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Advancing Excellence in Home Care

KNOWLEDGE NETWORK
Building Capacity... Improving Performance

VIRTUAL LEARNING SERIES

WHOLE COMMUNITY PALLIATIVE ROUNDS (WCPR)

Inter-professional communication and decision-making

SPRINT WCPR IMPROVEMENT COLLABORATIVE

Adapting and implementing leading practices in integrated home and community care

WELCOME

14, MAY 2019

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SPRINT IMPLEMENTATION COLLABORATIVE

Adapting and implementing leading practices in integrated home and community care

Nadine Henningsen
Chief Executive
Canadian Home Care Association

Building Operational Excellence

Home-Based Palliative Care

SPRINT Implementation Collaboratives

SPReading Innovation in **INT**egrated Home and Community Care

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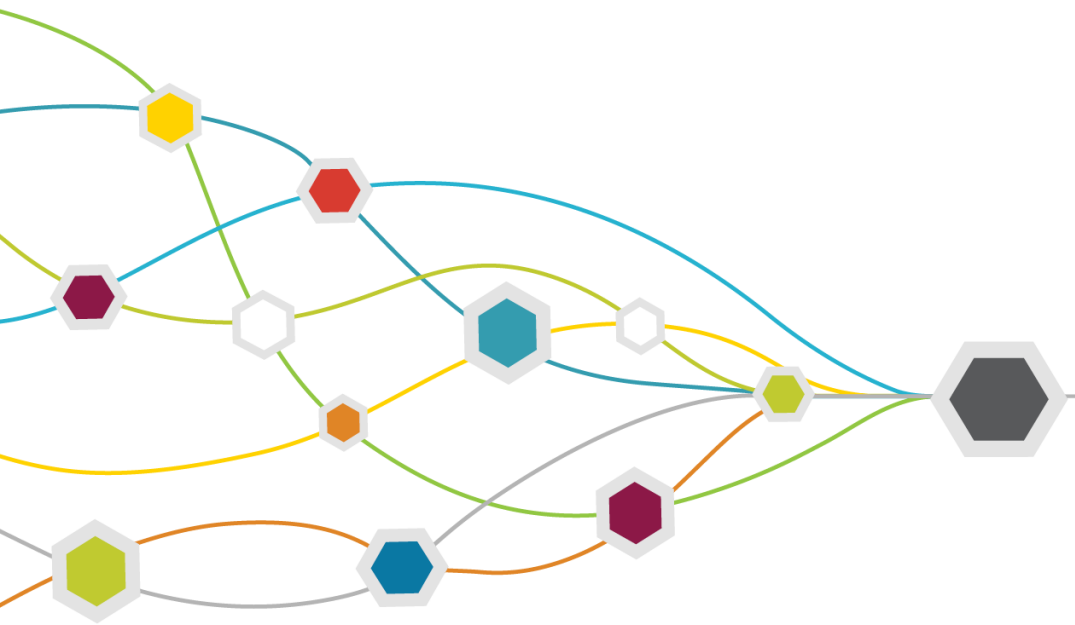
- 24-month project - Opportunities to improve home-based palliative care
  - Early assessment and care planning
  - Inclusion of advanced care wishes into care delivery
  - Effective communication strategies and tactics
  - Access, management and disposal of equipment, supplies and medications

- Engage with policy-makers, providers, patients and caregivers

Roadmap for operational excellence in home-based palliative care

Opportunities & gaps in operational process in home-based palliative care	Expert Roundtables e-Delphi Consultation https://www.homecarekn.ca/assessment-and-care-planning/  
Showcase the "**Experiences**" of providers, funders and caregivers	Experience Maps https://www.homecarekn.ca/0-advanced-plans/   
Identify and promote **leading practices**	22 Leading Practices 5 High Impact Practices https://www.homecarekn.ca/operational-innovations/  
Support the **application** of evidence-informed operational practices in home-based palliative care	**SPRINT Implementation Collaboratives** **SPR**eading Innovation in **INT**egrated Home and Community Care



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SPRINT Implementation Collaboratives

SPReading Innovation in **INT**egrated Home and Community Care

- **Integrated health system** that provides seamless patient- and family-centred care and supports for older adults living with frailty; those with complex, chronic disabling conditions; and individuals at the end-of-life.

- A **customized, structured approach** to implementing evidence-informed practices and enabling sustainable change in home and community care.

- Adapted from the Institute for Healthcare Improvement Collaborative Model for Achieving Breakthrough Improvement and the **E**vidence-**B**ased **S**ystem for **I**nnovation **S**upport (EBSIS).

