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North Simcoe Muskoka Hospice Palliative Care Network

Regional Team Development in North Simcoe Muskoka

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Goals for Discussion Today

- Review the current provision of palliative care in North Simcoe Muskoka LHIN
- Identify local initiatives to advance hospice palliative care in the region
- Discuss opportunities to implement recommendations within the region
- Discuss questions posed by the group

Current Provision of Palliative Care in NSM

- Long Term Care Homes
- First Nations Communities
- Retirement Homes
- Community Services
- Integrate/ Cancer Care Ontario & RVH

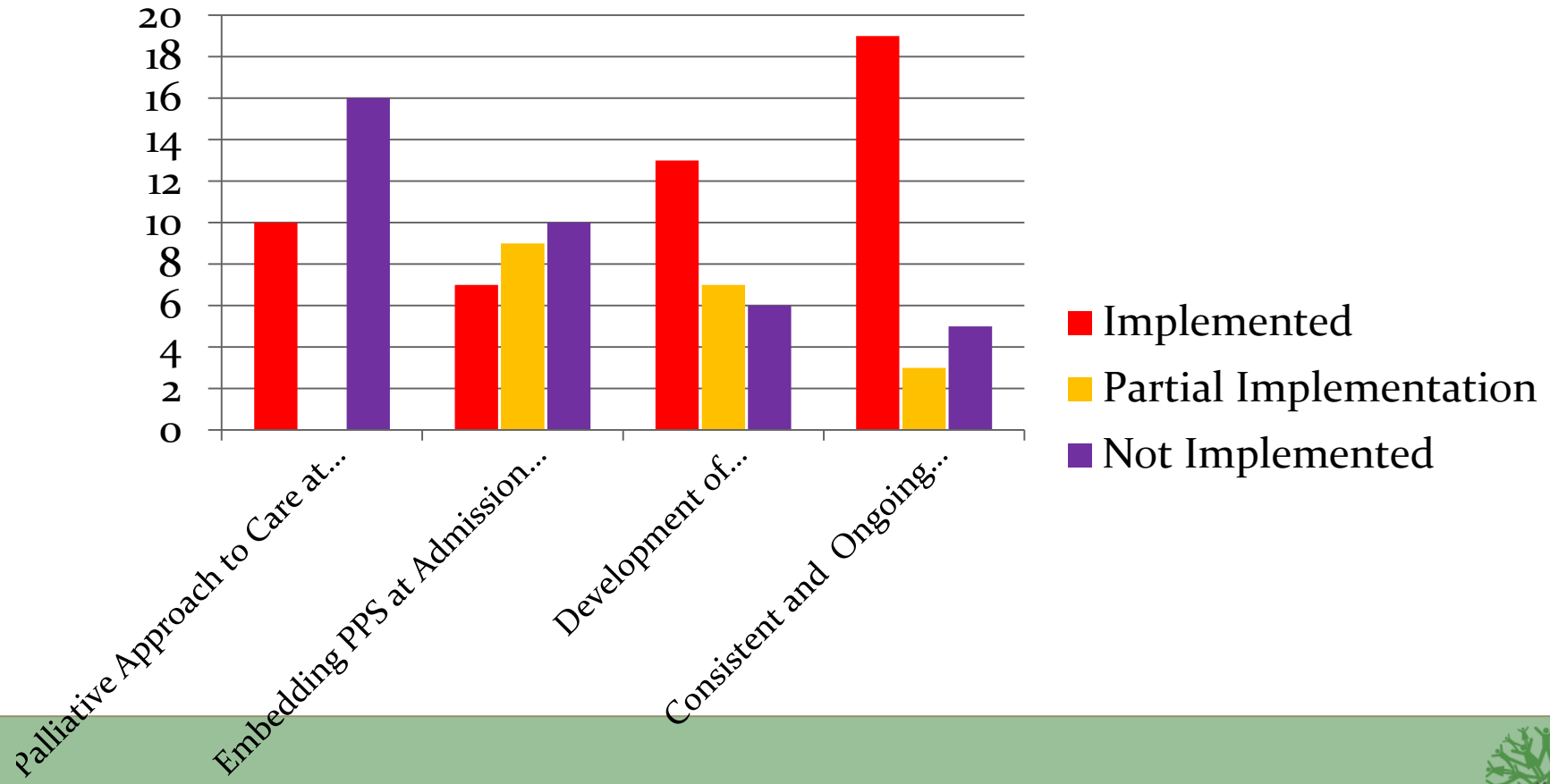
Long Term Care Homes

- 26 homes across NSM LHIN
- NSMHPCN consultants have become integrated into each of these homes to facilitate the implementation of best practice and gold standards in hospice palliative care and to provide consultation for pain and symptom management of complex residents
- Guiding documents include:
  - The Way Forward 2014
  - Advancing High Quality High Value Palliative Care in Ontario 2011
  - Quality Palliative Care in Long Term Care Alliance (and Toolkit)

Key Goals in Long Term Care

- Standardize a high quality of palliative care in each long term care home in NSM LHIN
- Implement a palliative approach to care from point of admission (Includes early and ongoing Advance Care Planning discussions)
- Embedding use of PPS into policy at point of admission and quarterly
- Development of interdisciplinary palliative care teams
- Consistent and ongoing education for all staff

LTCH Results to Date



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First Nations

- NSMHPCN consultants have been spending time over the past year creating relationships with local communities
- Learning about their wishes for palliative care programs and how we as a region can support these goals
- Regional Cancer Program, Aboriginal Patient Navigator
- Local hospices

First Nations- Key Goals

- Christian Island specific- development of a volunteer caregiver group and training and the implementation of EDITH and SRK processes for after hours
- Grief and Bereavement education and development of formalized debriefing processes
- Creating linkages to community palliative care: hospice, volunteers, EDITH protocol, CCAC services, EMS/ transportation processes, the Network for mentoring/ coaching, consultation, strengthening relationships
- Aboriginal system navigator at NSMRCC and patient navigator at GBGH

First Nations- Results to Date

- Christian Island- education has been initiated as well as a CAPCE certified nurse who lives in the community. Other linkages also continue to develop
- Grief and Bereavement inservices and support have been offered in each community, with a couple that have actually had this education delivered
- Linkages with various local palliative care providers is further ahead in some communities than others. Most have been linked with local hospices and other services such as CCAC are at varying levels of development
- Navigator role at GBGH has been established as well as the regional navigator at RVH cancer program

