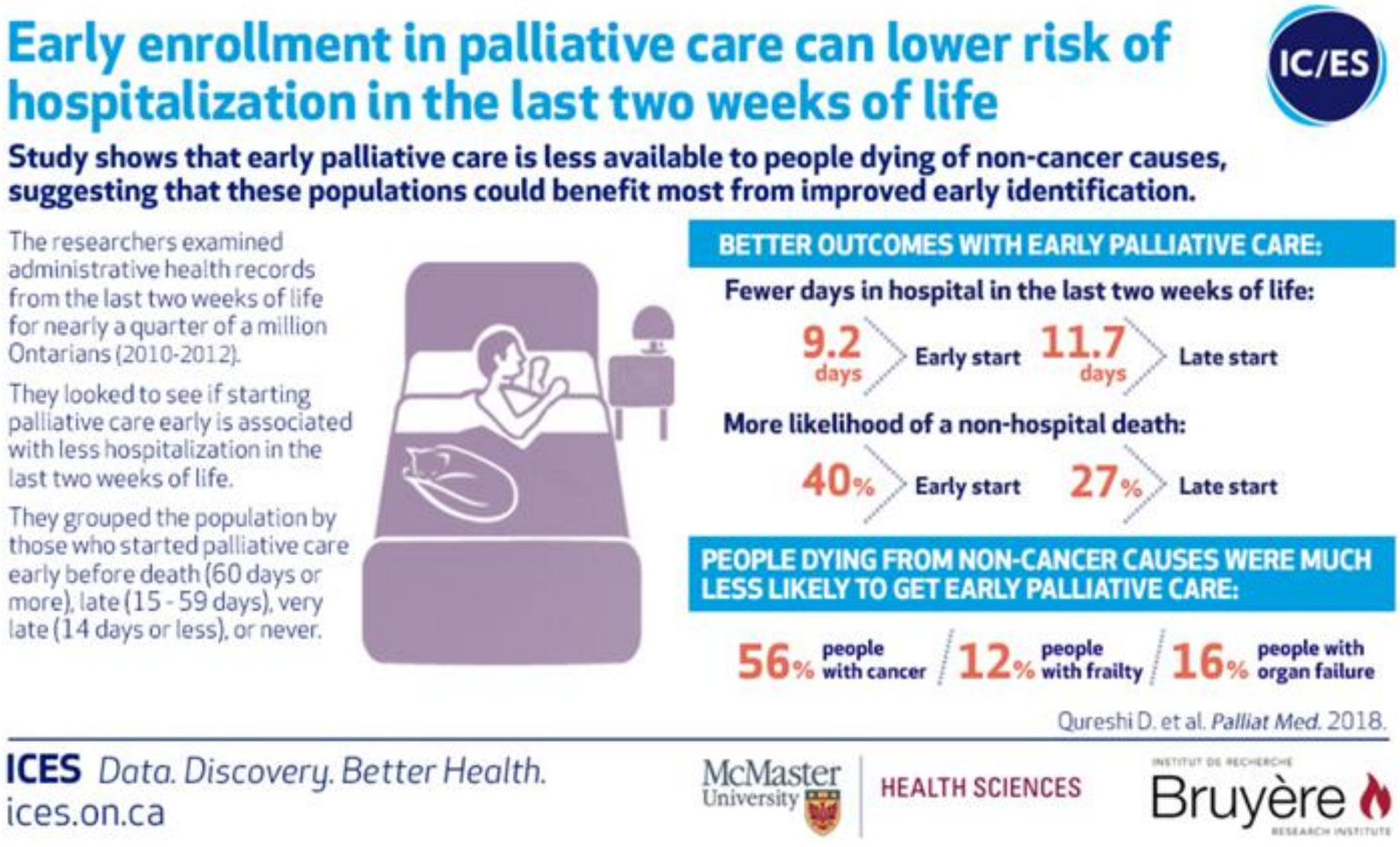

Image courtesy of ICES

OPCN Big Dots

- % decedents who died in hospital
- % decedents who had 1 or more ED visits or 2 or more ED visits in last 30 days of life
- % of community dwelling decedents who received physician home visits and/or palliative home care in the last 90 days of life

