Defining the Target Population
Referrals to the WCPR

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Implementation Team Members:

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*Beneficial to have an inter-professional team working on project, as well as a supportive sponsor

Aims and Objectives

Problem Statement:

- There are current gaps in inter-professional communication and shared decision-making for individuals requiring a palliative approach to care planning which leads to: slow response to change in patient needs, challenges in continuity of care and communication between providers as well as unclear roles and responsibilities of the health care team.
- For individuals, this results in frustration, unmet needs and family caregiver stress.
- For providers, this results in tension between professional care providers and programs as well as distress for the healthcare professional.

Aim Statement:

We will complete 5 Whole Community Palliative Care Rounds by November 28, 2019 with a focus on improving communication and shared decision making between providers as well as the continuity and quality of care for individuals receiving a palliative approach to care.

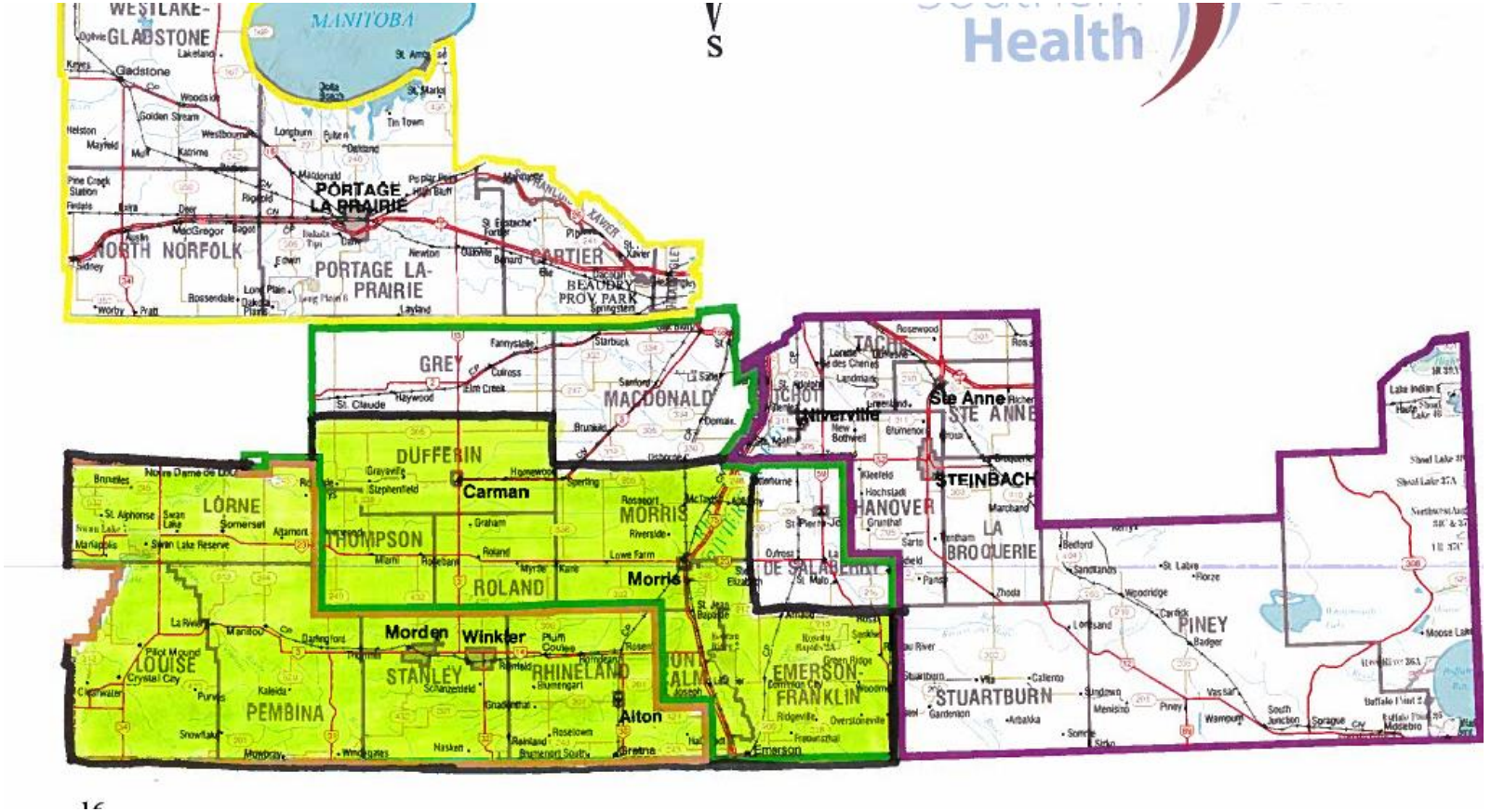
The path towards our aim:

- Defining the problem
- Defining "community enhanced circle of care“
- Identify and engage with a Medical Lead
- Identifying a site and catchment areas
- Identifying and supporting a WCPR Facilitator
- Identifying, engaging and educating front line partners and referral sources to participate in rounds
- Developing an appropriate referral process
- Developing documentation for follow up for referrals through WCPR

Identifying the target population

- Individual/caregiver(s) presenting with difficult physical/psychosocial/spiritual symptoms with patient's goal of care including a palliative approach. However, individuals do not have to be registered through the PC program.
- Any professional service provider in the defined catchment area can make a referral for patients/clients in long term, acute care or community.

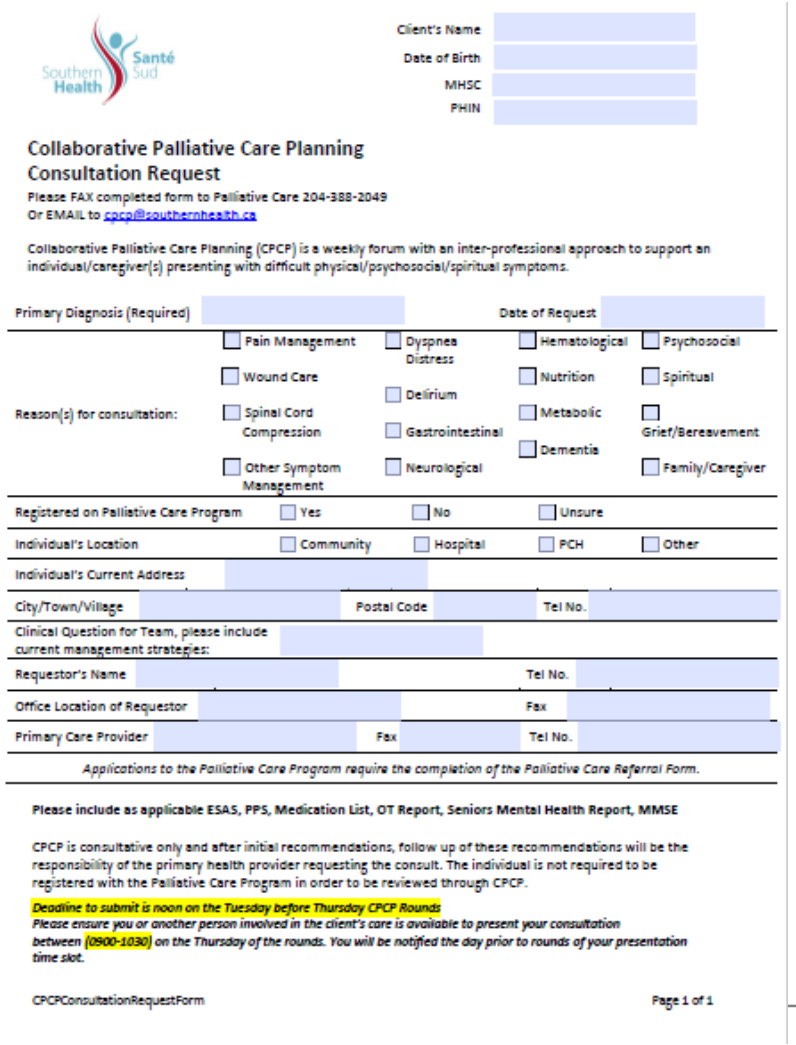
Identifying the target population



Supporting clinician's understanding of who to refer:

- Road Show in the defined catchment area: educated potential referrers with case study examples for acute patients, long term care residents and community clients
- Encouraged people when in doubt to send as we wanted to receive cases to "test"/review
- This will be an ongoing process to review as we receive referrals and measure.