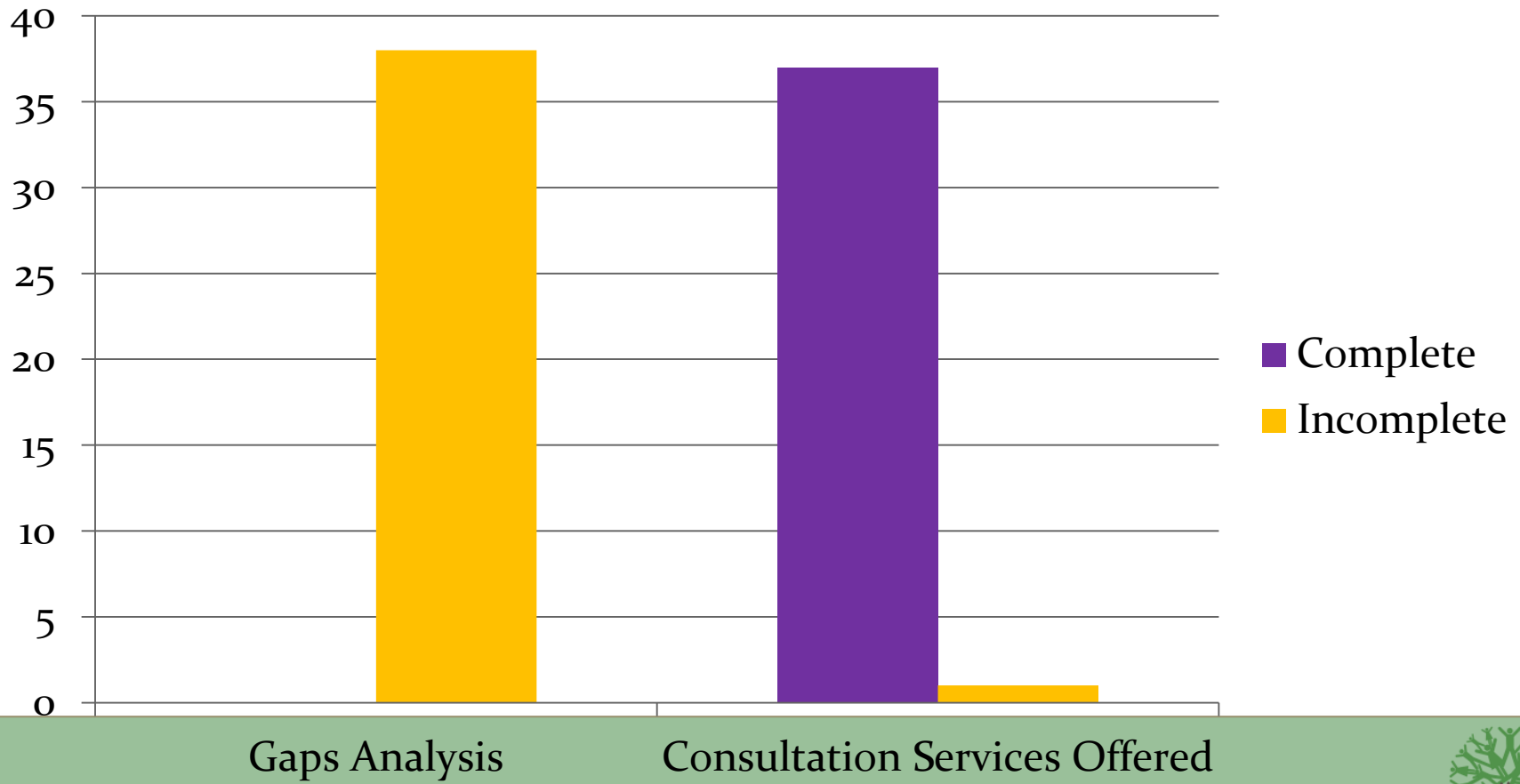
Retirement Homes

- This sector is the newest addition to be recognizing the need for a palliative approach to care

Initial goals include:

- Completing gap analysis
- Offering pain and symptom consultation services
- Creating linkages with community palliative care services
- Introduction of Advance Care Planning education and support

Retirement Homes- results so far



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NSM Community Care Access Centre

- Involved with the CCO Integrate project at various levels, including membership on steering committee and ground level implementation
- NSMCCAC staff attended the Value Stream Mapping in each sub-region to support development and implementation of comprehensive teams
- Working with Health Links planning tables to improve communication and coordination of care
- Partnered with the 3 residential hospices in LHIN 12 for the assessment, referral and waitlist of patients

NSM Community Care Access Centre

- Dedicated case loads- client care coordinator is focused on providing assessment, care planning and navigation to palliative patients and their care providers
- Nurse Practitioners- Hospice Palliative Care- 5 in NSM. Provide primary care support to community patients
- Working with primary care to enhance and develop communication tools and access to information to support planning and patient care
- Supporting community rounds

Community Nursing

- Participating in the regional change teams work that came out of the 5 Value Stream mapping events
- Participating in weekly community rounds
- Attending conferences
- Supporting regional committee work with the NSMHPCN
- Education- each organization is providing staff education in different ways. i.e. Bayshore has invested in developing a LEAP facilitator who is currently delivering this curriculum to registered staff

The North Simcoe Muskoka Integrate Project is a partnership between:

- Barrie and Community Family Health Team
- Hospice Simcoe
- North Simcoe Muskoka Community Care Access Centre
- North Simcoe Muskoka Hospice Palliative Care Network

Simcoe Muskoka Regional Cancer Program at Royal Victoria Regional Health Centre

An initiative of / Une initiative du
CANADIAN PARTNERSHIP AGAINST CANCER / PARTENARIAT CANADIEN CONTRE LE CANCER

Cancer Care Ontario
Action Cancer Ontario

INTEGRATE Background

- Spring 2013: Canadian Partnership Against Cancer (CPAC) released grant with focus on integrating cancer care and palliative and end of life care
- June 2013: CCO submitted INTEGRATE Project proposal in partnership with Champlain, NSM, Toronto Central and Quebec
- October 2013: CCO INTEGRATE Project accepted
- January 2014: INTEGRATE Project kicked off

The INTEGRATE Project spans 2014 – 2017 with $1M awarded from CPAC and significant in kind funds put forward from partners

CPAC – INTEGRATE Overview

1

Adapt and Implement Provider Education

Engage, adapt, implement and evaluate education for primary level providers (PCP, oncology, community) in **Ontario and Quebec**

Engage **First Nations, Inuit and Metis** to identify opportunities and barriers, develop, adapt, implement and evaluate

2

Implement Integrated Care Models

Implement and evaluate early identification campaign and linkages to community resources in **primary care setting**

Implement and evaluate early identification campaign and linkages to community resources in **cancer centre setting**

Local Initiatives to Advance Palliative Care in North Simcoe Muskoka

- Regional Team Development
  - What is it?
  - Where are we at?
  - Using Client Value Statements
  - Experience Based Design

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Regional Team Development- Purpose

Compare B, where care is coordinated between all involved team members to A, where everyone works independently and the patient has to navigate the system alone.