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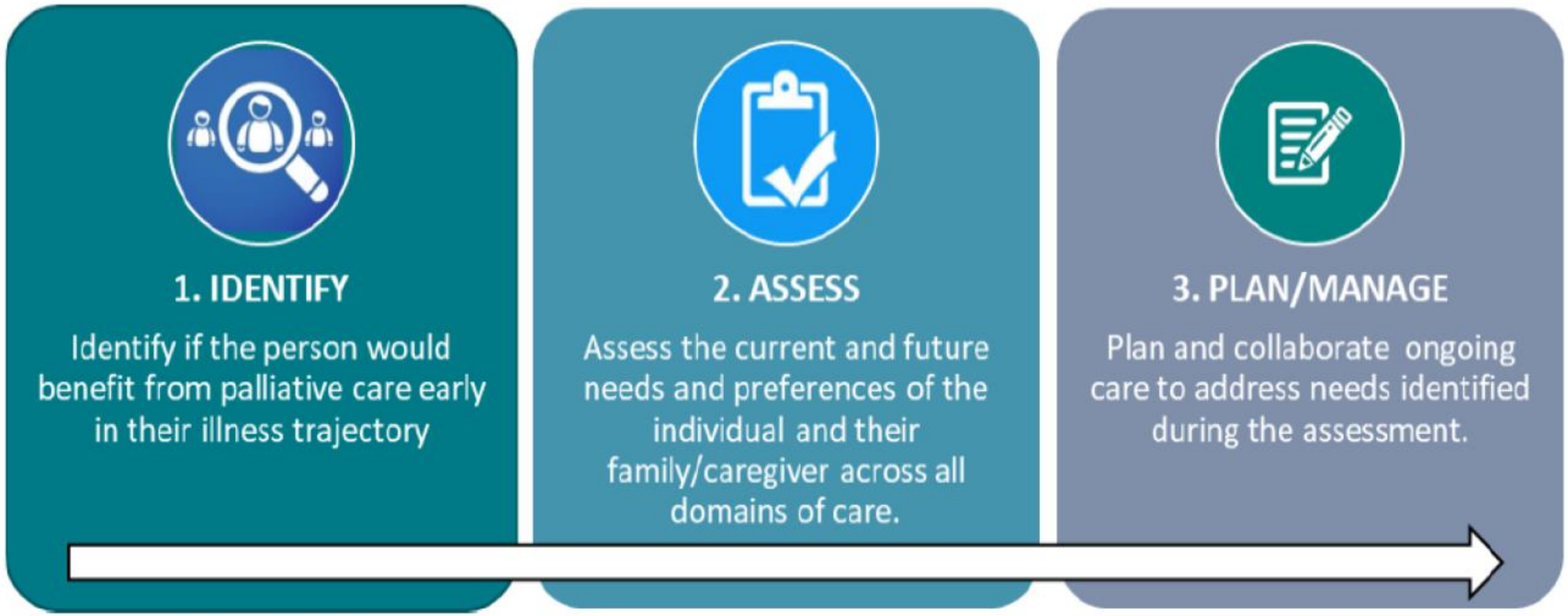
What are we trying to accomplish?	How will we know that change is an improvement?	What changes can we make that will result in improvement?
The transition from curative treatment to a palliative approach and recognition of end of life requires a shift in thinking for patients, their caregivers/families as well as health care providers. Early identification of patients who would benefit from the palliative approach and timely conversations about end of life enable patients, caregivers and health care providers to prepare for end of life. By March 2020, we will increase the proportion of primary care patients with a progressive, life limiting illness who have had their palliative care needs identified early through a comprehensive and holistic assessment. By doing this we expect to identify individuals for palliative care earlier and that more individuals with non-cancer diagnoses will be identified. Balancing Measure: - # palliative alerts triggered in EMR	**Early Identification for Palliative Care** -# individuals identified for palliative care -% patients who have had their palliative care needs identified early through a comprehensive and holistic assessment. (Target: TBD) - % of individuals identified in the stable phase (PPS 70-100%) Target 40% -% of individuals identified with non-cancer diagnosis Target 50% % of patients/caregivers who report assessment for palliative care was timely and met their needs	Local Customization of eHealth Centre of Excellence Palliative Care Toolkit for Practice Solutions Initial testing of Toolkit by 2-3 primary care providers in different primary care models: • Toolbar content • Validate triggers • Integrated workflow
	Comprehensive Holistic Assessment % patients identified for palliative approach with: - assigned care coordinator - completed assessment - documented care plan developed with patient	- Identification of an assessment tool (regional?) - Custom form integrated in toolkit -Identification of a Care Coordinator (RCHS, HCC, HL) ensuring continuity for patient -Referral to/collaboration with identified Care Coordinator to complete assessment - Care plan document for patient
	Structural Measures # Primary care providers using PC Toolkit for Practice Solutions (practice setting, type)	-Outreach to local primary care providers to invite input on tool, outreach packages including recorded demo of tool - Link to regional projects (e.g. Expanded Team Based Care, COPD Project) -Outreach with secondary and tertiary partners to communicate about our work

The Process of Identification



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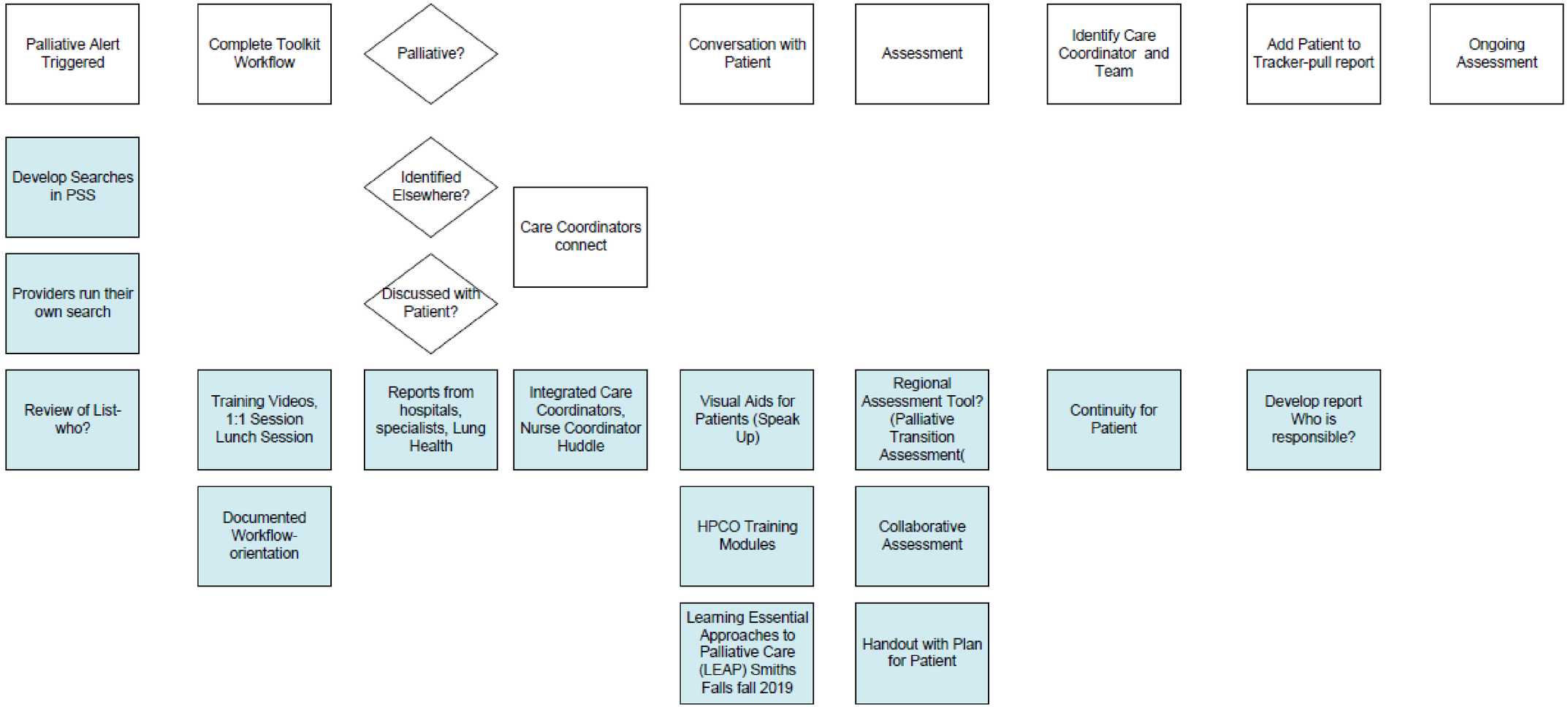
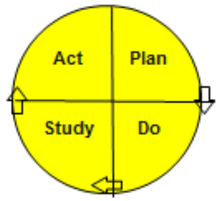
Process: Chart triggered for PC Assessment> Ongoing PC Assessment

