REDUCING THE SILO MENTALITY

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SETTING THE SCENE

CE LHIN
Oversees healthcare in the Central East region of Ontario

Seniors Care Network
Responsible for Specialized Geriatric Services in the CELHIN

GAIN
12 Interprofessional Geriatric Teams who complete CGAs

SPLC
Community Teams

Carefirst
<table>
<thead>
<tr>
<th>Introduction</th>
<th>Medical/Surgical History</th>
<th>Medication</th>
<th>Social History</th>
<th>Falls</th>
<th>Function</th>
</tr>
</thead>
</table>

A Competency Framework for Interprofessional Comprehensive Geriatric Assessment

<table>
<thead>
<tr>
<th>Cognition</th>
<th>Mood/Mental Health</th>
<th>Sleep</th>
<th>Pain</th>
<th>Nutrition</th>
<th>Continence</th>
<th>Physical Assessment</th>
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</thead>
</table>
So why not just make a referral to Palliative Home and Community Care???
BACKGROUND

• Patients were rejected by traditional community palliative care via CELHIN Home and Community Care

CELHIN Palliative Care Eligibility:

- PPS <30%
- Prognosis <3 months
- Terminal diagnosis
- Requirement of a physician*

GAIN patients often present with an atypical trajectory where a PPS score does not reflect prognosis
BMJ Open: Access to palliative care (PC) by disease trajectory: a population-based cohort of Ontario decedents


<table>
<thead>
<tr>
<th>Setting</th>
<th>Terminal Illness (cancer)</th>
<th>Organ Failure (heart or lung)</th>
<th>Frailty (dementia)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any PC</td>
<td>88%</td>
<td>44%</td>
<td>32%</td>
</tr>
<tr>
<td>Any PC in the Community Environment</td>
<td>67%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>LHINs PC Home Care</td>
<td>47%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Median Days in between 1st PC and death</td>
<td>107</td>
<td>22</td>
<td>24</td>
</tr>
</tbody>
</table>
“SILO MENTALITY”

SCHC-Palliative Community Care Team (PCCT) → Referral → GAIN → Referral → CELHIN
SCHC-PCCT
- 24/7 access to nurse
- Palliative services
- Criteria: “life-limiting illness”
- Informal communication with multiple LHIN Care Coordinators
- Difficulty with ongoing access to primary care physician/NP*

*SCHC-PCCT can make referral to 1 of 6 palliative physicians when PPS <30%*

SPLC & Carefirst GAIN
- Not 24/7
- Lack of palliative support
- Interprofessional team
- Embedded LHIN Care Coordinators on team
- Access to physician/NP
INNOVATION

Timely & Effective Communication
- Identify who to communicate with and when

Coordination of Services
- Prevent duplication
- Discuss the same message

Sharing of Resources
- Nurse Navigators & NP/Physician)
IMPLEMENTATION:
ADOPTION OF EXISTING PRACTICES

- Review of cases & learning
- Reviewed current state
- Identified community resources (i.e. SCHC-PCCT)
- Collaborative meetings
- Education
- Practice change
OUTCOMES: PRESENT

QUANTITATIVE

• Patient’s frailty level
• Dementia score
• Number of in-home visits
• Telephone visits
• Consults with palliative physician
• Hospital/ED visits avoided
• Unnecessary Specialist appointments avoided

QUALITATIVE

• Informal feedback
OUTCOMES:
FUTURE

QUANTITATIVE
• Cost reduction associated with:
  • Medication de-prescribing
  • Reduction of laboratory investigations
  • Avoiding ED visits/hospitalizations

QUALITATIVE
• Formal feedback including:
  • Caregiver stress
  • If families feel the patient’s preferences for a “good death” were met.
SUSTAINABILITY

- Decreased moral distress
- Increased inter-professional collaboration
- Education opportunities
- Utilization of preexisting programs at organizations
- Access to specialists within teams
- Does not require immediate additional funding
Dedicated to
RICHARD (WAYNE) POTTLE
REFERENCES

THANK YOU!
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everyone here belongs

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