Project: Coordination of Care

Region: Lanark Leeds Grenville

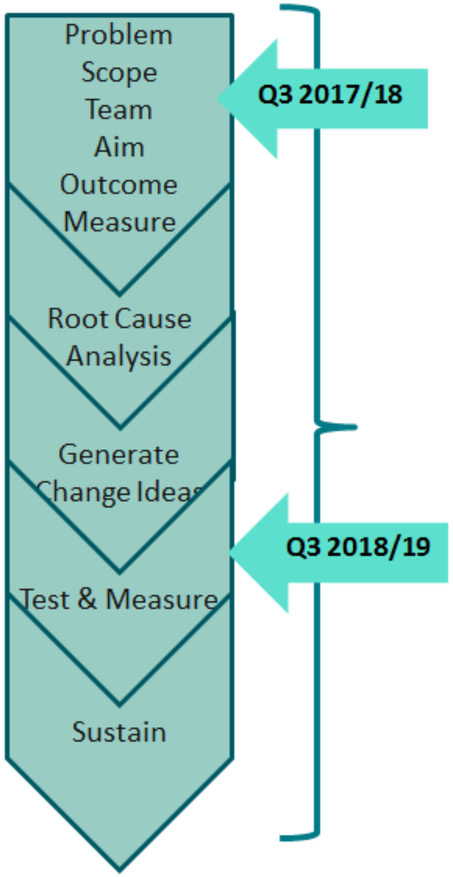
Executive Sponsor: Onalee Randall
Rideau Community Health Services

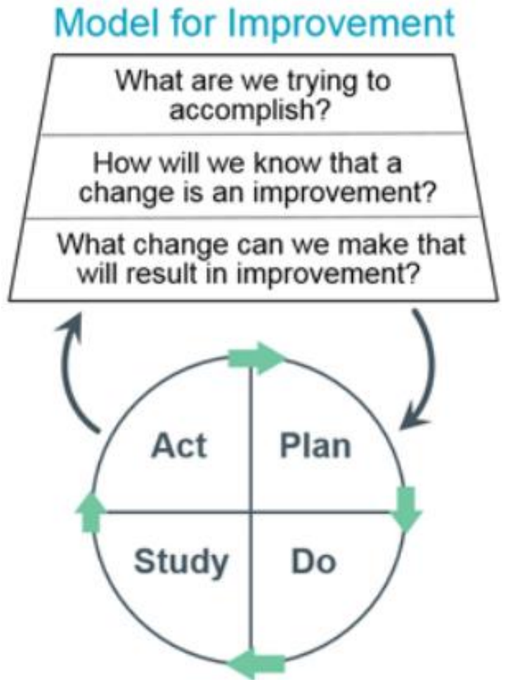
Team Lead: Ruth Dimopoulos

Master deck- Updated Dec 2018

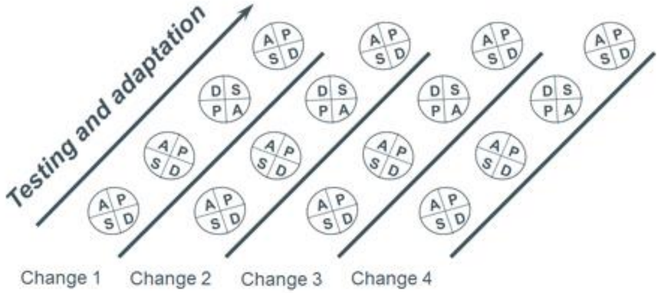
South East Regional
Palliative Care
Network

Quality Improvement Approach to SE RPCN Priority Projects





www.ihi.org



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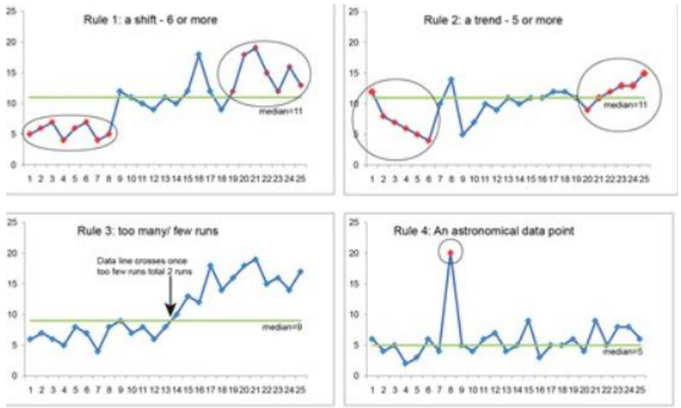

Formation of Team & Development of Charter (October -November 2017)

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, 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.

Project Measures

Outcome

- # patients identified for palliative care approach
- % patients identified with a non-cancer diagnosis
- % caregivers who 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.

Process:

% Patients identified for palliative approach with:

- 2 or more documented conversations related to disease trajectory, values history, ACP, EOL
- SDM identified
- ACP and/or Goals of Care shared with care team

Balancing: HCC PC Care Coordinator Caseload

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Alignment with Provincial Priorities

HQO Quality Standard

Statement #1 Identification and Assessment

Statement #4 Discussions and Goals of Care

Annual Quality Priority 2019-20 Quality Improvement Plans

Early identification: Documented assessment of needs for palliative care patients

Health Services Delivery Framework Priority Indicator

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

Core Team at Project Launch November 2017

Project Team

Executive Sponsors: Rideau Community Health Services (RCHS)
Peter McKenna Executive Director - until Oct 2018
Onalee Randall Director of Community Services

Team Lead & QI Coach: Ruth Dimopoulos

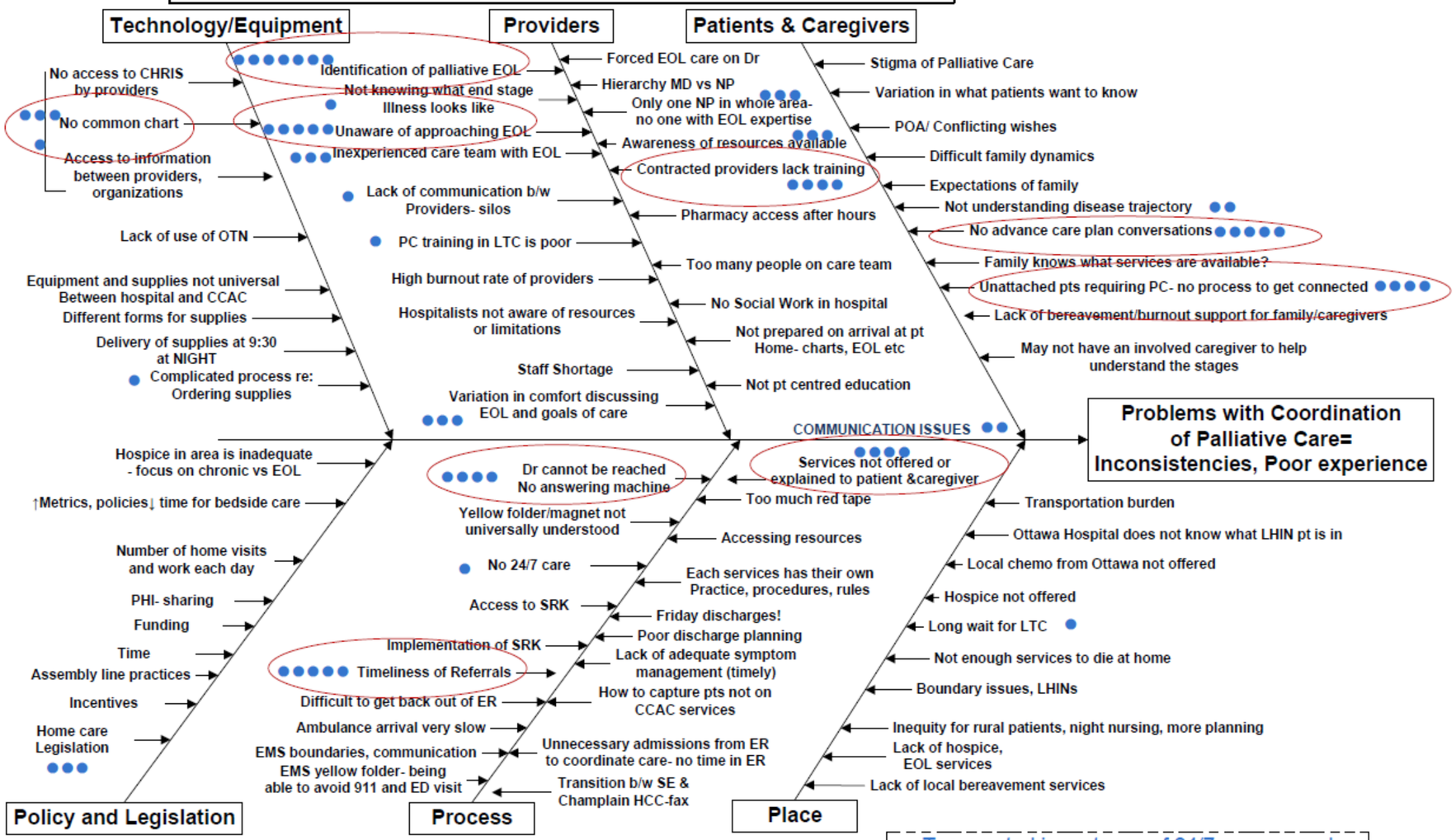
Team Members:
Anne Janssen, Caregiver
Sarah Kearney- Nolet, Care Coordinator PC, H&CC
Dzvena Krivoglavyi, NP LTC, HCC
Maureen McIntyre, Rideau Tay Health Link
Travis Wing, Manager BGH Palliative Care
Nicole Gibson, Palliative Care Consult Nurse BGH
Kelly Barry Clinical Manager RCHS

