



Shared Care Final Project Report Template & Instructions

Project Title	Building Capacity to Care for Palliative Care Patients
Physician leads	Dr. Ali Sanei-Moghaddam, Family Physician Lead Dr. Wai Phan, Palliative Care Lead Dr. Fify Soeyonggo, Palliative Care Lead Dr. Elizabeth Wu, Palliative Care Lead (March 2022-Present) Dr. Joan Eddy, Palliative Care Lead (August 2019 - March 2022) Dr. Cindy (Lou) Roper, Palliative Care Lead (August 2019 - March 2022)
Project lead	Cindy Young
Date of submission	May 19, 2023



EXECUTIVE SUMMARY

Background

The Palliative Shared Care Initiative in the Fraser Northwest (FNW) emerged from the ongoing system development and strengthening of the existing Patient Medical Homes and Primary Care Networks across the FNW. Palliative physicians have little capacity to take over the care of complex palliative patients, including unattached patients which is out of their scope of practice. Family physicians feel discomfort with opioid prescribing, serious illness conversations, advance care planning and have a lack of understanding of the palliative referral process and resources. With the Expression of Interest funding received in 2019, family physicians, palliative physicians and palliative care nurses came together to discuss strategies aimed at improving the following aspects for palliative patients in the FNW:

- Continuity of Care
- Timely Access
- Coordination of Care
- *and* Patient self-management/education

Project Objectives

1. Conduct a needs assessment with providers and patients to understand the gaps and challenges
2. Identify strategies, education and resources needed to improve family physicians confidence and capacity in managing palliative care patients
3. Develop a resource that compiles palliative resources and services to increase awareness of the supports available
4. Develop an attachment solution for palliative patients who do not have a primary care provider
5. Enhance communication and relationships between providers to improve physician satisfaction and collaboration

Project Outcomes

Improved Provider Experience

- Increased family physician satisfaction and confidence in their capacity to care for palliative care patients in the community
- Improved relationships and communication among healthcare providers involved in the circle of care
- Improved understanding of the services and resources in the community

Improved Patient Experience

- Improved understanding of patient and caregiver care experience
- Improved care coordination and patient transitions between providers in circle of care

Improved Health Outcomes

- Improved family physician's comfort with pain medicine prescribing and having advance care planning discussions

System Costs

- Improved relationships and a better understanding of palliative care resources can be assumed to have a positive impact on system costs



INTRODUCTION

The Palliative Shared Care Initiative in the Fraser Northwest (FNW) emerged from the ongoing system development and strengthening of the existing Patient Medical Homes and Primary Care Networks across the FNW. Palliative physicians have little capacity to take over the care of complex palliative patients, including unattached patients which is out of their scope of practice. Family physicians feel discomfort with opioid prescribing, serious illness conversations, advance care planning and have a lack of understanding of the palliative referral process and resources. With the Expression of Interest funding received in 2019, family physicians, palliative physicians and palliative care nurses came together to discuss strategies aimed at improving the following aspects for palliative patients in the FNW:

- Continuity of Care
- Timely Access
- Coordination of Care
- *and* Patient self-management/education

Problem statement:

Palliative physicians overwhelmed with taking over the care for complex palliative patients, including unattached and orphaned patients. Family physicians have discomfort with opioid prescribing, serious illness conversations, advance care planning and have a lack of understanding of the palliative referral process and resources.

Aim Statement:

The goal of the Palliative Shared Care project is 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 OBJECTIVES

The objectives of the Palliative Care Shared Care Initiative are:

1. Conduct a needs assessment with providers and patients to understand the gaps and challenges
2. Identify strategies, education and resources needed to improve family physicians confidence and capacity in managing palliative care patients
3. Develop a resource that compiles palliative resources and services to increase awareness of the supports available
4. Develop an attachment solution for palliative patients who do not have a primary care provider
5. Enhance communication and relationships between providers to improve physician satisfaction and collaboration

TARGET POPULATION

The target population for this project included primary care providers, the palliative care teams, palliative patients and caregivers in the Fraser Northwest communities.



ENGAGEMENT STRATEGY

In the planning phase, the FNW Division engaged with family physicians supporting palliative patients, palliative physicians, palliative care nurses and community organization partners who identified challenges in the community that required collaboration to reach the intended goals. The following individuals and organizations were involved in the planning phase of the project and throughout the project's implementation:

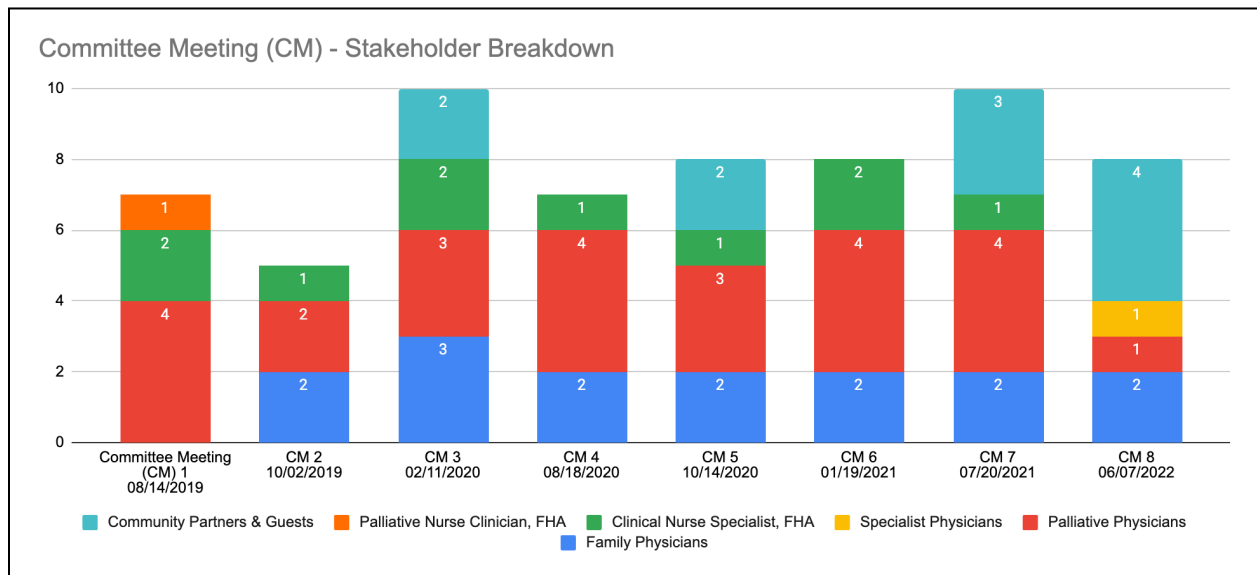
Name	Role	Primary Practice Location
Physician Engagements		
Dr. Ali Sanei-Moghaddam	Family Physician Lead	Port Coquitlam
Dr. Wai Phan	Palliative Care Lead	New Westminister
Dr. Fify Soeyonggo	Palliative Care Lead	Tri-Cities
Dr. Elizabeth Wu	Palliative Care Lead (March 2022-Present)	Tri-Cities
Dr. Joan Eddy	Palliative Care Lead (August 2019 - March 2022)	Previously Tri-Cities
Dr. Cindy (Lou) Roper	Palliative Care Lead (August 2019 - March 2022)	New Westminister & Tri-Cities
Dr. Cristina Liciu	Family Physician	Previously New Westminister, presently Kamloops
Dr. Guillermina "Mina" Perez Flores	Family Physician	Port Coquitlam
Dr. Tracy Monk	Family Physician	Burnaby
Dr. Doris Barwich (Guest)	Medical Director	BC Centre for Palliative Care
Dr. Shiraz Mawani (Guest)	Family Physician	Ridge Meadows
Dr. Leanne Chew (Guest)	Family Physician	Ridge Meadows
Dr. Nicola Macpherson (Guest)	Anesthesiologist	Ridge Meadows
Non-Physician Engagements		
Bella Wang	Clinical Nurse Specialist	Fraser Health Authority
Shelly Briggs	Clinical Nurse Specialist	Fraser Health Authority

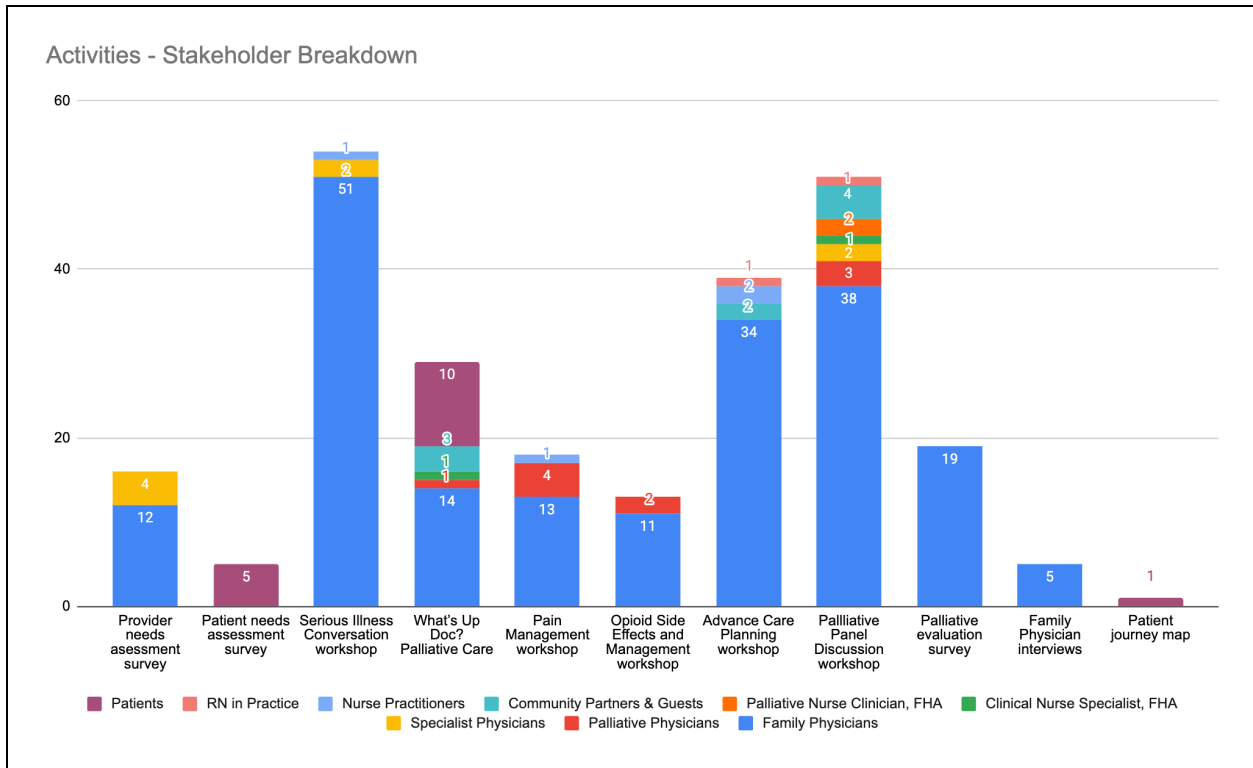


TEMPLATES AND FORMS

Joanne Hum	Palliative Nurse Clinician	Royal Columbian Hospital, FHA
Aubyn McKay	Palliative Nurse Clinician	Fraser Health Authority
Kay Johnson	Executive Director	New Westminster Hospice Society
Cari Borenko	Advance Care Planning Manager	Fraser Health Authority
Andrew Saunderson	Advance Care Planning Social Worker	Fraser Health Authority
Christine Delos Santos	RN in Practice	Fraser Health Authority
Byron Salahor (Guest)	Practice Support Program Leader	PSP, Fraser Health Authority
Kathleen Yue (Guest)	Education & Partnerships	BC Centre for Palliative Care
Natasha Raey (Guest)	Project Manager	Ridge Meadows Division

A breakdown of stakeholder engagement and involvement in committee meetings and project activities are graphed below.





