Early Identification for Palliative Care
Lanark Leeds Grenville

Executive Sponsor: Onalee Randell
Team Lead: Ruth Dimopoulos

Project Status: September 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

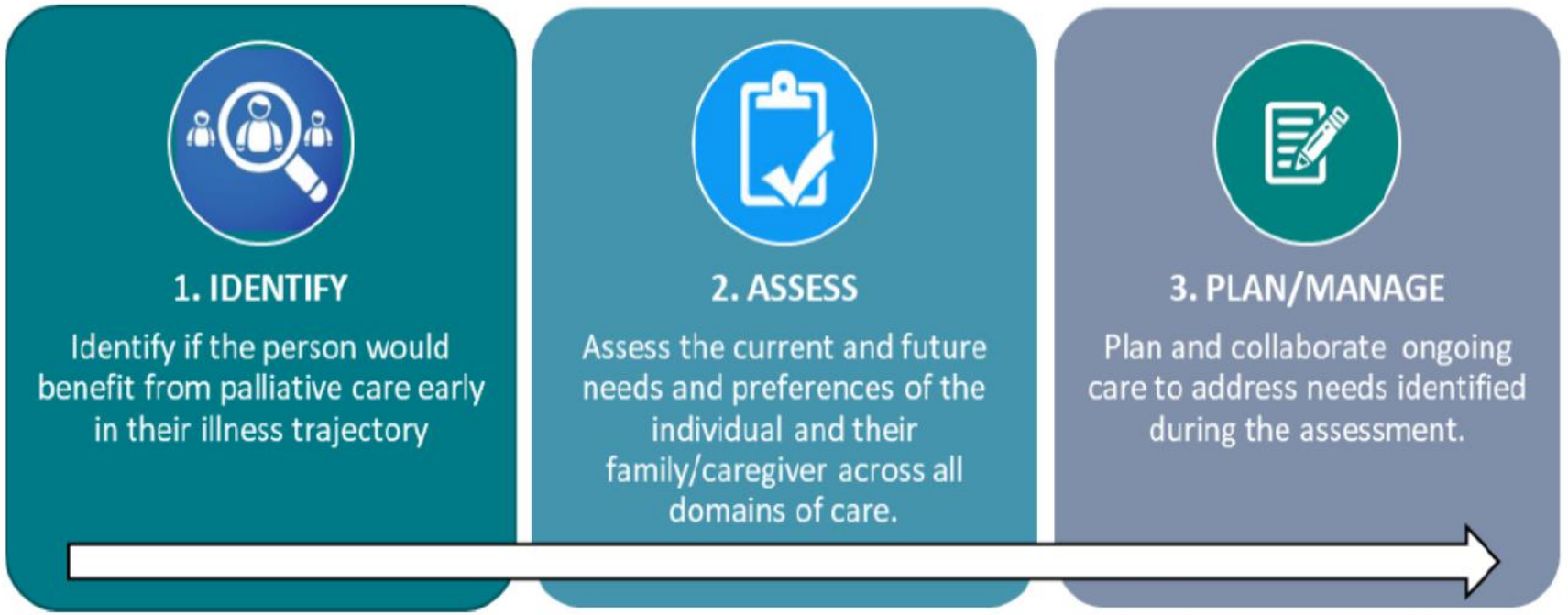
Pilot Site- Perth Family Medical
Dr Stephanie Popiel

Data Support – Sue Calver RCHS

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%) 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 • 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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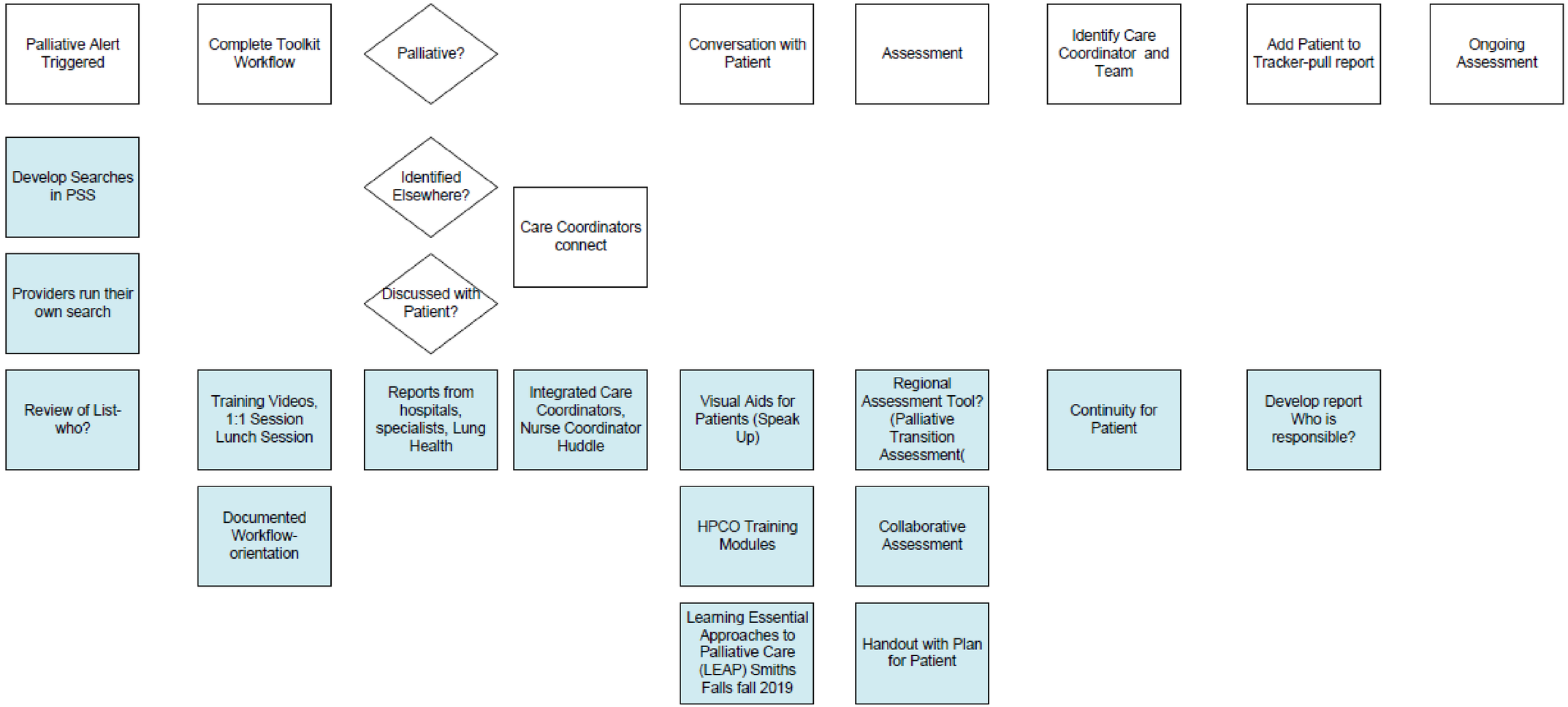
Process: Chart triggered for PC Assessment> Ongoing PC Assessment