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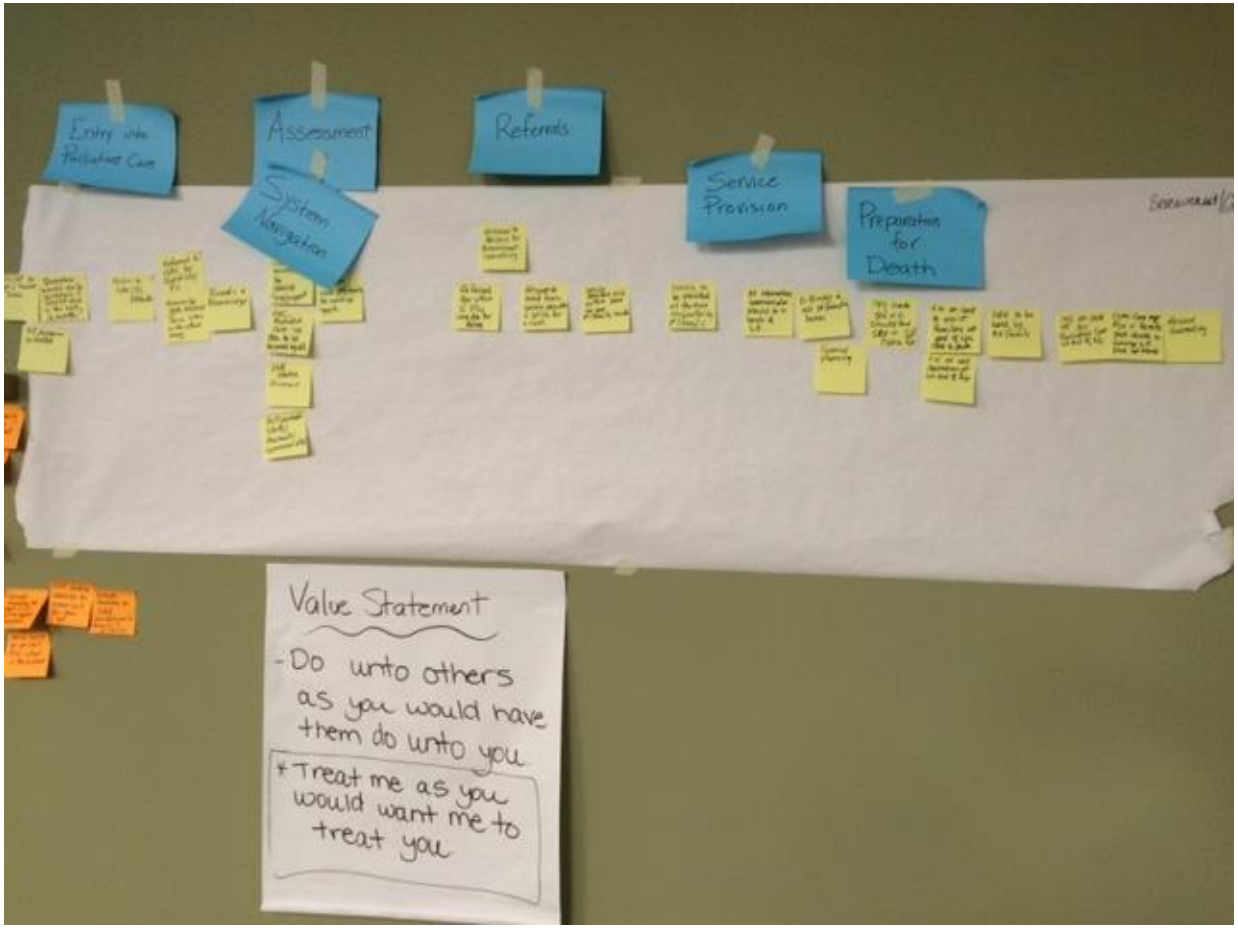
Value Stream Mapping- a vehicle for change

- Community stakeholders came together for a value stream mapping event to determine the palliative needs of their region. Value stream mapping (VSM) and analysis is a technique that facilitates identification and implementation of system level changes.
- Through this approach, clients, caregivers, providers and other stakeholders co-design a desired “future state” that removes waste and increases value for the target population.

Current State

Future State



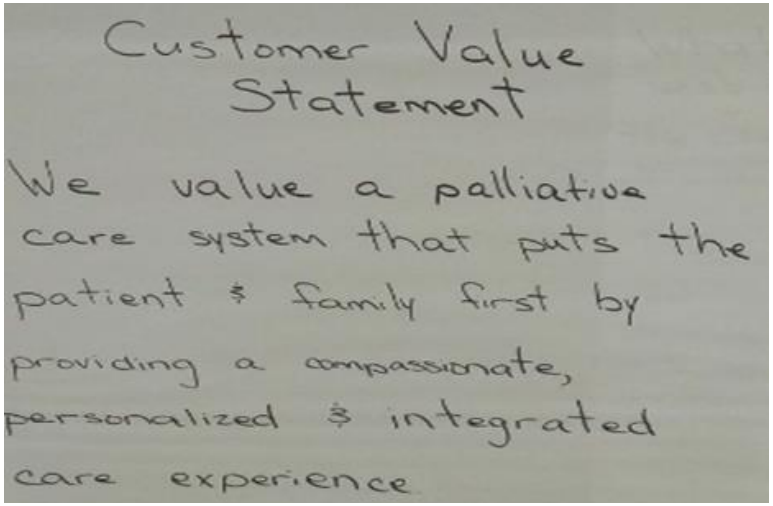
Common Change Concepts across NSM

- Reduce the amount of time patient and family spends repeating information through the development of a common assessment
- Streamline the process for entry into the palliative care team by implementing a common intake/ referral form
- Implementation of a standardized approach to Advance Care Planning
- Improve early introduction to palliative care by utilizing volunteer navigators
- Improve early identification for palliative services by utilizing the surprise question and implementing a common entry point