RCHS Pilot Site
Dr Kevin Mooney, Primary Care Physician
Amber Gilmour and Jane Doyle, Nurses
Louise Besserer Medical Secretary

Consulting team members as needed to support project work.

Diagnostics- Root Cause Analysis (November 2017- February 2018)

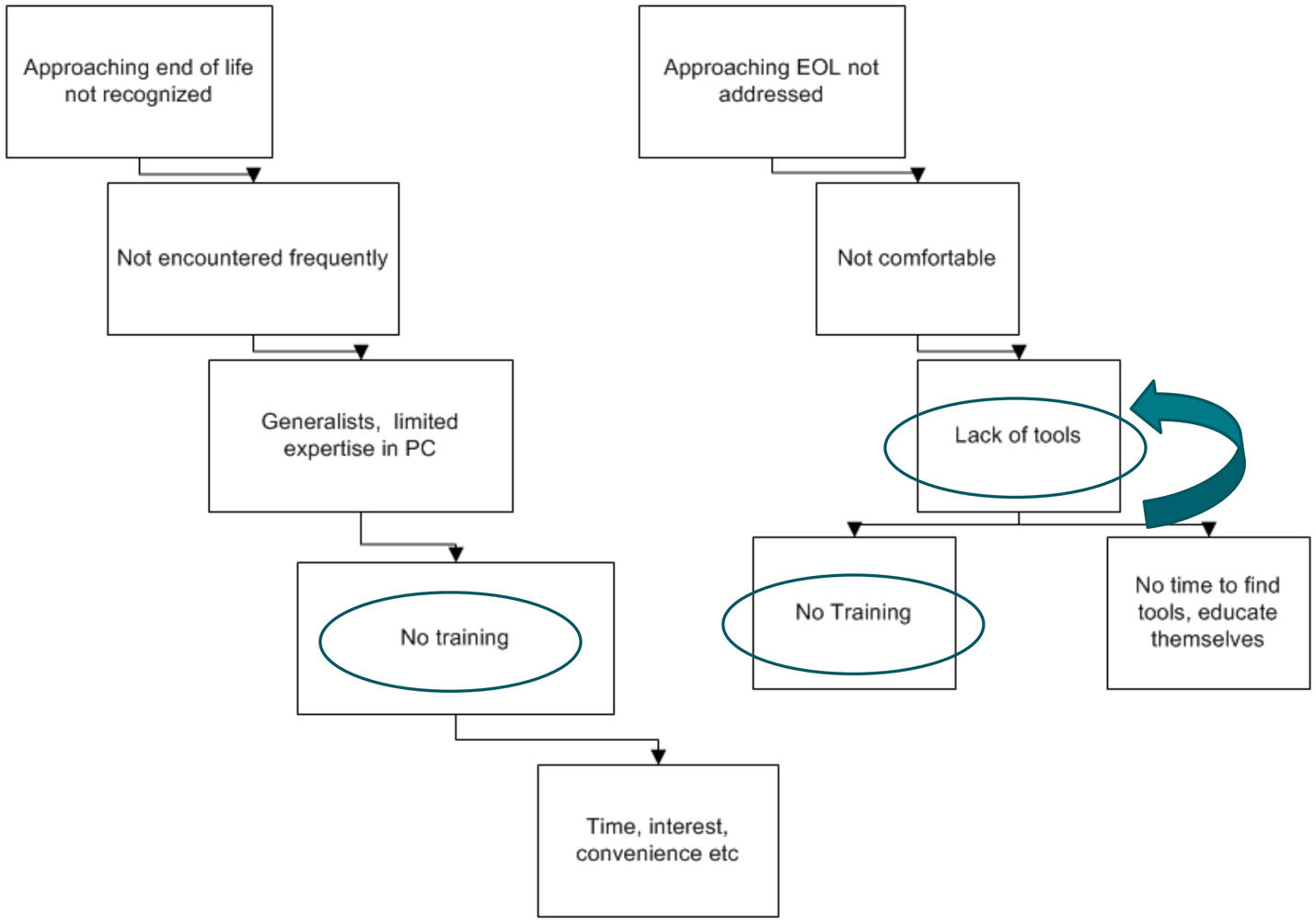
Coordination of Palliative Care Fishbone Nov 30, 2017