SPRINT Implementation Collaboratives

WHAT WE **KNOW**

WHAT WE **DO**

FOUNDATION FOR SUCCESS

- Tools
- Training
- Engagement
- Coaching/ Technical assistance

IMPLEMENTATION STRATEGY

- Quality improvement – PDSA
- Outcome measurement
- Co-creation
- Change management

COLLABORATIVE PROCESS

- Local participation—national sharing
- On-boarding and group learning
- Interactive sessions
- Capstone event—experiences and sustainability

UPTAKE OF EVIDENCE- INFORMED PRACTICES

The SPRINT-WCPR Collaborative: test, adapt and implement the leading practice **Whole Community Palliative Rounds**.

Goal: Help inter-professional teams engage in purposeful and timely communication, shared decision making and collaborative care planning all within an integrated palliative care model

- 7-months - annual sustainability “check-in”
- Tools, training and education, coaching/technical assistance
- Access to recognize experts and resources

Building Operational Excellence
Home-Based Palliative Care

HIGH IMPACT PRACTICES

Evidence-informed practices in home and community care that result in better care, better outcomes and better value.

Whole Community Palliative Rounds

An innovative approach to inter-professional care planning and delivery in Interior Health

Whole Community Palliative Rounds is a strategy to enable rapid clinical problem-solving for symptom burden in high-risk individuals, purposeful and timely communication, shared decision-making and collaborative care planning among members of an inter-professional care team. **This High Impact Practice showcases how Interior Health in British Columbia has successfully implemented this strategy.**

BACKGROUND

People with palliative needs and their families often experience periods of escalating and fluctuating symptom burden as their illness advances. Responding to the complex needs of the individual's physical and psychological symptoms requires coordinated and active involvement between the person, their caregiver(s) and an inter-professional health and social care team. Lack of communication structure, inadequate sharing of clinical information, poor reconciliation of medicines and duplicate or missing assessments are among the operational gaps that leave many people with palliative needs and their caregivers experiencing fragmented and poorly integrated care.[1]

Ensuring responsive, coordinated care for individuals receiving palliative care throughout the Interior Health (IH) region is a challenge given the large geography (215,000 sq. km) and low population density (3.5 people per sq. km). In 2017, the population of the region was 749,853 (15% of the BC population), with an average life expectancy of 81 years. With a 21% expected growth rate for individuals aged 75+ and a 17% expected growth for individuals aged 85+, the demand for quality palliative care services in the area will increase over the coming years.[2] In anticipation of this challenge, IH has embraced a primary generalist palliative model with consultation services to serve the majority of people living in small communities.

The BC Ministry of Health's *2018/19-2020/21 Service Plan*[3] emphasizes the importance of transformational health system redesign across metro, urban, rural and remote communities. Creating team-based care with linkages to specialized services was identified as a key priority. In response to this strategic directive, IH committed to an inter-professional integrated approach to care. Specific to palliative care, this emphasizes active symptom management for individuals and their families. Whole Community Palliative Rounds (WCPR) is one of the strategies IH has developed and implemented to meet this goal.

This inclusive approach reflects the reality that we all experience and define our lives within the context of our relationships. Professionals from various health sectors and programs, as well as community partners are all included. The goal is to encourage collaborative input into the discussion and management of an individual's symptom burden and ultimately their quality of life and well-being.

Under the guidance of the IH Regional Palliative and End-of-Life Care Team, the concepts of "whole community" and "palliative rounds" were adapted to meet the needs of the palliative population, particularly for rural and remote areas.

"Whole Community" Recognizes the inter-relationship and connections between formal and informal care (volunteers, family, friends) across all care settings.

"Palliative Rounds" An expanded inter-professional team (circle of care) across health sectors, programs and disciplines focused on providing the best supports for the palliative population.

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Building Operational Excellence: Home-Based Palliative Care builds on "The Way Forward. An Integrated Palliative Approach to Care" by identifying innovative operational practices to address specific service gaps and improve the quality, efficiency and accessibility of home-based palliative care. The project is supported through a health funding contribution agreement from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

“Should we participate in the SPRINT-WCPR Implementation Collaborative ….”

- Enhance the quality and effectiveness of home-based palliative care
- Address communication challenges with inter-professional teams
- Accelerate decision-making and team collaboration
- Build on knowledge and experience in QI methodology & measurement
- New ways to ensure sustainable change
- Designated resources to work locally and share nationally

The 2019 SPRINT-WCPR Collaborative is your opportunity

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WHOLE COMMUNITY PALLIATIVE ROUNDS

Inter-professional communication and decision-making

Karyn Morash
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Interior Health, BC

Elisabeth Antifeau
Regional Clinical Nurse Specialist
for Palliative Care
Interior Health, BC

Interior Health

Whole Community Palliative Rounds: Building Operational Excellence in Palliative Care

Canadian Home Care Association Webinar – May 14th, 2019

Elisabeth Antifeau, Regional Clinical Nurse Specialist, IH Palliative and End-of-Life Care

Karyn Morash, Director, IH Palliative and End-of-Life Care

Interior Health
Every person matters

Objectives

01 Our Story

02 MANY Questions

03 Whole Community Palliative Rounds

04 Key Findings

05 Next Steps

‘Our’ Story of Whole Community Palliative Rounds

Where the idea originated

- Fluctuating and complex experiences of symptom burden in advancing illness;
- Complex care needs that are best supported through inter-professional collaboration
- High “whole health system” use - especially in the last year of life
- Rural and remote health care requires infrastructure to support a primary palliative approach
- Imperative from the Ministry of Health regarding availability of Hospice Spaces

Who are we and what are our needs?