May-June 2019



PDSA Updates

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 Cycle 3: Testing Toolkit in NP Panel RCHS

- Difficult as she is getting to know clients- takes more time to go through
- Surprise Question workflow is otherwise okay to navigate
- Resource section is a bit overwhelming- learning about local resources, description of resources could be better
- Some links not working
- More training would be helpful- interactive session

PDSA Cycle 4 - Add more providers: Nurse Coordinator & NP

Feedback:

- Toolbar pops up for most of her patients
- Workflow for identification (Toolbar) is intuitive
- Toolkit resources overwhelming- suggests changing order of resources, grouping, resources and renaming to be more descriptive
- consider “less is more” and add over time
- Nurse Coordinator using tool the most- sharing it with PCP’s during consultations who are showing interest in using it
- NP feedback pending

Palliative Care Toolkit _LLG Customized Version

V2 of LLG Customized toolkit nearing completion

Changes:

- Revised order of toolkit resources, categories added e.g. ACP, Referrals
- Renaming of documents- more descriptive
- Colour coding of SE versus Champlain resources – working on having only SE resources popping up fro SE patients, same for Champlain patients
- CHC version and Non-CHC version required
- Addressing over/under triggering for PC assessment > adding CHC codes (Encode-FM) to triggers for CHC version
- Encounter note specific to CHC for reporting

Toolkit Data Reporting Function

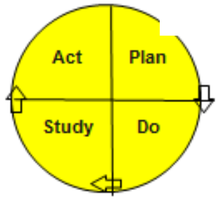
- Generating reports for individual providers – shows triggers for quick review

Reports

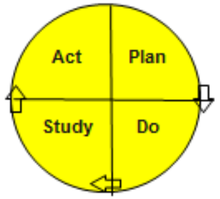
- Lots of data but challenging to find
- Tedious to get data for project measures- assigned support to develop reports
- CHC ‘J-reports’ will be developed for project and spread package

PDSA cycles to date for Palliative Care Toolkit

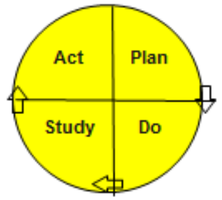
Cycle 5 (Planned) Testing V2 toolkit, add providers



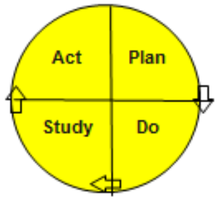
Cycle 4 in progress: Add RCHS Nurse Coordinator and NP



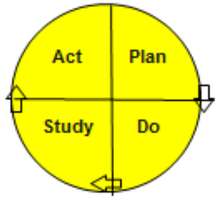
Cycle 3: Small scale testing V1 toolkit, two sites (CHC, FHO) with one provider per site



