WHOLE COMMUNITY PALLIATIVE ROUNDS (WCPR)
Inter-professional communication and decision-making

SPRINT WCPR IMPROVEMENT COLLABORATIVE
Adapting and implementing leading practices in integrated home and community care

WELCOME
14, MAY 2019
SPRINT IMPLEMENTATION COLLABORATIVE
Adapting and implementing leading practices in integrated home and community care

Nadine Henningsen
Chief Executive
Canadian Home Care Association
• 24-month project - Opportunities to improve home-based palliative care
  – Early assessment and care planning
  – Inclusion of advanced care wishes into care delivery
  – Effective communication strategies and tactics
  – Access, management and disposal of equipment, supplies and medications

• Engage with policy-makers, providers, patients and caregivers
### Roadmap for operational excellence in home-based palliative care

| Opportunities & gaps in operational process in home-based palliative care | Expert Roundtables  
e-Delphi Consultation  
https://www.homecarekn.ca/assessment-and-care-planning/ |
|---|---|
| Showcase the “Experiences” of providers, funders and caregivers | Experience Maps  
https://www.homecarekn.ca/0-advanced-plans/ |
| Identify and promote leading practices | 22 Leading Practices  
5 High Impact Practices  
https://www.homecarekn.ca/operational-innovations/ |
| Support the application of evidence-informed operational practices in home-based palliative care | SPRINT Implementation Collaboratives  
SPReading Innovation in INTEGRated Home and Community Care |
SPRINT Implementation Collaboratives
SPReading Innovation in INTEGRated Home and Community Care
• Integrated health system that provides seamless patient- and family-centred care and supports for older adults living with frailty; those with complex, chronic disabling conditions; and individuals at the end-of-life.

• A customized, structured approach to implementing evidence-informed practices and enabling sustainable change in home and community care.

• Adapted from the Institute for Healthcare Improvement Collaborative Model for Achieving Breakthrough Improvement and the Evidence-Based System for Innovation Support (EBSIS).
SPRINT Implementation Collaboratives

**WHAT WE KNOW**

**FOUNDATION FOR SUCCESS**
- Tools
- Training
- Engagement
- Coaching/ Technical assistance

**WHAT WE DO**

**SPRINT IMPLEMENTATION STRATEGY**
- Quality improvement – PDSA
- Outcome measurement
- Co-creation
- Change management

**COLLABORATIVE PROCESS**
- Local participation—national sharing
- On-boarding and group learning
- Interactive sessions
- Capstone event—experiences and sustainability

**UPTAKE OF EVIDENCE-INFORMED PRACTICES**

Canadian Home Care Association
canadienne de soins et services à domicile
The SPRINT-WCPR Collaborative: test, adapt and implement the leading practice Whole Community Palliative Rounds.

Goal: Help inter-professional teams engage in purposeful and timely communication, shared decision making and collaborative care planning all within an integrated palliative care model

• 7-months - annual sustainability “check-in”

• Tools, training and education, coaching/technical assistance

• Access to recognize experts and resources
“Should we participate in the SPRINT-WCPR Implementation Collaborative ....”

• Enhance the quality and effectiveness of home-based palliative care

• Address communication challenges with inter-professional teams

• Accelerate decision-making and team collaboration

• Build on knowledge and experience in QI methodology & measurement

• New ways to ensure sustainable change

• Designated resources to work locally and share nationally

The 2019 SPRINT-WCPR Collaborative is your opportunity
WHOLE COMMUNITY PALLIATIVE ROUNDS
Inter-professional communication and decision-making

Karyn Morash
Director of Palliative and End-of-Life Care
Interior Health, BC

Elisabeth Antifeau
Regional Clinical Nurse Specialist for Palliative Care
Interior Health, BC
Interior Health
Whole Community Palliative Rounds: Building Operational Excellence in Palliative Care