DATA COLLECTION ACTIVITIES

The evaluation approach was through a mixed-methods design (i.e. collection of both qualitative and quantitative data). Quantitative data was collected from FHA analytic data and program administrative records. Qualitative data was collected from surveys and interviews with physicians, specialists, stakeholders, patients, and program administrators will be collected and collated. The data collected had a developmental lens that focuses on continuous quality improvement and links back to the overall Shared Care goals. All comparative data will review data available from the inception of the project and compare to the completion of this project. The results shared in the next section are broken down by evaluation questions.

RESULTS / DATA MATRIX

The purpose of this evaluation is to align and support the overall Shared Care goal which is to provide coordinated, continuous and comprehensive patient care in a way that fits the local context and community needs specific to the FNW. Implementing evaluation measures throughout this initiative supports real-time data collection and clear identification of when progress markers have been attained or when adjustments need to be made to existing measures. The evaluation program's main purpose is to support the cyclical quality improvement processes focusing on the PDSA cycle which supports the implementation, identifies opportunities for improvement, and allows for ongoing feedback between and amongst PCN stakeholders.



The work of this project and its subsequent evaluation are to focus and improve the following key attributes:

- Shared Care Project Goals
- PMH Attributes
- PCN Attributes
- Quadruple Aim

The evaluation has two main objectives and their subsequent evaluation questions below:

- 1. To evaluate the effectiveness of the Palliative Care Shared Care Initiative in the Fraser Northwest community**
 - a. To what extent does the program contribute to increased communication and care coordination among family physicians, specialists and other healthcare providers involved in the circle of care?
 - b. To what extent does the program contribute to improved patient care?
 - c. To what extent does the program contribute to improved health outcomes for patients seeking care for palliative care?
 - d. To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?
- 2. To identify areas for quality improvement and document lessons learned**
 - a. What were the unanticipated outcomes of the proposed strategies?

PROJECT ACTIVITIES & DELIVERABLES

1. Priority attachment process for unattached patients

During the gap analysis, unattached patients with a life limiting illness with a prognosis of less than 1 year were identified as high priority for attachment. Palliative physicians are not able to assume the role of the Most Responsible Physician (MRP) as primary care is outside of their scope of practice and further reduces their already limited capacity. In coordination with the FNW Attachment Hub, a priority attachment process was developed as follows: 1) Patients with an expected less than 1 year prognosis 2) women who are pregnant or have an infant under 18 months in their care. The outcomes of the development of this process are shared in the data matrix in the following section.

2. Education and workshops

A total of five workshops were developed for primary care providers based on the top barriers and challenges identified during the needs assessment phase. The goal of these sessions was to advance primary care provider's palliative care knowledge and skills. One education session was hosted as part of a public education series for community members. Originally the workshops were planned to be in-person but due to the pandemic, all workshops were hosted virtually with the exception of the last workshop being hybrid.

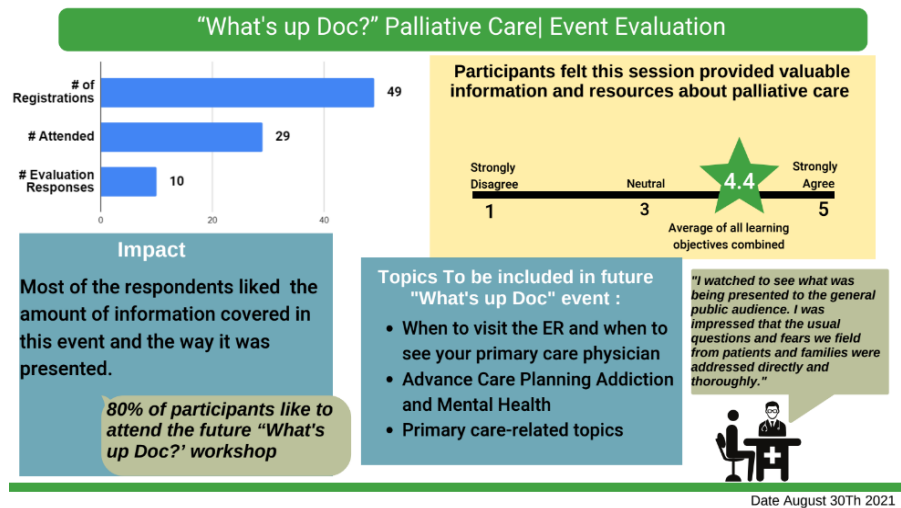


a. Serious Illness Conversation event - Thursday, April 23, 2020

The need for this workshop was identified pre-COVID during the needs assessment phase, however, due to the pandemic this became the top priority. In preparation for the waves of patients presenting to the hospital, it was critical to engage primary care providers to ensure they were comfortable and prepared with having these difficult conversations with their patients and caregivers ahead of time. Approximately 54 primary care providers attended this workshop.

b. What's Up Doc? Palliative Care - August 30, 2021

What's Up Doc? was a public education series hosted virtually online to increase patients' and families' understanding of certain healthcare topics. The focus of this session was about palliative care, what it is, what to expect and how to navigate the system. A total of 34 family physicians, allied health professionals and members of the community attended this workshop.

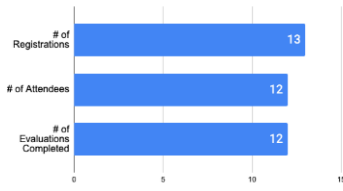


c. Pain Management - November 26, 2020

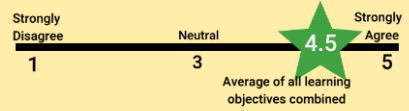
Participants gained a better understanding of how to select and manage medications and symptoms such as opioid side effects for cancer related pains. As this workshop was limited to 20 spaces for a more targeted learning, a total of 18 primary care providers and palliative physicians attended this workshop.



Palliative Care Learning Session | Event Evaluation



Participants felt this session provided valuable information and resources which supported their own learning in palliative care and skills.



Impact to Patients

- More confidence in providing symptom control management of opioid side effects to cancer pains in patients

"Much more confidence in treating cancer pain for sure. Including dealing with side effects and breakthrough pain. This will definitely impact my patients."

Takeaway Learnings and Impact on Practice:

- Medication management of opioids and the use of antiemetics to treat nausea and constipation in cancer patients

"Useful practice tips and therapeutics in palliative care management."



d. Opioid Side Effects and Management - April 19, 2021

Participants who attended the previous Pain Management workshop were encouraged to sign up for this workshop as it was a continuation of the learning material. An opioid calculations worksheet was given to participants prior to the workshop to complete. Participants gained more confidence in initiating and titrating opioids for their patients. Registration for this workshop was also limited to ensure attendees could have enough time to ask questions and build relationships with the palliative physicians. A total of 13 family physicians and palliative physicians attended this workshop.

Opioid Side Effects and Management | Event Evaluation



Participants felt this session provided valuable information and resources which supported their own learning in palliative care and skills.



Impact to Patients

- More confidence in providing symptom management of palliative care concerns.
- Improve patients care and resources provided.

"Much more confidence with simply initiating and titrating, determining BT pain doses, and figuring out when to change to another opioid, etc"

Takeaway Learnings and Impact on Practice:

- Gained a better idea of which opiate to use, and starting doses, and Setting limits on PRNs per day.
- Converting dosage

"More opportunities to interact with the palliative docs, and learn what the roles are of the palliative Home Health team".

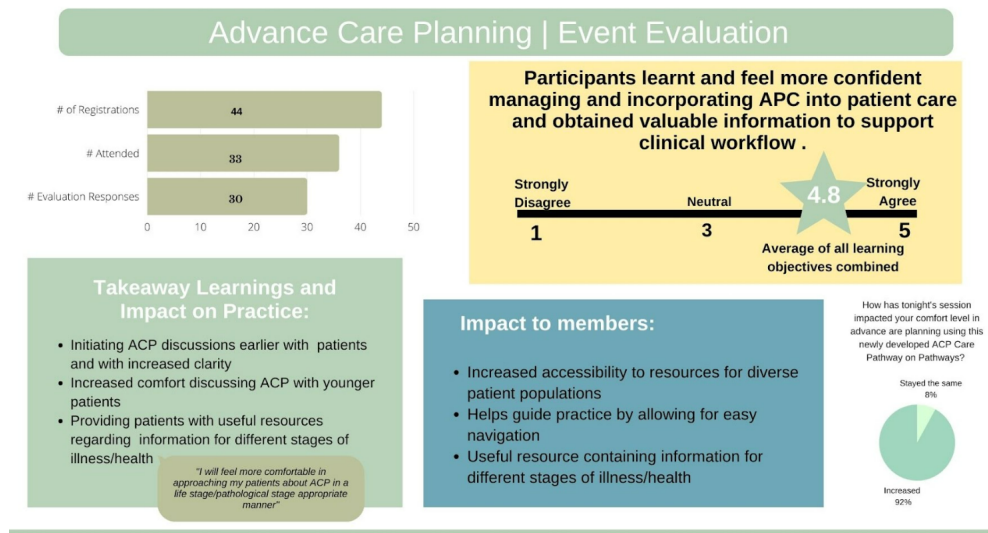


Date April 19Th 2021



e. Advance Care Planning (ACP) & Care Pathway Demo - November 16, 2021

Participants gained a better understanding of how to initiate and document ACP conversations during patient visits and obtained tools to refer to or use in their clinical workflow. The ACP care pathway was also demonstrated in the context of a case study, more information about the care pathway resource can be found below in 3b. This workshop was open to all FNW Division members. A total of 39 primary care providers and allied health attended this workshop.



