Project Early Integration of Palliative Care Presentation #3

PEI Provincial Integrated Palliative Care Program

Health PEI

One Island Health System

The Project
"Early Integration of Palliative Care"

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What will you learn?

At the end of this presentation, you'll have an understanding of:

1. Project Background - Gaps, Strengths, Limitations
2. Palliative care earlier – motivation for change and benefits of early palliative care
3. Rational for Project
4. The Project "Early Integration of Palliative Care"

Identified Gaps in Palliative Care

- Lack of accountability and provincial standards
- Lack of awareness and education among the public and among health care providers
- Lack of seamless, integrated care
- Lack of use of technology
- Lack of access to services
- Lack of caregiver supports

Health PEI Palliative Care Framework and Action Plan (2015-2020)

Service Strengths

- Provincial Integrated Palliative Care Program (P-IPCP) integrated with community paramedics, acute, LTC, and based on need
- Island size & Family Physician profile(multiple work settings)
- Prior experiences in implementation, i.e., P-IPCP, Paramedics Providing Palliative Care at Home, ACP/GOC
- Openness of many Family Physicians/NP to provide the palliative approach
- Community of practice and previous training provided to front line staff
- Palliative Care champion's group
- Successes/relationships building over the last decade of developing program across PEI

Limitations

- Limited financial and human resources
- Absence of Health Information Unit and analyst support within our programs
- Insular reality: years behind in many ways when it comes to progress and culture change
- At a population level, misunderstanding of what Palliative Care (PC) can provide and its place in the system
- Confusion between PC and hastening of death
- CTC culture still generally does not embrace or support early integration in an active way (influences the "sales pitch" to the patient). Lack of education around PC and early integration amongst staff leading to many late referrals

Motivation for Change

- **Recent research from CIHI (2018)**
  - Few Canadians receive PC @ home – less than 15% (Ontario/BC)
  - Those receiving PC – less likely to visit ER frequently or to receive aggressive treatment at EOL
  - Most LTC residents > 6 months to live don't have record of PC
  - 94% of patients who died in hospital could have benefited from PC
  - 88% of people who died in hospital had no record of palliative needs when 1st admitted to hospital
  - PC in LTC helps prevent avoidable hospital transfers
  - Receiving home-based PC in last year of life, increase the chance that patient will die @ home

- **Similar Ontario project**
  - 40% reduction in hospital readmissions/admissions
  - More patients dying at home (54%) compared with patients not identified as palliative (35%); Early identification improved end of life experience and showed decreased anxiety due to better planning and earlier conversations with their loved ones

Benefits of Early Palliative Care

Patient

- Reduced symptom burden
- Less anxiety and depression
- Less caregiver burden
- Better quality of life
- Less aggressive treatments
- Longer life expectancy
- Improved satisfaction with care

System

- More appropriate referral and use of palliative resources
- Decreased Emergency Department visits
- Admission avoidance
- Measurable hospital savings through significant reductions in pharmacy, laboratory and intensive care costs

Smith et al., 2012; Temel et al., 2010; Bakitas et al., 2009; Myers et al., 2011; Zimmerman et al 2013

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Rational for Project

- Builds upon the work of the P-IPCP and accelerates the *Health PEI Palliative Care Framework and Action Plan*
- Aligns with the Health PEI Strategic Plan (2017-2020) strategic priorities of patient-and family-centered care and increase use of innovative practices that improve care
- Palliative and EOL priorities set out in Provincial Cancer Strategy released in 2016
- Furthers ACP/GOC work across care settings resulting from the ACP/GOC project in partnership with CPAC and CHPCA
- Research is showing that early integration of palliative care can improve patient outcomes, including symptom control and quality of life, and caregiver outcomes, such as reduced stress and dysfunctional grief

Project Description

- HPEI led collaboration in partnership with **HPEI ACP Steering Committee, Provincial Cancer Coordination Steering Committee** and **Canadian Partnership Against Cancer** to provide earlier integration and better access to high quality palliative care and end of life care in settings of care including: 5 Home Care Regional Sites, 9 Public Long-Term Care Facilities, 1 Acute Psychiatric Hospital, 2 Acute Care Hospitals, 5 Community Hospitals, 12 Primary Care Health Centres, Provincial Cancer Treatment Centre and Satellite Site, Island EMS, 2 First Nations Health Centres
- Early identification of patients who would benefit from a palliative approach is essential to ensuring that patients have access to the services they need, at the right time, at the right place, by the right care provider
- Builds upon foundation of Provincial Integrated Palliative Care Program
- Accelerates *HPEI Palliative Care Framework and Action Plan*
- 4-year project (July 2018 – June 2022)
- Funded by Canadian Partnership Against Cancer (CPAC)

