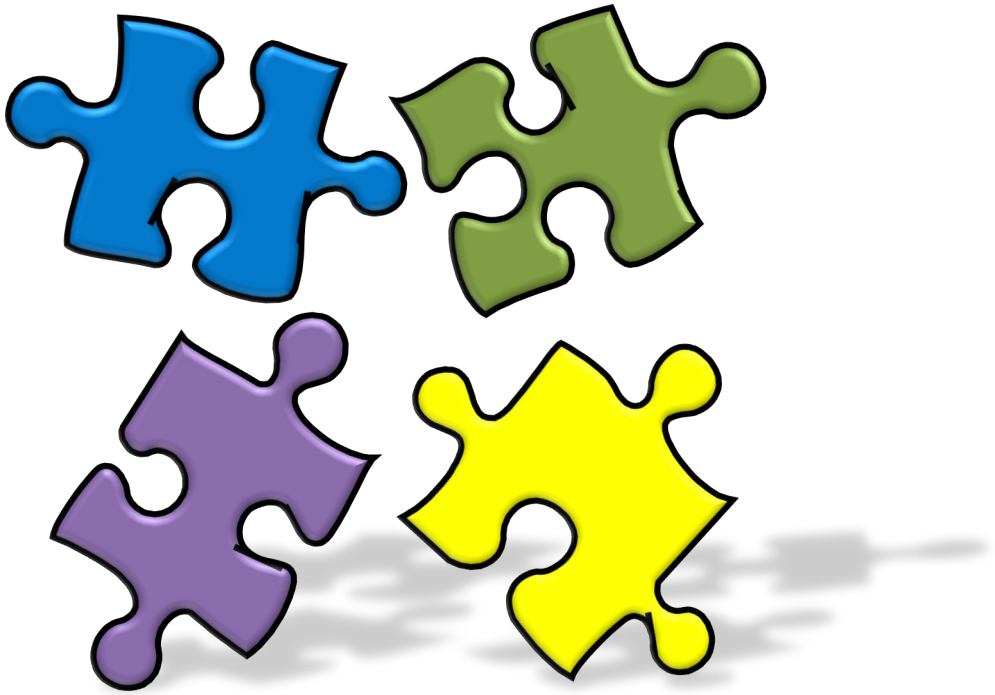

REDUCING THE SILO MENTALITY

CHRISTINE DEGAN, NP-ADULT