Cycle 3 Outreach Package CHC

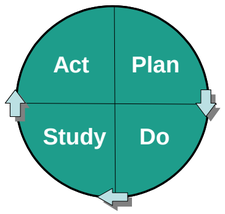


Cycle 2: Customizing Toolkit Draft 1 LLG

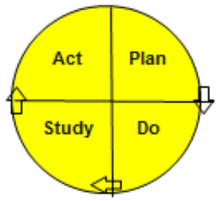


Cycle 2 Outreach Package FHT-2

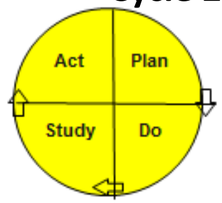
Cycle 2 Training Session



Cycle 1: Customization tool with local forms and links identified



Cycle 1 Outreach Package FHT-1



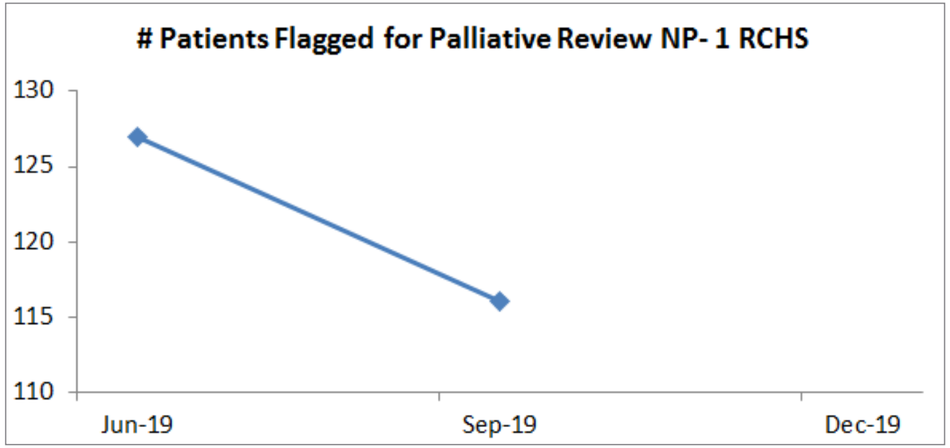
Cycle 1 Training Video

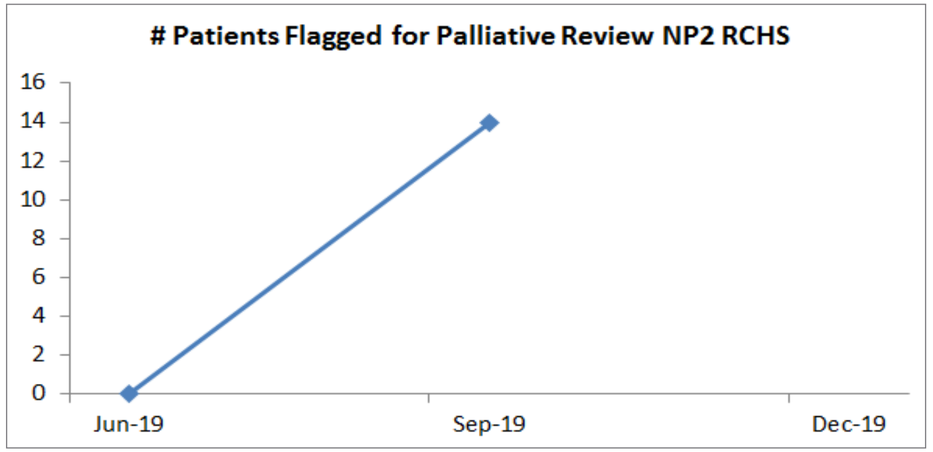
Activities Q2

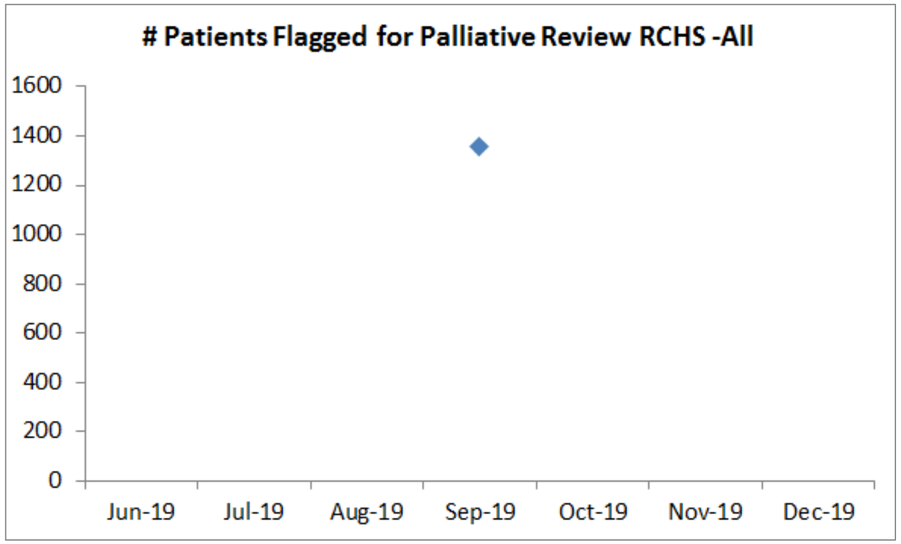
- Connection to Athens Project
- Presentation HQO PC Community of Practice July 9- QI Help Session
- Participation in HCC-Team Lead monthly meetings
- Work on data reporting
- Outreach meetings- primary care (2 CHC’s)