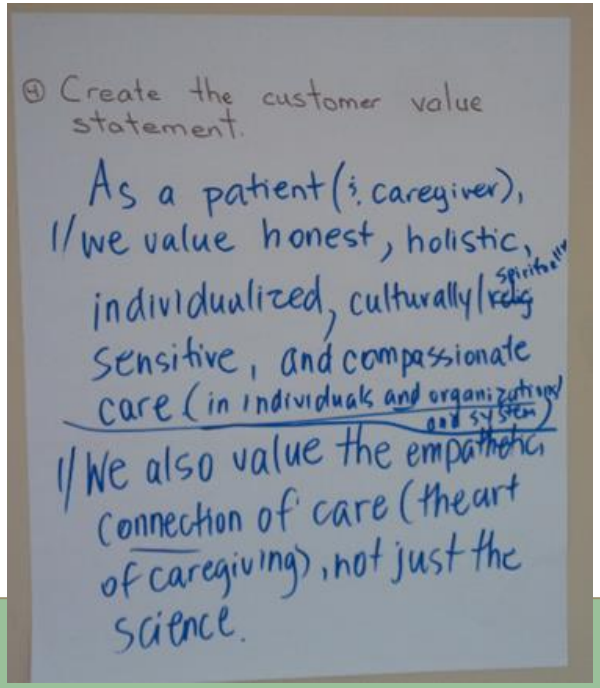
Client Value Statements and Experience Based Design

- Part of the work during the Value Stream Mapping is to incorporate the voice of the customer (patient) into our change ideas and future state maps.
- One way we accomplish this is through the development of customer value statements
- This is part of Experience Based Design (we design systems based on the experience and values of the people it serves)

Client Value Statements



Provide me and my family with consistent, informed supportive care through my palliative and end of life experience.



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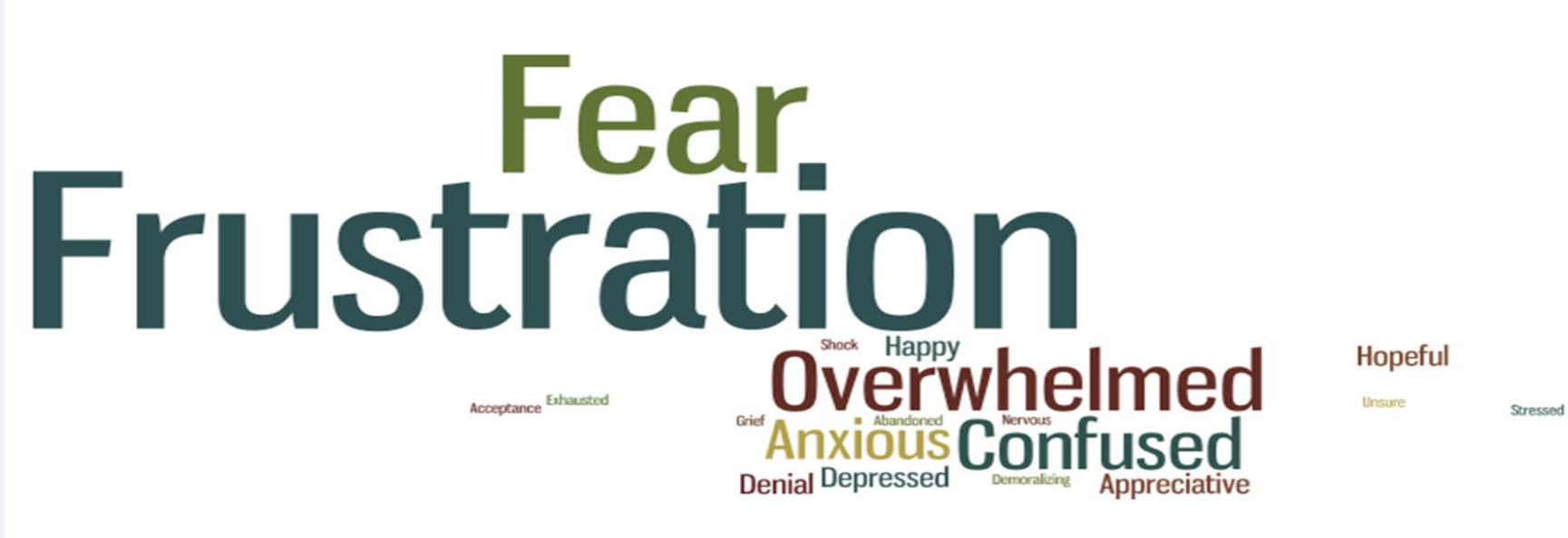
Capturing Patient Emotions

- Another method of Experience Based Design which helps us reflect on the value and experience of the customer…