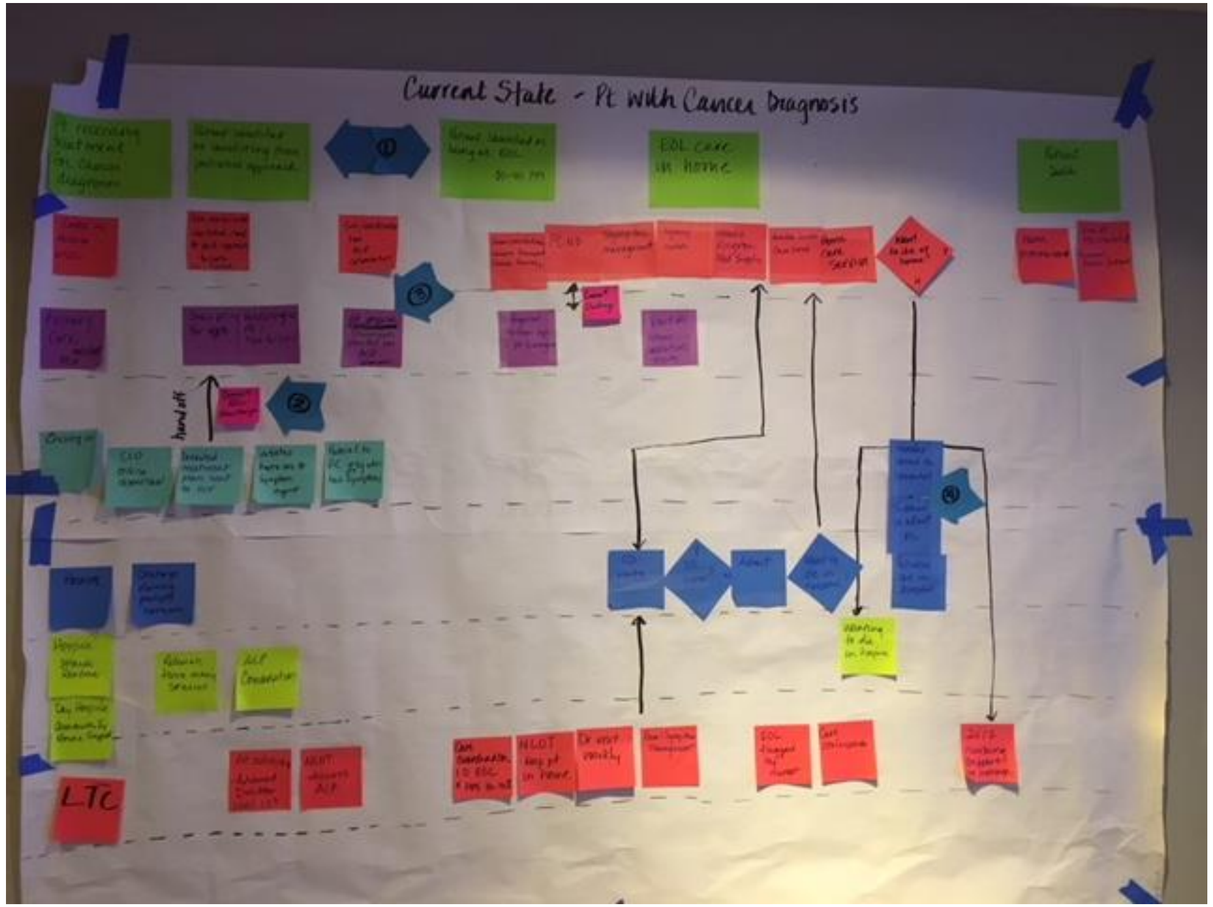
Team noted importance of 24/7 access, and palliative care training/competency, but did not focus where other projects are working.

Root Cause Tools: 5 why's completed for 6 prioritized causes

Example:



What can we impact within our scope?
What can we share with other projects?



Joint Mapping Session with Rideau Tay Health Link Hospice Palliative Care Working Group

Patient palliative journey with cancer diagnosis - journey looking at transitions

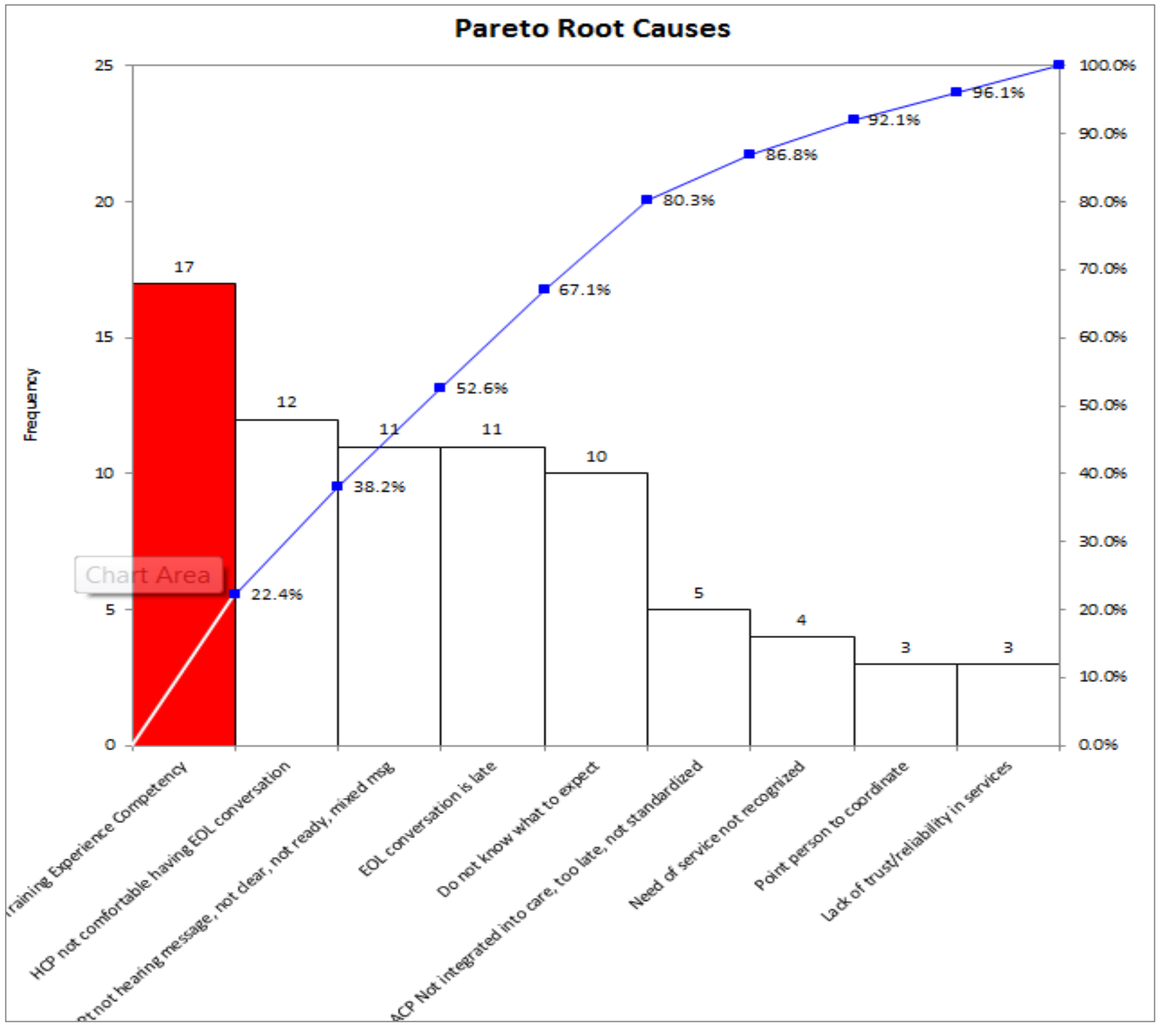
Experience Based Design- Interviews

Interviews conducted across LLG

9 Caregivers (2 others declined)

9 Health Care Providers (3 also shared their caregiver experience) representing:
Primary care, LTC, Hospital, Nursing Agency, Health Links

Root Causes Identified in Diagnostics: Pareto



Results:

Training/ Experience/ Competency issues
PCPs not comfortable with EOL conversations
Pts don't hear, not engaged/ready, mixed mgs
ACP/ EOL conversations late, not integrated
Pts Caregivers do not know what to expect & available options

Root Cause: Providers not comfortable raising palliative care and end of life discussion, messages may not be clear or consistent, occur early or often enough

"Meetings with our doctor here would be light and he would try to offer us hope. He's a lovely man, but we are talking about her death. We're talking about death here, death and dying. Let's talk about death and dying". Caregiver

"The doctors they talk to you and you are verbatim writing the words down and you look at them and what they really mean is "She is full of Cancer"! But they say "compromised" or I don't know, they use, some phrase…well put together phrase, words and you don't quite grasp it until you read it again. So they are spewing these words out and you think this is what they are saying to you and it isn't until you get home or you just have a minute and you realise-she is dying!" Caregiver