Canadian Home Care Association Webinar – May 14th, 2019
Elisabeth Antifeau, Regional Clinical Nurse Specialist, IH Palliative and End-of-Life Care
Karyn Morash, Director, IH Palliative and End-of-Life Care
Objectives

01 Our Story

02 MANY Questions

03 Whole Community Palliative Rounds

04 Key Findings

05 Next Steps
Where the idea originated
• Fluctuating and complex experiences of symptom burden in advancing illness;
• Complex care needs that are best supported through inter-professional collaboration
• High “whole health system” use - especially in the last year of life
• Rural and remote health care requires infrastructure to support a primary palliative approach
• Imperative from the Ministry of Health regarding availability of Hospice Spaces

Who are we and what are our needs?
• Large geography (215,000 sq. km) and low population density (3.5 people per square km)
• 21% growth rate/5 years for people 75+ and 17% expected growth rate for people 85+
• Ministry of Health direction to use a population based approach to health system redesign
• Analysis and planning for team based, cross-sectoral and whole community innovation

Knowledge as Action
• To use a population-based, “whole community” lens that is inclusive of partners both within (cross sector, cross program) and external to our Health Authority
• To create integrated, inter-professional team approaches for active symptom management through rapid clinical problem-solving, care-planning and communication that contributes to effective symptom relief and Quality of Life
• To build System Capacity by using WCPR as a purposeful rural strategy to support primary generalist palliative care
It started with MANY QUESTIONS!

**People**
- Who is “the palliative team”?
- What do you mean by cross-sector?
- What is meant by “whole community?”
- Which external health partners should be invited? (and why?)
- What are the roles? Who leads rounds?
- Who is referred each week (criteria)

**Risks and Benefits**
- What are the risks of starting something like this?
- What are the benefits to people? Families? For health professionals?
- What resources are needed to be successful?

**Indicators & Outcomes**
- How might WCPR make a difference?
- How quickly is symptom burden relieved?
- How will we know if this is effective? What measures should we use?
- Is this best practice?

**Time and Resources**
- How much time does this take?
- Which staff need to attend?
- How is this coordinated and organized?
- Do staff need to be relieved to attend?
Whole Community Palliative Rounds

1. Principles, Values & Vision
2. Defining Whole Community and Team
3. Enablers for Success and Challenges
4. It takes a Team
5. Outcomes To-date
Principles, Values and Vision

• BC Ministry of Health (2013) identified the need for “transformational health system redesign”

• Visioning for a strong primary generalist palliative approach

• Focus is to build capacity with linkage to champion and specialized services for support and consult

• “24/7 access to palliative care” looks different in smaller communities – opportunities arise through relational strengths

Whole Community Palliative Rounds
Defining Whole Community and Team

• Concept of “whole community” arose from the developmental disability and emergency response literature

• Whole Community recognizes the inter-relationship and connections between formal and informal care providers across all settings of care

• The inter-professional team is expanded to include:
  • Cross-sector representation (community, hospital and long-term care)
  • Most Responsible Providers (physicians and nurse practitioners)
  • Health professionals: nursing, allied health, social work
  • Cultural competencies: First Nation partners
  • External partners: Hospice Society Coordinators, Community Paramedicine, contracted LTC partners
Whole Community Palliative Rounds

• Referrals made throughout the week for people with unstable symptom management, complex needs or transitioning

• Once per week gathering of the team in the hub and in spoke communities that call in (set date, place and time)

• Rapid clinical problem solving and care planning

• Documentation and information sharing back to most responsible clinicians (MRC)
Enablers for Success

- The ‘Circle of Care’ was formally defined to better meet population-based needs

- Written guidelines and a toolkit was developed to clearly define:
  - Vision, purpose and goals
  - Roles and responsibilities
  - Referral criteria
  - Practical guidance on the format of how to organize and conduct weekly rounds

- Clinical Decision Support Tools were developed:
  - Referral forms
  - Physician/Nurse Practitioner communication Sheet
  - Palliative Rounds Tracking Record

- Physician Engagement – Palliative Medical Leaders sought; budgeted sessional time

- Education, Communication and Promotion of WCPR as an important strategic priority supported by senior leadership
Addressing Challenges

• Creating a common and shared understanding

• “Other” Rounds – how is this different?