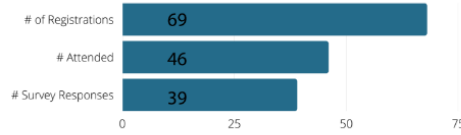
f. Panel Discussion with Palliative Services & Providers - September 28, 2022

The goal of this session was to increase primary care provider's knowledge around palliative care services by bringing together the providers involved in a palliative patient's care. Healthcare providers provided clarity around the palliative referral processes, how to communicate with the different palliative care team members and what the role of each healthcare provider is. The following healthcare providers presented in a round table format: a Home Health nurse, a Clinical Nurse Specialist, radiation and medical oncologists, palliative physicians, a Palliative Nurse Clinician, a social worker, a spiritual care worker and the regional FHA MAiD lead. This workshop was open to all FNW Division members. A total of 51 primary care providers, specialists and allied health professionals attended the hybrid workshop.

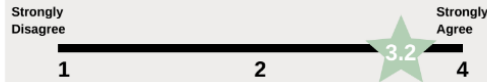


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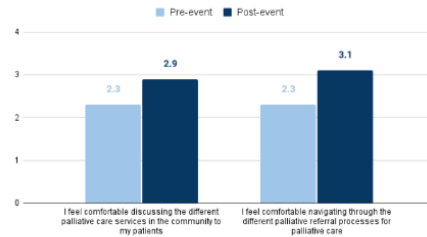
Palliative Panel Discussion | Event Evaluation



Members gained a better understanding of the available palliative care services provided within the FNW community, where to access key information and resources for patients and providers, in addition to better understanding the role of different palliative care teams



Please rate your level of agreement for the following



Note: Level of agreement is scored on a scale from 1 to 4

Key Takeaways

- Providers reported an increased understanding of the services and resources offered for MAID patients, with the anticipation of improved access to care
- Generally a better understanding of the referral process but also recognizing the complexity of the referral process
- Providers believe this session will help alleviate some of the challenges experienced within the landscape of palliative care

General Feedback

- **Future topics:** diabetic management, palliative care management, chronic pain, symptom management for end of life care & clinic/medical aspects of palliative care.
- **Anticipated Challenges:** limited services and resources available for MAID patients, time constraints, and navigating referrals forms.

3. Provider resources

a. Palliative Approach to Care - Cheat Sheet

PALLIATIVE APPROACH TO CARE

RESOURCE FOR PRIMARY CARE PROVIDERS

GENERAL PALLIATIVE CARE APPROACH

BC Guidelines - Palliative Care for the Patient with Incurable Cancer or Advanced Disease – Part 1: Approach to Care
https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc_guidelines/palliative-care-approach

SYMPTOM MANAGEMENT

BC Centre for Palliative Care Symptom Management Guidelines – Comprehensive, free, evidence-based symptom guidelines developed for primary care providers
<https://pathwaysbc.ca/ci/2456>

BC Guidelines – Palliative Care for the Patient with Incurable Cancer or Advanced Disease - Part 2: Pain and Symptom Management
<https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/palliative-pain-management>

Pallium Canada – Online palliative care (paid) courses for more formal CME opportunities
<https://www.pallium.ca/courses/>

ADVANCE CARE PLANNING

Advance Care Planning Care Pathway – Clinician tool with quick links to common physician and patient resources with the ability to email patient resources via Pathways
<https://pathwaysbc.ca/ci/5524>

Fraser Health Advance Care Planning Record, MOST Form and fax cover letter
<https://pathwaysbc.ca/f/1502>

Fraser Health Advance Care Planning – Website with resources for patients
<https://pathwaysbc.ca/ci/5374>

BC Centre for Palliative Care Serious Illness Conversation Guide – Resource for primary care providers
<https://pathwaysbc.ca/ci/2560>

Uptodate "Survival estimates in advanced terminal cancer" – Prognostication of patients with untreated cancer
https://www.uptodate.com/contents/survival-estimates-in-advanced-terminal-cancer?search=Survival%20estimates%20in%20advanced%20terminal%20cancer&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

ePrognosis – Prognostication of patients with frailty
<https://eprognosis.ucsf.edu/porock.php> & <https://eprognosis.ucsf.edu/calculators/#/>

END OF LIFE SERVICES/RESOURCES IN COMMUNITY

BC Palliative Care Benefits (Plan P) – Information for Prescribers
<https://pathwaysbc.ca/programs/3423> [log in required]

BC Cancer Pain and Symptom Management Clinic – Palliative care physician referral for patients receiving active cancer treatments with complex symptoms
<https://pathwaysbc.ca/clinics/1940> [log in required]

During the needs assessment, providers identified a lack of clarity regarding palliative care resources hence a two-pager resource for primary care providers was developed. The resource includes links to available palliative care learning opportunities, clinician forms, community supports and resources. The resource was disseminated to primary care providers through the Division's newsletter, Pathways and Division events.

[Click here to view the full resource.](#)



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b. Advance Care Planning (ACP) Care Pathway

In preparation for the ACP workshop, creating a care pathways with the most relevant, applicable information with top recommended resources to navigate the ACP process was suggested by committee members. Through collaborating with the ACP team at FHA, this clinician resource was developed and posted on Pathways. The resource is interactive and the quick links direct clinicians to resources directly within

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

Pathways. Depending on the patient's clinical context, each row provides guidance on how ACP may be relevant with links to commonly used forms and top recommended physician and patient resources. Providers are also able to email the listed patient resources to their patients.

The aim of utilizing links routed through Pathways is that local services and resources are maintained in Pathways either by Provincial, Regional or local Division Administrators, which prevents the duplication of work of checking if resources are up to date and if links are still working.

To find this resource on Pathways, click on "Palliative Care" under the specialty drop-down menu and click on the button at the top that says "Advance Care Planning Care Pathway" or [click here to view the full resource.](#)

LESSONS LEARNED

What worked well?

Relationships enhanced - good engagement, collegiality and collaboration among family physicians, palliative care team

Improved communication and sharing of

Challenges

Palliative patients were identified as a priority population and a process for expediting attachment was developed, however, due to limited provider capacity, many on the waitlist encountered (and continue to encounter) significant delays. Without



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

Workshops were held virtually through Zoom which decreased barriers to joining. Sessions were recorded which are housed in the Division's member website for viewing.

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.

Utilizing existing tools and resources in our community for partnership, expertise and sustainability - working with Pathways and ACP FHA team on creating educational materials

anywhere for these unattached patients to go, palliative physicians are often faulted for not being able to assume the MRP role despite primary care not being in their scope of practice or within their capacity.

Gap remaining - primary care providers still indicated a lack of clarity around College expectations of their involvement in palliative care along with discomfort around roles and responsibilities (including opioid prescription). There is also an incorrect assumption that palliative physicians are to be involved in the care of every palliative, frail and/or homebound patients, which is out of their capacity and scope as they are a consult service focusing on complex palliative symptom management.

New providers joining the community - need continuous learning and knowledge sharing opportunities.

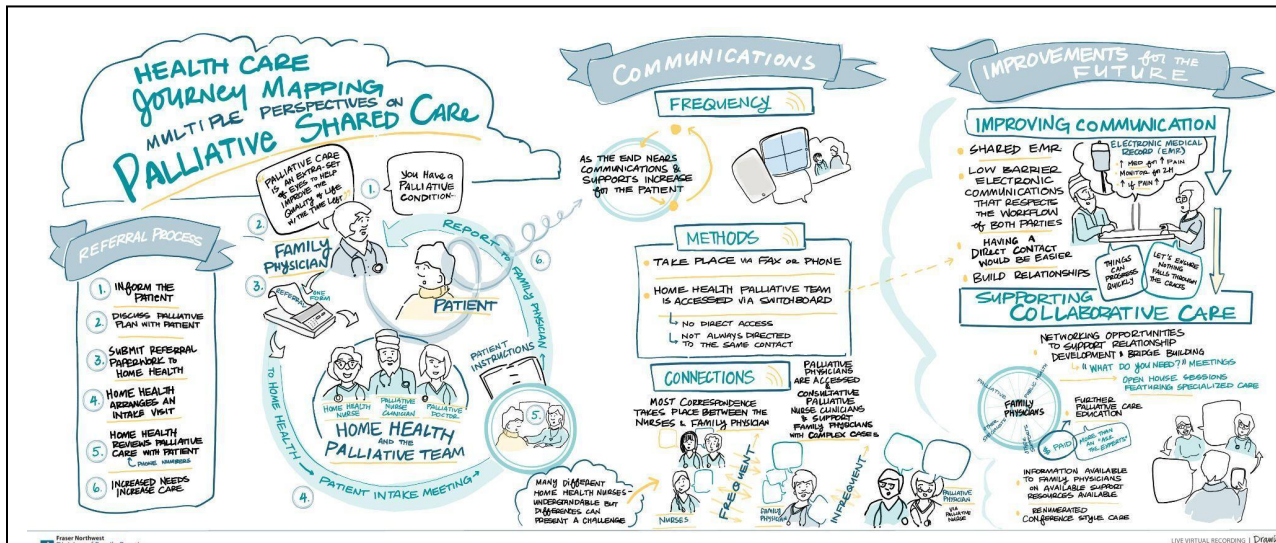
Information and systems may change that the project has to adapt to.

Difficult to balance demands of complex patient populations, providing quality, patient-centered care and efficiency in current fee for service environment. Many important but time consuming issues to discuss with palliative patients such as, having serious illness conversations, advance care planning and discussing goals of care.



NEXT STEPS

Before closing out the project, interviews with community family physicians were held to identify challenges experienced providing care for palliative patients to identify the gaps and opportunities that still exist.



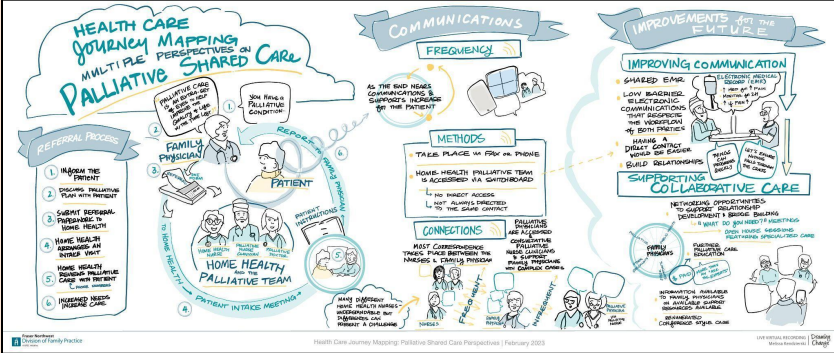
The journey map shows the various experiences, level of support, communication and relationships that providers have had with the palliative teams. The right of the journey map indicates the ideal state of how primary care providers would like to work with palliative teams.