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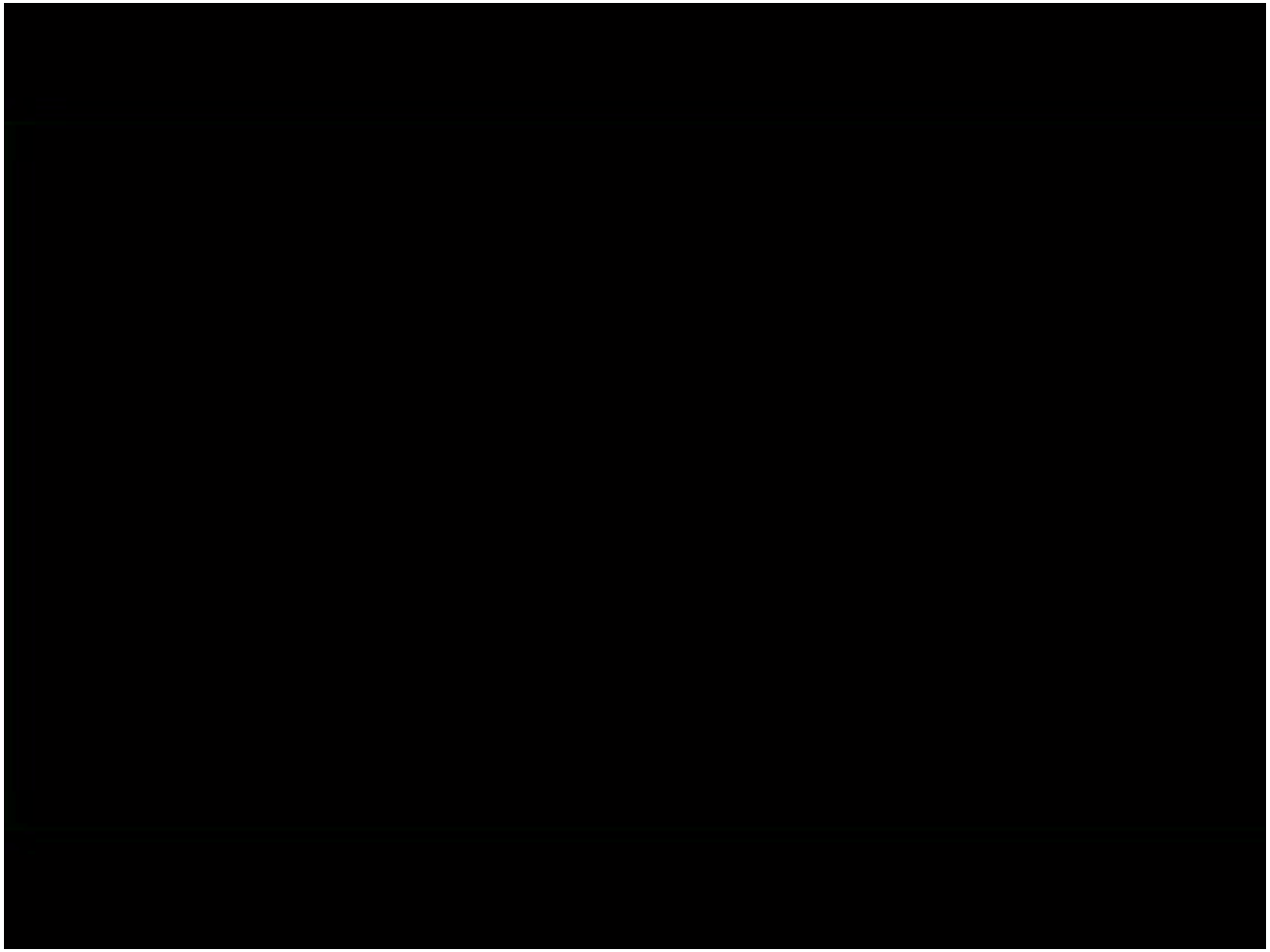
Patient and provider perspectives

- With permission from the Stillwater Medical Group, Stillwater, MN



Shared Decision Making

- Palliative care requires an interdisciplinary team approach to care for patients with life limiting illness and their family members.
- Shared Decision Making (SDM) is an approach where clinicians and patients share the best available evidence when faced with the task of making decisions where patients are supported to consider options to achieve informed preferences in care.

Shared Decision Making

- Shared decision making (SDM) is a concept that has been supported for decades by clinicians and researchers.
- SDM is an approach to clinical decisions in which patients and healthcare providers work together to reach a mutually agreed upon decision that is consistent with the best available evidence, as well as the patients' preferences.

Why SDM is important?

- Decision making in palliative care has a special quality where the desired outcomes of a palliative patient will differ from the outcomes desired when prevention of disease or cure is still possible.
- Engaging patients in decisions about their care increases their involvement and satisfaction.

Why SDM is important?

- In many cases there are several treatment options available.
- Evidence-based assessments of treatments and interventions often fail to identify one treatment as clearly superior to another.
- Shared decision making (guided by providers) can help patients understand the benefits and harms of the options and clarify their own values and preferences.

The SHARE Approach

- The SHARE Approach is a five-step process for shared decision making that includes exploring and comparing the benefits, harms, and risks of each health care option through meaningful dialogue about what matters most to the patient.

The SHARE Approach

- **Step 1**: **S**eek your patient's participation
- **Step 2**: **H**elp your patient explore and compare treatment options
- **Step 3**: **A**ssess your patient's values and preferences
- **Step 4**: **R**each a decision with your patient
- **Step 5**: **E**valuate your patient's decision

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Collaborative roles in SDM – Key Roles

- Patient
  - Actively participates and is the center of shared decision making
- Physician, physician assistant, or nurse practitioner
  - Lets their patient know there is a choice and invite patient to be involved in the decision
  - Presents options and describes the risks and harms
  - Explores patient's values and preferences

Benefits for your patients

- Shared decision making can:
  - Improve the patient's experience of care
  - Improve patient participation to treatment recommendations - emerging evidence that it can help improve health outcomes

