Early Identification for Palliative Care
Lanark Leeds Grenville

Executive Sponsor: Onalee Randell
Team Lead: Ruth Dimopoulos

Project Status: June 18, 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
NP Nicole Roller (new) MDCHC Pilot Site
Amber Gilmour RN MDCHC Pilot Site

Pilot Site MDCHC
Jane Doyle RN, Louise Besserer Medical Secretary, Lisa Wan Admin Manager

Pilot Site- Perth Family Medical
Dr Stephanie Popiel (new)

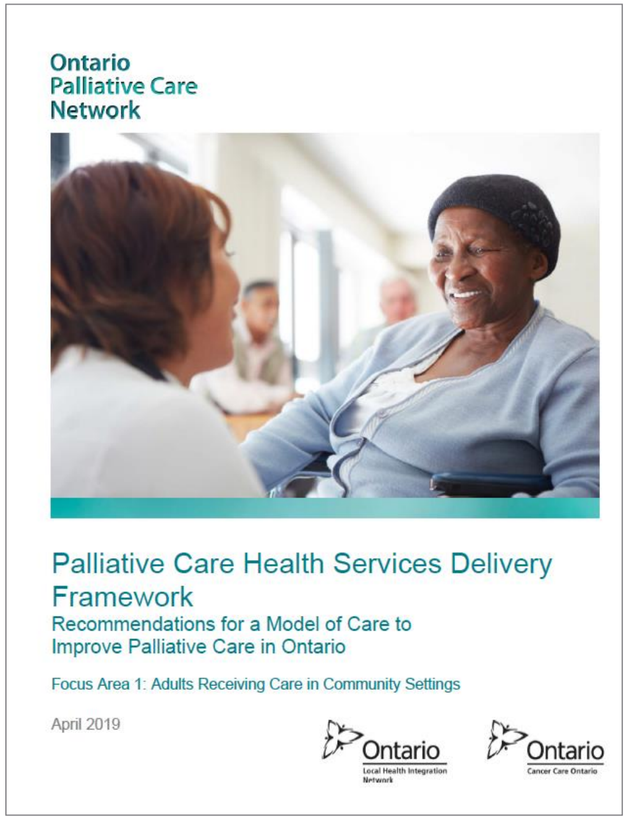
Project Alignment

HQO Palliative Care Standard

2019/19 Quality Improvement Plan

Early Identification Indicator

✓RCHS QIP



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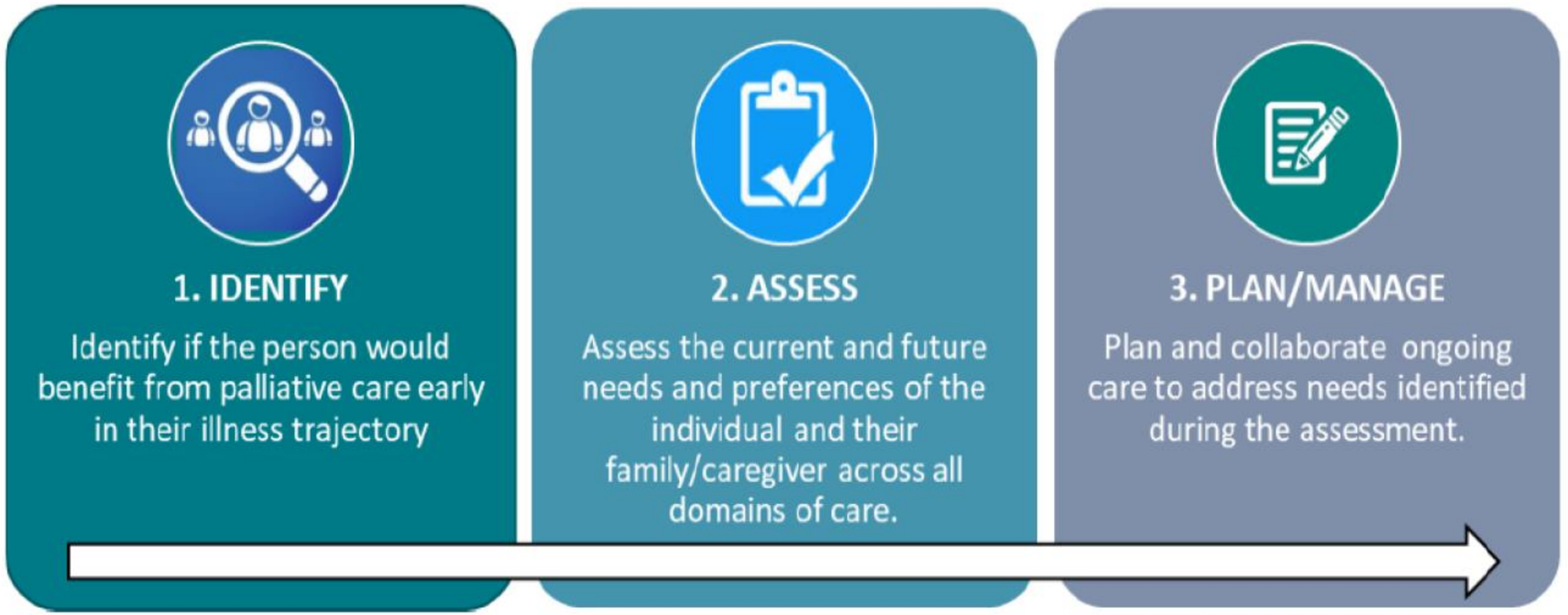
The Process of Identification