May-June 2019

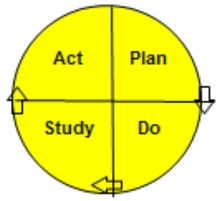


PDSA Updates

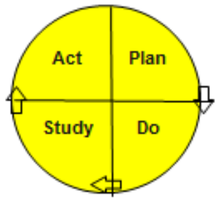
PDSA cycles for Palliative Care Toolkit



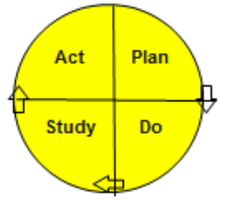
Cycle 5: Increase # providers testing toolkit RCHS



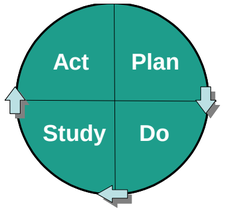
Cycle 4: Testing LLG Toolkit V2



Cycle 3: Small scale testing of toolkit, two sites (CHC, FHO) with one provider per site

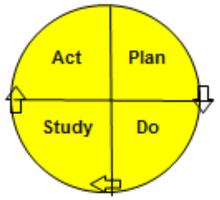


Cycle 2: Customizing LLG Toolkit V1



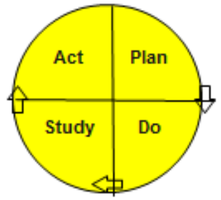
Cycle 1: Customization tool with local forms and links identified

Toolkit Content/Format

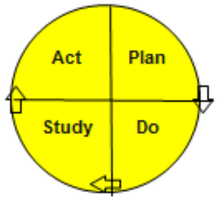


Cycle 1: RCHS Complex Care Coordinator testing tool

HCC Palliative Care Transition Assessment



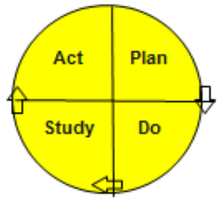
Cycle 3: Add CHC Encodes to reminder and search (CHC)



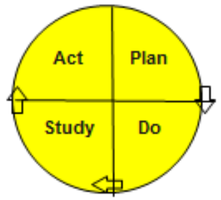
Cycle 2: Test and edit word phrase search in CPP (FHO, CHC)

Cycle 1: Test existing reminder/search in FHO and CHC EMR

Editing Reminder/Search



Cycle 2: Catalogue of resources



Cycle 1: Drop Box package

Toolkit Package

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Dr Stephanie Popiel - Perth Family Medical

- 3 week trial with Toolkit
- Focused on validation of triggers for palliative review
- Uses CPP, ICD-9 and ICD-10 not used

Excerpt of Findings:

- “MS” picks up words with ms such as problems
- I use older acronyms for kidney disease, weren’t being picked up
- Sometimes use a disease term in my narrative CPP even when the patient doesn’t have the disease e.g. a line in the CPP that reads “Tremor, no evidence for Parkinson’s” >triggers

Who got missed?

I went through all my 80+ patients and asked myself the question with them.
I had a bunch of “no” patients that hadn’t shown up with the toolbar, essentially all the ‘vasculopaths’. I added a section to the reminder check list to search for patients with HTN + DM + CAD + smoker