- Large geography (215,000 sq. km) and low population density (3.5 people per square km)
- 21% growth rate/5 years for people 75+ and 17% expected growth rate for people 85+
- Ministry of Health direction to use a population based approach to health system redesign
- Analysis and planning for team based, cross-sectoral and whole community innovation

Knowledge as Action

- To use a population-based, “whole community” lens that is inclusive of partners both within (cross sector, cross program) and external to our Health Authority
- To create integrated, inter-professional team approaches for active symptom management through rapid clinical problem-solving, care-planning and communication that contributes to effective symptom relief and Quality of Life
- To build System Capacity by using WCPR as a purposeful rural strategy to support primary generalist palliative care

Time and Resources

- How much time does this take?
- Which staff need to attend?
- How is this coordinated and organized?
- Do staff need to be relieved to attend?

People

- Who is “the palliative team”?
- What do you mean by cross-sector?
- What is meant by “whole community?”
- Which external health partners should be invited? (and why?)
- What are the roles? Who leads rounds?
- Who is referred each week (criteria)

Indicators & Outcomes

- How might WCPR make a difference?
- How quickly is symptom burden relieved?
- How will we know if this is effective? What measures should we use?
- Is this best practice?

Risks and Benefits

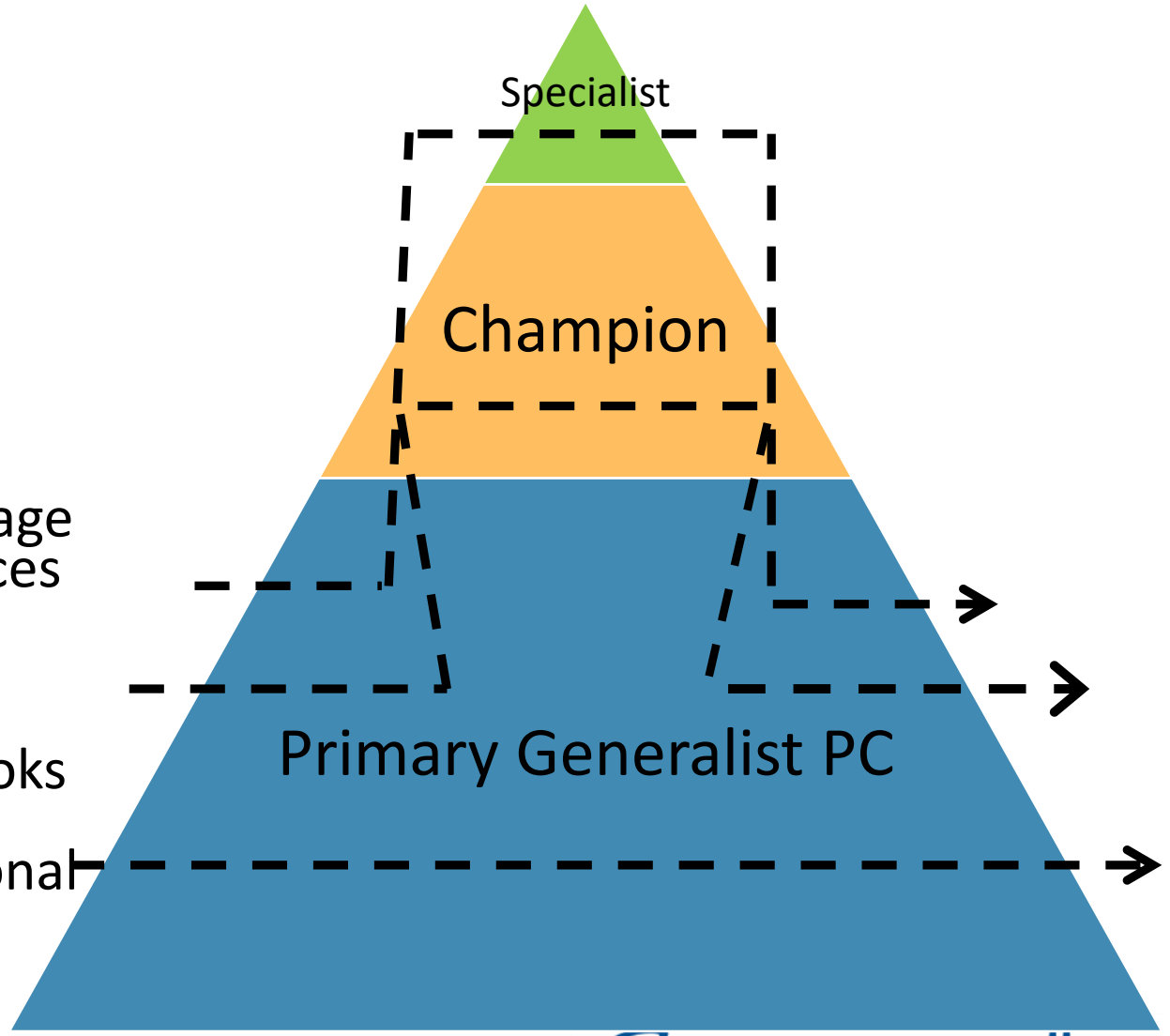
- What are the risks of starting something like this?
- What are the benefits to people? Families? For health professionals?
- What resources are needed to be successful?