October 1, 2018

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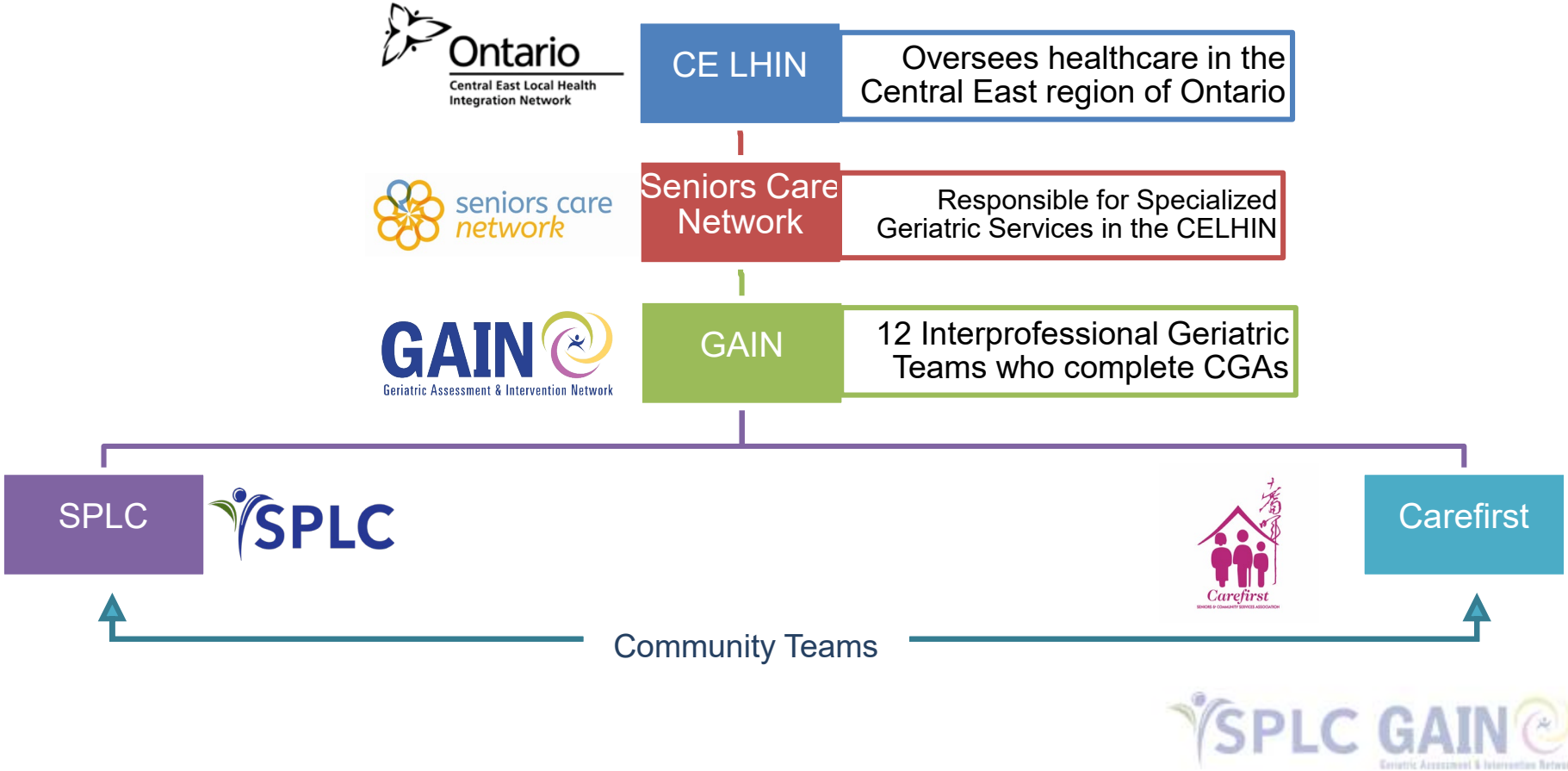
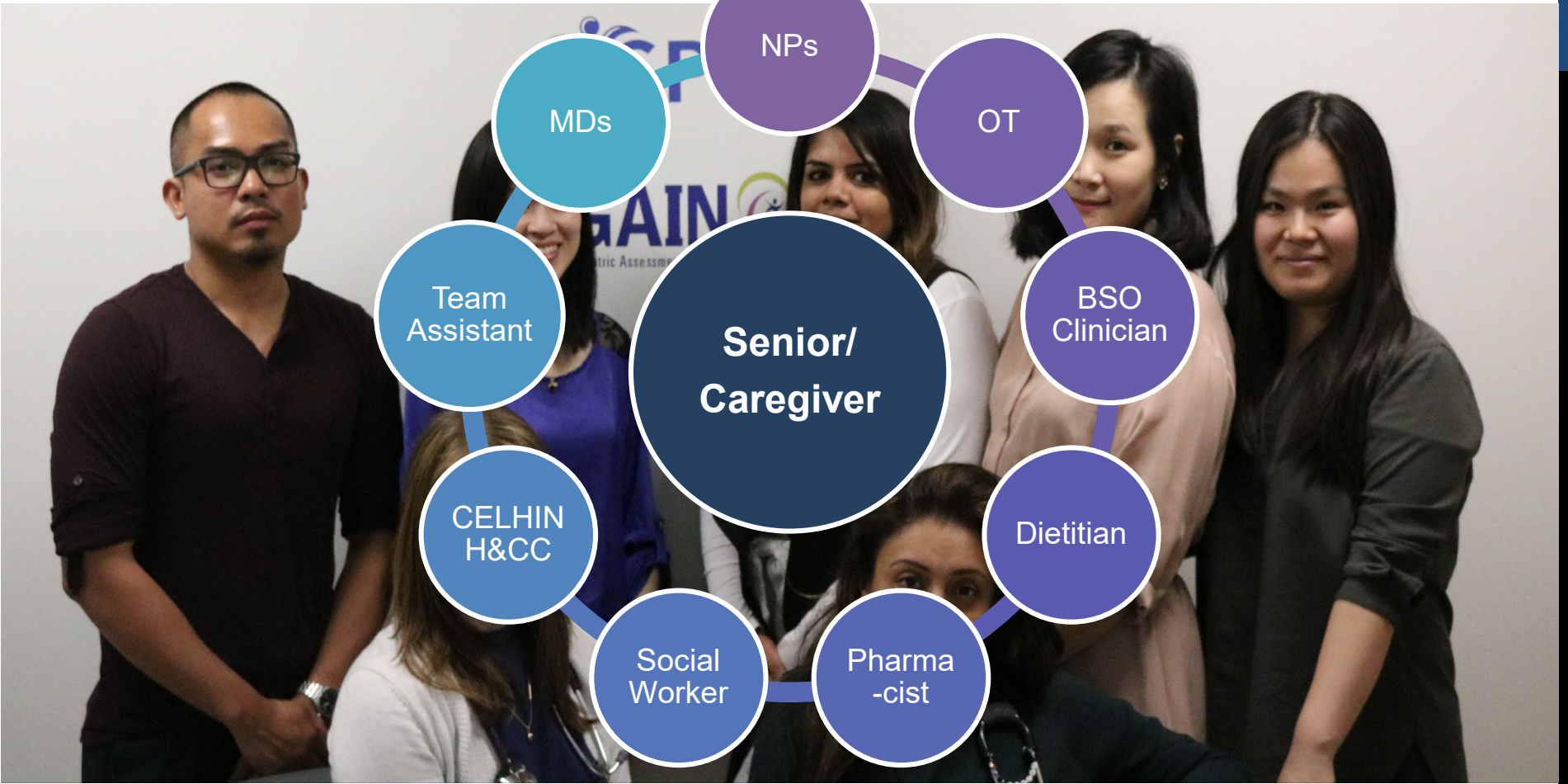
SETTING THE SCENE