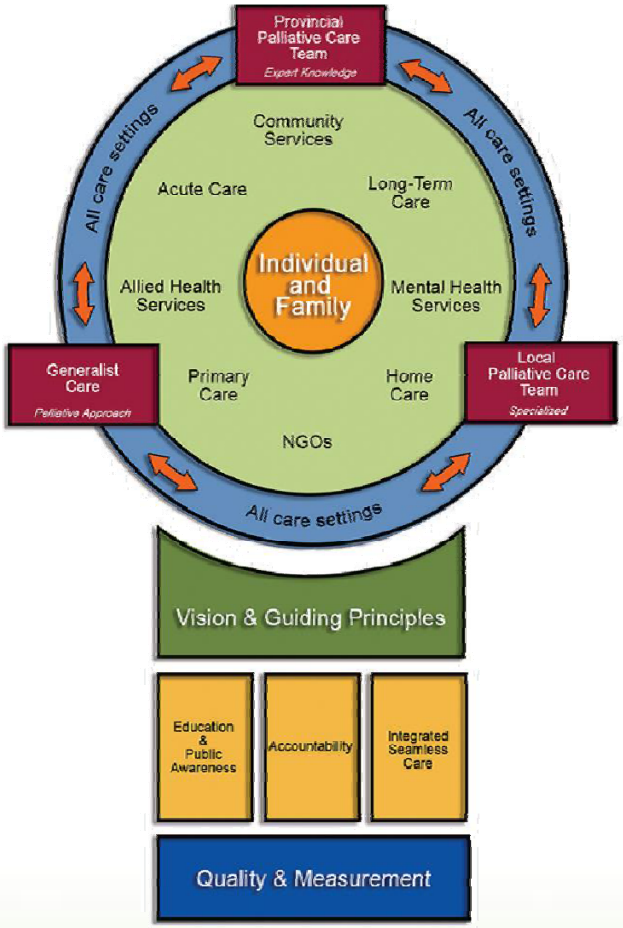
Project Objectives

- Increase competency and capacity of providers, patients and caregivers to offer early palliative and EOL care province wide in a variety of care settings
- Develop tools, processes and pathways to support clinicians in identifying patients with palliative care needs
- Strengthen the P-IPCP and build communities of practice
- Build a fully integrated sharing system to provide seamless, coordinated and integrated patient-centred care
- Better reporting and monitoring of palliative care indicators and quality measures
- Build awareness of ACP and GOC to help break down misconceptions and increase informed decisions

Three Key Implementation Tools

- Framework for an Integrated Palliative Approach to Care - a Shared-Care Model
- Australian Model for Population-based Palliative Approach (2005)
- Palliative Approach to Care Algorithm

Framework – A Shared-Care Model



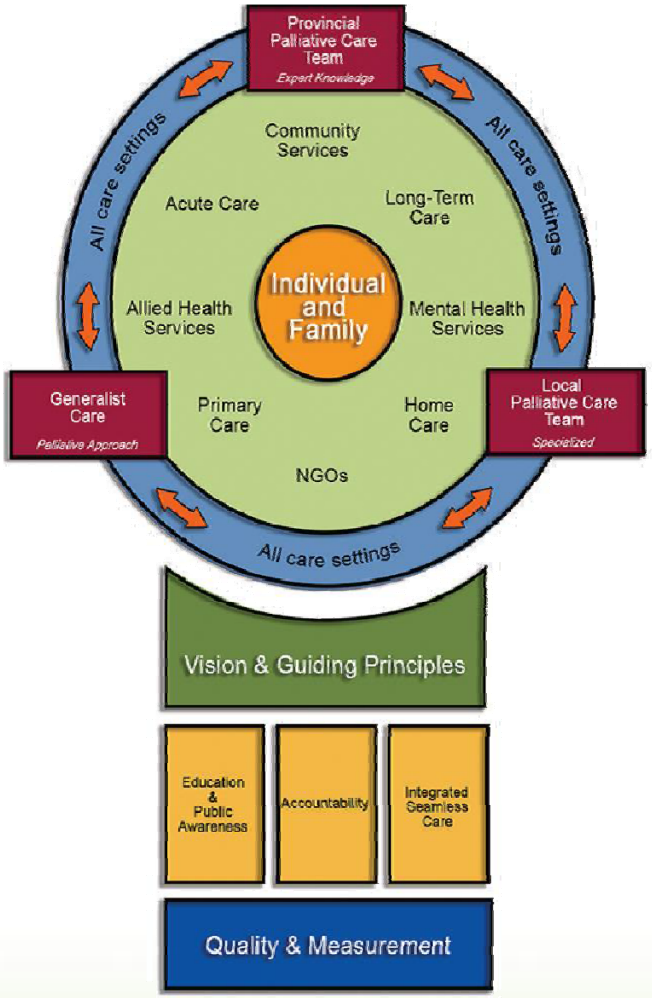
An integrated palliative approach is a **Shared-Care Model** where -