Project Measures

Charts Triggered by Toolbar







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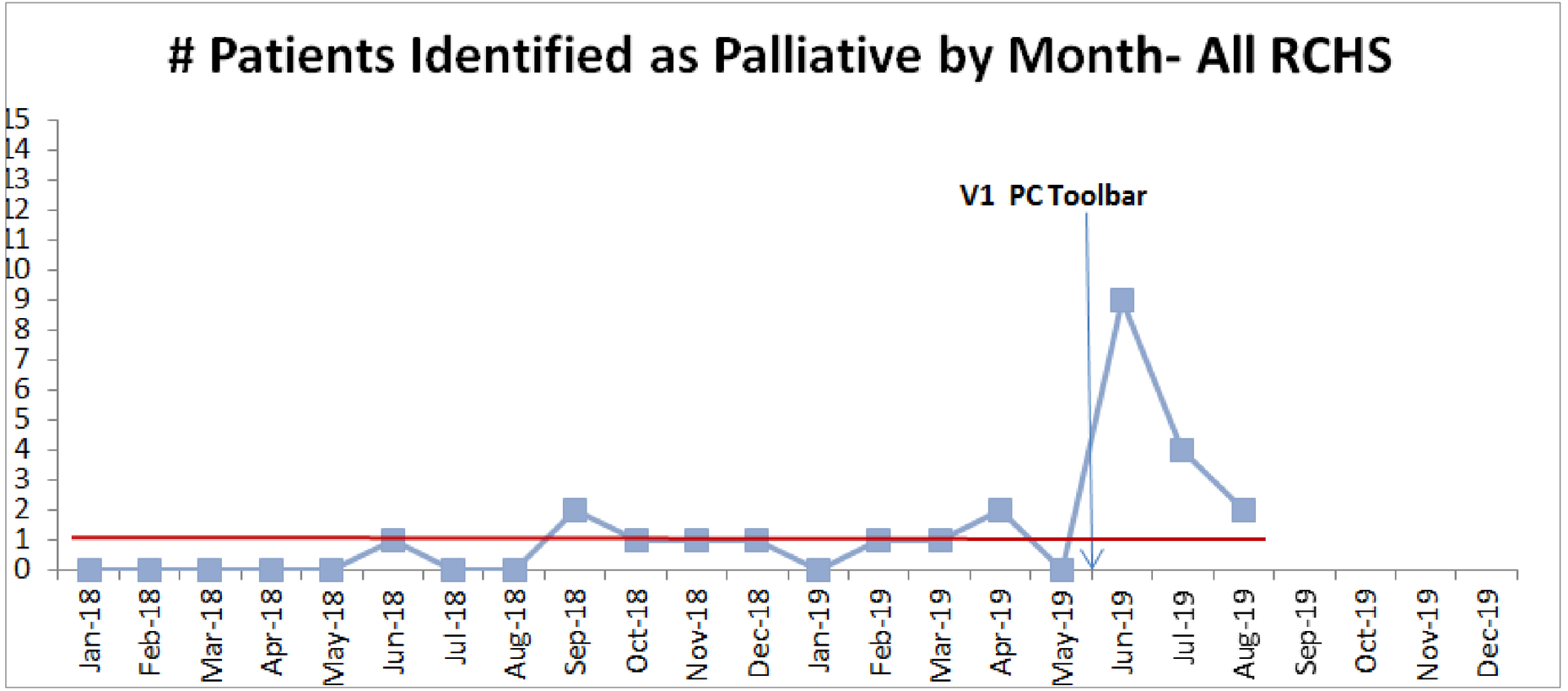

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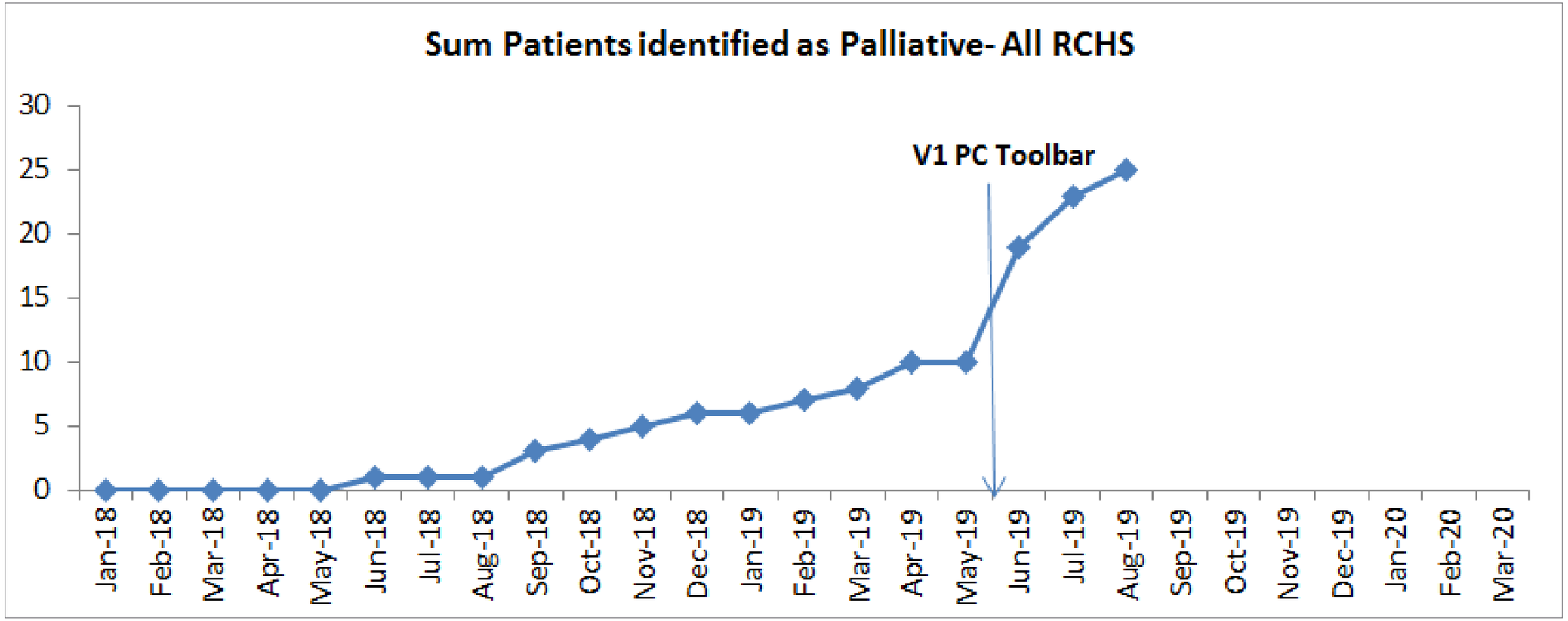