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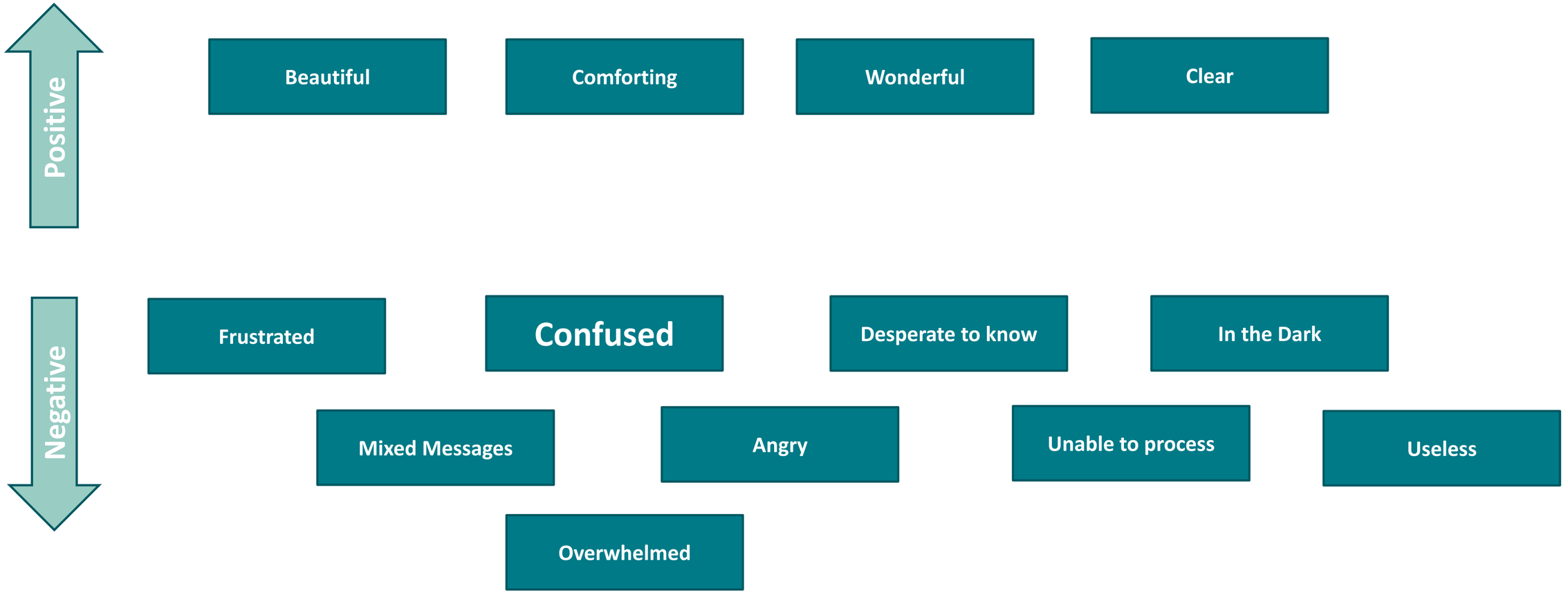
Root Cause: Some patients and caregivers not ready, don't hear or don't understand the conversation

"I received a note from the oncologist about him having a frank conversation with patient about long term outcomes. I get great notes from this guy- he's terrific. But when I met with patient, it was clear he did not "hear" the prognosis and was still full of hope despite his obvious decline in physical and functional status. Its difficult to have the needed conversations with patients when they still have hope". Physician

Some Words used by Caregivers to Describe Conversations with Physicians About End of Life



Root Cause: ACP not integrated into care, often happening too late and in crisis. Planning for end of life is not part of our culture, there is fear of death, & people are not aware of importance of ACP.

He was gone- it was fast. I called 911 out of panic, we had been discussing that week about a DNR, my dad had already told me that he had a DNR put into place and the paperwork was supposed to come from the hospital via the RN into the home that week…when the firemen showed up because there wasn't a DNR in place they insisted on resuscitating him….

Caregiver

Patients and caregivers do not know what to expect

It would help to have someone sitting down and giving you a clear outline of what to expect next or even just to have some kind of literature would have been nice, that's broken down for a family to know what happens when and how it works. A lot of it was kind of a guessing game. It could have been less nerve-wracking, things could have been laid out a bit better so that I would have had clearer expectations about what would come next. You're already worried about losing somebody and worried about how to look after them, how you're going to adapt your life to doing all this and on top of that you don't know what to expect. Caregiver

Family and patients don't know what to expect in end of life. There are times family send family to ED because of burn out or because they panic over end of life symptoms. Education, prep and services are needed. Community Nurse

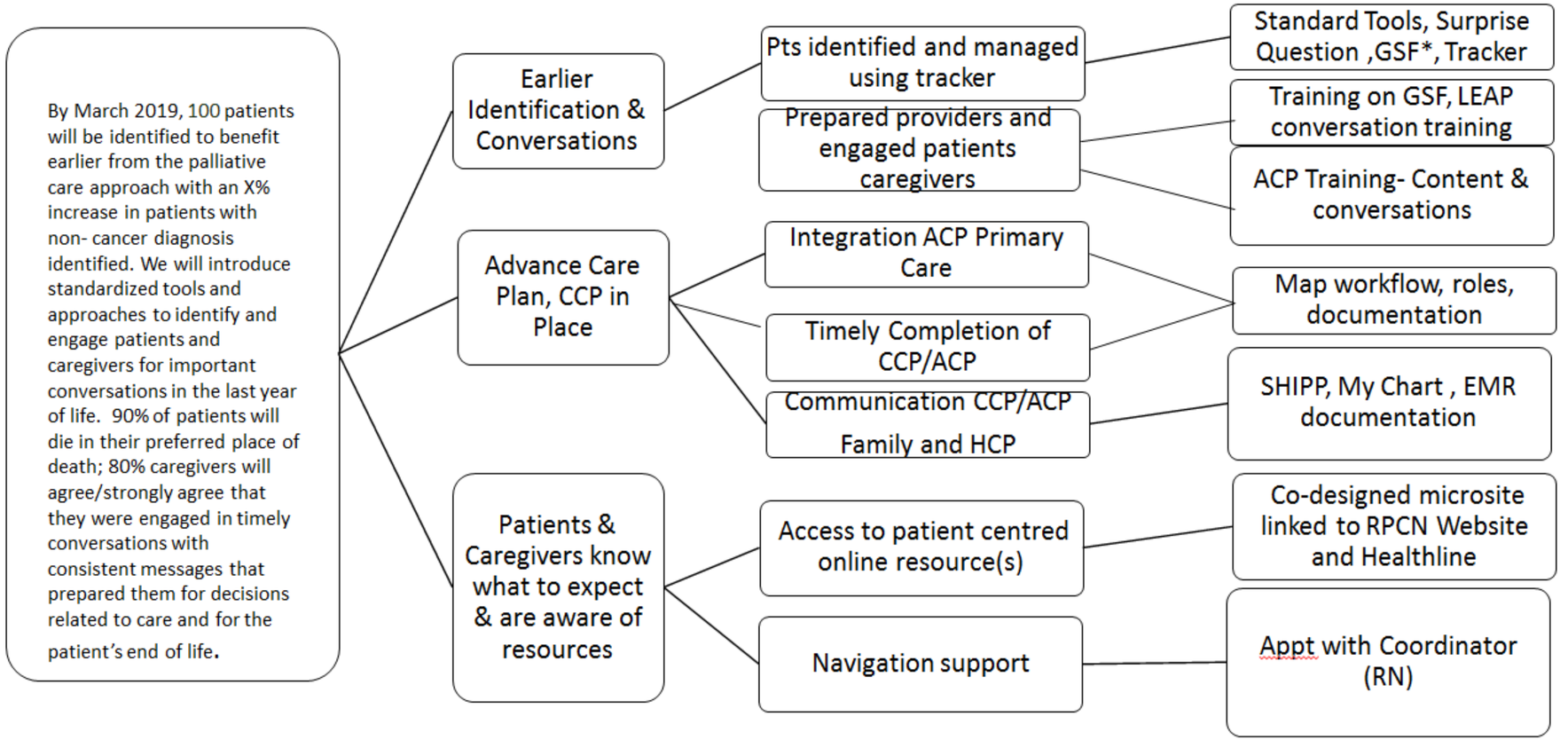
Training and experience of health care providers in Palliative Care