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Accomplishments Q1

- Revised charter, tree diagram to reflect alignment with QIP indicator
- Refreshed team
- First customization of toolkit for testing
- Data collection plan developed
- Two providers testing toolkit in two sites- others interested
- Continued outreach in primary care
- Involved in early discussions about a standard assessment tool for the region
- Participation in HQO Community of Practice

Tree Diagram: Early Identification for Palliative Care Project

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 waiting > 30 days for initiation of assessment	**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%) -% of individuals identified with non-cancer diagnosis % 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 • 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

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 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.

Outcome Measures

% patients who have had their palliative care needs identified through a comprehensive and holistic assessment

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

Balancing Measure

- # palliative alerts triggered in EMR waiting > 30 days for initiation of assessment

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Process Measures

#/% of patients identified in the stable phase (PPS 70-100%)
#/% of patients identified with non-cancer diagnosis

#/% patients identified for palliative approach with:
- assigned care coordinator
- completed assessment
- care plan document developed with the patient

Structural Measure
Primary care providers using PC Toolkit

Palliative EMR Toolkit & Toolbar (Telus PS Suite)

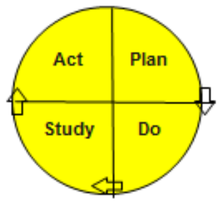
Customized for LLG: First version being tested at two sites

- *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.*

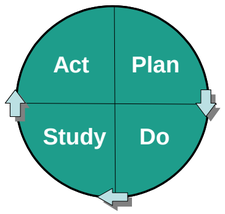
- Discussing custom form in Toolkit that would pull info from EMR/Toolkit- populate an assessment tool (e.g. regional tool)

PDSA cycles to date for Palliative Care Toolkit

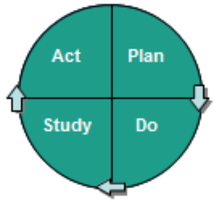
Cycle 3: Small scale testing of toolkit, two sites (CHC, FHO) with one provider per site