Whole Community Palliative Rounds

Every person matters

Principles, Values and Vision

- BC Ministry of Health (2013) identified the need for "transformational health system redesign"
- Visioning for a strong primary generalist palliative approach
- Focus is to build capacity with linkage to champion and specialized services for support and consult
- "24/7 access to palliative care" looks different in smaller communities – opportunities arise through relational strengths

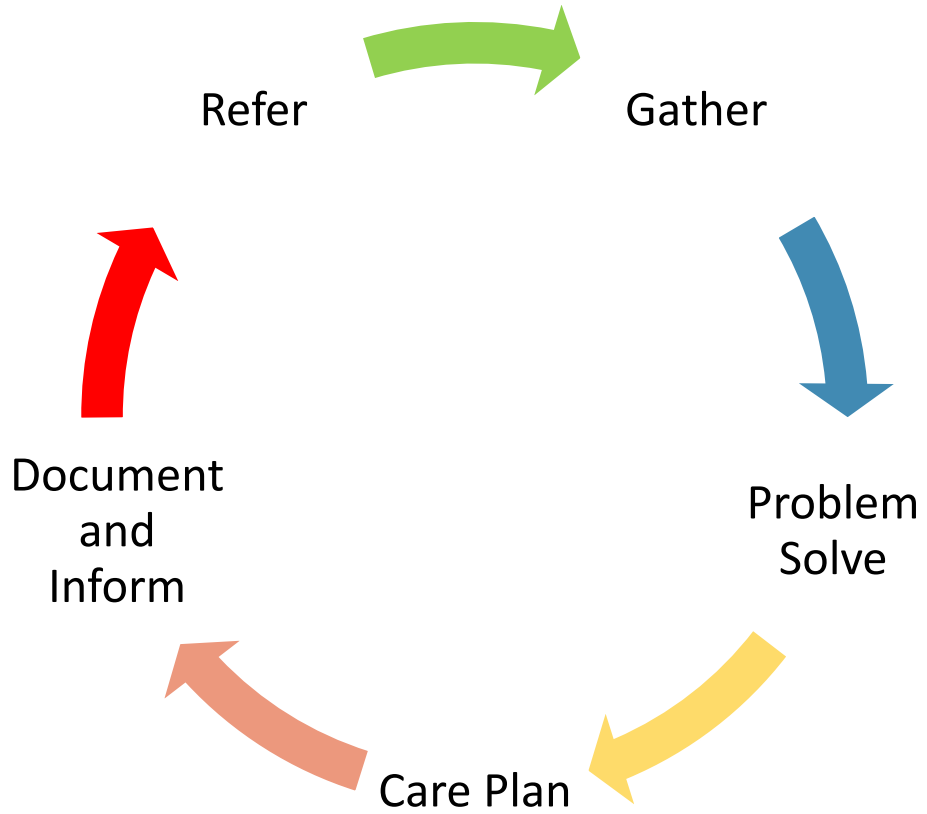


Defining Whole Community and Team

- Concept of “whole community” arose from the developmental disability and emergency response literature
- Whole Community recognizes the inter-relationship and connections between formal and informal care providers across all settings of care
- The inter-professional team is expanded to include:
  - Cross-sector representation (community, hospital and long-term care)
  - Most Responsible Providers (physicians and nurse practitioners)
  - Health professionals: nursing, allied health, social work
  - Cultural competencies: First Nation partners
  - External partners: Hospice Society Coordinators, Community Paramedicine, contracted LTC partners