When we met with palliative care doctor in Ottawa, he'd sit down and just look at my sister for a minute & say "you've been through a lot recently haven't you, this must be very difficult for you" It was just 360 degrees different … It was beautiful how they did it. My sister was able to be stronger and she would talk. Even the emerg doctor understood palliative care and their approach was different. Caregiver

Development of Change Ideas (February- March 2018)

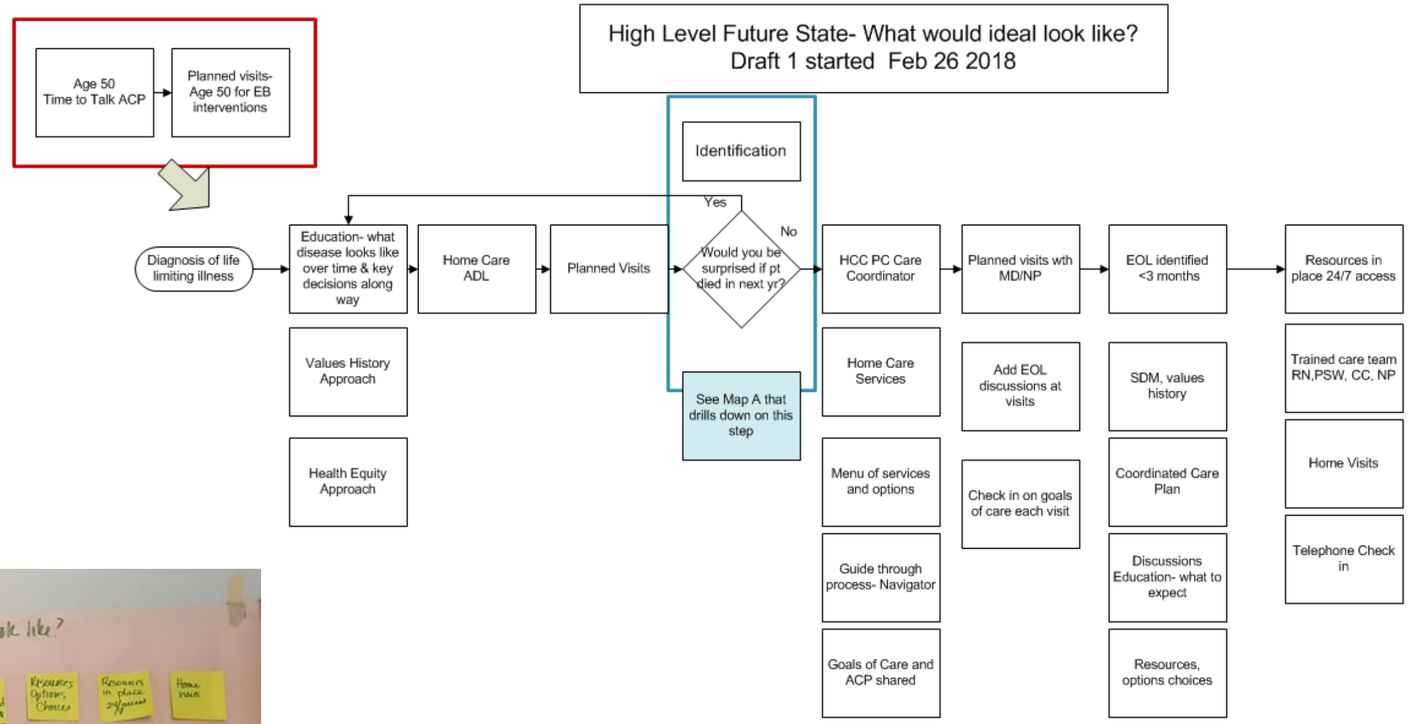
Generation of Change Ideas: Development of Driver Diagram