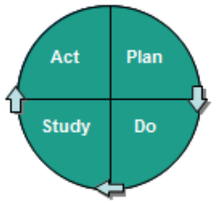


Cycle 2: Customizing Toolkit Draft 1 LLG



Cycle 1: Customization tool with local forms and links identified





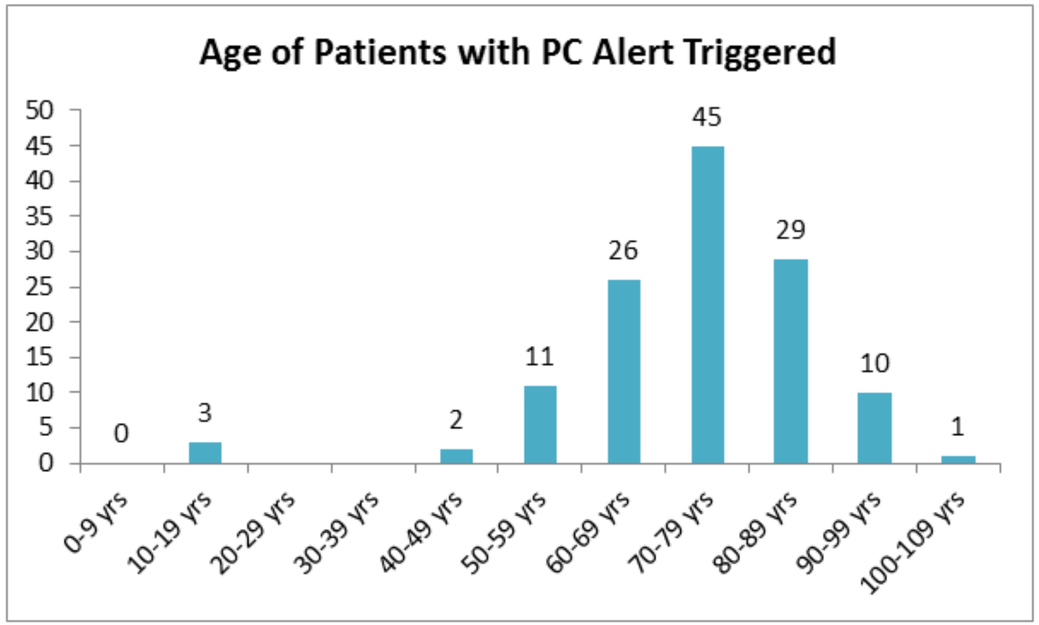
Cycle 1&2 : Outreach Package

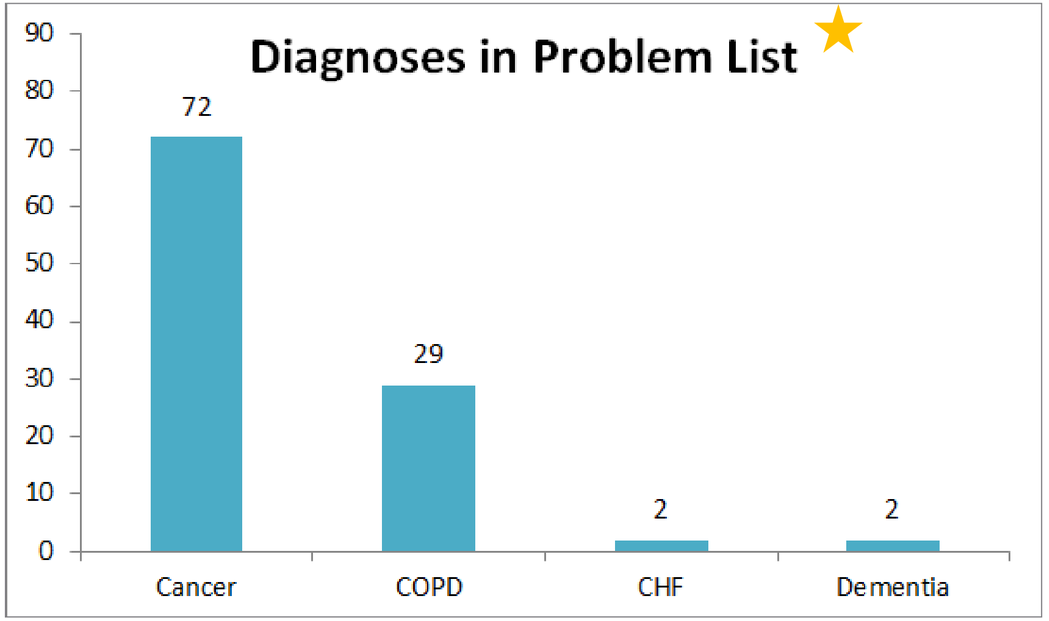
Preliminary Findings PDSA Cycle 3: Testing Toolkit in NP Panel RCHS

- Ran a report of records triggered by Toolbar
- Unexpected: 127 patient records triggered (20% panel)

- **Data validation** in progress
  - Example: 72 of records triggered had cancer in problem list
  - suspect “family history of cancer” triggered toolbar
  - Still looking into specific triggers by patient (new feature of Toolbar)

Patients with PC Alert Triggered NP Panel RCHS





★ We don't know what specifically triggered the alert…yet.