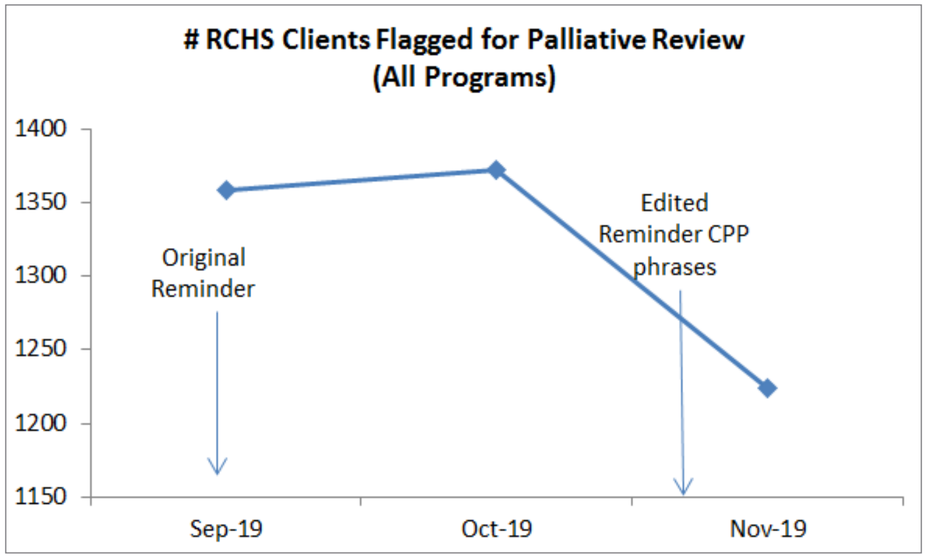
Dr Stephanie Popiel Perth Family Medical

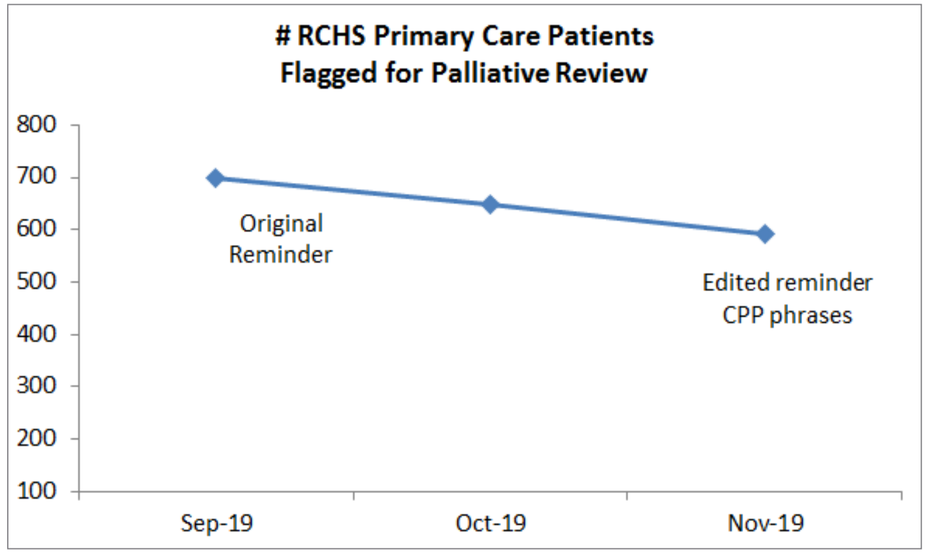
722 rostered patients
2 weeks = 6 patients popped up (About as predicted)
Question “no surprise”, 2 total, so average of 1/week

I either addressed with substitute decision maker questions as a starter, or deferred to another visit where I could think about it. In an ideal world, I’d run through all my patients of the day before the day starts and check.

Both patients identified were in the stable phase.

PDSA Review of Triggers- Rideau Community Health Services





- Original reminder uses ICD-9, ICD-10 codes and word search in Cumulative Patient Profile (CPP)
- CHC uses Encode-FM, not ICD codes- matched coding to create reminder with Encodes
- Compared Encode reminder with original reminder
- Discovered MS flags words containing “ms” such as problems, similar potential with ALS
- Some charts triggered by encodes but not on original search - e.g. “fatty liver”

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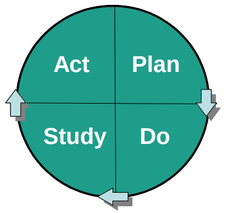
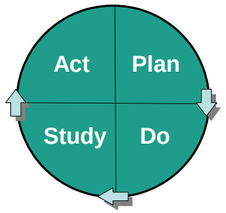
PDSA cycles for Palliative Care Toolkit

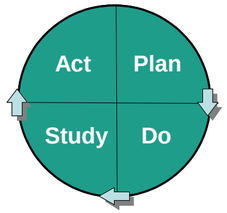


Cycle 2: V2 Slides

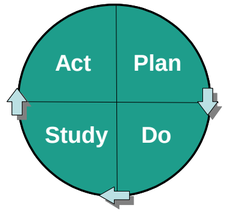


Cycle 1: V1 Slides

Waiting Room Slides
PC Messages



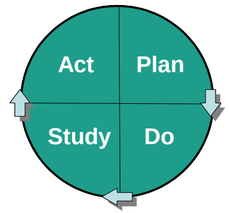
Cycle 2: V2 Handout



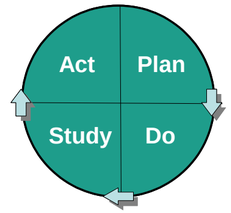
Cycle 1: V1 Handout

Patient Handout for Toolkit

Cycle 3: Distribute at LEAP session



Cycle 2: V2



Cycle 1: V1 Toolkit Handout for Providers

Toolkit Handout

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Expanded Testing/Spread *

Requests for Toolkit:

North Lanark CHC

- Lung Health Program

Country Roads CHC

Upper Canada FHT (Brockville)

Smiths Falls Nurse Practitioner Led Clinic

Ottawa Valley FHT (Almonte)