Generation of Change Ideas: Driver Diagram

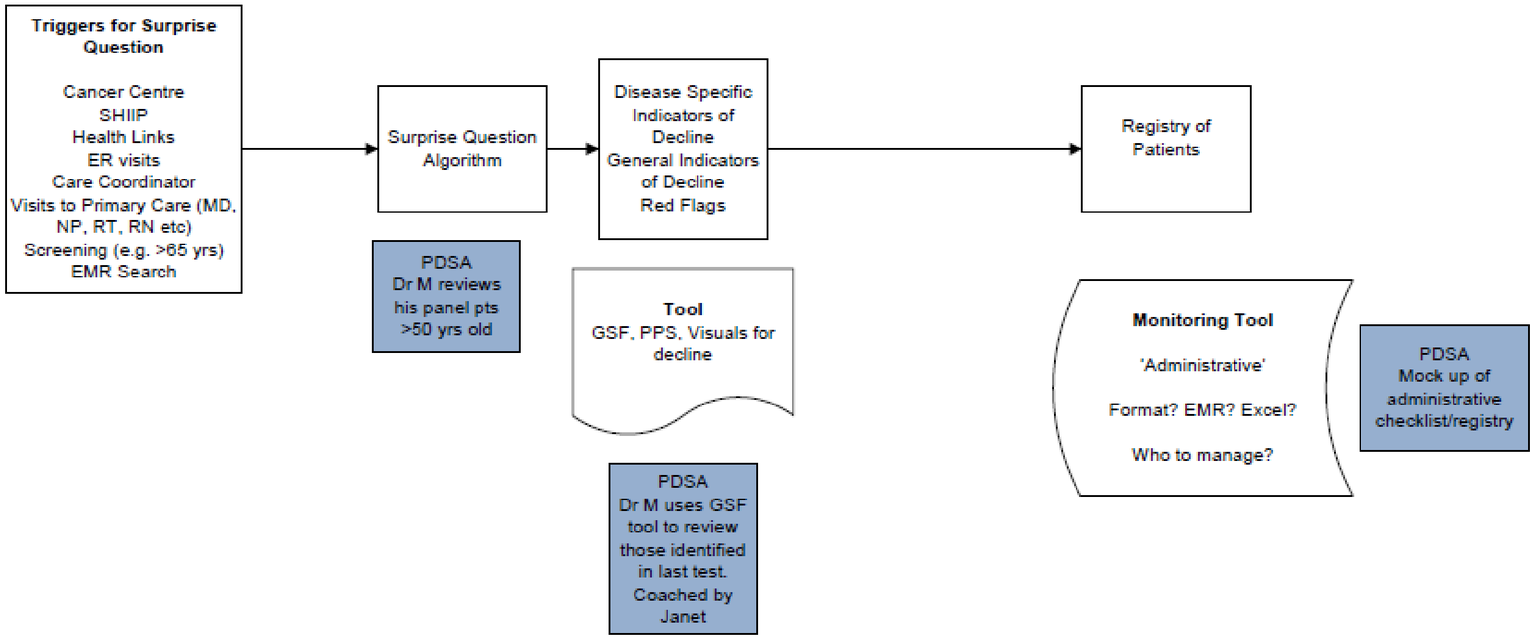


*GSF- Gold Standard Framework

Developing Change Ideas- Future State in Primary Care

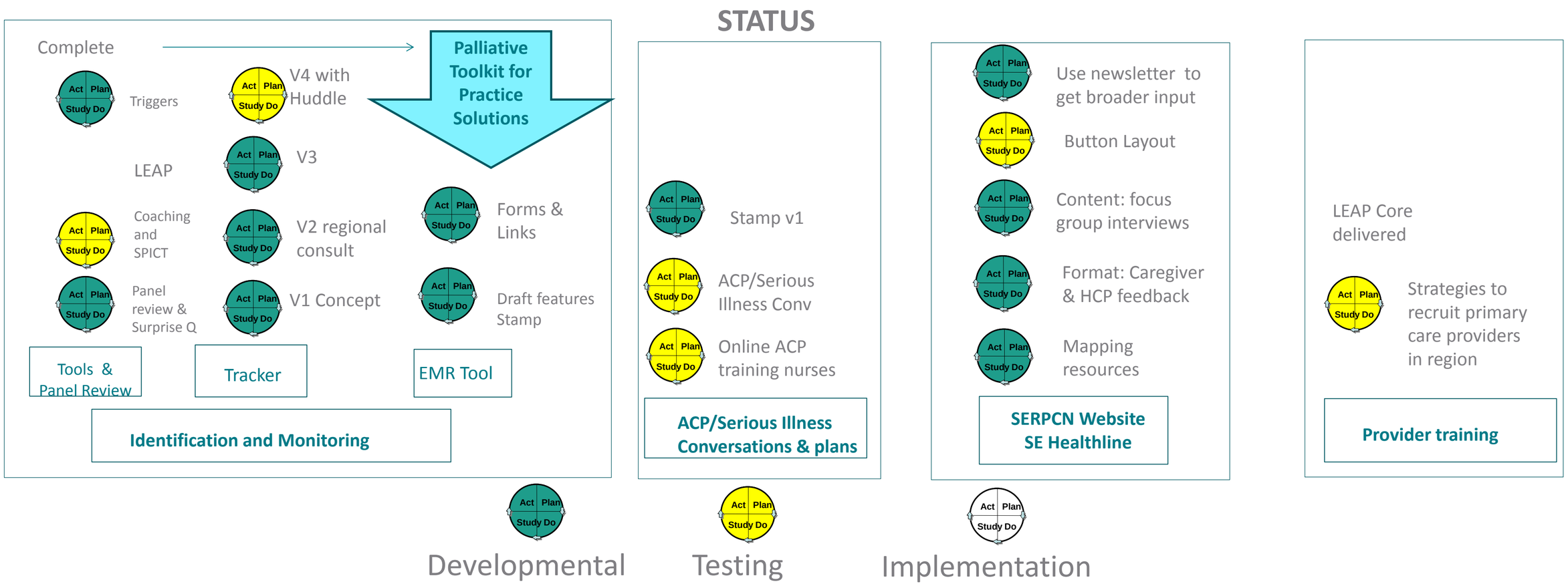


Map A: Identification for Palliative Approach and Monitoring in Primary Care (apr 23, 2018)



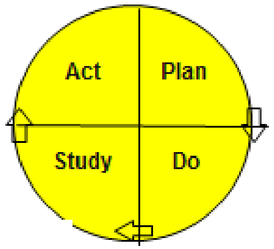
Testing Changes (March 2018 >)

PDSA Status: Small tests of change and a big one on the horizon

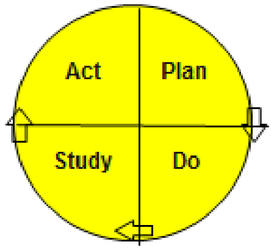


	Develop	Test	Implement	Total # Cycles
Summary	12	6		18

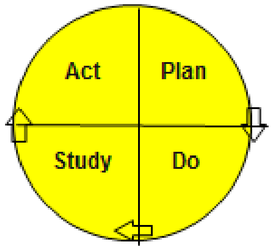
PDSA cycles for Identification of Patients



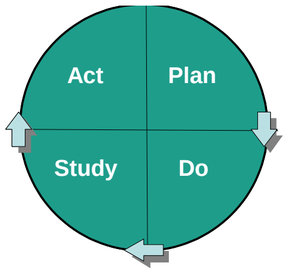
Second review of panel
3 months later.



Coaching conversation with
PC Nurse- LEAP Certified



Review_GSF tools, Pallium video
and second review of panel



First review of panel with Surprise Q:
Identify pts who could potentially benefit from PC approach, identify diagnoses in addition to cancer, questions raised for MD when reviewing

Testing complete for review of panel by physician with GSF training. Not implemented- not sustainable. EMR tool with triggers will be tested next.

Testing

Developmental

We found a tool- Finally!

Palliative EMR Toolbar (Telus PS Suite)

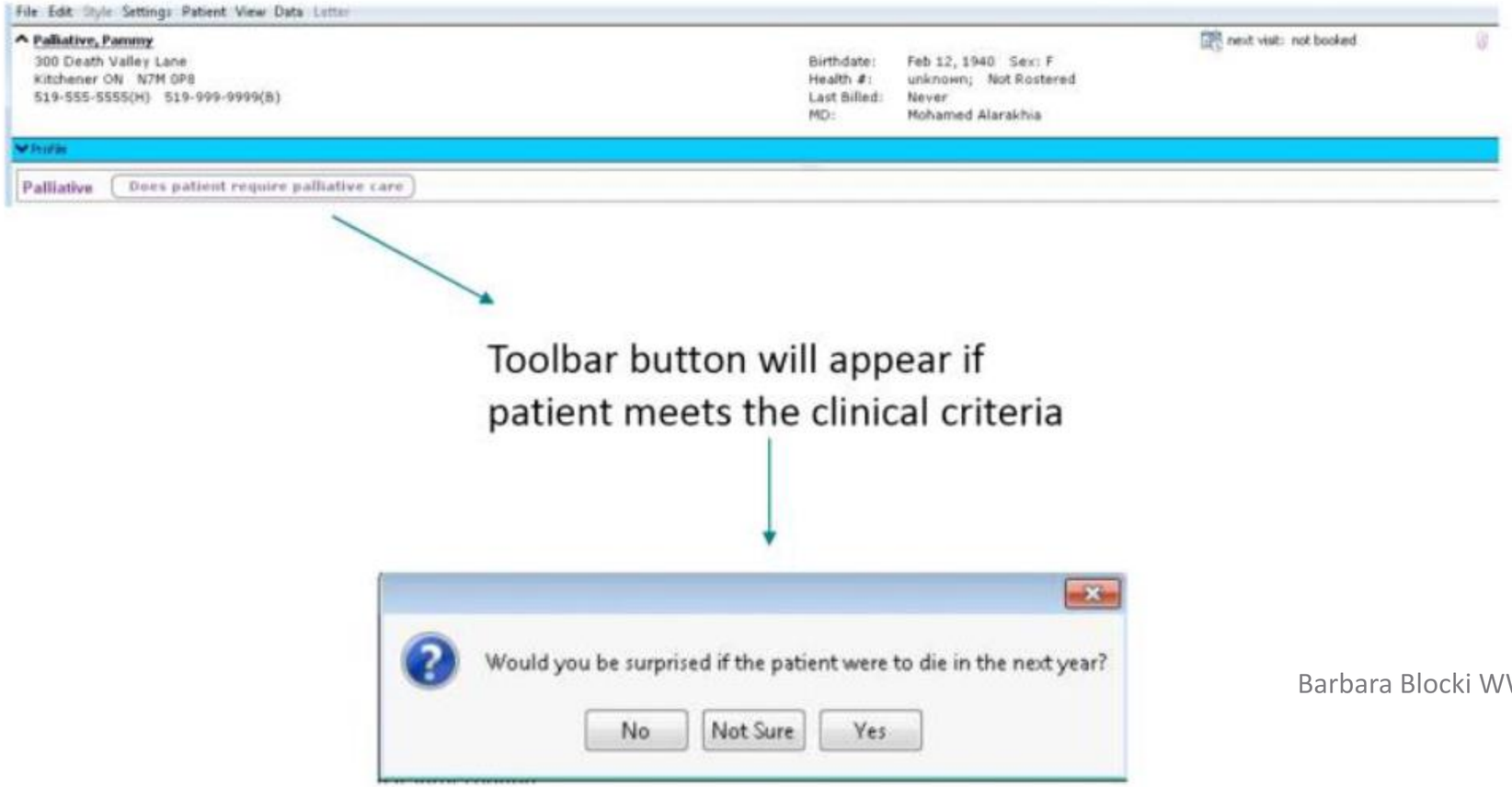
e-Health Centre of Excellence www.ehealthce.ca- Waterloo Wellington LHIN

- *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.*

Barbara Blocki WW Presentation to OPCN Nov 2018

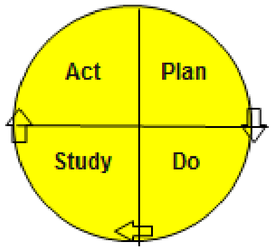
*Special thanks to Justin Wolting and Alan Vong Application Development Specialists for their assistance.