Generalist care providers such as primary care providers, home care nurses, long-term care staff, hospital staff and other health care workers will provide an integrated palliative care approach

Local Palliative Care Teams (coordinated by Home Care Palliative Care Coordinators in each of 5 regions) with specialized palliative care knowledge will provide support and consultation for generalist care providers as necessary within their local care setting

Provincial Integrated Palliative Care Team
(palliative care physicians, nurses, social worker, spiritual care adviser - located at the Provincial Palliative Care Centre) will provide expert palliative care knowledge to the Local Palliative Care Teams and to Generalist care providers as necessary

Framework – A Shared-Care Model



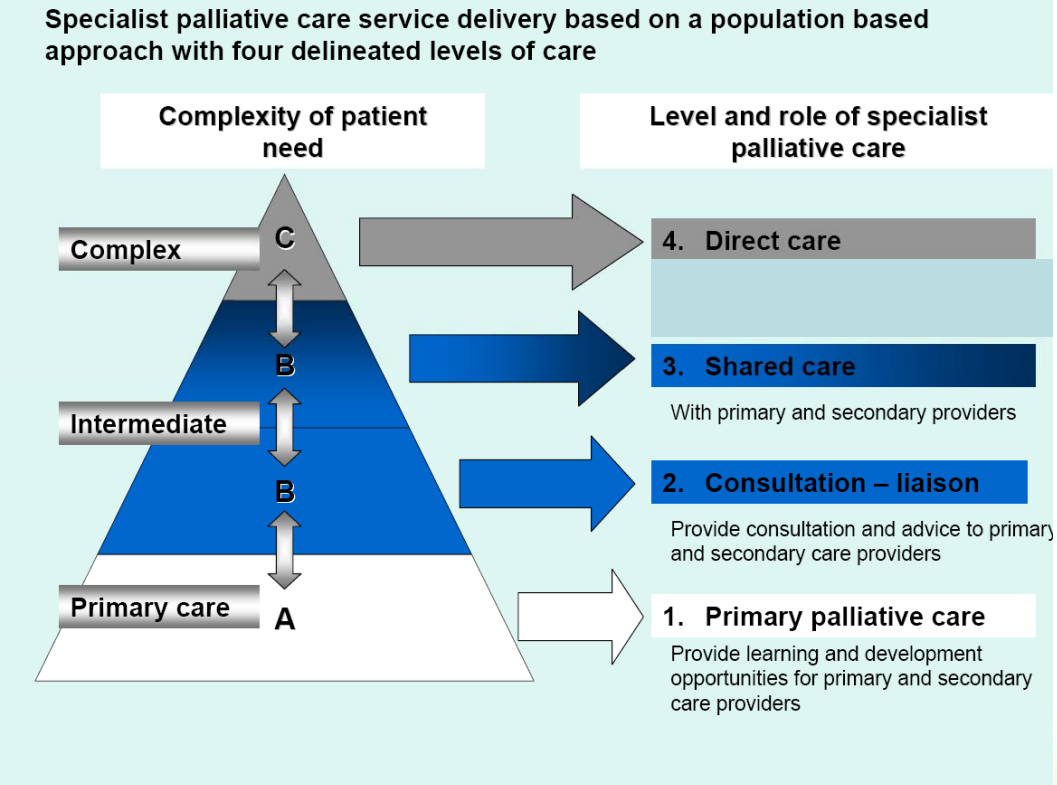
Shared-Care Model
within an integrated palliative approach utilizes tested and valid assessment tools and other appropriate resources to support care settings to identify patients who could benefit from a palliative approach to care earlier in the disease trajectory