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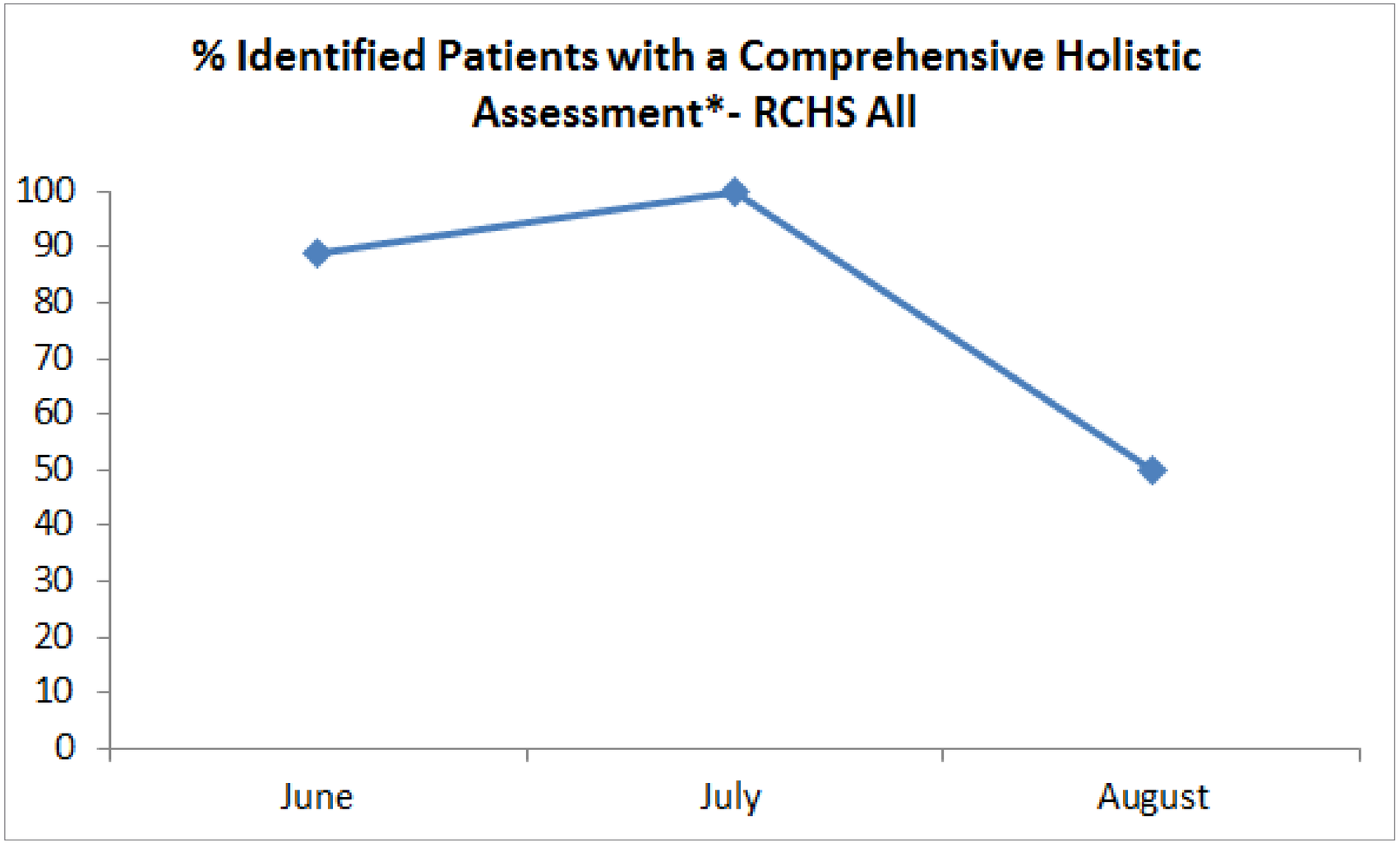