Whole Community Palliative Rounds

- Referrals made throughout the week for people with unstable symptom management, complex needs or transitioning
- Once per week gathering of the team in the hub and in spoke communities that call in (set date, place and time)
- Rapid clinical problem solving and care planning
- Documentation and information sharing back to most responsible clinicians (MRC)



Enablers for Success

- The ‘Circle of Care’ was formally defined to better meet population-based needs
- Written guidelines and a toolkit was developed to clearly define:
  - Vision, purpose and goals
  - Roles and responsibilities
  - Referral criteria
  - Practical guidance on the format of how to organize and conduct weekly rounds
- Clinical Decision Support Tools were developed:
  - Referral forms
  - Physician/Nurse Practitioner communication Sheet
  - Palliative Rounds Tracking Record
- Physician Engagement – Palliative Medical Leaders sought; budgeted sessional time
- Education, Communication and Promotion of WCPR as an important strategic priority supported by senior leadership

Addressing Challenges

- Creating a common and shared understanding
- “Other” Rounds – how is this different?
- Supporting Family Physician Practices
- Making the commitment
- Seeking Clinical Excellence

It Takes a Team

1. Designated Rounds Facilitator (permanent or rotating):
   a) Manages local palliative registry
   b) Discussions are documented and ethically shared
   c) Conducts rounds to start and stop on time and stay focused on problem solving from an inter-professional/interdisciplinary/whole community lens
   d) Ensures appropriate follow-up and communication results

2. Support may be needed – agenda, minutes, rooms, etc.

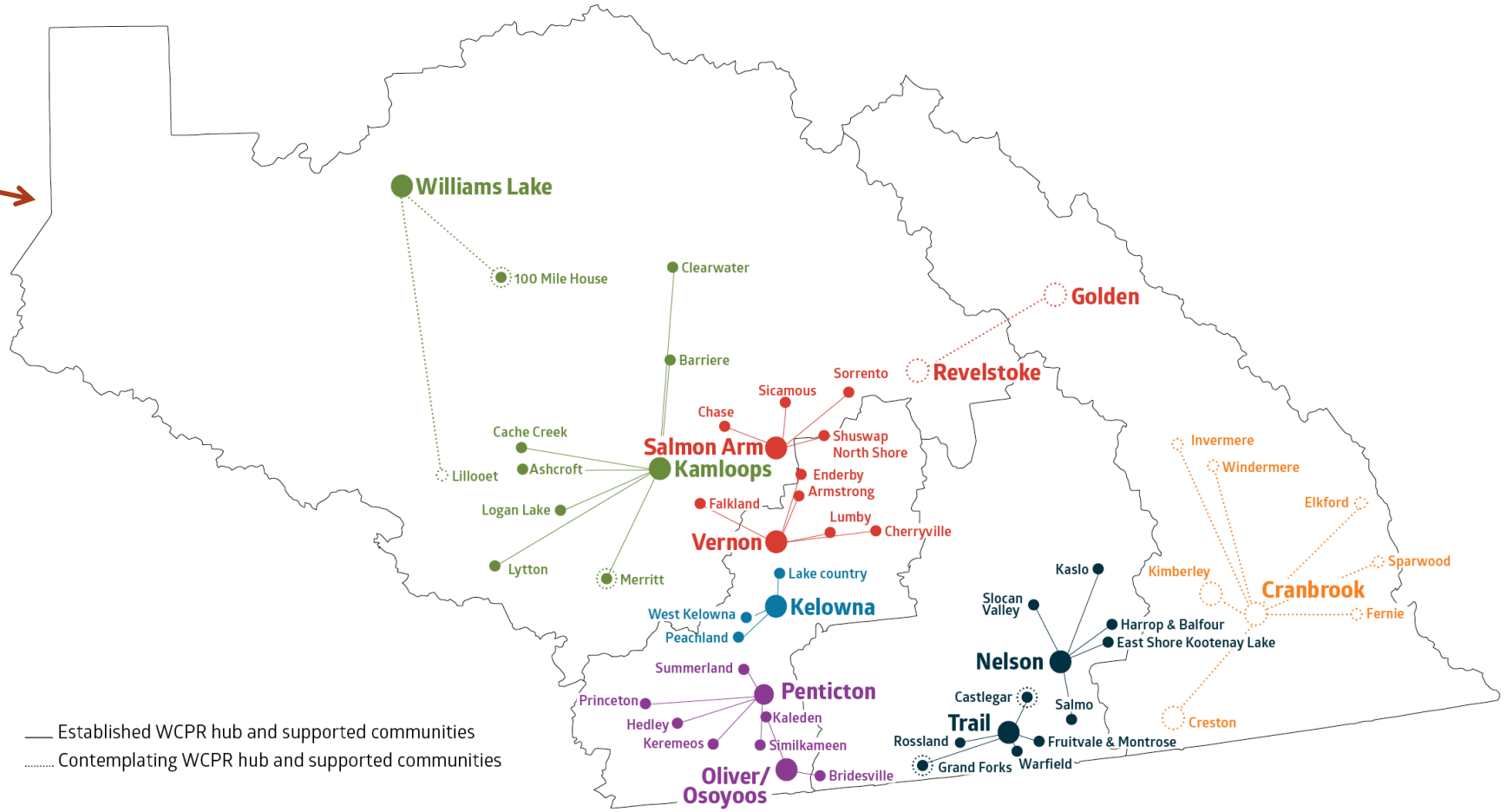
3. Participants need to make the commitment to attend &/or gather locally if dialling in; this may mean (self) release from clinical time for (15 mins to 1 hour)