As for next steps, FNW Division Shared Care staff will be responsible for updating and maintaining provider education materials, which will be reviewed and updated yearly. The Shared Care Steering Committee will be responsible for reviewing content for relevance, updates and providing feedback based on the needs of the community. The Division's Local Pathways administrator will ensure the updated resources are hosted on Pathways and easily accessible. Strong relationships have been formed with the palliative physicians and palliative teams which allows for continued engagement when needing their expertise and sharing of any updates and changes that are applicable to primary care providers. The Division's communication staff will ensure key messaging will be shared out with Division members through various communication channels.

Linkages were also made with the Chronic Pain Shared Care committee to discuss the common challenge around management of opioid prescribing for primary care providers. An education event targeted for new to practice physicians is being explored as a potential next step.



EVALUATION FRAMEWORK & DATA MATRIX

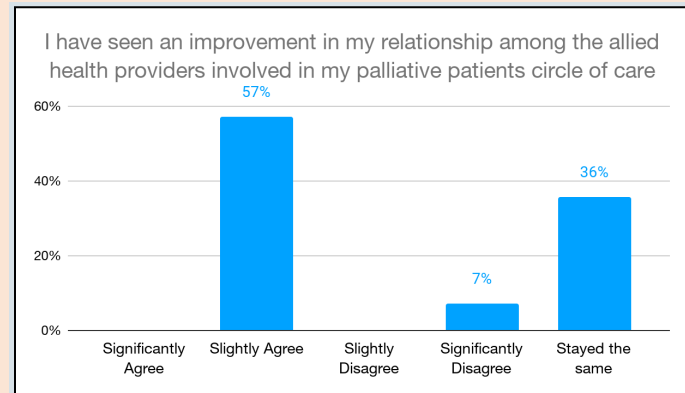
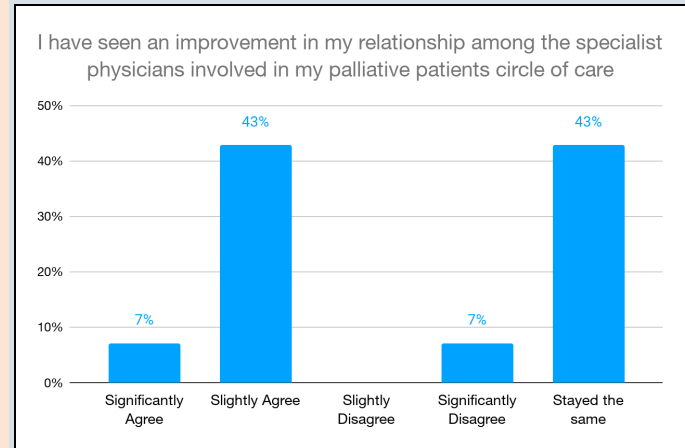
IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
<p>Provider Experience: To what extent does the program contribute to increased communication and care coordination among family physicians, specialists and other healthcare providers involved in the circle of care?</p>	<p>Improved family physician comfort with pain medicine prescribing</p> <p>Improved relationships and communication among healthcare providers involved in the circle of care</p> <p>Improved referral process</p> <p>Improved understanding of the services and resources in the community</p> <p>Improved family physician satisfaction and confidence that</p>	<p>FNW Attachment Hub data</p> <p>FNW Program Documentation</p> <p>FHA Community Service referral data</p> <p>FP survey/MSO interviews</p> <p>Specialist survey/MSO interviews</p>	<p>Since this project began, the number of family physicians practicing in the FNW has significantly decreased due to high costs to practice, work/life balance, and compensation. Communication and coordination between health care providers supporting palliative patients continues to identify future opportunities to improve the system and communication of care. The visual below was a product of themes identified through interviews with family physicians who provide care to palliative patients:</p>  <p>A survey conducted in December 2022 to all providers who attended at least one out of the four palliative project education events identified that the majority of providers found their confidence in providing care to palliative patients increased. The graphs below provide a snapshot of this:</p>



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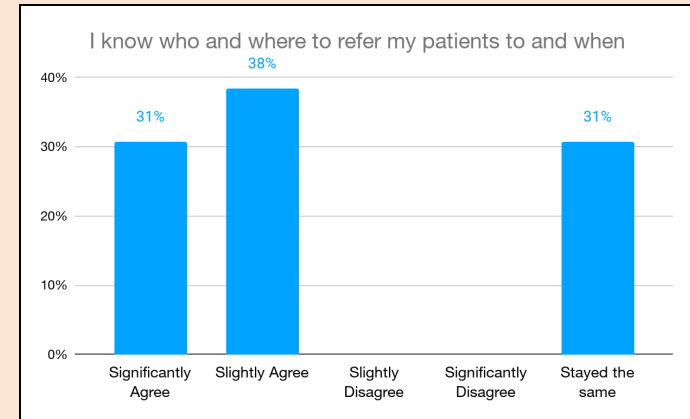
their capacity to care for palliative care patients in the community is meeting needs

Improved care coordination and patient transitions between care settings





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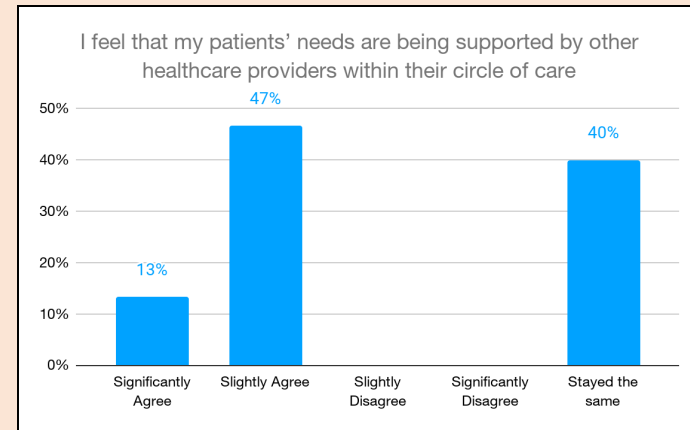


Regarding attachment for patients, the FNW Attachment Hub introduced an identifying metric when people join the FNW Waitlist which notes if the person has been given a terminal or life-limiting diagnosis with an expected prognosis of <1 year. The data below illustrates those that have been attached in each community as of March 31, 2023:

	Attached	Waiting to be attached
Coquitlam	13	6
New Westminster	13	2
Port Coquitlam	11	-
Port Moody	1	4
Total	38	12



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As identified in the previous section, the identification, development and implementation of a priority attachment mechanism for people who have been given a terminal or life-limiting diagnosis with an expected prognosis of <1 year was a successful project activity. The data below illustrates those that have been attached proportionally compared to the larger general attachment hub:

	Proportion attached	Total FNW proportion attached
Coquitlam	68%	35%
New Westminster	87%	46%
Port Coquitlam	100%	63%
Port Moody	20%	17%
Total	76%	40%



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Health Outcomes:

To what extent does the program contribute to improved health outcomes for patients seeking palliative care?

Improved family physician comfort with pain medicine prescribing

Improved understanding of the services and resources in the community

Improved family physician satisfaction and confidence that their capacity to care for palliative care patients in the community is meeting needs

Improved care coordination and patient transitions between care settings

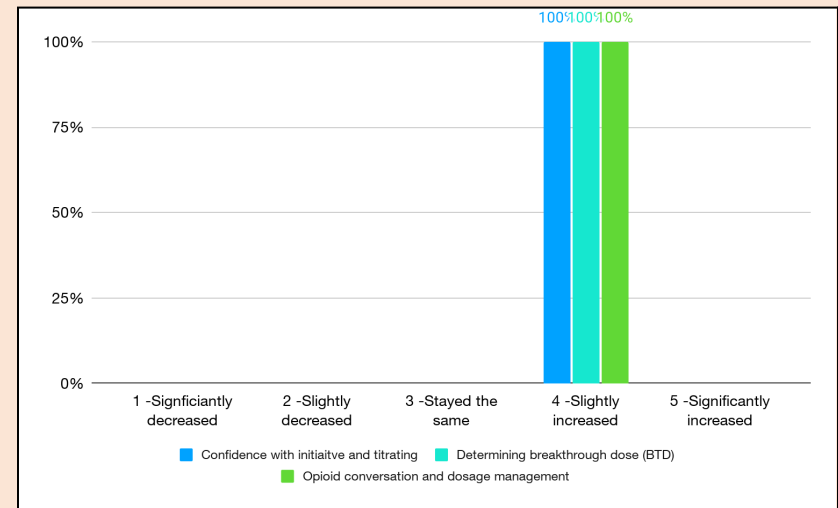
Improved patient and caregiver care experience

FNW Attachment Data

FHA Community Program Data

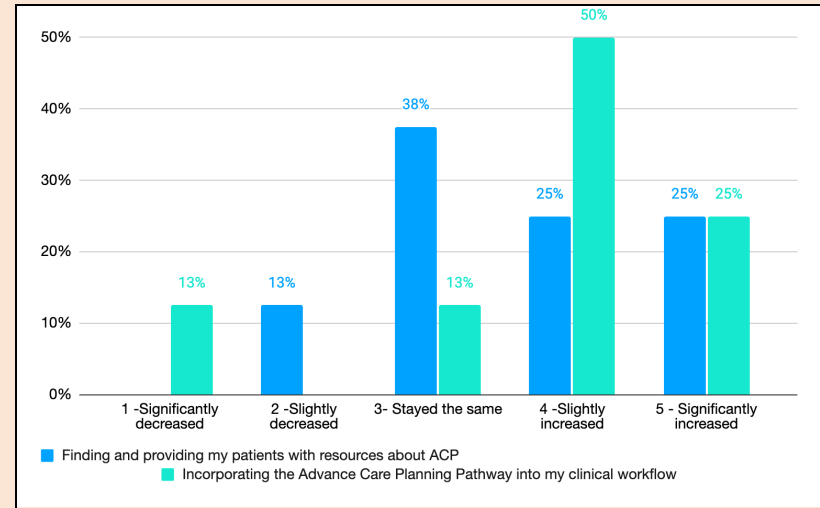
Measuring the impacts of the project on improving patient health outcomes is difficult to identify within the project's implementation timeline. Attachment data indicated above provides an indication of increased access to healthcare thus intending to have a positive impact on patient health outcomes.

The project's engagement activities identify an increased understanding from longitudinal primary care providers through enhancing clinical skills in providing palliative care. Providers participated in these event indicated changes in confidence in the following areas:





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The above graphs provide a snapshot around the overall increases in confidence for providers in all objectives identified at each palliative learning session thus we can assume that this increase in confidence to provide care to palliative patients has had a positive impact on the patients themselves.