Outreach Activities

Networking

Leadership CHC's, FHT's, NPLC, Sub-region Lead, Expanded Team Based Care Lead

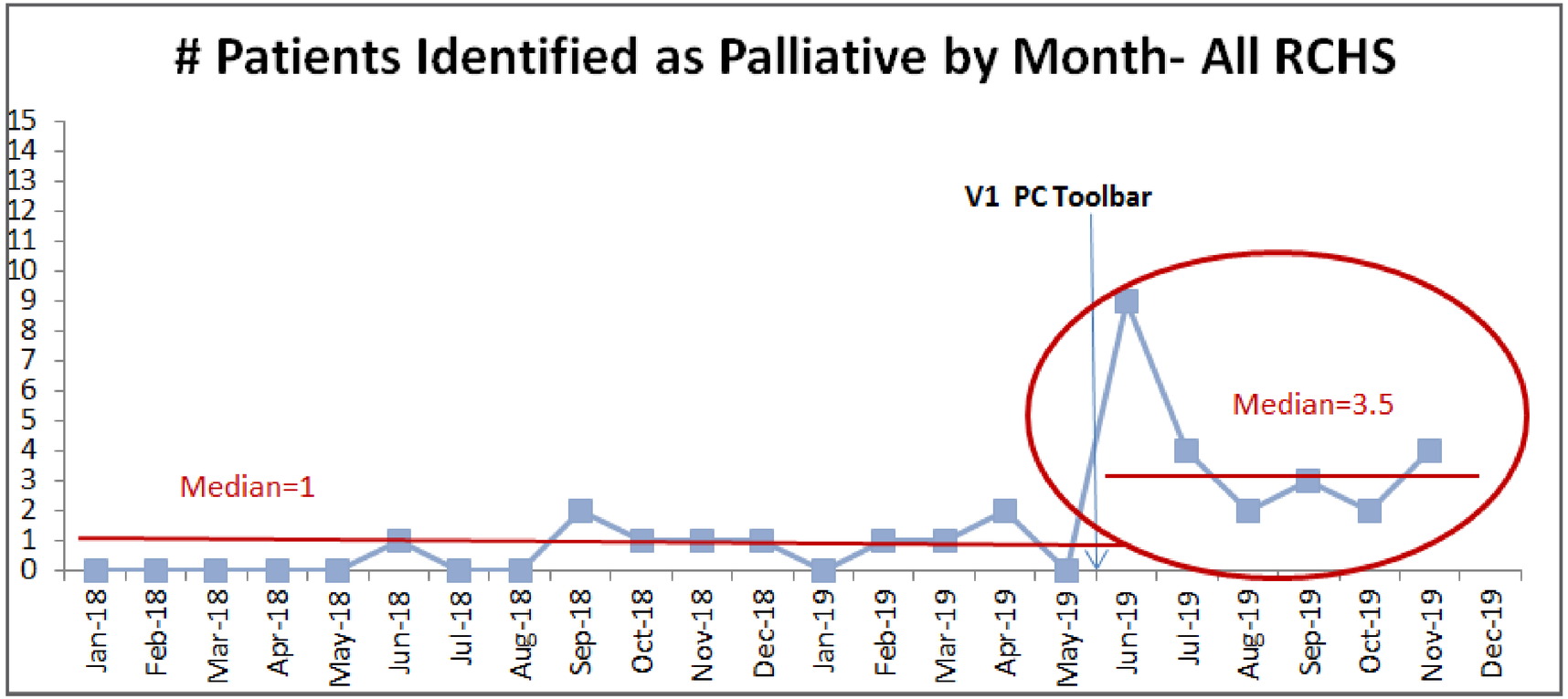
Presentations

Quality Committee Country Roads CHC
Primary Care and Lung Health Manager North Lanark CHC
Brockville General Palliative Care Team
Palliative Care Committee Smiths Falls Nurse Practitioner Led Clinic
Palliative Care Education Day Smiths Falls with Dr Popiel

Handout at LEAP Core Session Perth

Project Measures

Identification of Patients



- 7/10 RCHS MD's & NP's have used the Toolkit at least once
- Complex Care Coordinator (RN) launching toolkit most frequently

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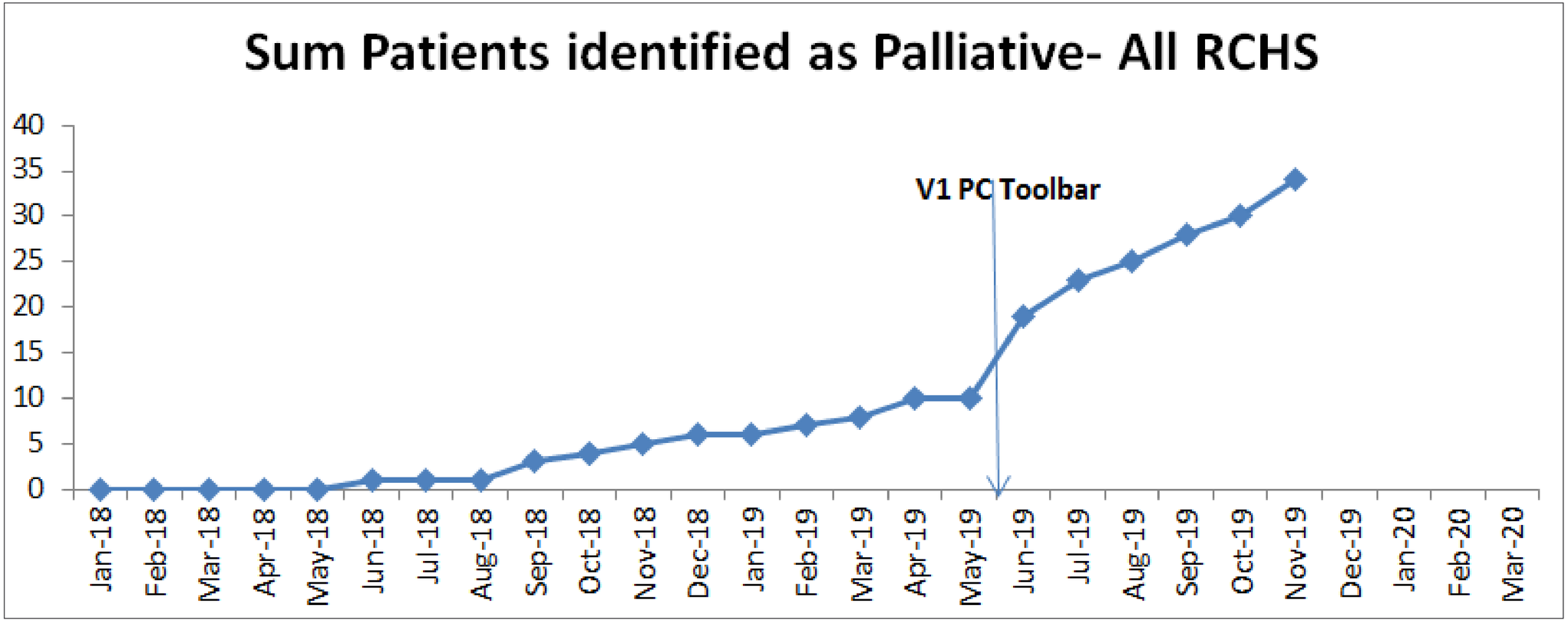
Identification of Patients