4. Teams vary in composition, size and relationship; best discussed, defined and addressed locally

Outcomes To-date

- Nine well-established WCPR “Hubs” supporting 36 smaller outlying “spoke” communities
- An additional eight communities are in contemplation of becoming hubs and would support an additional 10 spoke communities
- CNSs attend many rounds per week and anecdotally report an improved shift towards standardized palliative assessment, use of BC Symptom Management Guidelines, enhanced palliative clinical problem-solving, greater awareness and consistency of care
- Teams talking together! Enhanced trust and improved relationships within and across team boundaries is both reported and evident

Outcomes To-date - continued



Outcomes To-date: Impact on Team

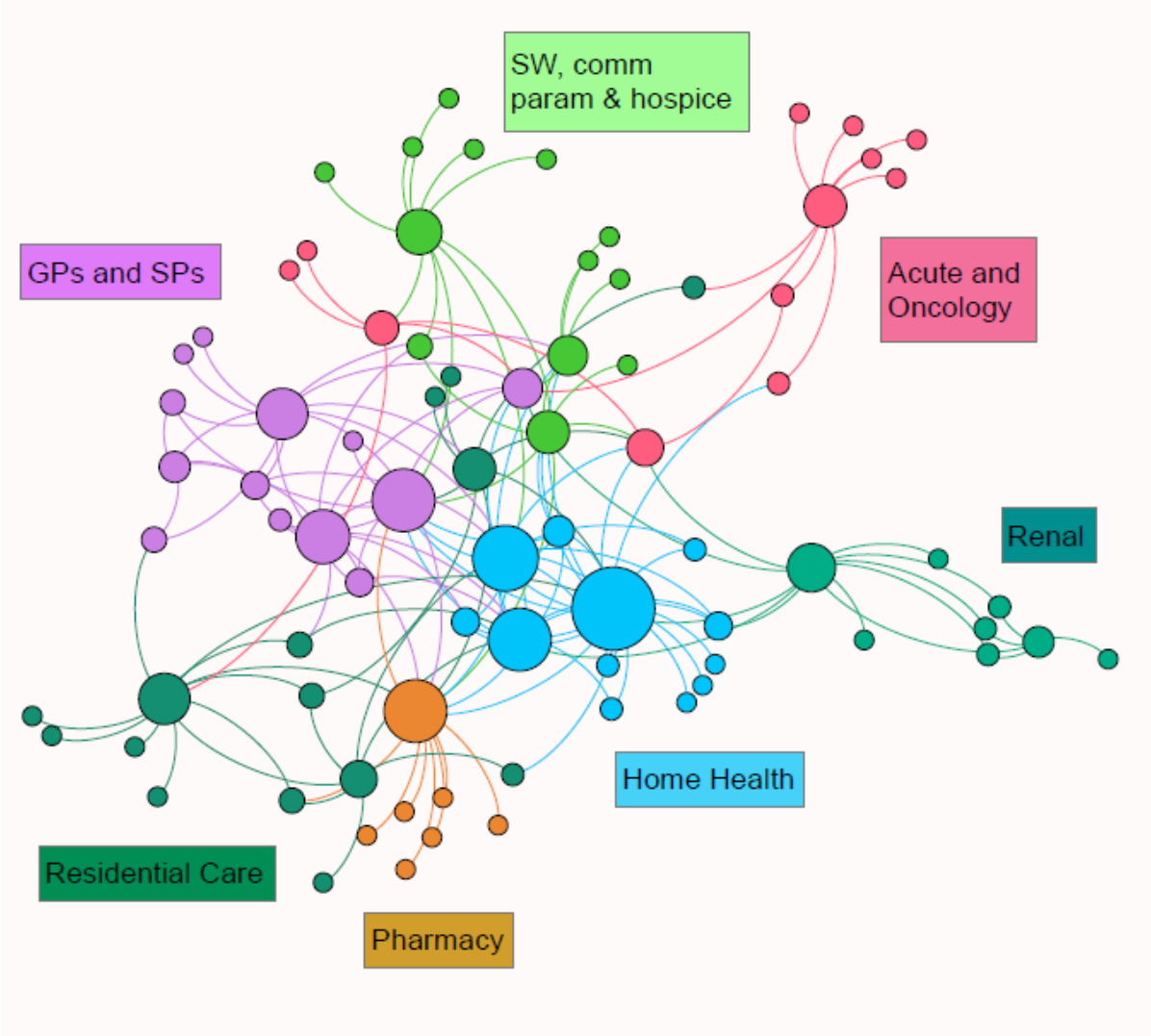
- Formal evaluation efforts are just starting
- Results in a recent pre/post survey of WCPR participants in 2 communities indicates:

	At Baseline (Sept 2018) N=22	Follow-up (March 2019) N=12
Feeling well or very well supported in the provision of PC	27%	58%
Team Communication about PC is rated as good	38%	83%
Teamwork is rated as good or very good	50%	92%

What is your level of agreement with the following statements for palliative care in your area? (Post only)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Palliative care rounds have improved communication among palliative care providers in my area	6	6	0	0	0
	50.00%	*50.00%*	*0.00%*	*0.00%*	*0.00%*
Palliative care rounds have built new relationships among palliative care providers in my area	8	4	0	0	0
	66.67%	*33.33%*	*0.00%*	*0.00%*	*0.00%*
Palliative care rounds have improved patient care in my area	4	8	0	0	0
	33.33%	*66.67%*	*0.00%*	*0.00%*	*0.00%*
I have learned a lot about palliative care approaches from palliative care rounds	4	6	0	1	1
	33.33%	*50.00%*	*0.00%*	*8.33%*	*8.33%*
The multi-disciplinary approach to palliative care rounds helps to improve patient care	9	2	1	0	0
	75.00%	*16.67%*	*8.33%*	*0.00%*	*0.00%*

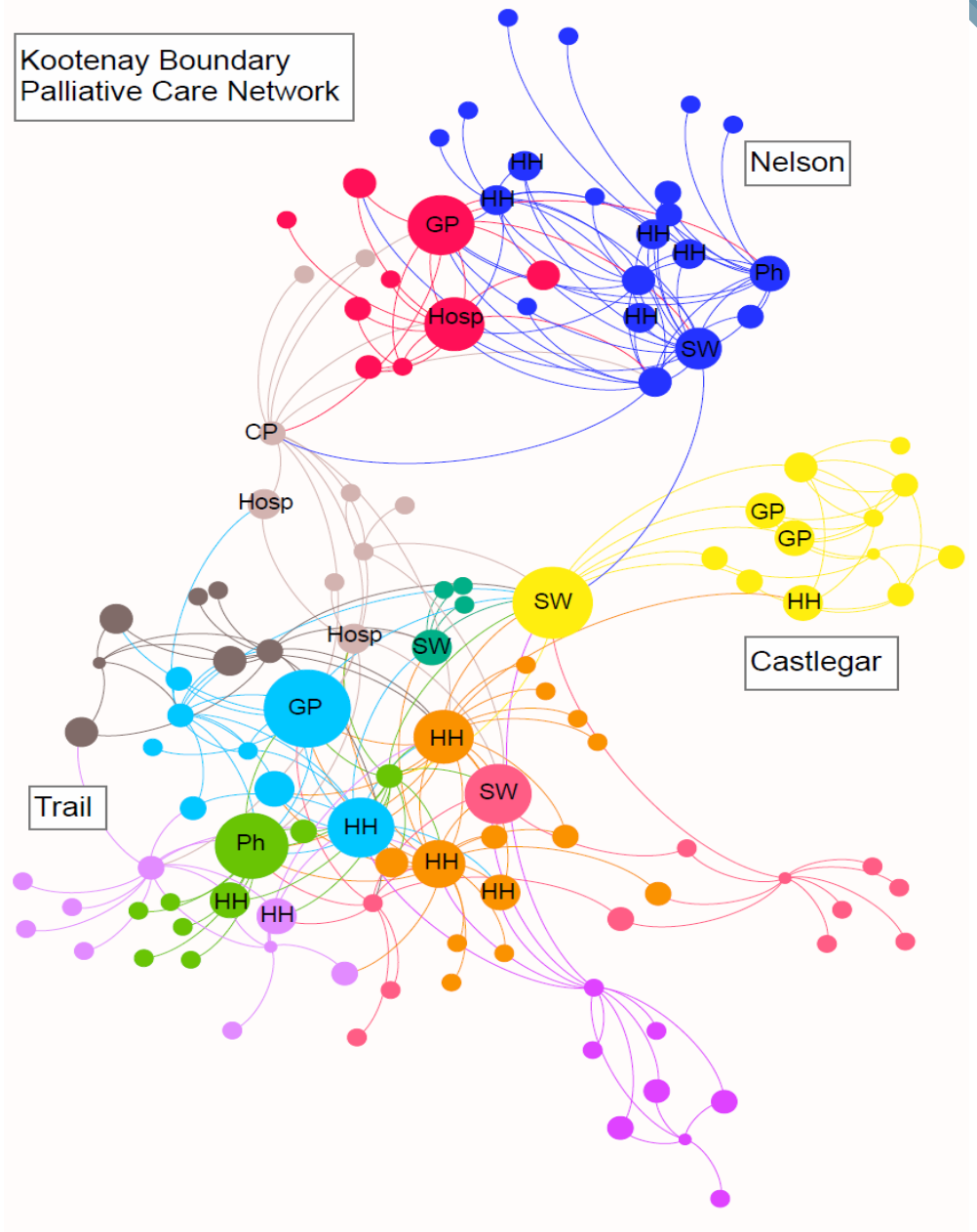
Social Mapping of Palliative Networks



Social Mapping of Palliative Networks: Spokes and Hubs

36

9



Every person matters

Key Findings

1 Collaboration

- Across care settings
- Across programs
- Across disciplines
- Across communities

2 Communication

- More and timely care conversations;
- Shared understanding of the goals of care;
- Ability for different team members to take a similar approach to care conversations with people/families

3 Clinical Responsiveness and Flexibility

- Symptom Burden Relief;
- Self management;
- Improved options to stay home;
- Family/Caregiver Support and Education;
- Consistency of care and information from the team

4 Knowledge as Action

- Real time clinical learning “in the moment”
- Clinical problem-solving from a team perspective
- Safe place to try out new assessment skills and knowledge;
- Mentoring

5 Inclusiveness

- Awareness of people, roles and resources both within and external to the health authority.
- Improved ability to network and refer outside of WCPR

6 Capacity Building

- Relationship building
- Team development
- New partnerships
- Knowledge building
- Connections and communication reinforced locally and geographically

7 Palliative Excellence

- Best practice palliative care is fully supported;
- Use of the BC Inter-professional SMG and standardized assessment tools;

Summary of Key Findings

Whole Community Palliative Rounds