Further evaluation and measurement of this outcome is needed to accurately measure long-term impacts to improving patient health outcomes.

<p>System Costs: To what extent did</p>	<p>Improved relationships and communication</p>	<p>FNW Attachment Data FHA Community Program</p>	<p>At the time of writing this report, calculating the change in system costs is difficult to measure; however, feedback from providers details a comparative analysis of the changes over the last 3 years:</p>
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TEMPLATES AND FORMS



the program contribute to a change in health care utilization and what effect did it have on system costs?

among healthcare providers involved in the circle of care

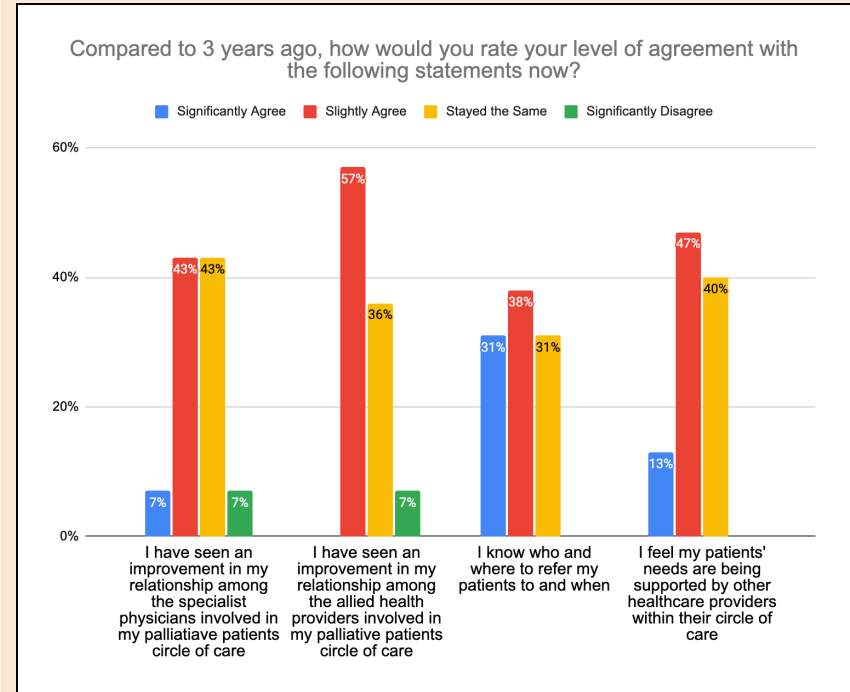
Improved referral process

Improved understanding of the services and resources in the community

Improved care coordination and patient transitions between care settings

Decrease in acute care utilization

Data
FHA Acute Care Data



Based on the feedback provided, there does indicate an increase in agreement around improved relationships and knowing how to support the care of patients in a palliative stage of their life. It can be assumed that these improvements in relationships do have positive impacts on system costs.

Further evaluation and measurement of this is needed as measuring the overall impact to system costs as this is a longer term anticipated outcome.



TEMPLATES AND FORMS

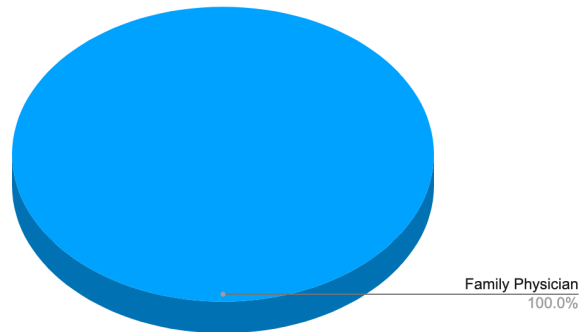


Sustainability & Spread: What were the unanticipated outcomes of the proposed strategies?	Sustainability of the program	Program documentation Survey/interview feedback (patient, FP, specialist)	Based on the activities of this project coupled with the evaluation outcomes identified as being successful, there continues to be a community wide need for additional support for palliative care. Opportunities for future improvement include: <ul style="list-style-type: none">• Primary care providers still have indicated a lack of clarity around roles and responsibilities (e.g. pain management)• New providers - need continuous learning and knowledge sharing opportunities• Changing environment within the health system and establishment of pathways for adaptation to changing services and community resources.
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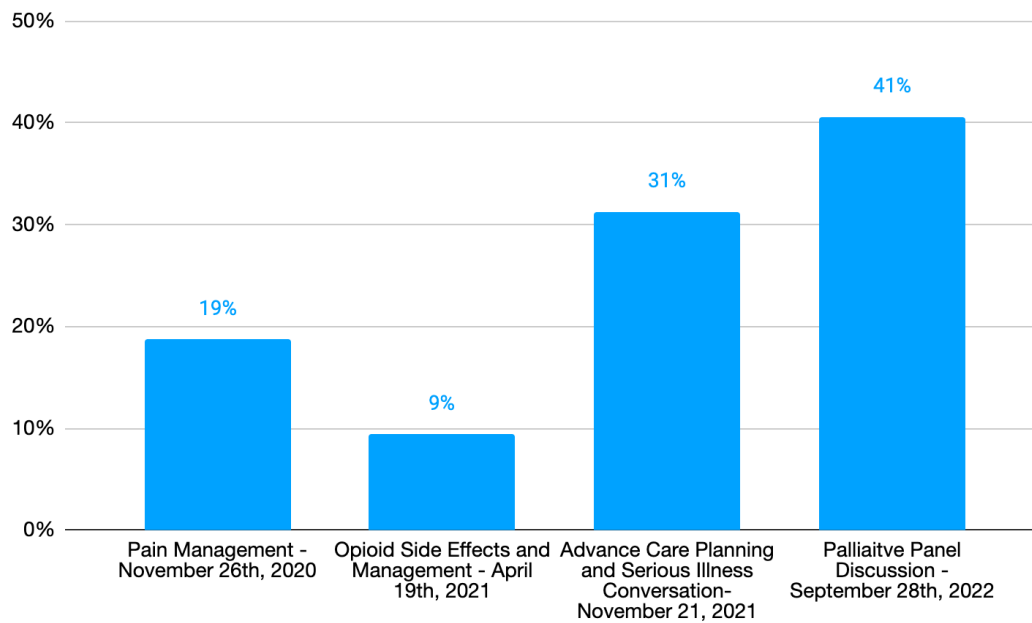
**Shared Measures* were not implemented at the time of this project creation/implementation



TEMPLATES AND FORMS

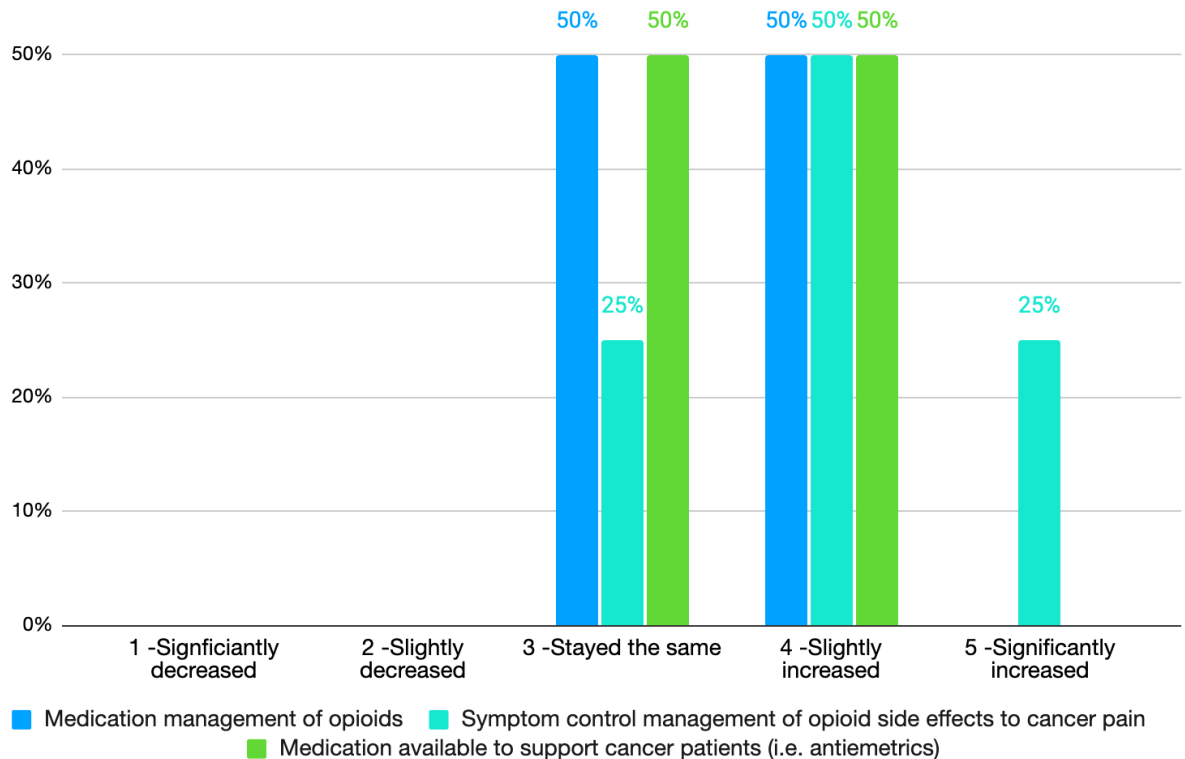


2. Please select the events you attended as part of the palliative learning/mentorships (*check all that apply*):



Pain Management (4 respondents)

3. Over the last 2 years, how would you rate your comfort level with the following statements:



4. If any, what benefits have you experienced from the knowledge and tools provided from this session?

- More confident of other options available
- Confidence in management of these patients