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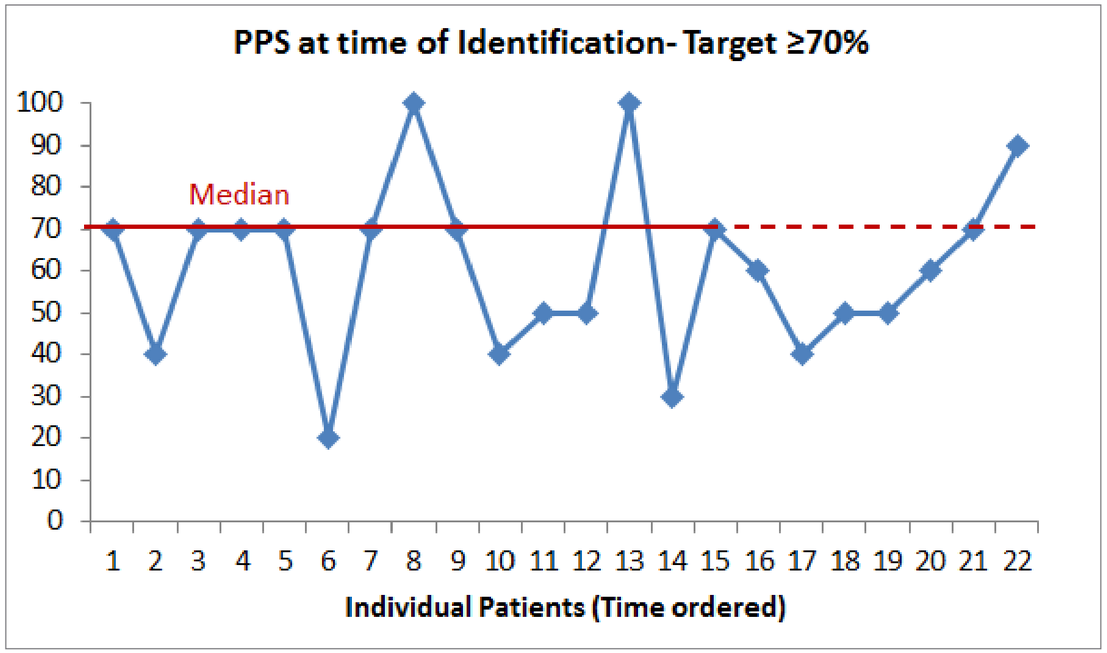
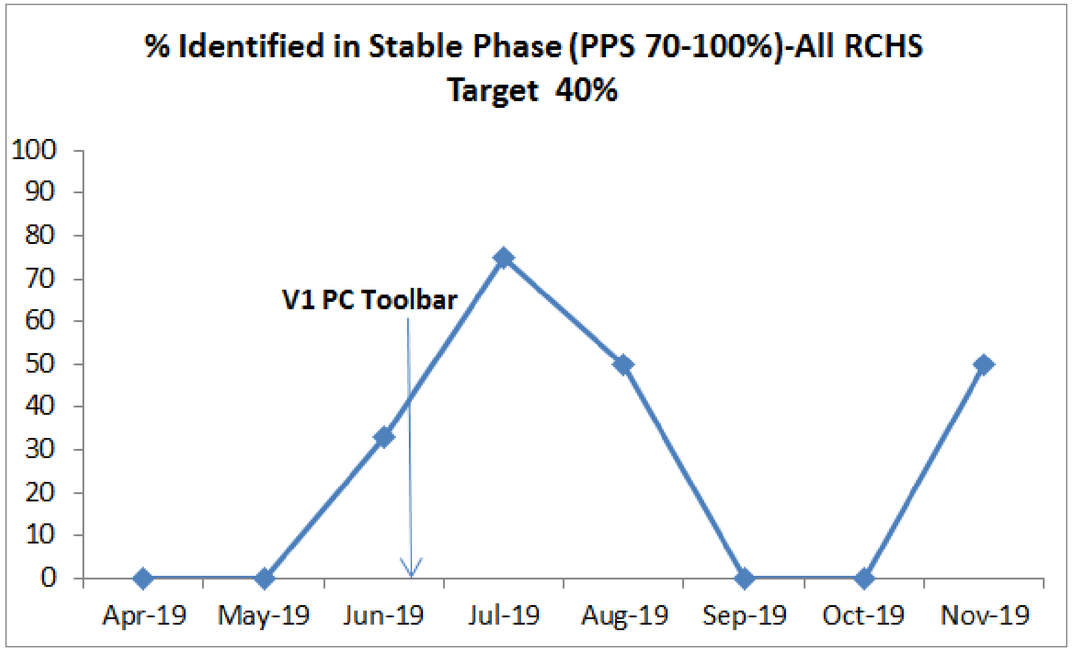
Earlier Identification