WW Palliative EMR Toolbar

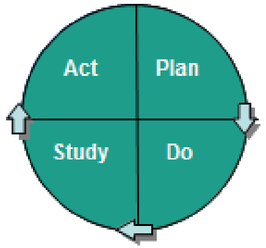


Barbara Blocki WW Presentation to OPCN Nov 2018

PDSA cycles for identification- EMR Tool Telus Practice Solutions Suite

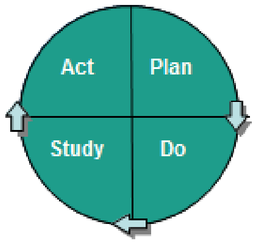


PLANNED- Test Palliative Toolbar with 1-2 providers to collect feedback. Scale up to multiple providers

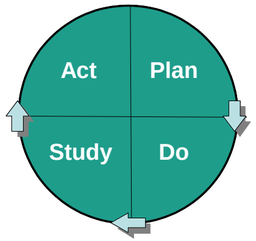


Planned- development of workflow for testing

Testing



Underway -Customization of Palliative Care Toolbar- identification of links and handouts from SE and Champlain Regions



Review of existing tools and creation of content list.

Developmental

How will the Palliative Toolkit improve the experience for patients and caregivers?

The toolkit provides prompts, conversation guides, resource links and other tools to facilitate :

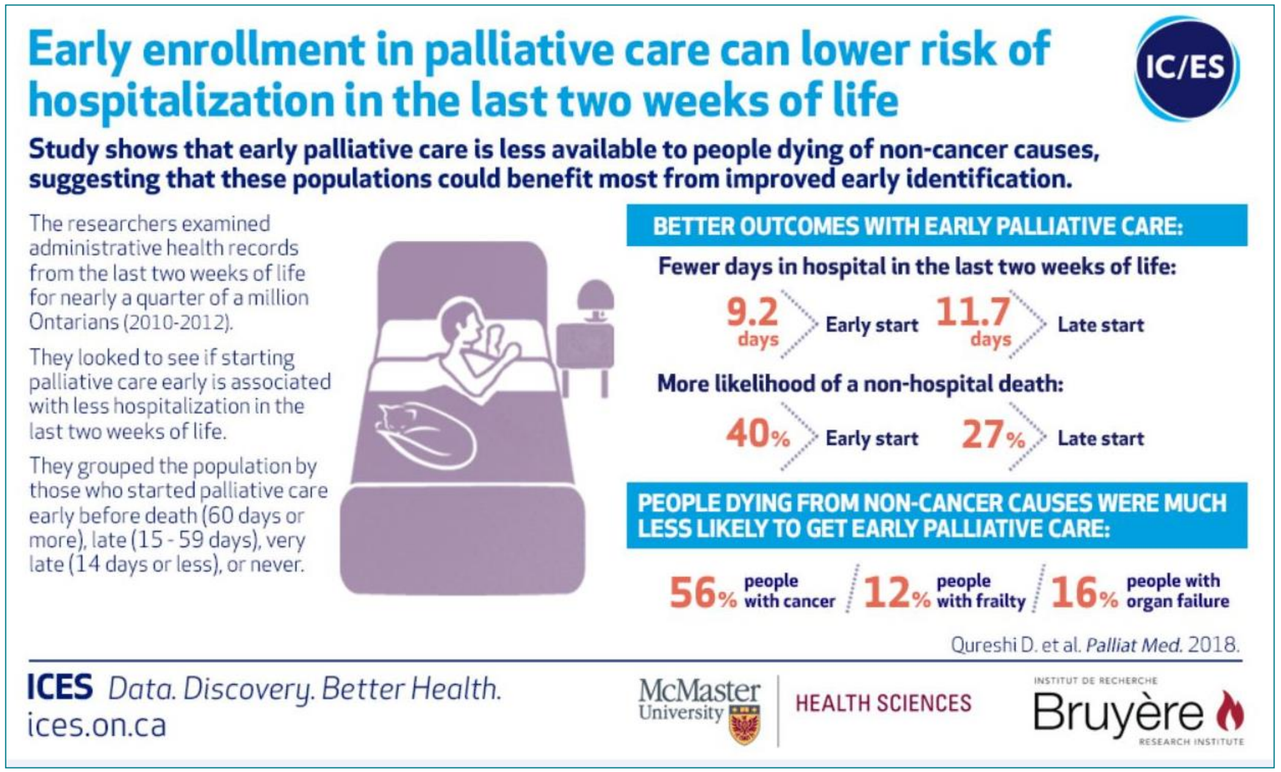


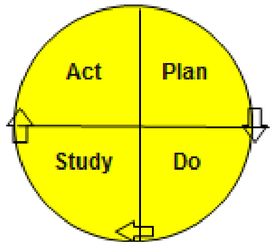
Image courtesy of ICES http://www.ices.on.ca)

- ✓ Earlier identification and assessment of patient and caregiver needs
- ✓ Earlier access to palliative care providers, resources and supports
- ✓ Resource links and print outs for patients
- ✓ E-fax reports to broader care team
- ✓ Proactive approach to reduce crises
- ✓ Engagement of patient to discuss wishes, values, goals of care and get plans in place

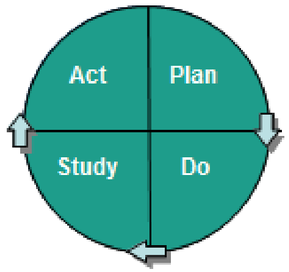
South East Regional Palliative Care Network

PDSA cycles Palliative Patient Tracker

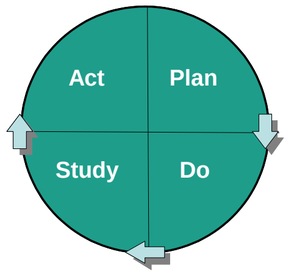
Plans for next cycles:
Huddle/check-in with other members of broader palliative care team
More patients, sorting by PPS
Run reports to populate tracker-
Integrate into PC Toolkit?



Primary Care Huddle with electronic tracker - conversations



Next iterations taken to PCP's in sub-region, and anyone else who would listen!



Conceptual model drafted after reviewing materials from UK and US. Input from Project Team.

Testing

Developmental

Palliative Care Patient Tracker (Excel document)

Registry of Palliative Patients in Primary Care Practice (concept draft for discussion)

Checklist examples taken from CCO: A Palliative Approach for Primary Care

Patient and Provider Info					Discussions					Referrals in place?									
atient ID	Diagnoses	MRP	SDM	Primary Caregiver	Illness Trajectory	ACP	Goals of Care	Consents	EOL Planning PPS<70	HCC	Comm support services	Hospice Services	Spiritual Care	Social work	PT/OT	Nutrition	Other	PPS < 50%	
			S. Smith		✓	✓	✓	✓	✓									SRK ordered	✓
						✓			✓									PC Standing orders	✓
	Stg 4 Bowel		613-555-															Nurse Pronouncement	✓
1111	Cancer	Dr A	5555	Same						✓		✓	Minister visiting			✓ HCC		DNR-c	✓
					✓	✓	✓											SRK ordered	
																		PC Standing orders	
																	Lung Health	Nurse Pronouncement	

We heard that a few physicians and NP's in the SE region use a similar approach to discuss and monitor patients identified as palliative. There is interest in a tool integrated with and populated by EMR. Telus Practice Solutions Suite users tell us it is possible! Pilot site is interested in using this excel tool to track identified patients- will test at a 'huddle". Will be used to collect project data.