Three key priorities for action:
Education & Public Awareness
Accountability
Integrated Seamless Care

Foundation of Framework is
Quality and Measurement

Australian Population-based Palliative Approach Model

- Emphasizes the integrated approach to provide palliative care in all settings
- Integrates aspects of palliative care with chronic disease management

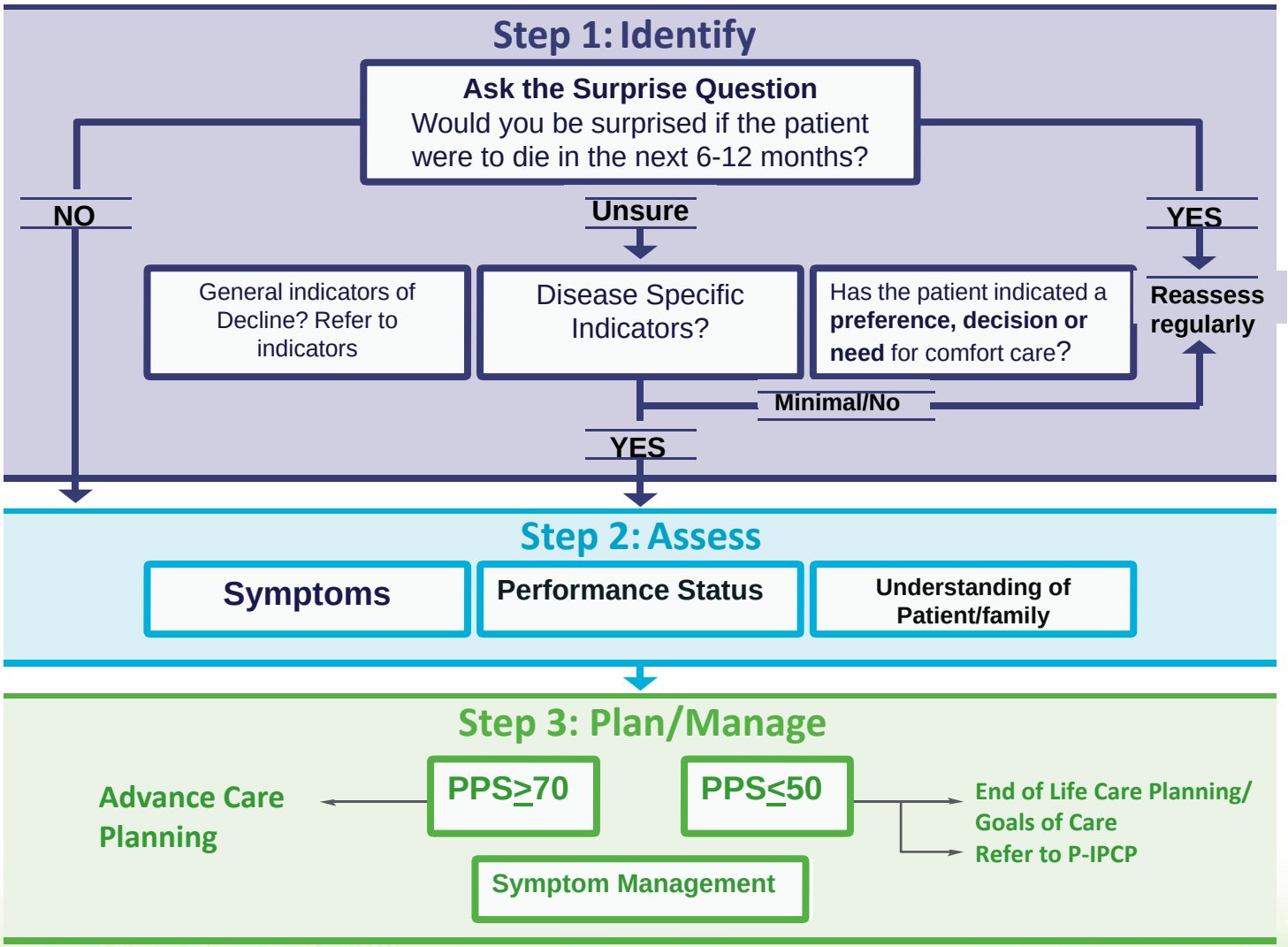


Group C (Complex)
Patients having complex needs requiring skilled specialist practitioners