Referral Process



Client's Name
Date of Birth
MHSC
PHIN

Collaborative Palliative Care Planning Consultation Request

Please FAX completed form to Palliative Care 204-388-2049
Or EMAIL to cpcp@southernhealth.ca

Collaborative Palliative Care Planning (CPCP) is a weekly forum with an inter-professional approach to support an individual/caregiver(s) presenting with difficult physical/psychosocial/spiritual symptoms.

Primary Diagnosis (Required) | Date of Request

Reason(s) for consultation:
- ☐ Pain Management
- ☐ Wound Care
- ☐ Spinal Cord Compression
- ☐ Other Symptom Management
- ☐ Dyspnea Distress
- ☐ Delirium
- ☐ Gastrointestinal
- ☐ Neurological
- ☐ Hematological
- ☐ Nutrition
- ☐ Metabolic
- ☐ Dementia
- ☐ Psychosocial
- ☐ Spiritual
- ☐ Grief/Bereavement
- ☐ Family/Caregiver

Registered on Palliative Care Program ☐ Yes ☐ No ☐ Unsure

Individual's Location ☐ Community ☐ Hospital ☐ PCH ☐ Other

Individual's Current Address

City/Town/Village | Postal Code | Tel No.

Clinical Question for Team, please include current management strategies:

Requestor's Name | Tel No.

Office Location of Requestor | Fax

Primary Care Provider | Fax | Tel No.

Applications to the Palliative Care Program require the completion of the Palliative Care Referral Form.

Please include as applicable ESAS, PPS, Medication List, OT Report, Seniors Mental Health Report, MMSE

CPCP is consultative only and after initial recommendations, follow up of these recommendations will be the responsibility of the primary health provider requesting the consult. The individual is not required to be registered with the Palliative Care Program in order to be reviewed through CPCP.

Deadline to submit is noon on the Tuesday before Thursday CPCP Rounds
Please ensure you or another person involved in the client's care is available to present your consultation between (0900-1030) on the Thursday of the rounds. You will be notified the day prior to rounds of your presentation time slot.

CPCPConsultationRequestForm Page 1 of 1

Referral form is found on our Region's website

The referrals must be submitted (email/fax) to our palliative care program by noon Tuesday for case to be reviewed on Thursday morning

Process for Intake of Referrals

By Tuesday noon: PC Admin Receives Requests for Consults

Information is entered into the Virtual Chart and Admin sends requests and applicable attachments to Facilitator

By Wednesday morning: Facilitator sends confirmation to PC Admin for cases to be reviewed including length of time for each case

By Wednesday at Noon: PC Admin Emails Team Members and Individuals Requesting Consult:

Individuals requesting consult will receive an email with phone number, access code and time to call in

Team members will receive a CPCP Rounds Document with clients names, time for review and applicable attachments

By Friday following call - Facilitator completes follow up information

Facilitator will fax/email the follow up information with the recommendations made by the team to the requester, and if applicable the primary care provider (physician or NP)

Adaptions of Existing Rounds:

- Most standard cases are well managed by sites and palliative care program.

- There is a greater need for review of more complicated cases, therefore we have extended our time for review from 10 minutes to a pre-determined amount of time suggested by the facilitator based on the complexity of the case.

Motivating partners to make referrals

* Make connections with individual service providers – face to face promotion
* Leadership buy-in is crucial
* Education Roadshow for WCPR
* Utilize team members to do local promotion:
  * Medical Lead emailed other physicians about service
  * PC Team encouraged service providers to refer certain cases

Engaging Team Members to Participate Weekly

PDSA: Some actions worked better than others….

- PC Director requesting program managers to identify team member
- Approaching individuals to participate with the promise we are measuring and request a small (5 week) commitment
- Some individuals volunteered after our education roadshow

Anticipated Challenges and Opportunities

Challenges:

- Sustainability: continuing to promote WCPR to professionals to refer = keep up team momentum
- More referrals from Home Care to build inter-professional communication = continuing with PDSAs
- Team members who are on weekly call but not feeling they are able to contribute = reviewing cases and who contributed in early January. This will help team decide who should continue on call

Opportunities:

- Spreading throughout the region
- All PC Team playing more of a role promoting and educating on service
- Increasing capacity and confidence for service providers to provide end of life care