- is an effective strategy to enable rapid clinical problem-solving of symptom burden in people with advancing illness and palliative needs and to support them to self manage and remain at home

Expanded Inter-Professional Teams

- Enhances collaboration, communication, collegiality, appreciation of different roles and disciplines, improved palliative care knowledge, networking and quality of care delivery

Builds System Capacity

- WCPR is used as an intentional rural and remote strategy to reinforce and strengthen local primary generalist teams to deliver best possible, evidence-based palliative care.

Next Steps

Continued support to existing WCPR

- Reflective practice, quality improvements sought
- Greater consistency of member attendance, involvement

Formal evaluation of existing WCPR

- Pre/post surveys, FamCARE, PROMS, PREMS, sharing of results
- Social network mapping

Further development

- Establishment of new hub and spoke WCPR to cover all areas of IH
- Refining of guidelines and clinical decision support tools as needed

Enhancing Primary, Secondary & Specialist Linkages

- Stronger linkages and capacity building amongst and between WCPR members and between primary and specialized care programs (renal, heart failure, diabetes and oncology, etc)
- Possible Community of Practice for designated WCPR Facilitators

SPRINT-WCPR Implementation Collaborative

Download and complete the EXPRESSION OF COMMITMENT - **Deadline June 3**

Visit https://www.homecarekn.ca/sprint-implementation-collaboratives/

4 – 8 Successful Teams – Notified June 5

On-boarding/learning forum – June 24 & 25 (Toronto) (3 team members)

MAY 2019	JUNE 2019	JULY 2019	AUG 2019	SEPT 2019	OCT 2019	NOV 2019	DEC 2019	NOV 2020
MAY 14 Launch SPRINT-WCPR	**JUNE 3** Deadline for submission of EXPRESSION OF COMMITEMENT	**JULY 19** Virtual Learning Session (1.5 hrs)		**SEPT 9** Virtual Learning Session (1.5 hrs)	**OCT 9** Virtual Learning Session(1.5 hrs)	**NOV 4** Virtual Learning Session	**DEC 2 & 3** Capstone Event 2 days (Location TBD)	**NOV 2 & 3** 1 year Check-in 2 days (Location TBD)
	JUNE 5 Successful team notified							
	JUNE 24 & 25 On-boarding, learning forum 2 days (Toronto)	ACTION PERIOD (PDSA)	ACTION PERIOD (PDSA)	ACTION PERIOD (PDSA)	ACTION PERIOD (PDSA)	TEAM EXPERIENCES	NATIONAL SHARING	SUSTAINABILITY

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Question and answer session

Webinar participants – please post questions for our speakers in the 'Questions and Comments' chat pod to the left of the presentation.

Please tell us who your question should be directed to.

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