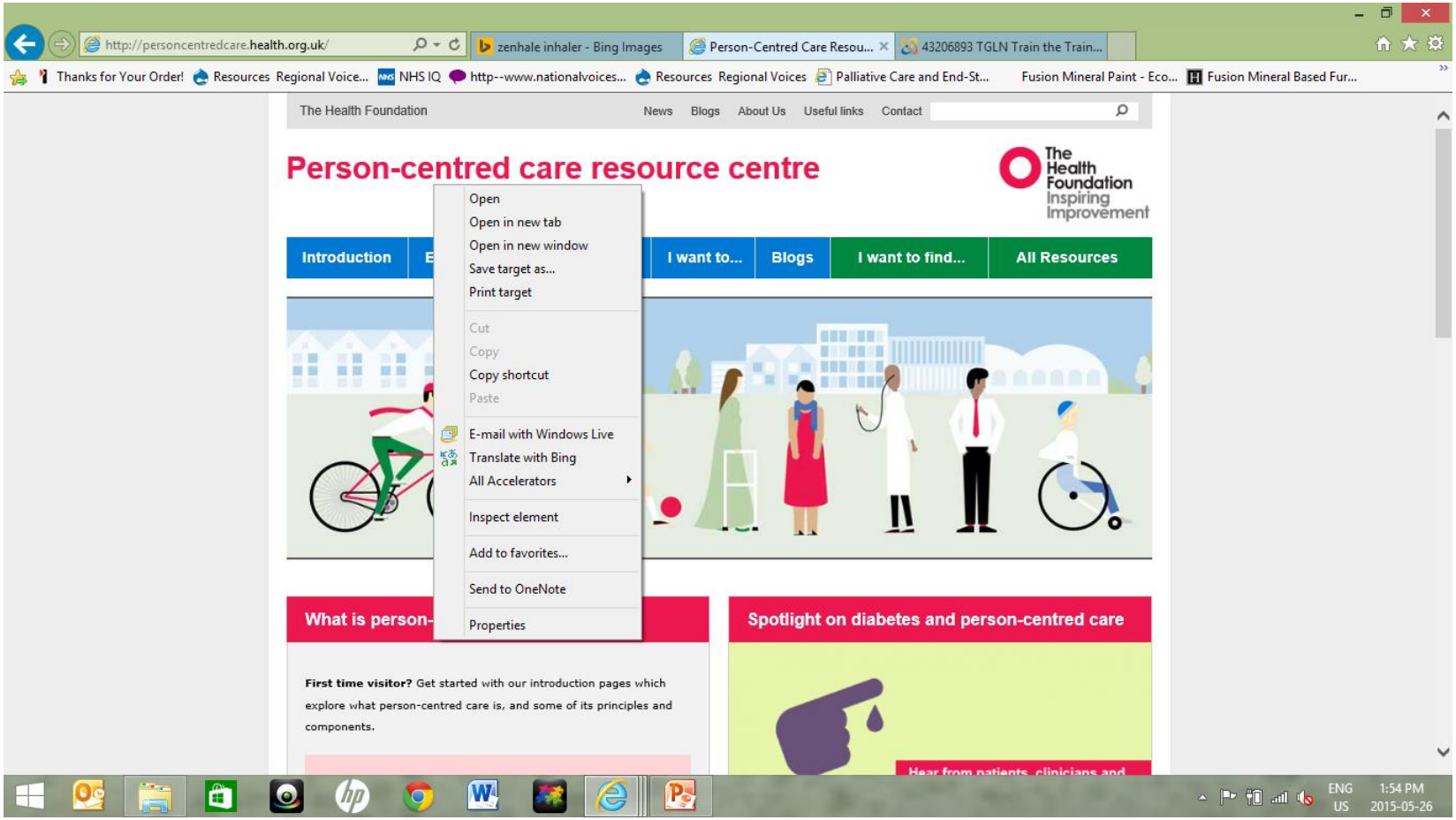
Benefits of SDM in Palliative Care

- The benefits of SDM include better informed patients regarding treatment options and prognosis, more satisfied patients, increased efficiency of office visits and increased utilization of resources.
- The implementation of the SDM framework in the palliative care teams holds promise for ensuring that palliative care is truly patient centered and services are integrated thereby ensuring an improved end of life journey for palliative patients.

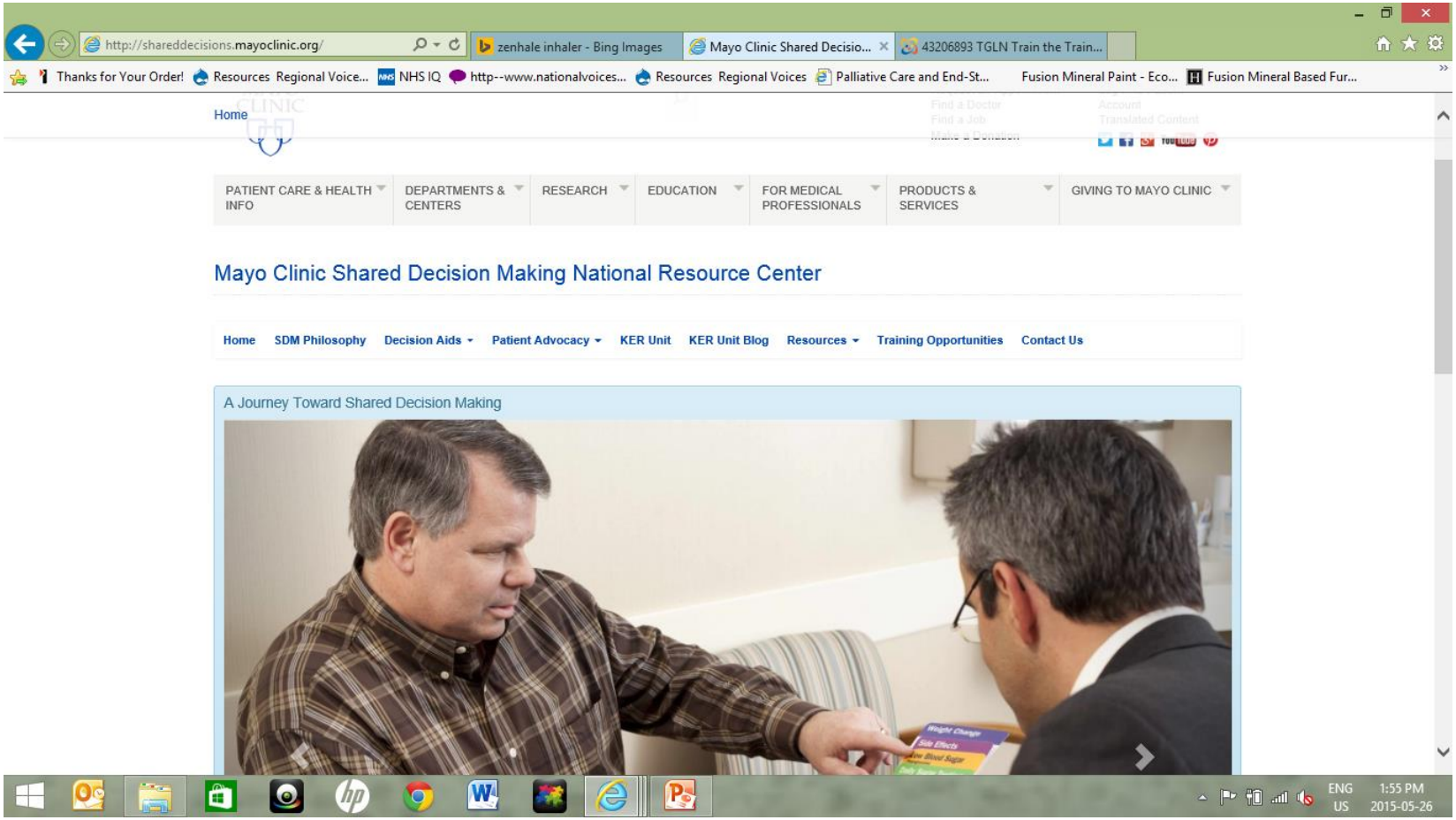
Benefits of SDM in Palliative Care

- Palliative care patients represent a very vulnerable population and it may be assumed that they are too sick to be involved in decision-making about their care.
- The results of quantitative research, although based on small convenience samples from different settings, show that the preferences of palliative care patients for participation in decision-making may not differ drastically from those of healthier patients