Palliative Care Patient Tracker modified for Huddle Test

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				
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							DNR-c				
							SRK ordered				
							PC Standing orders				
							Nurse Pronouncement				
							DNR-c				

Action Items:	Who?	When?

Huddle with Tracker Tool- Feedback from PDSA

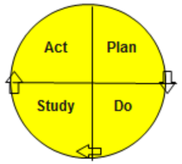
Man what a great huddle! Everything that should be happening …. being proactive, catching potential safety issues, thinking about impact of death on spouse and how we can help her, each team member had something valuable to contribute, well organized.

No doubt about the value of huddle, tool helped to focus us, prevention of crises, would be useful for on-call handoff, share responsibility across team. Physician

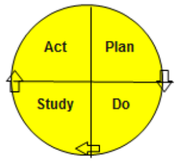
How will tracker/huddle improve the experience for patients and caregivers?

- Monitoring of identified patients to ensure resources in place
- Allows team to anticipate needs and be proactive
- Promotes communication with broader care team including patient and family

PDSA cycles for South East Regional Palliative Care Network Website

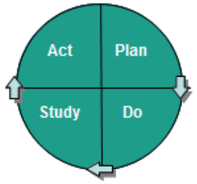


Test use of regional newsletter to get feedback on layout and content

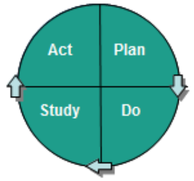


Created Button Layout- collecting regional feedback

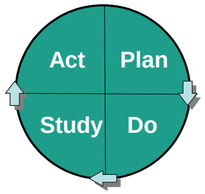
Testing



Focus group with caregivers to get more input on content and format



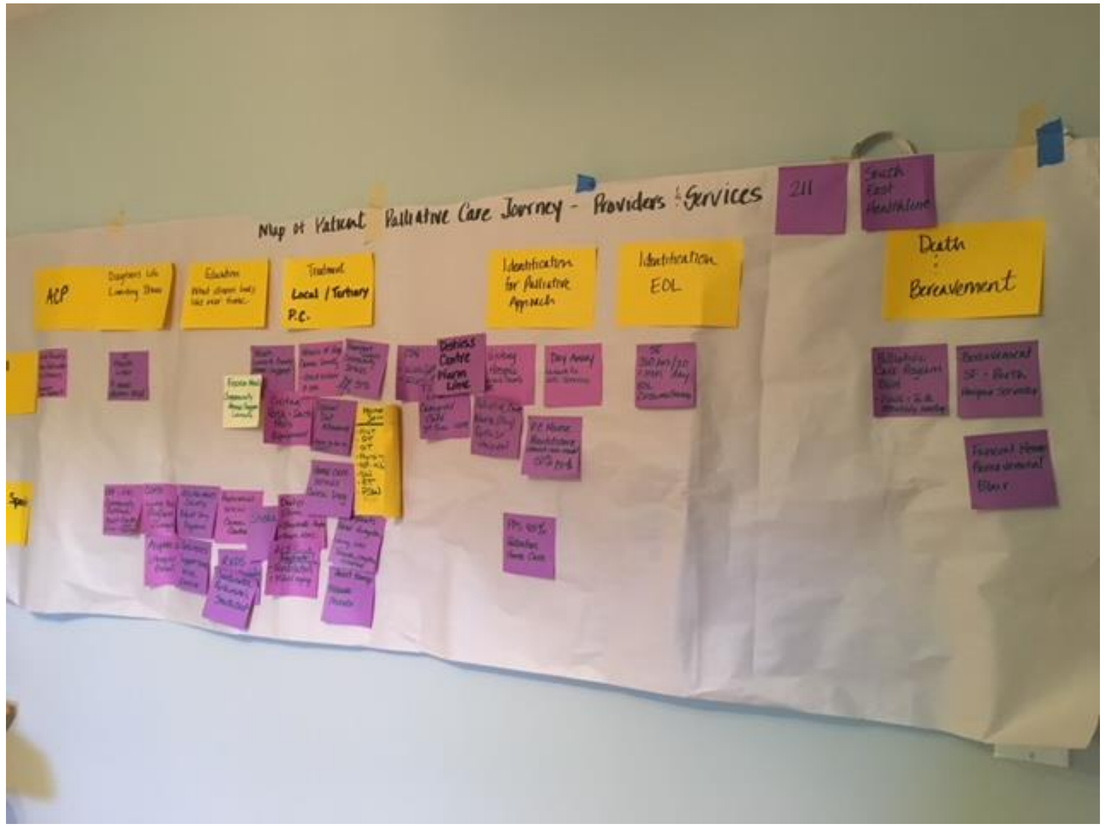
Created different formats to sort resources, input from caregivers, health care providers



Mapped Palliative Care Journey and Resources-questioned initial plan to link SE Healthline resources to steps in patient journey

Developmental

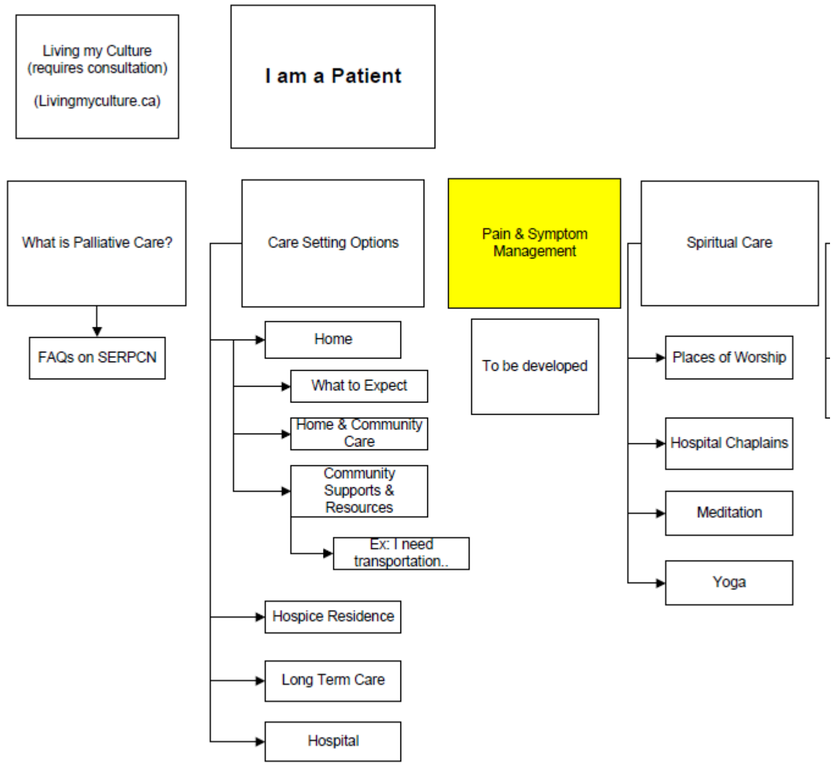
Palliative Care Mini-site- Southeast Healthline (SERPCN Work Plan E2i)



- ✓ Map resources to timelines Rideau Tay area
- ✓ Identify additional/missing resources
- ✓ Meet with Healthline Team to discuss possibilities and discuss resources to support change
- ✓ Confirmation of Healthline support (fall 2018)

This work plan item is regional in scope- reaching out across South East region to inform/support this work.

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



- Research other RPCN websites
- Collaboration with hospice programs in Kingston and Perth to get caregiver input
- Feedback from other priority Priority Teams

- Seeking broader input and perspectives from communities:
  - SERPCN newsletter with link to document posted on website

How will layout of website experience for patients and caregivers?

- Easier to navigate using button
- Content and wording
- Website link will be included in EMR Tool- care team can work with patients and caregivers to find resources
- Caregivers and healthcare providers have told us that:
  - Need to find ways to get both to the website
  - Review of website resources together- coordinator role

Project Data Updates Posted Separately

More updates to come!

If you have questions or comments, please contact:

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