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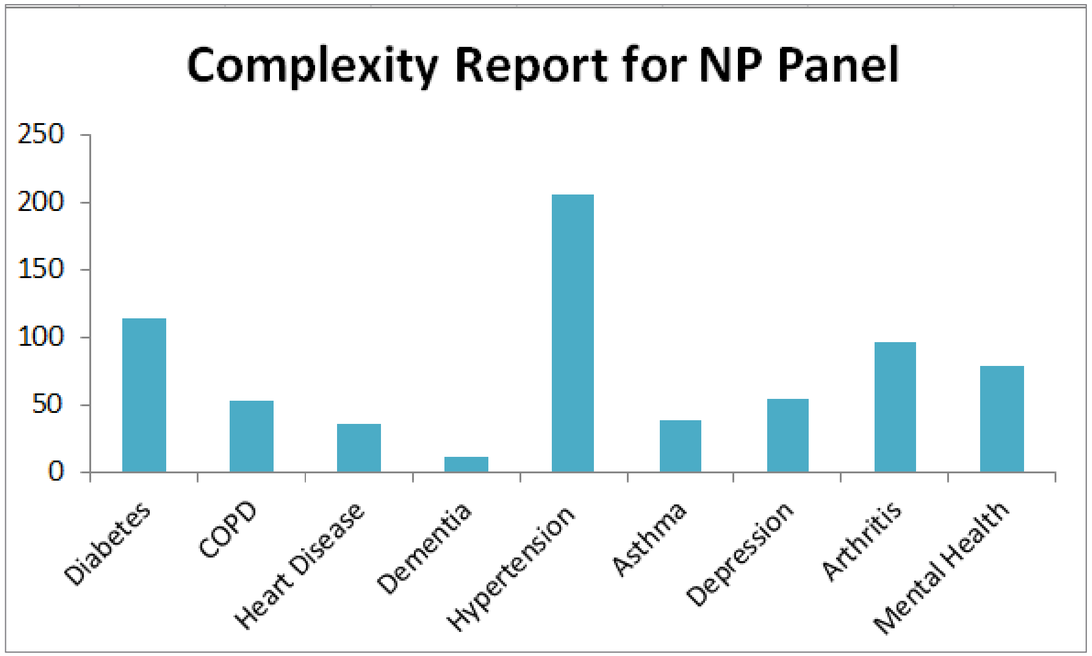
NP Pilot Panel

Panel Size = **650**

Number of Patients ≥ Age 65 = **324 (49%)**



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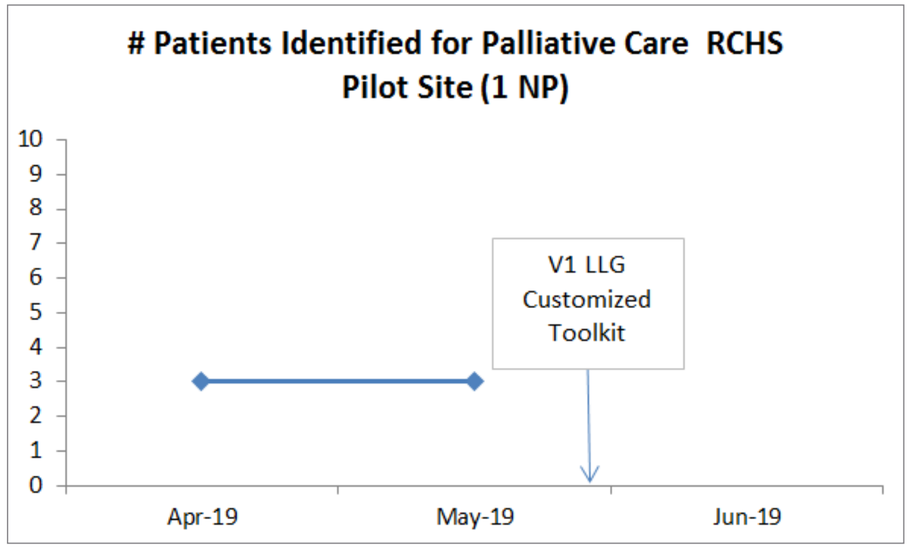
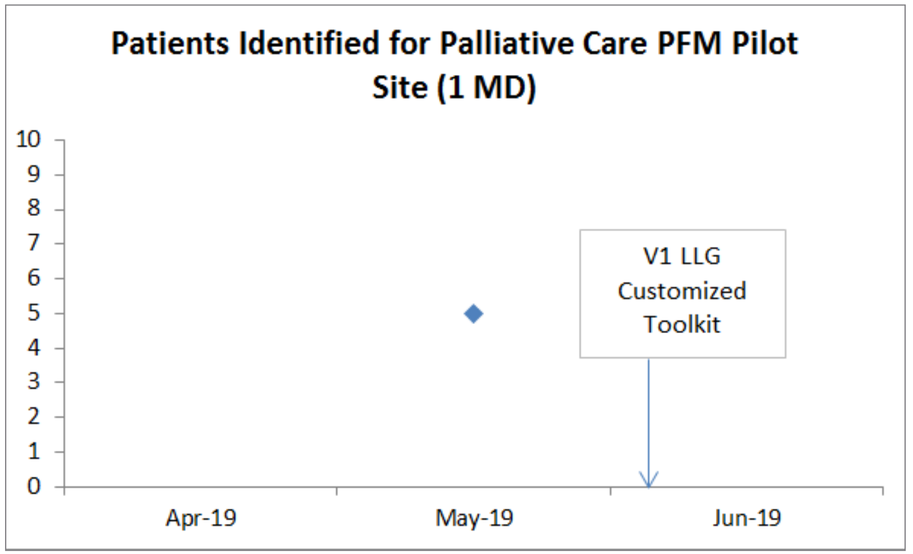
Run Charts