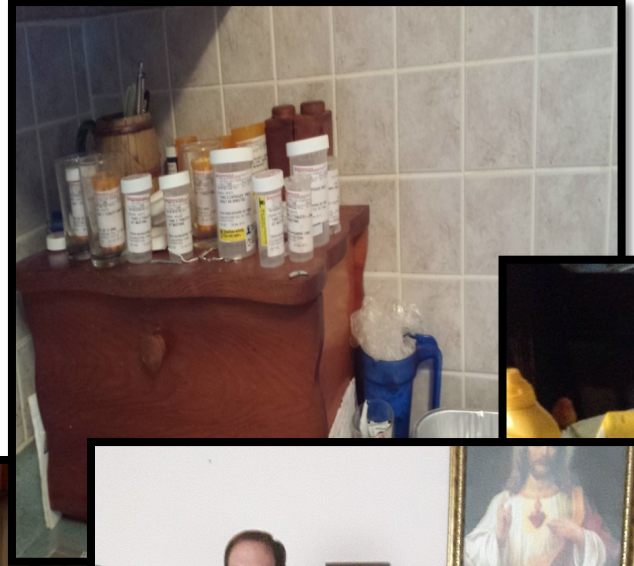
SPLC GAIN TEAM

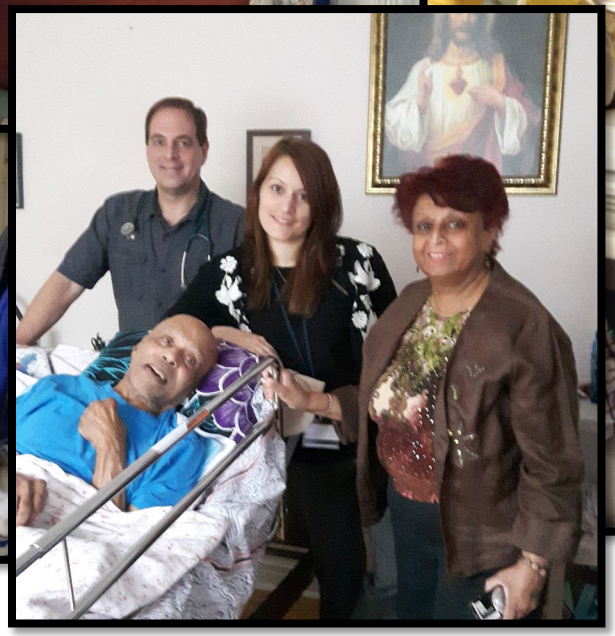


Introduction	Medical/Surgical History	Medication	Social History	Falls	Function

A Competency Framework for Interprofessional Comprehensive Geriatric Assessment

Cognition	Mood/Mental Health	Sleep	Pain	Nutrition	Continence	Physical Assessment





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So why not just make a referral to Palliative Home and Community Care????

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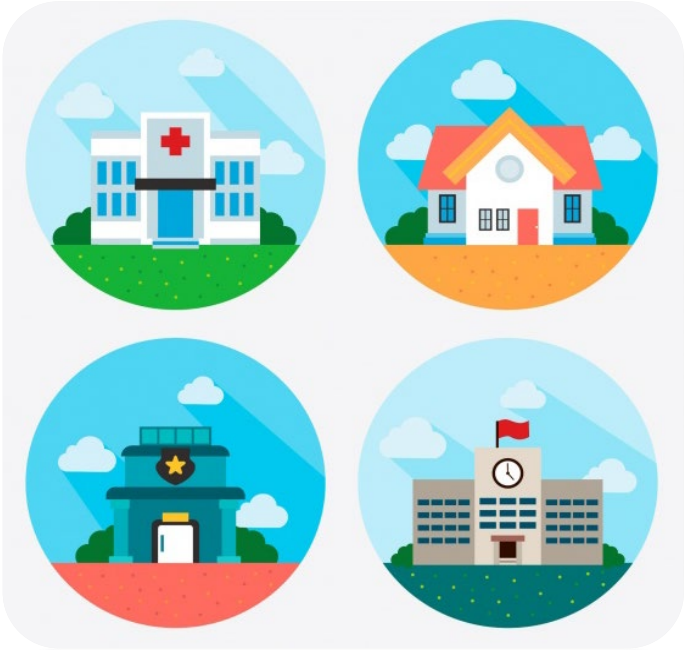
BACKGROUND

- Patients were rejected by traditional community palliative care via **CELHIN Home and Community Care**

CELHIN Palliative Care Eligibility:

- ❑PPS <30%
- ❑Prognosis <3 months
- ❑Terminal diagnosis
- ❑Requirement of a physician*



GAIN patients often present with an atypical trajectory where a PPS score does not reflect prognosis

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BMJ Open: Access to palliative care (PC) by disease trajectory: a population-based cohort of Ontario decedents Hsien, S., Leary, E., Perez, R. & Tanuseputro, P. (2017)

Setting	Terminal Illness (cancer)	Organ Failure (heart or lung)	Frailty (dementia)
Any PC	88%	44%	32%
Any PC in the Community Environment	67%	17%	15%
LHINs PC Home Care	47%	6%	3%
Median Days in between 1st PC and death	107	22	24

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“SILO MENTALITY”

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Scarborough Centre for Healthy Communities

SCHC-PCCT

- 24/7 access to nurse
- Palliative services
- Criteria: “life-limiting illness”
- Informal communication with multiple LHIN Care Coordinators
- Difficulty with ongoing access to primary care physician/NP*

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- Not 24/7
- Lack of palliative support
- Interprofessional team
- Embedded LHIN Care Coordinators on team
- Access to physician/NP