Caution:
Small numbers

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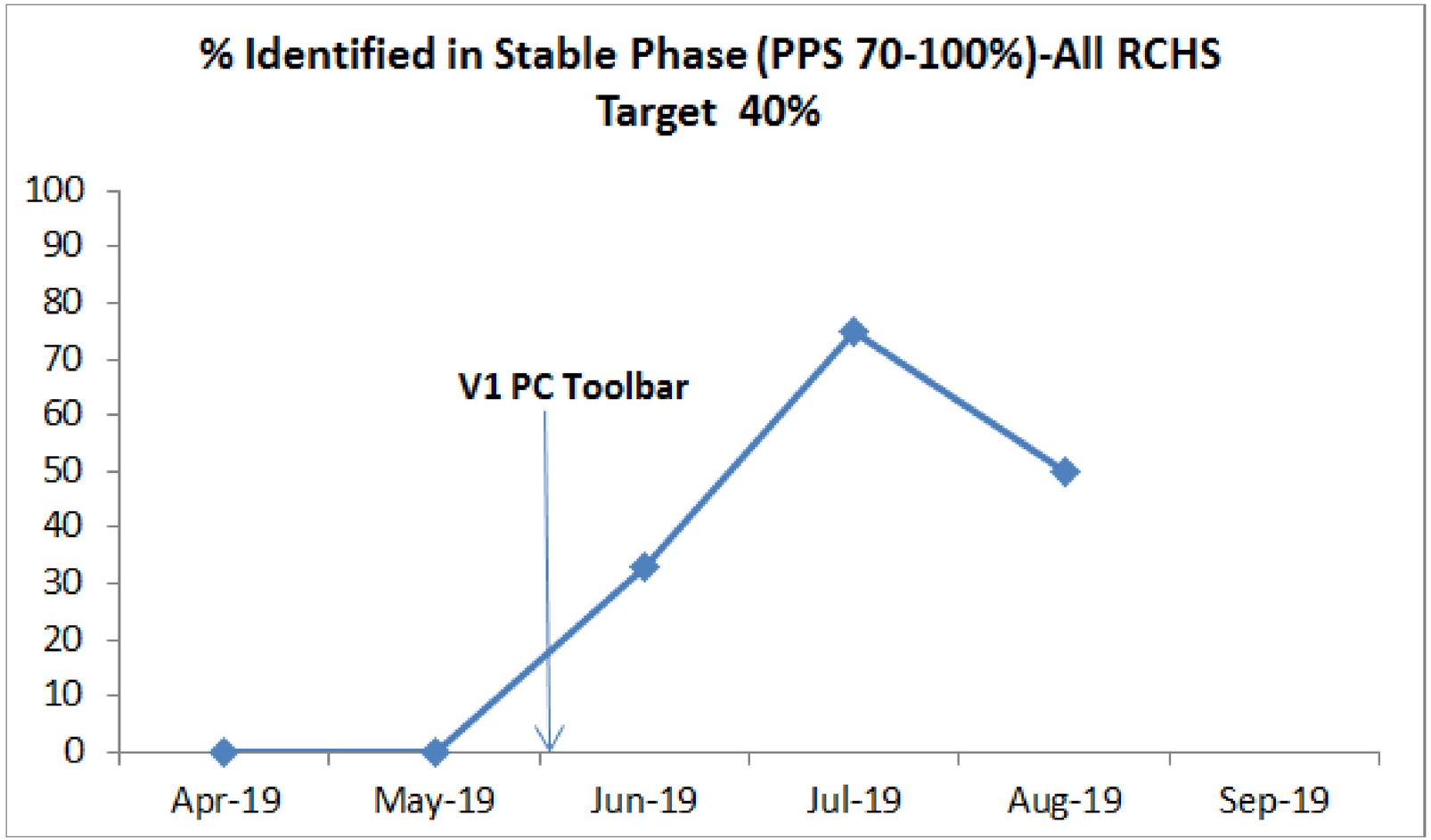

