Fraser Northwest
Division of Family Practice
An FPSC initiative

SharedCare
Partners for Patients

BUILDING CAPACITY TO CARE FOR PALLIATIVE CARE PATIENTS

Link to full report

Shared Care Project

Project Overview

Project Aim: To build capacity, enhance communication between providers, streamline the referral process, resolve prescribing gaps, and to improve the patient and caregiver experience in the palliative care journey.

Project Leads: Dr. Ali Sanei-Moghaddam- FP Lead, Dr. Wai Phan-Palliative Care Lead, Dr. Fify Soeyonggo-Palliative Care Lead, Dr. Elizabeth Wu- Palliative Care Lead, Dr. Joan Eddy- Palliative Care Lead, Dr. Cindy (Lou) Roper- Palliative Care Lead

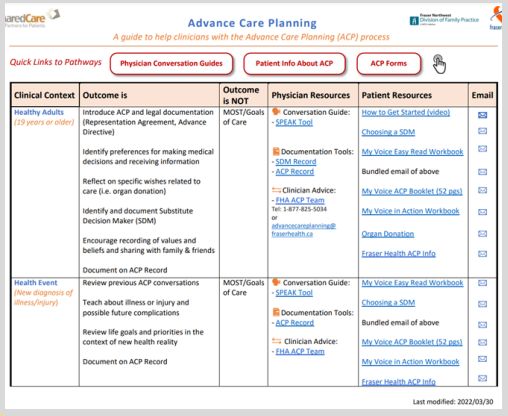
Project Activities

- **April 23, 2020** — Serious Illness Conversation Event — 54 attendees
- **Sept 23, 2020** — Creation of Palliative Approach to Care Cheat Sheet
- **Nov 26, 2020** — Pain Managememt workshop — 54 attendees
- **Aug 30, 2021** — What's Up Doc? Palliative Care — 34 attendees
- **Apr 19, 2021** — Opioid Side Effects and Management — 13 attendees
- **Nov 16, 2021** — Advanced Care Planning & Care Pathway Demo — 39 attendees
- **Sept 28, 2022** — Panel Discussion with services and providers — 51 attendees

PROJECT OUTCOMES

- **Increased family physician satisfaction and confidence in their capacity to care for palliative care patients in the community.** *(After attending the pain management session, 92% of attendees reporting that the pain management session enhanced their understanding and skills in palliative care).*
- **Improved relationships and communication among healthcare providers involved in the circle of care.**
- **Improved understanding of the services and resources in the community.** *(After the Palliative Panel event, attendees were in 80% agreement of a better understanding of palliative care services within the FNW).*
- **Improved care coordination and patient transitions between providers in circle of care.**
- **Improved family physician's comfort with pain medicine prescribing and having advance care planning discussions.** *(After the Opioid side effects and management session, 73% of attendees agreed that their understanding of prescribing and pain management had increased. After the Advanced Care Planning event, 92% of participants said that their comfort level with advanced care planning had increased due to the Care Pathway).*
- **Improved relationships and a better understanding of palliative care resources can be assumed to have a positive impact on system costs.**

ADVANCED CARE PLANNING PATHWAY



Advance Care Planning

A guide to help clinicians with the Advance Care Planning (ACP) process

Quick Links to Pathways: Physician Conversation Guides | Patient Info About ACP | ACP Forms

Clinical Context	Outcome is	Outcome is NOT	Physician Resources	Patient Resources	Email
Healthy Adults (19 years or older)	Introduce ACP and legal documentation (Representation Agreement, Advance Directive) Identify preferences for making medical decisions and receiving information Reflect on specific wishes related to care (i.e. organ donation) Identify and document Substitute Decision Maker (SDM) Encourage recording of values and beliefs and sharing with family & friends Document on ACP Record	MOST/Goals of Care	Conversation Guide: - SPEAK Tool Documentation Tools: - SDM Record - ACP Record Clinician Advice: - FHA ACP Team Tel: 1-877-825-5034 or advancecareplanning@fraserhealth.ca	How to Get Started (video) Choosing a SDM My Voice Easy Read Workbook Bundled email of above My Voice ACP Booklet (52 pgs) My Voice in Action Workbook Organ Donation Fraser Health ACP Info	
Health Event (New diagnosis of illness/injury)	Review previous ACP conversations Teach about illness or injury and possible future complications Review life goals and priorities in the context of new health reality Document on ACP Record	MOST/Goals of Care	Conversation Guide: - SPEAK Tool Documentation Tools: - ACP Record Clinician Advice: - FHA ACP Team	My Voice Easy Read Workbook Choosing a SDM Bundled email of above My Voice ACP Booklet (52 pgs) My Voice in Action Workbook Fraser Health ACP Info	

Last modified: 2022/03/30

Click here for a full resolution of the visual

Provider Feedback

" Easy to use and can quickly access many resources for diverse patient populations"

"Easy to email things to patients. So nice to have a concise "go to", saves time in busy office practice"

"Convenient easy to access in one PDF, I can see adding this my future EMR for even quicker access"

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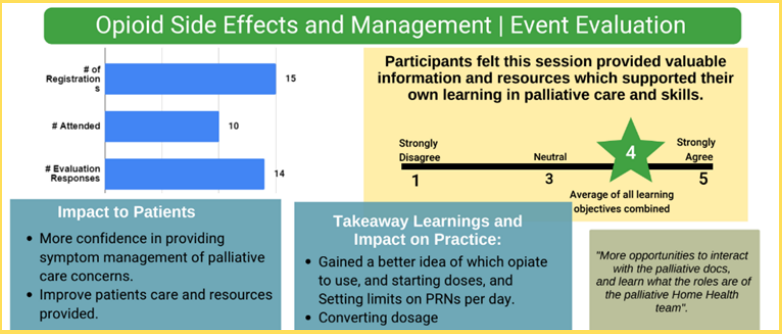
Project Activities: Overview

Link to high resolution image



Lessons Learned: What Worked Well?

Fostered strong engagement and collaboration between physicians and the palliative care team, leading to improved communication and information sharing.

Improved communication and sharing of information through continued relationships. Able to connect with palliative contacts to clarify questions around palliative referral processes that came up from other projects.

Regular evaluation and feedback collected through workshops, member surveys and committee meetings allowed the project to tailor the education topics based on the needs and interest of the community. Topics such as advanced care planning and opioid management emerged.

Conducted workshops virtually through Zoom, reducing barriers to participation, and recorded sessions for convenient viewing on the Division's member website.

Challenges & Gaps

- Palliative patients prioritized, but delays persist due to limited provider capacity. Palliative physicians criticized for not assuming the MRP role, exceeding their scope and capacity.
- Primary care providers uncertain about College expectations in palliative care. Discomfort around roles, responsibilities, and opioid prescription remains. Incorrect assumption of palliative physicians' involvement in all cases, exceeding their capacity.
- New community providers require continuous learning and knowledge-sharing opportunities.
- Project must adapt to evolving information and system changes.
- Difficulty balancing complex patient populations, patient-centered care, and efficiency in the fee-for-service environment. Time-consuming issues with palliative patients, such as serious illness conversations and advance care planning, present challenges.

Next Steps

- FNW Division Shared Care staff to update and maintain provider education materials annually.
- Shared Care Steering Committee to review content for relevance and updates, providing feedback based on community needs.
- Division's local Pathways administrator to ensure updated resources are hosted on Pathways for easy access.
- Strong relationships established with palliative physicians and teams for continued engagement and sharing updates applicable to primary care providers.
- Division's communication staff to disseminate key messaging to Division members through various channels.
- Exploration of an education event for new-to-practice physicians.