Personcentredcare.health.org.uk



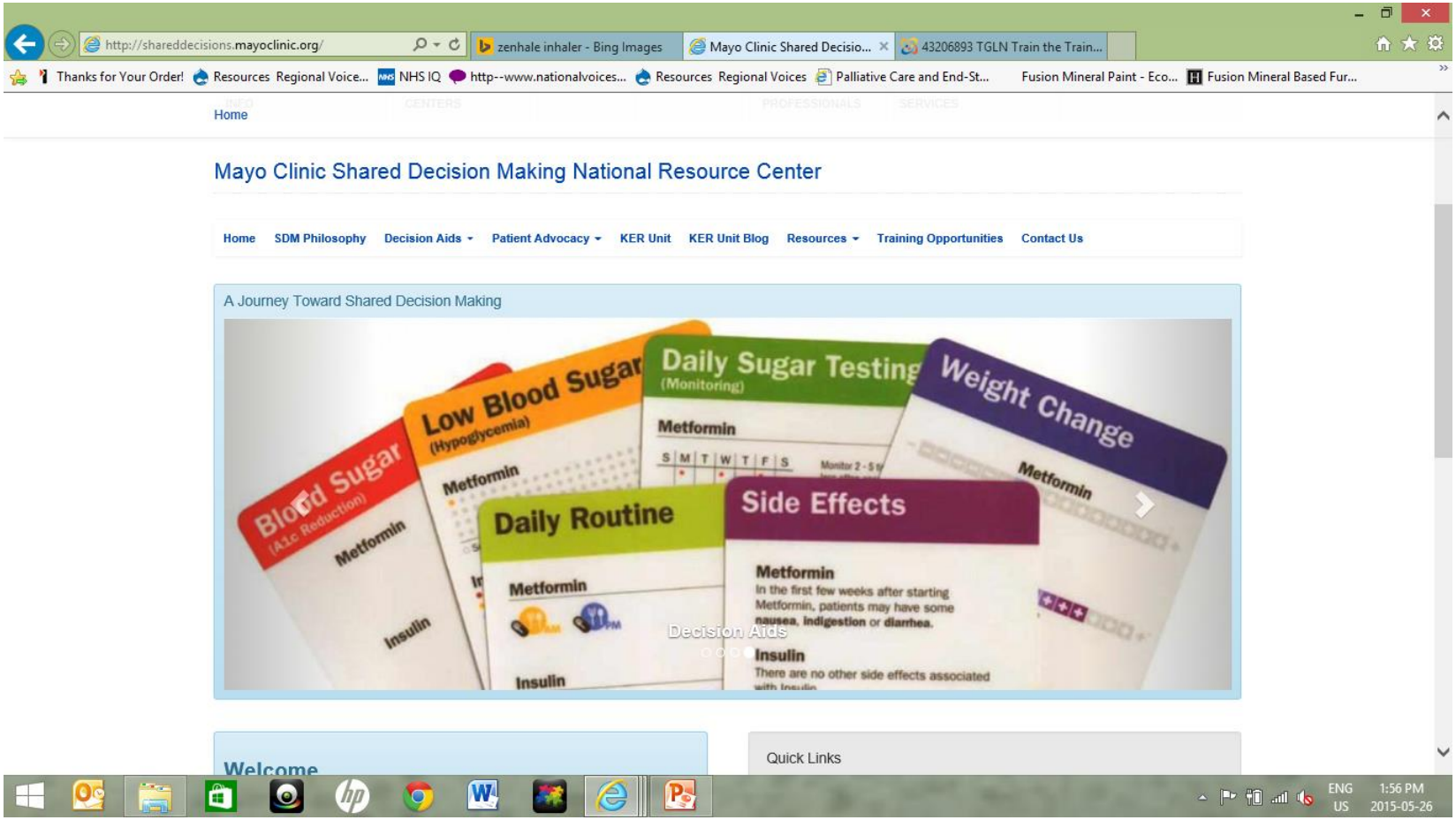
Shareddecisions.mayoclinic.org



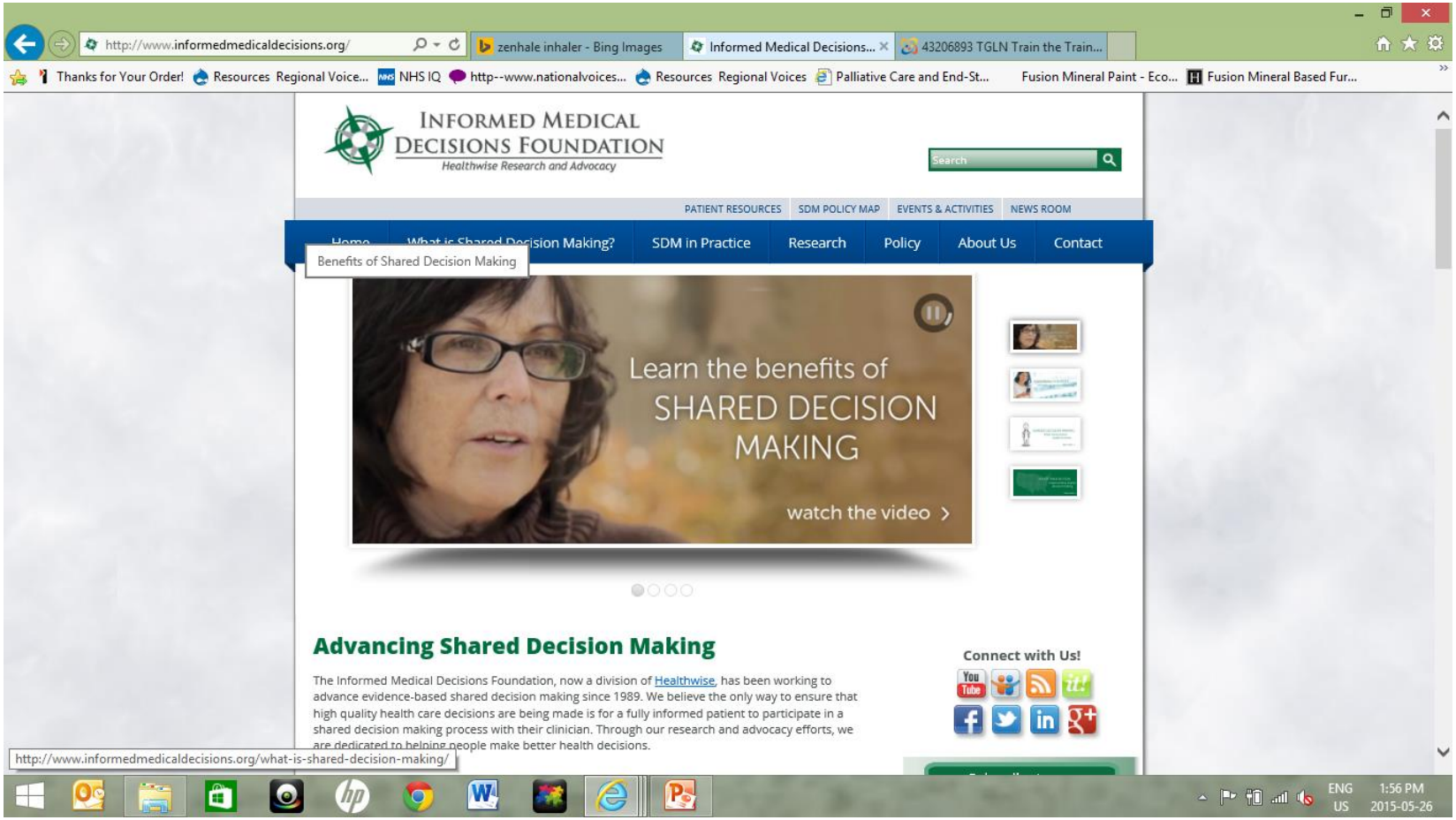
Benefits of using decision aids in shared decision making