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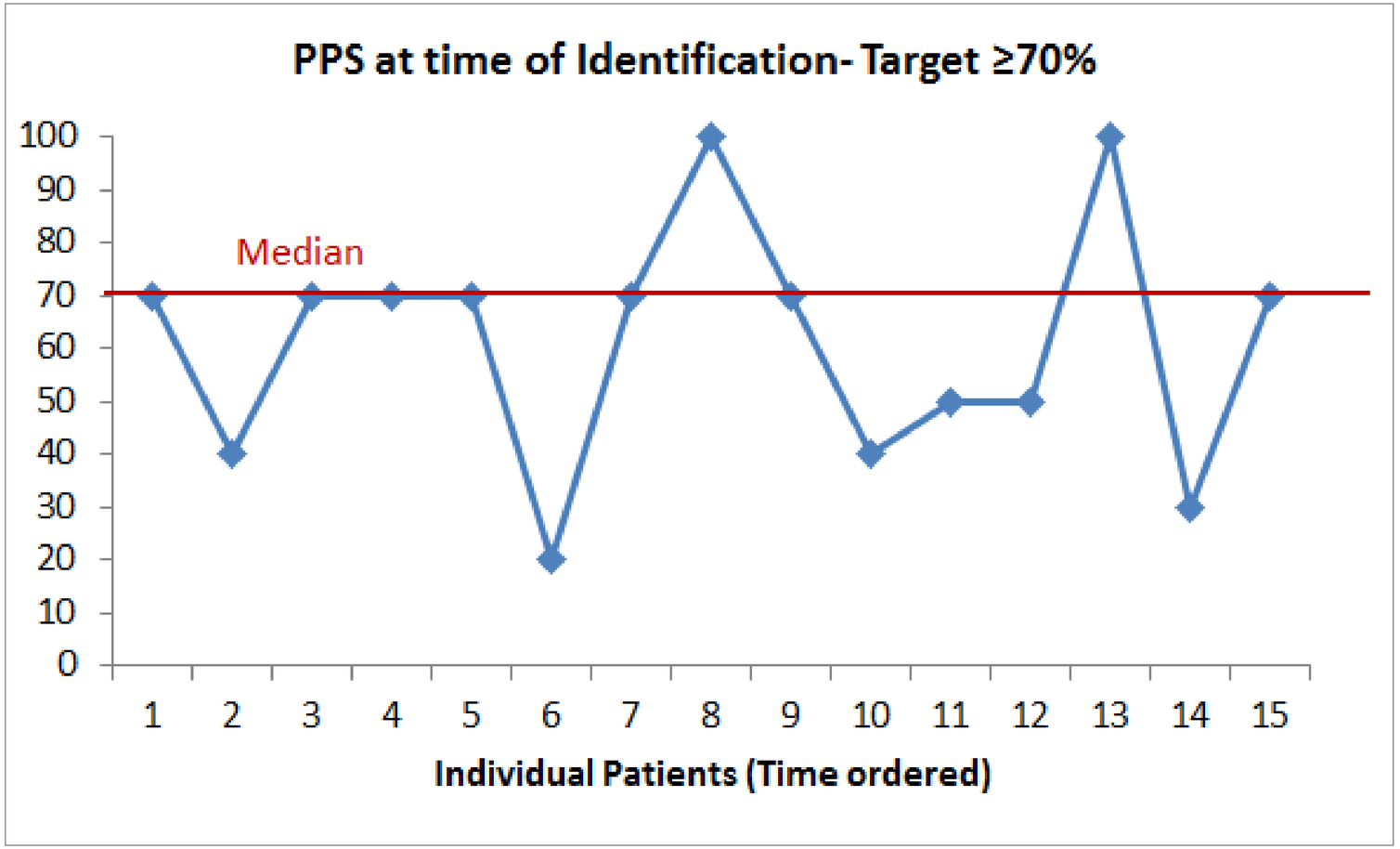
PPS at time of Identification- Target ≥70%
100
90
80
70
60
50
40
30
20
10
0
Median
1
2
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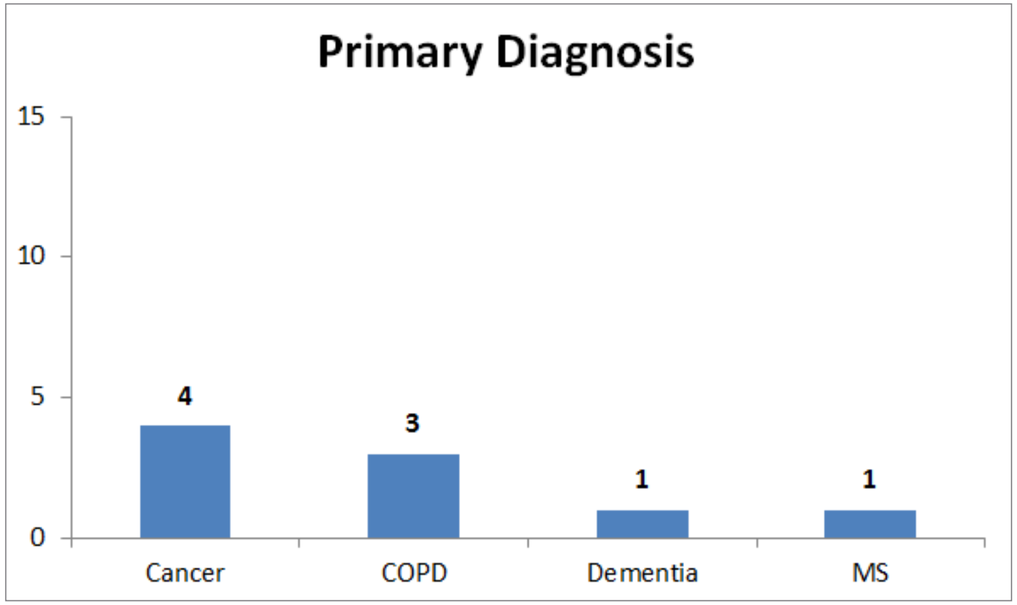
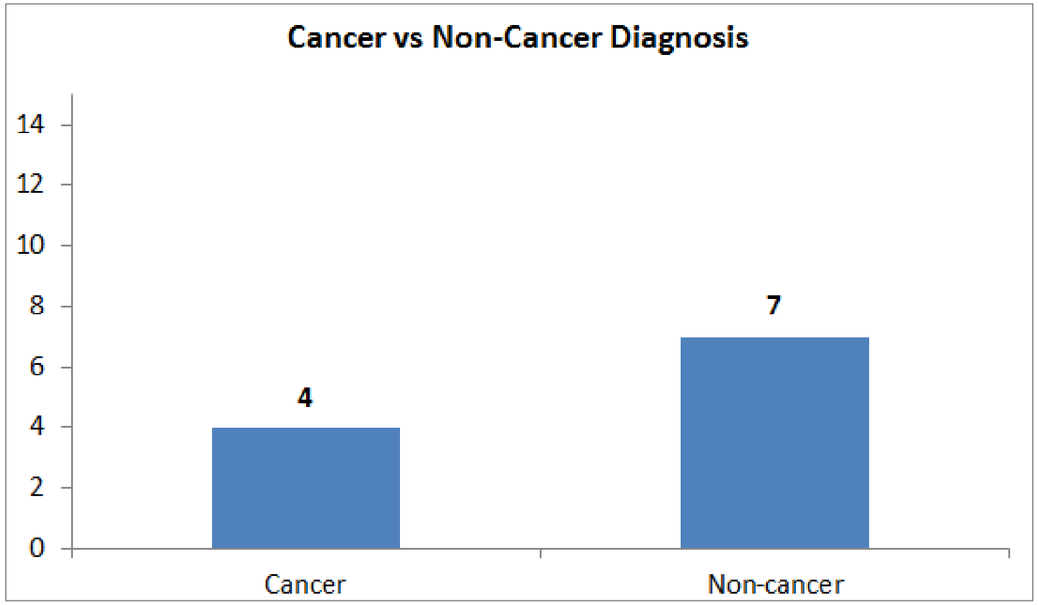
15
Individual Patients (Time ordered)