5. If any, what challenges have you experienced from the knowledge and tools provided from the session?

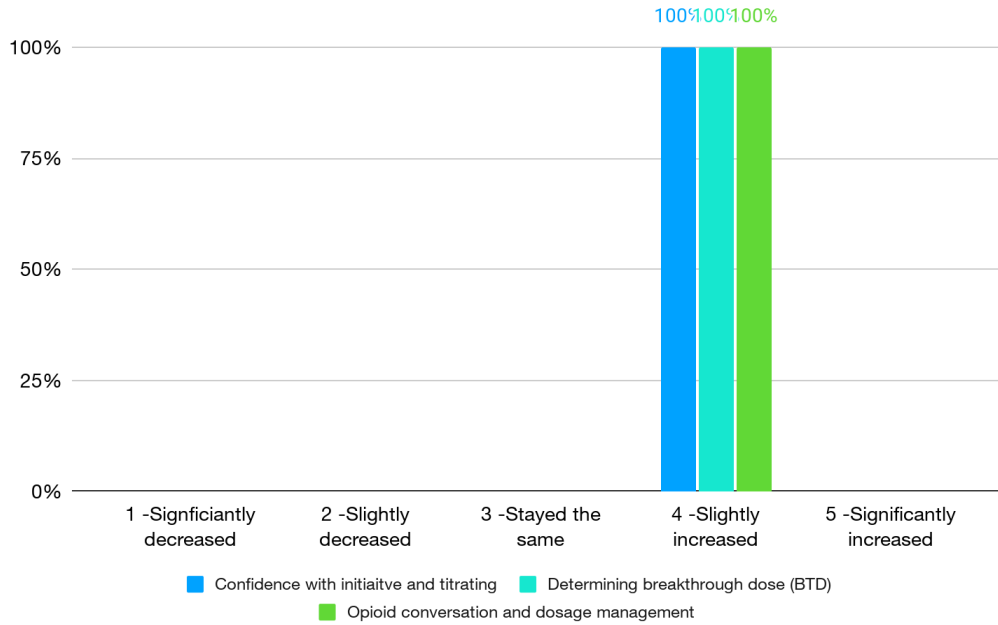
- Was very frustrated that the sessions did not help us find useful palliative info in Pathways. The listing of health authority palliative services in Pathways was never shown at the sessions and it would have helped me a lot because things got easier to figure out once I knew where to look in Pathways
- None x2

Opioid Side Effects and Management (1 response)

6. Over the last 1.5 years, how would you rate your comfort level with the following statements:

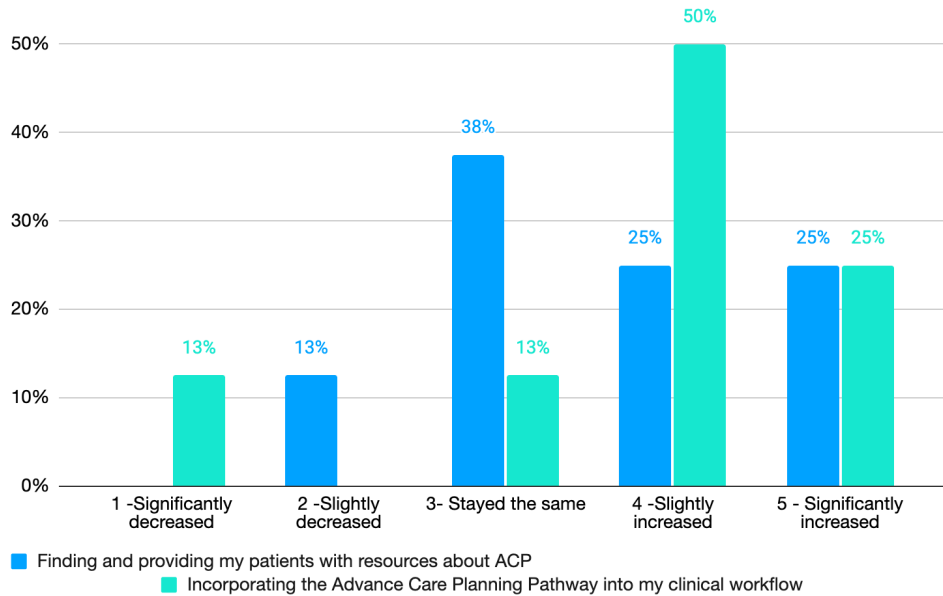


TEMPLATES AND FORMS



Advance Care Planning (8 respondents)

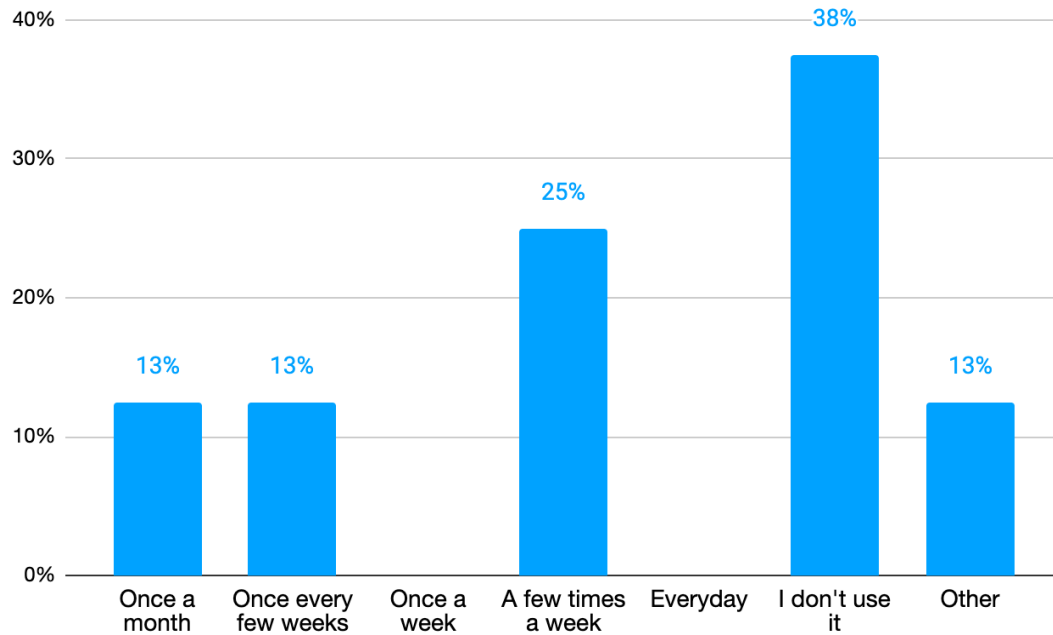
7. Over the last year, how would you rate your comfort level with the following statements:



8. How often do you refer to - or use - the Advance Care Planning Pathway?



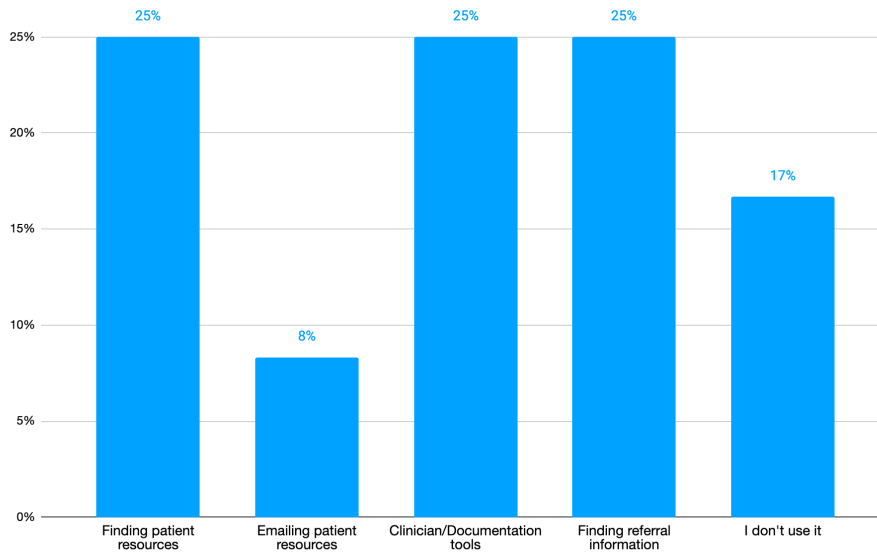
TEMPLATES AND FORMS



Others include:

- Refer to our nurse in practice

9. What do you use the care pathway for? (select all that apply)

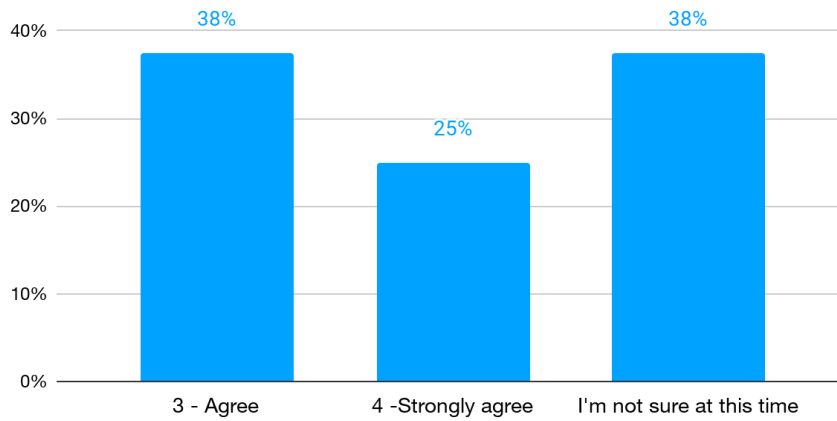


10. Please rate your level of agreement with the following statements:



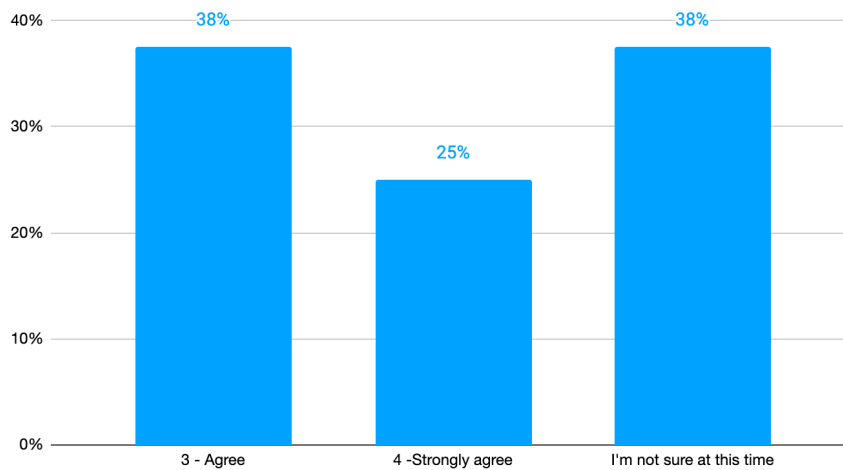
TEMPLATES AND FORMS

This care pathway has helped me find relevant referral information



Average score of: 3.4

This care pathway has made sharing available patient resources easier

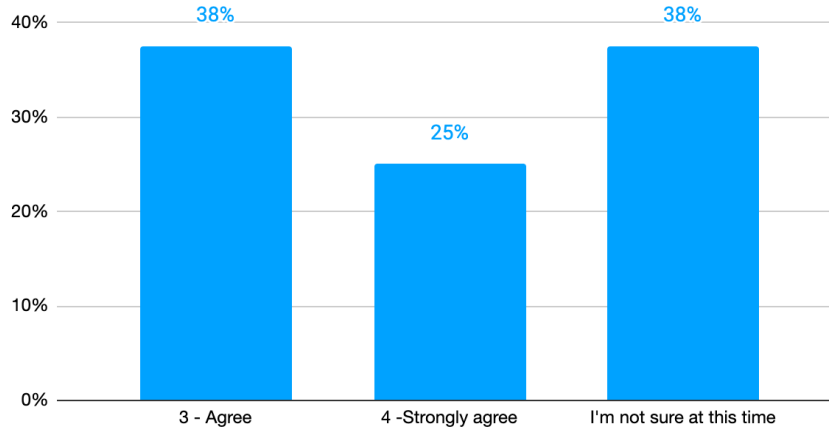


Average score of: 3.4



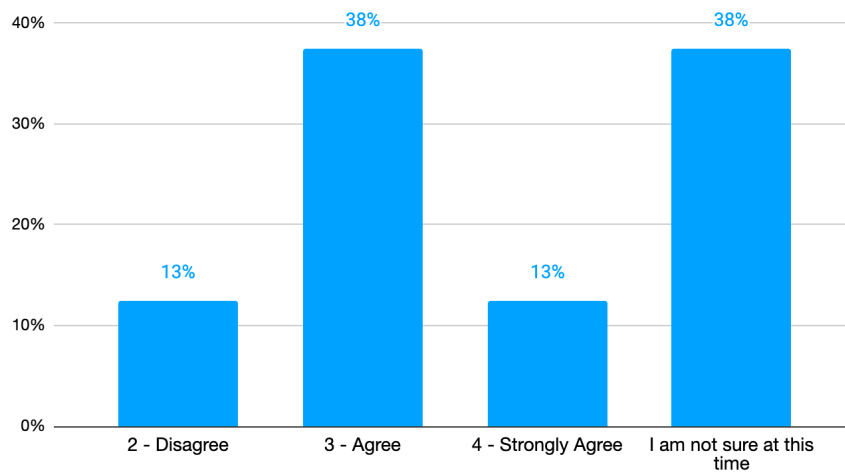
TEMPLATES AND FORMS

This care pathway has provided me with useful clinical and documentation tools



Average score of: 3.4

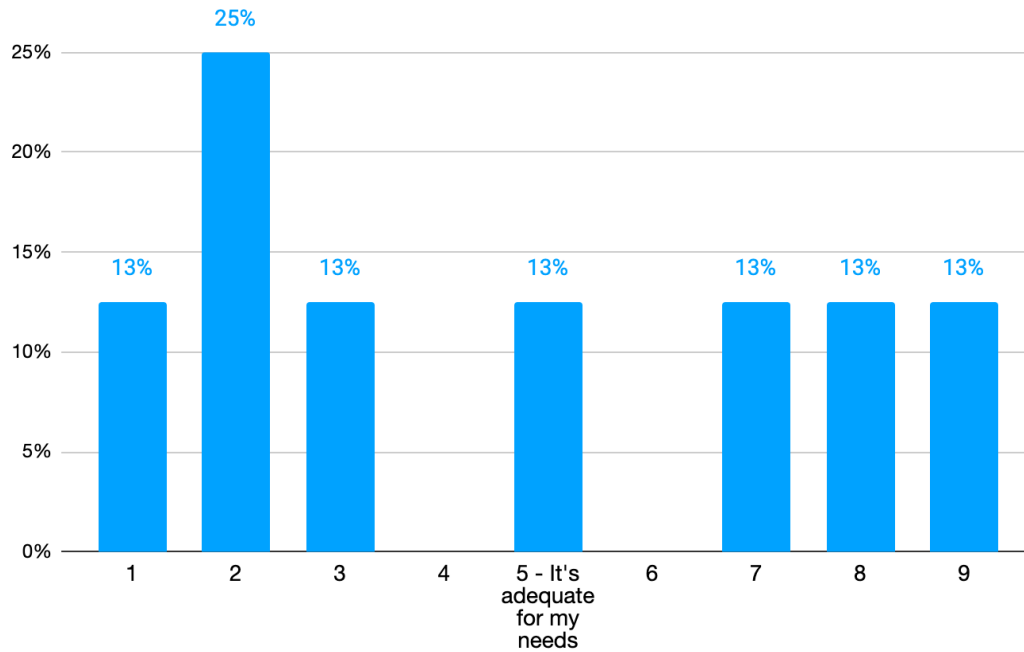
This care pathway has helped me save time during patient encounters



Average score: 3.0

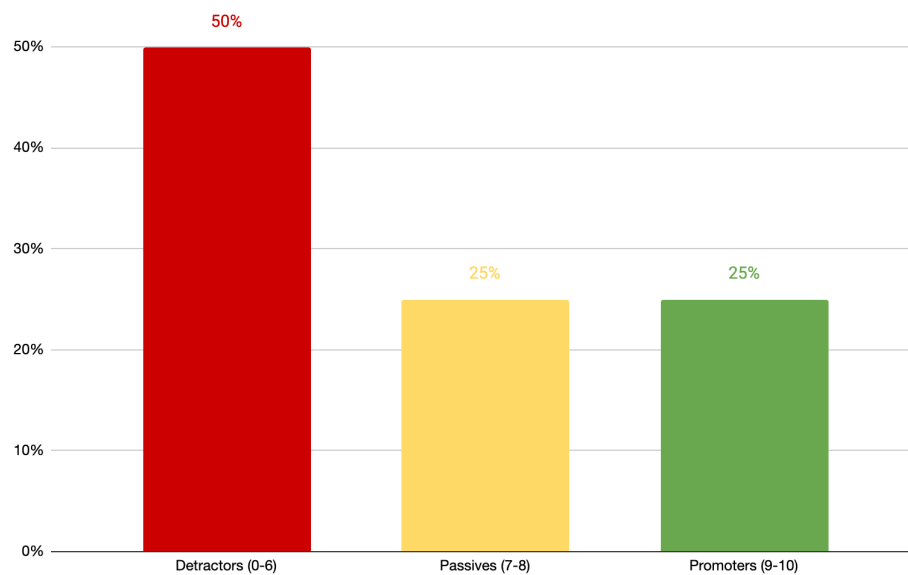


11. On a scale of 0-10, how would you rate your overall experience using the ACP Care Pathway?



Average Score: 4.6

12. On a scale of 0 to 10, how likely are you to recommend the ACP Care Pathways to other colleagues?



NPS Score: -25 | Average Score: 6.6



TEMPLATES AND FORMS

13. What do you like about the ACP Care Pathway?

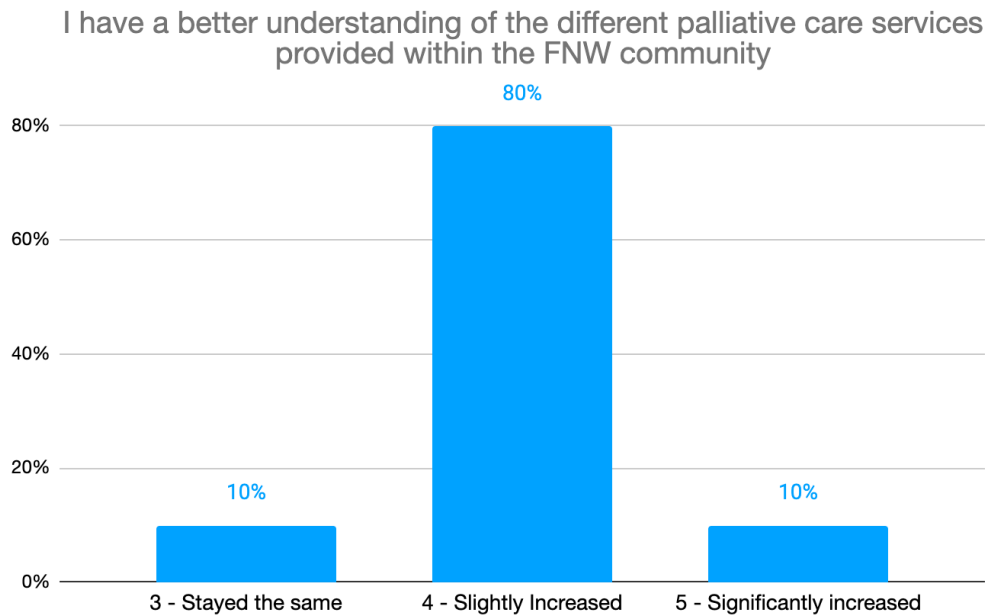
- Clear, concise and robust.
- Easy to follow, and to find relevant documents to send patients
- The format and categorization
- NA

14. Do you have any recommendations or suggestions to improve this tool?

- n/a at this time.
- It seems a refreshing session may help me using it more often and efficiently
- NA

Palliative Panel Discussion (10 respondents)

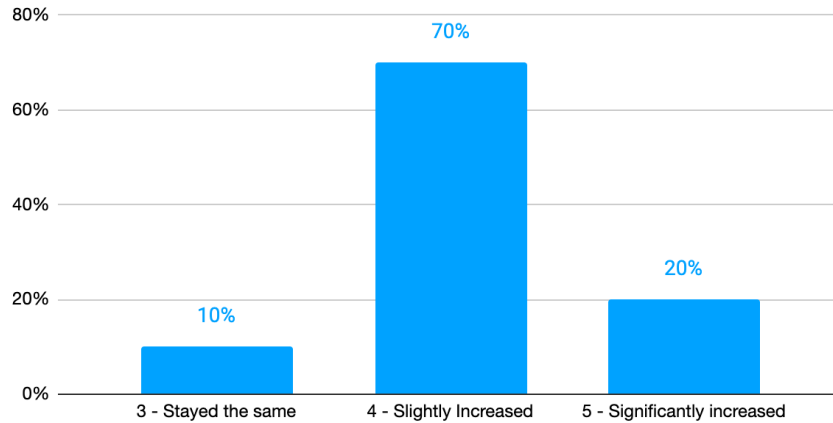
1. Since attending the September event, how would you rate your comfort level with the following statements:



Average score: 4.0

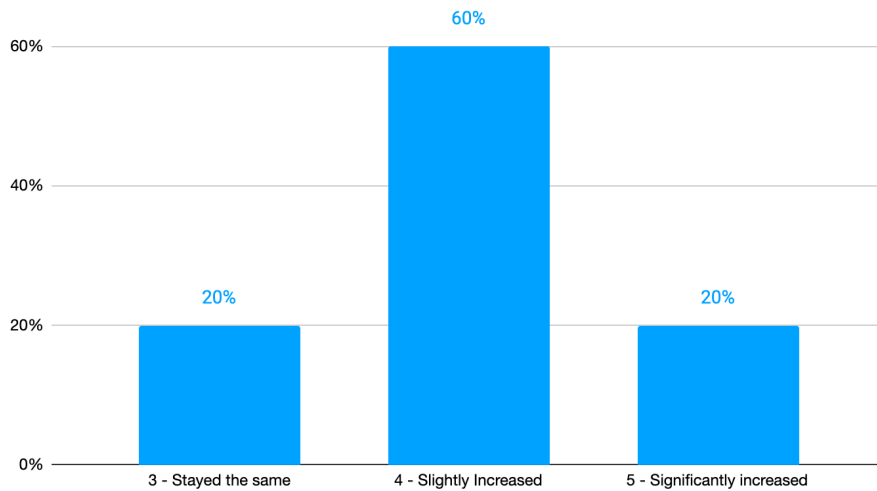


I have a better understanding of what the different palliative care teams do to support patients

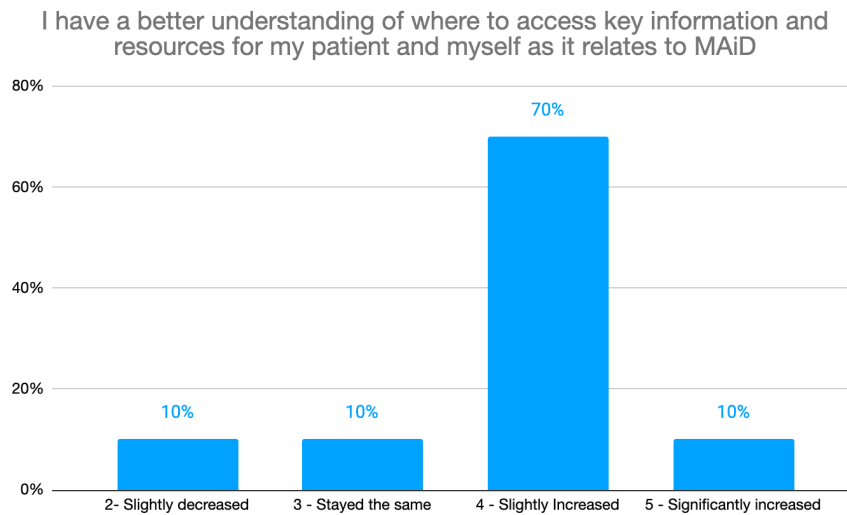


Average score: 4.1

I have a better understanding of the oncology services provided within the FNW community



Average score: 4.0



Average score: 3.8

2. If any, what benefits have you experienced from the knowledge and tools provided from this session?
 - This session was no where near as helpful as the MAiD session that Grace Park did later that showed the MAiD care pathway
 - Good to know how the palliative care team is structured
 - Knowing where to turn to for more support
 - Now I'm aware of where to refer patients when they become palliative and what each services provides for support.
 - It's nice to see everyone and get to know who is on the other side of the form/phone.

3. If any, what challenges have you experienced from the knowledge and tools provided from this session?
 - The challenge of not knowing where to find what, and forgetting the information presented at the se the palliative sessions, was addressed later by the MAiD session and also being simply shown the Fraser Health palliative listing in Pathways and the palliative symptom management guidelines in Pathways.
 - Nonex2
 - Too many to remember all the details. Pain management
 - N/A



TEMPLATES AND FORMS

General questions to all respondents

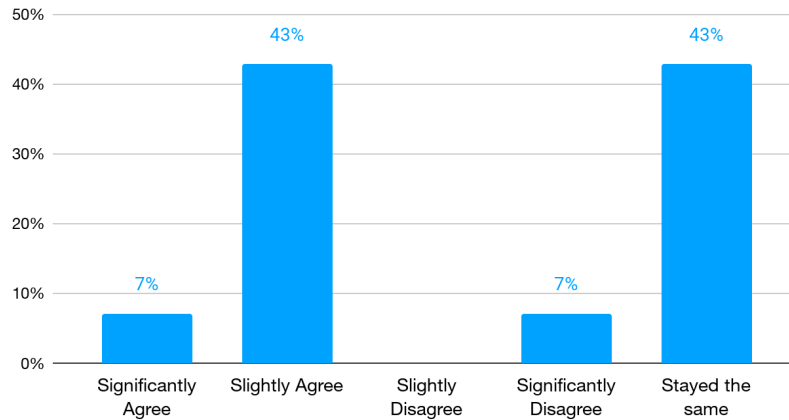
1. Please rank the following barriers you experience from most common (score of 1) to least common (score of 10) when providing care to your patients requiring a palliative care approach:

Barriers	Average Score
Lack of time required to manage complex end of life patients	4
Discomfort around managing patients who are no longer able to come to my office	4.1
Lack of appropriate compensation for the time required to look after palliative patients	4.3
Opioid prescribing and overall symptom management	5.2
Lack of detailed knowledge on how to support patient's functional care needs (ADLs and iADLs) at the end of life	5.3
Difficult/complicated referral process to palliative care services	6.6
Lack of timely consult from a palliative care physician or nurse specialist	6.8
End of life care conversations and advance care planning:	7.1
Lack of effective communication with palliative care services	7.3
There are no barriers to me providing care to my palliative patients	9.3

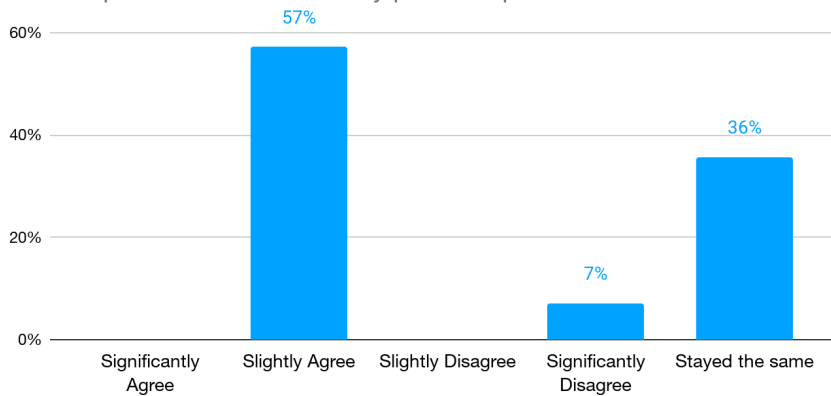


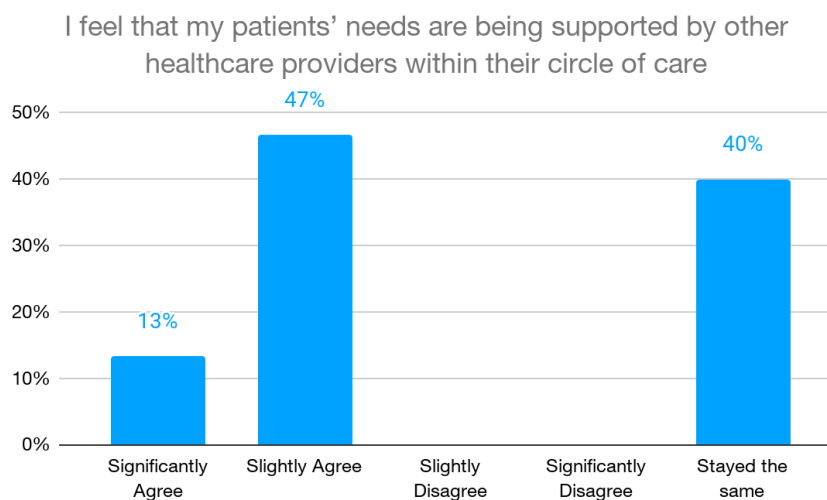
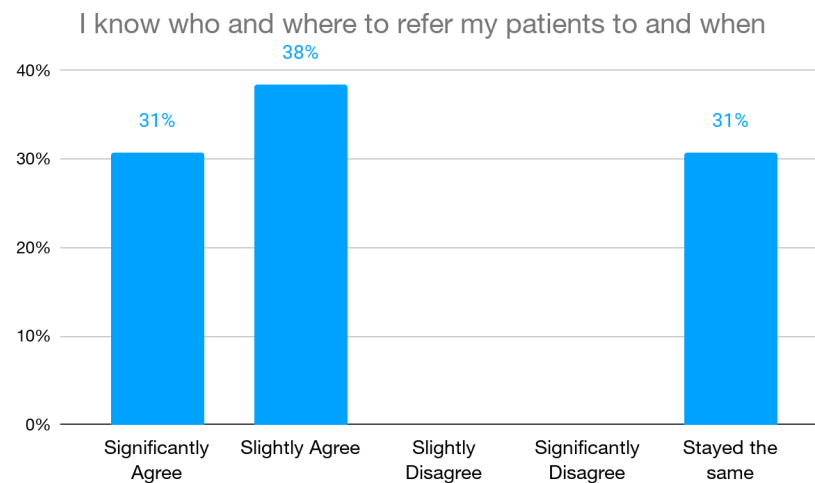
2. Compared to 3 years ago, how would you rate your level of agreement with the following statements now?

I have seen an improvement in my relationship among the specialist physicians involved in my palliative patients circle of care



I have seen an improvement in my relationship among the allied health providers involved in my palliative patients circle of care





3. What is working well with regards to palliative care provision in the Fraser Northwest communities?

- Improved access to palliative care consultations.
- They are responsive when I get a hold of them
- Patients and families generally have good feedback regarding services received by palliative care
- Palliative care provided in hospice
- Connection with Palliative care team
- Good communication with palliative home care nurses through fax
- Dedicated team at ERH and RCH



4. What is needed to improve palliative care provision in the Fraser Northwest communities?
- Clearer integration of palliative pain management options.
 - Earlier access to palliative care (not just in last year of life)
 - Nothing
 - "Better communication by palliative care physicians to GPs. I'm usually the one trying to connect with the palliative team and if I get through to someone it's usually the nurse. The palliative care physicians expect us to continue prescribing opioids and pain control, sometimes delaying the process for patients, when they can prescribe themselves."
 - Earlier consult, follow up
 - "Availability of services after hours, over WE.
Lack of Hospice beds"
 - Shorter wait times for physician specialist consult when there are difficulties managing sx, like uncontrolled pain.
 - "More direct contact w/ the palliative physician would be helpful. So far, we are only able to communicate with the Palliative RNs in the community. It would be helpful to have the contact for the palliative on- call physician to be able to ask questions. I have tried the RACE line but they are also very difficult to reach.

Also, often the palliative RN will ask for changes to the medication or add to the medication without asking the patient to contact the family doctor. This can happen multiple times a week with is onerous for the family doctor. It would be helpful if the RN can make these changes with the support of the palliative care doctor."

- Resources - compensation, "time", patient education