- Improves patient's knowledge of options
- Results in patient having more accurate expectations of possible benefits and risks
- Leads to patient making decisions that are more consistent with his/her values
- Increases patient's participation in decision making

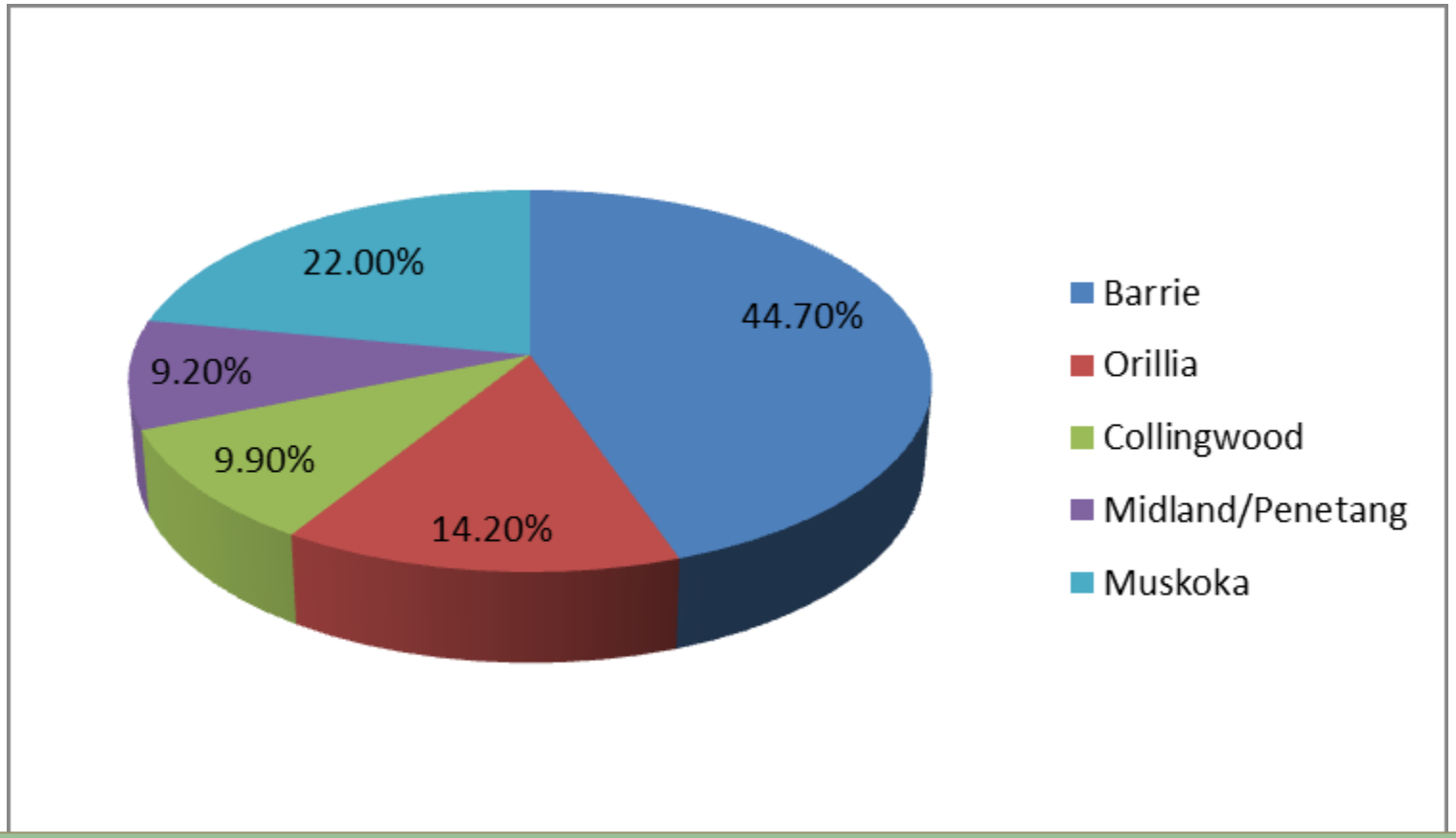
Patient Aids



www.informedmedicaldecisions.org



Stakeholder Analysis



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Themes that Emerged

- Our last survey question asked respondents to tell us how they felt we could improve our services. One hundred and forty one responses were received
- Themes that emerged from the responses include:
  - Mandatory ongoing education in palliative care for volunteers.
  - Improved communication between service providers;
  - Additional sessions of palliative care courses and increased flexibility for learning (i.e. on line).

Themes that Emerged

- More education of the public and the importance of advanced care planning.
- Palliative care needs to begin at diagnosis so that care delivery can be planned more effectively.
- Regular communications on education /conferences.
- Share best practice from other districts.
- Promotion of the Hospice Client Volunteer - helping people stay in their own home.
- Education for direct care agency providers to ensure continuity in care and communication.
- More linkages and collaboration.

Conclusions

- Update on Palliative care service provision in NSM has been provided.
- Strategies aligned with quality improvement within palliative care have been shared.
- Through the VSM process regional teams are identifying the wastes and are owning the accountability associated with developing an improved integrated service delivery model for the palliative patients in the LHIN.
- The implementation of the SDM framework in the palliative service delivery model of care holds promise for ensuring that palliative care is truly patient centered and services are integrated thereby ensuring an improved end of life journey for palliative patients.

Questions

Contact Information

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