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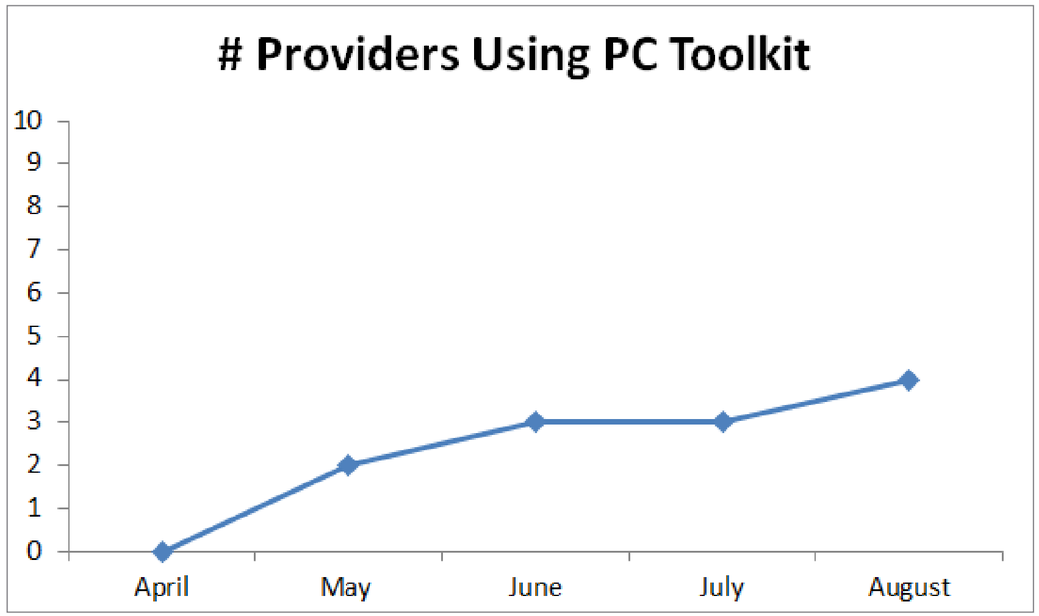
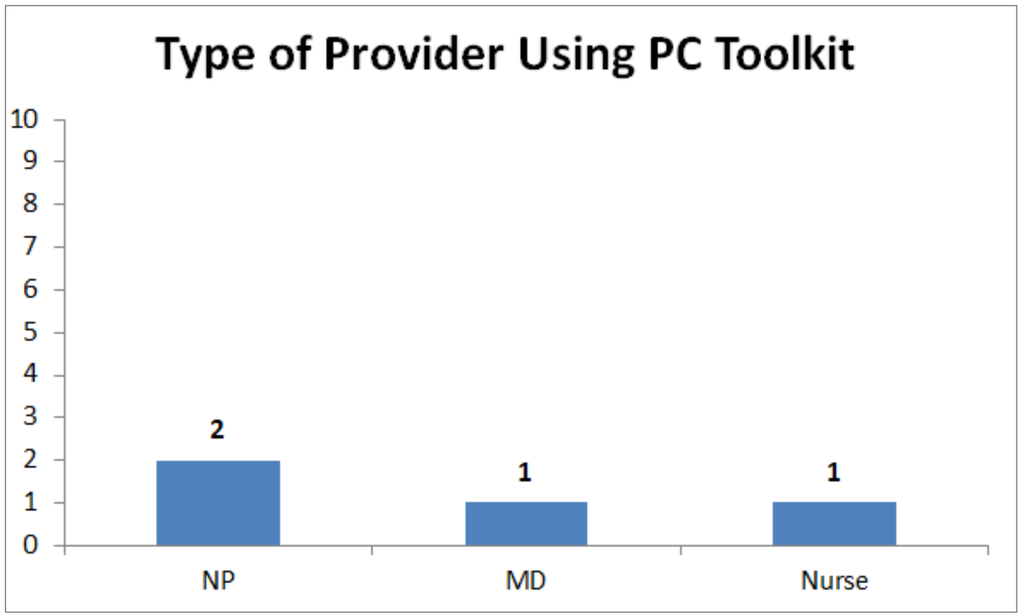

Providers Using PC Toolkit
10
9
8
7
6
5
4
3
2
1
0
April
May
June
July
August


Type of Provider Using PC Toolkit
10
9
8
7
6
5
4
3
2
1
0
2
1
1
NP
MD
Nurse

Plan for Patient-Family Reported Measure

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

- Conversations with patient versus survey
- Keeping process internal - acknowledge potential for bias
- Learning vs research focus

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

- Capacity of Primary Care Sites for participation due to staffing- team members are committed, support of leaders to address barriers
- Developing searches to get data directly from PSS, Data manager will develop ‘j-reports’ using reporting tool
- Multiple PSS systems- need CHC and non-CHC versions of toolkit
- 30% practices not using PSS, no interface with hospital systems YET

Barriers That Might Be Addressed Through Steering Committee Assistance

- Support for standard regional Assessment Tool

Lessons Learned

“Aha’s”

“Excited to finally have data- yay!”
“More referrals coming to PC”

Factors Enabling Project Progress and Pace

- PSS Super Users- updating tool
- Nurse Coordinator championing tool
- Support from RCHS Clinical Manager - balancing project participation with clinic needs,
- Additional data support provided

THANK YOU
QUESTIONS??