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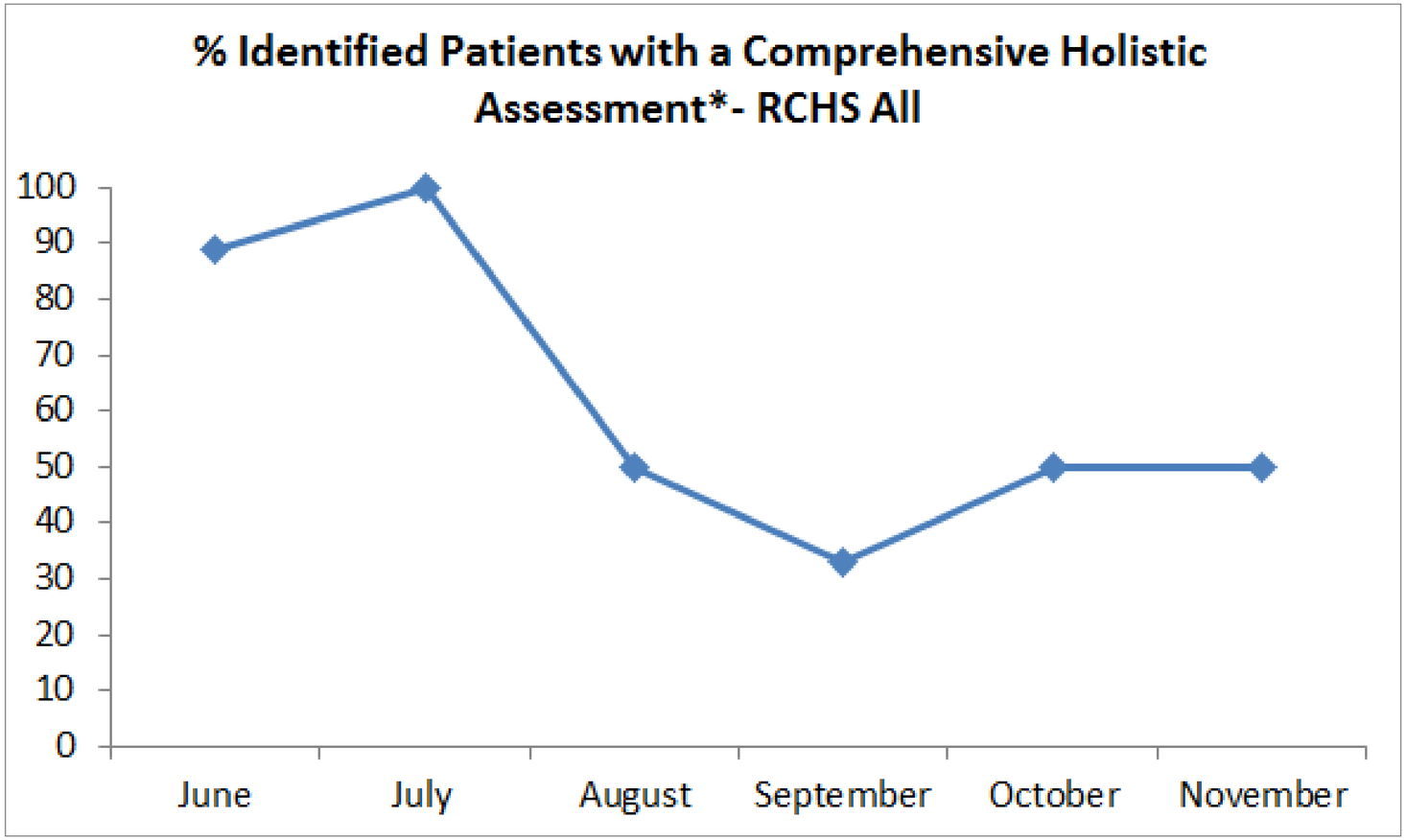
Comprehensive Holistic Assessment