Group B (Intermediate)
Patients having sporadic exacerbations requiring access to specialist palliative care services for consultation and advice. Will continue to receive care from their primary care provider

Group A (Primary Care)
Patients not requiring specialist care as needs are met through primary care providers

Palliative Approach to Care Algorithm



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5 Key Strategies of Project

1. Planning for palliative care integration across the Health System
2. Patient/Caregiver Engagement & Education
3. Health Care Provider Engagement & Education
4. Identify and connect palliative care providers
5. Measure and report on progress

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Our Spread Plan

- "LEAP", a two-day education program will be offered as a key component to increase knowledge and comfort in palliative care for clinicians
- Palliative Care Champions within each care setting will be identified and engaged to assist with the spread of the plan
- Education for providers in all care settings to identify and embed assessment tools/related resources to increase capacity for early integration and identification of patients with palliative care needs
- On-line Staff Resource Center established for "all things" palliative care including educational presentations
- SERIOUS ILLNESS CONVERSATION workshops will be conducted
- Additional support for physicians in community by access to email – pallcaredocs@gov.pe.ca
- Additional support for nursing in the workplace by access to 24/7 email to the palliative care unit charge nurse (24/7 pall care physician support) – palliativenursing@ihis.org (not active yet)

High-Level Project Plan

- Year 1 (2019/20)
  - Project planning for integration of project across health system
  - Patient/caregiver engagement & education (ACP/GOC)
  - LEAP (Learning Essential Approaches to Palliative Care) training
  - Identifying and connecting palliative care providers throughout project life
- Year 2 (2020/21)
  - Patient/caregiver engagement & education - continued
  - Provider engagement & competency/tools/resources education
  - LEAP training - continued
  - Measuring and reporting on progress
- Year 3 (2021/22)
  - Patient/caregiver engagement & education - continued
  - Provider engagement & competency/tools/resources - continued
- Year 4 (2022)
  - Accountability & measurement
  - Share learnings

How Do We Know When We Get There?

	Benefits of the Project
Outperforms current practice	• The process of identifying patients with palliative needs is streamlined, integrated and standardized across the health system
Improves patient & family experience of care	• Unnecessary transfers & transition to specialized palliative caseloads • Supports patients to die in their homes if desired
Improves outcomes	• Increased identification of patients with palliative needs will be increased and access to services will improve • ED and Hospital Admissions will decrease
Increases ACP capacity in system	• Build awareness of ACP amongst providers, patients/families, public
Increases provider satisfaction and capacity	• Providers experience increased confidence and skill level leading to greater satisfaction • Increased competency and capacity of providers to offer early palliative high EOL care province-wide

A Word about Evaluation

- All participating sites responsible for collecting data
- Data submission occurs quarterly to Health Information Unit
- Data linkages to HPEI databases to access impact of project
- Providers that attend LEAP sessions from participating sites asked to complete survey at two points during the project: baseline & mid-implementation
- Over time, intent is to measure change in participants' current practice, comfort and attitudes towards palliative care, and barriers and opportunities in the provision of palliative care
- Final assessment following completion of the project (Spring 2022) to measure changes in responses over the duration of the project

Resources and References

- Australian Population-based Palliative Approach Model, Palliative Care Australia, 2005
- Cancer Care Ontario
- Health PEI. (2015). *Health PEI Palliative Care Framework and Action Plan 2015-2020*. Charlottetown: Health PEI
- Health PEI Strategic Plan (2017-2020)
- Smith et al., 2012; Temel et al., 2010; Bakitas et al., 2009; Myers et al., 2011; Zimmerman et al 2013
- The Way Forward National Framework: a roadmap for an integrated palliative approach to care, Quality End of Life Coalition and CHPCA, Published March 2015.
- http://www.hpcintegration.ca/media/60044/TWF-framework-doc-Eng-2015-final-April.pdf