SCHC-PCCT can make referral to1 of 6 palliative physicians when PPS <30%

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INNOVATION

Timely & Effective Communication

- Identify who to communicate with and when

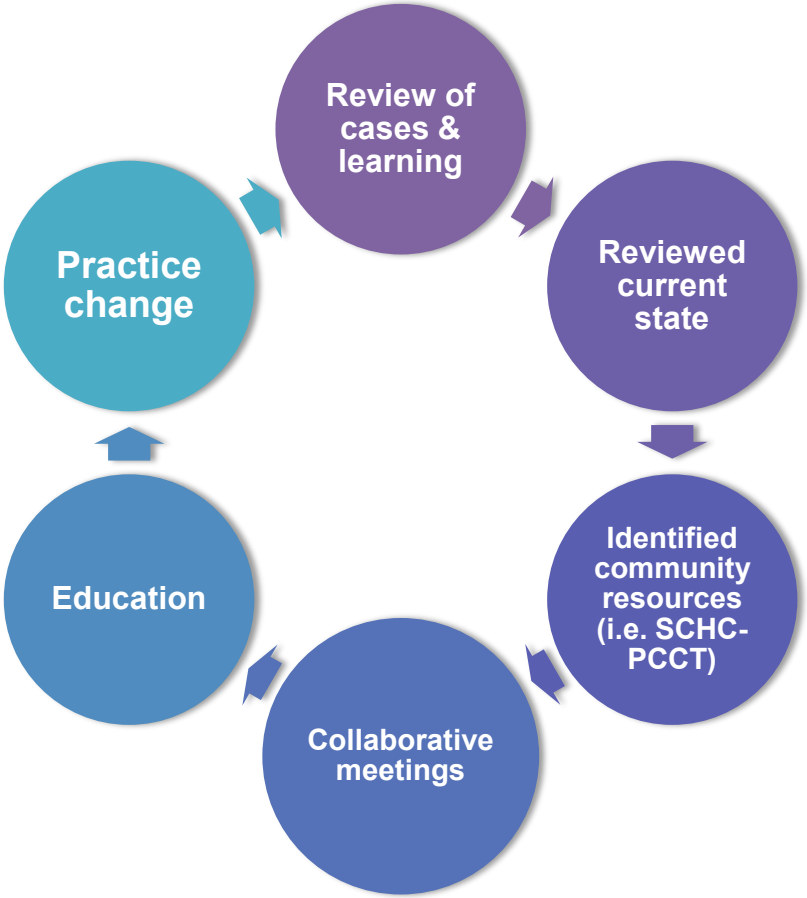
Coordination of Services

- Prevent duplication
- Discuss the same message

Sharing of Resources

- Nurse Navigators & NP/Physician)

IMPLEMENTATION:
ADOPTION OF EXISTING PRACTICES



OUTCOMES:
PRESENT

QUANTITATIVE

- Patient's frailty level
- Dementia score
- Number of in-home visits
- Telephone visits
- Consults with palliative physician
- Hospital/ED visits avoided
- Unnecessary Specialist appointments avoided

QUALITATIVE

- Informal feedback

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OUTCOMES:
FUTURE

QUANTITATIVE

- Cost reduction associated with:
  - Medication de-prescribing
  - Reduction of laboratory investigations
  - Avoiding ED visits/hospitalizations

QUALITATIVE

- Formal feedback including:
  - Caregiver stress
  - If families feel the patient's preferences for a "good death" were met.

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SUSTAINABILITY

Increased inter-professional collaboration

Education opportunities

Decreased moral distress

Utilization of preexisting programs at organizations

Access to specialists within teams

Does not require immediate additional funding

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Dedicated to
RICHARD (WAYNE) POTTLE

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REFERENCES

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2. Scarborough Centre for Healthy Communities. (2017). https://www.schcontario.ca/
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5. Seow H, O'Leary E, Perez R*, et al*. Access to palliative care by disease trajectory: a population-based cohort of Ontario decedents. *BMJ Open* 2018;**8:**e021147. doi: 10.1136/bmjopen-2017-021147

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THANK YOU!

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