NP is new to RCHS and getting to know panel. Will take longer to work through identification process. Not as familiar with Palliative Care. Signed up for LEAP in June.

Experienced MD. Long time user of PSS. Delays in getting tool loaded. Data pending.

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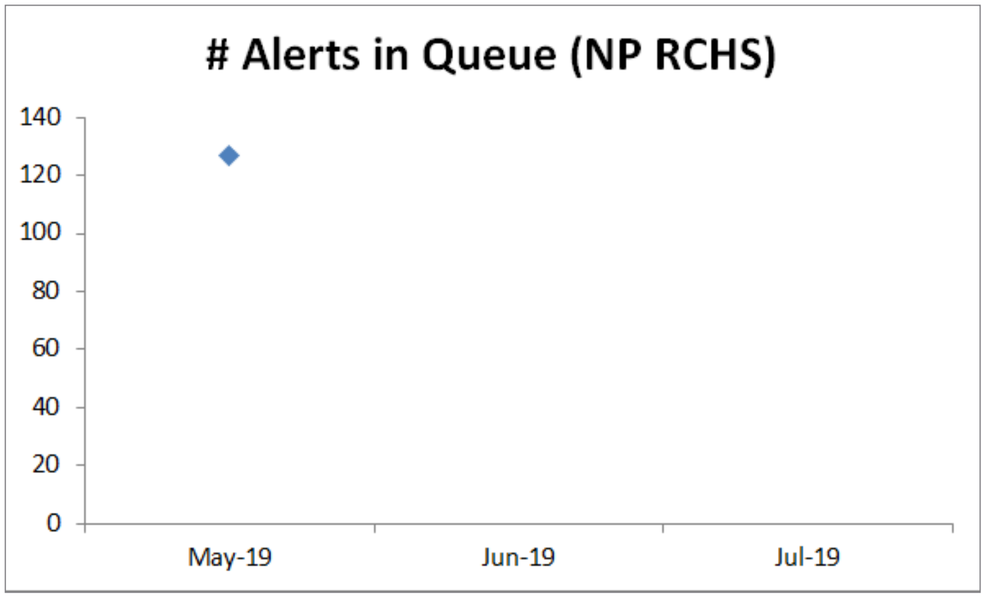
Run Charts


Alerts in Queue (NP RCHS)
140
120
100
80
60
40
20
0
May-19
Jun-19
Jul-19

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.

Lessons Learned

Challenges Encountered

- Loss of physician champion at RCHS site- fortunate to recruit NP champion to team, identification process may be slower, plan to bring on others sooner
- Capacity of Primary Care Sites for participation due to staffing- team members are committed, support of leaders to address barriers
- Data validation, version control

Kudos:

- Practice Solutions Super Users to customize tool
- Great data support at RCHS and support from eHealth CE

THANK YOU
QUESTIONS??