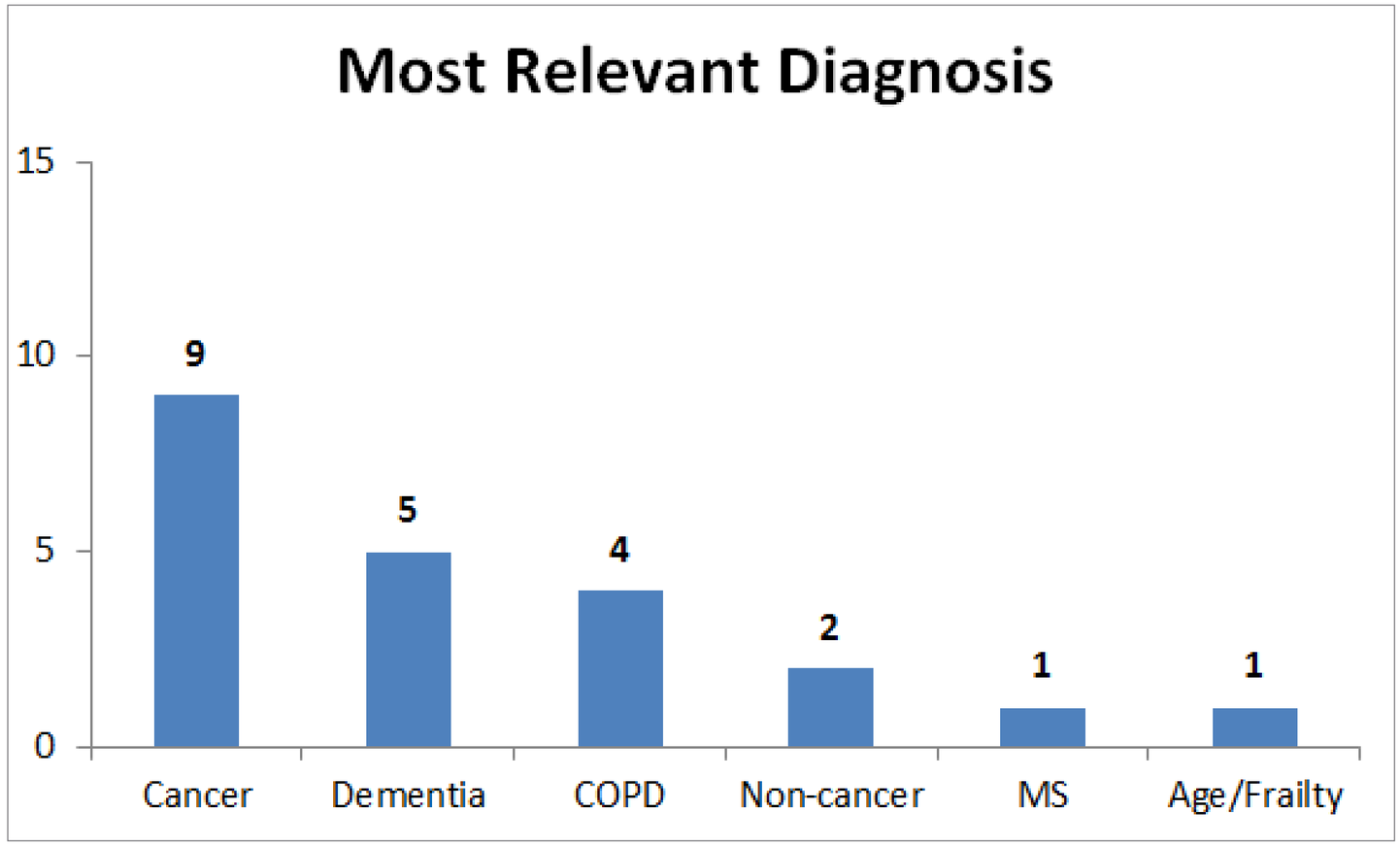


Challenge with data collection- predict numbers are higher

- **Assessed elsewhere?**
- **Comprehensive & holistic?**
- **Tool not embedded in toolkit**
- **Need to tighten up process**

Caution: Small numbers

Palliative Care offered for non-cancer diagnoses



Plan for Patient-Family Reported Measure

% of patients/caregivers who report assessment for palliative care was timely and met their needs

- Onalee has committed resources for interviews
- Telemedicine nurse will call patient due to capacity issues in primary care
- Keeping process internal - acknowledge potential for bias
- Sample of patients seen by Complex Care Coordinator
- Caregiver representative concerns

CHANGE IDEA: Palliative Care Toolkit in the EMR

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

	Earlier Identification of Patient for Palliative Care	Facilitation of Palliative Care Competencies	Increased Awareness & Access to Resources	Improved Communication and Coordination
How Patient Experience will be improved	Earlier and more frequent conversations for patient to discuss their values, goals and wishes.	Prompts in Toolkit increase likelihood of getting right service at right time	Links to SE Palliative Care Website/Healthline within EMR can be reviewed with patient	Standard searchable data entry making information more available to care team and patient/family
	Patient receives earlier assessment and identification of needs to plan supports	Discussion tools facilitate difficult conversations about illness trajectory and goals of care	Tools and resources can be discussed with patient, printed from EMR and given to patient	Information can be printed and efaxed to others in circle of care and provided to patient
	Fewer crises with proactive approach to meet patient needs		Patients will feel more prepared and aware of resources	
	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]			

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.

Sustainability- beyond March 2020

- Process Owner and accountability RCHS
- Operational plan
- QIP
- Strengthen Data collection and reporting- “J reports”
- Hospital –Community Palliative Care Committee

Spread Plan-What we are spreading

LLG Palliative Care Toolkit Package including:

- Toolkit/Toolbar V 1.1.0 for Practice Solutions with associated tools and resources
- Training Video- How to edit Toolkit
- Toolkit Guide
- Customization Catalogue of resources

We are sharing learning to support spread:

- Link to our page on SERPCN webpage
- Resources such as workflow- will require adaptation to specific sites

Drop Box- Custom Folders by organizations > Generic Folder
SE RPCN Webpage

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Spread Plan – LLG and Beyond

- Outreach offering support for Palliative Care Indicator in 2019-20 Quality Improvement Plan
- Identify PC Champions and influencers
- Leverage RCHS relationships with FHOs in Perth Smiths Falls and Brockville (e.g. through Expanded Team Based Care connections)
- Leverage existing CHC and FHT networks
- Link to existing projects and committees e.g. Lung Health Early ID project, Hospital PC Programs and committees

Lessons Learned

Challenges Encountered

- This is a technical change with a significant cultural component- affecting uptake
- Capacity issues at RCHS site- everyone doing their best
  - Impacting revisions of toolkit, data collection for project measures
- Communication of assessment across sectors

Factors Enabling Project Progress and Pace

- Ruth has been given remote access to Practice Solutions and informal training on editing reminder/search

THANK YOU
QUESTIONS??