• Supporting Family Physician Practices

• Making the commitment

• Seeking Clinical Excellence
It Takes a Team

1. Designated Rounds Facilitator (permanent or rotating):
   a) Manages local palliative registry
   b) Discussions are documented and ethically shared
   c) Conducts rounds to start and stop on time and stay focused on problem solving from an inter-professional/interdisciplinary/whole community lens
   d) Ensures appropriate follow-up and communication results

2. Support may be needed – agenda, minutes, rooms, etc.

3. Participants need to make the commitment to attend &/or gather locally if dialling in; this may mean (self) release from clinical time for (15 mins to 1 hour)

4. Teams vary in composition, size and relationship; best discussed, defined and addressed locally
Outcomes To-date

• Nine well-established WCPR “Hubs” supporting 36 smaller outlying “spoke” communities

• An additional eight communities are in contemplation of becoming hubs and would support an additional 10 spoke communities

• CNSs attend many rounds per week and anecdotally report an improved shift towards standardized palliative assessment, use of BC Symptom Management Guidelines, enhanced palliative clinical problem-solving, greater awareness and consistency of care

• Teams talking together! Enhanced trust and improved relationships within and across team boundaries is both reported and evident
Outcomes To-date - continued

Established WCPR hub and supported communities
Contemplating WCPR hub and supported communities
Outcomes To-date: Impact on Team

- Formal evaluation efforts are just starting
- Results in a recent pre/post survey of WCPR participants in 2 communities indicates:

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<th>At Baseline (Sept 2018) N=22</th>
<th>Follow-up (March 2019) N=12</th>
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<tbody>
<tr>
<td>Feeling well or very well supported in the provision of PC</td>
<td>27%</td>
<td>58%</td>
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<tr>
<td>Team Communication about PC is rated as good</td>
<td>38%</td>
<td>83%</td>
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<tr>
<td>Teamwork is rated as good or very good</td>
<td>50%</td>
<td>92%</td>
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What is your level of agreement with the following statements for palliative care in your area? (Post only)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<tbody>
<tr>
<td>Palliative care rounds have improved communication among palliative care providers in my area</td>
<td>6 / 50.00%</td>
<td>6 / 50.00%</td>
<td>0 / 0.00%</td>
<td>0 / 0.00%</td>
<td>0 / 0.00%</td>
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<tr>
<td>Palliative care rounds have built new relationships among palliative care providers in my area</td>
<td>8 / 66.67%</td>
<td>4 / 33.33%</td>
<td>0 / 0.00%</td>
<td>0 / 0.00%</td>
<td>0 / 0.00%</td>
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<tr>
<td>Palliative care rounds have improved patient care in my area</td>
<td>4 / 33.33%</td>
<td>8 / 66.67%</td>
<td>0 / 0.00%</td>
<td>0 / 0.00%</td>
<td>0 / 0.00%</td>
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<tr>
<td>I have learned a lot about palliative care approaches from palliative care rounds</td>
<td>4 / 33.33%</td>
<td>6 / 50.00%</td>
<td>0 / 0.00%</td>
<td>1 / 8.33%</td>
<td>1 / 8.33%</td>
</tr>
<tr>
<td>The multi-disciplinary approach to palliative care rounds helps to improve patient care</td>
<td>9 / 75.00%</td>
<td>2 / 16.67%</td>
<td>1 / 8.33%</td>
<td>0 / 0.00%</td>
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Social Mapping of Palliative Networks

Whole Community Palliative Rounds
Social Mapping of Palliative Networks: Spokes and Hubs

Supporting rural communities

36 9

Whole Community Palliative Rounds
Key Findings

1. Collaboration
   - Across care settings
   - Across programs
   - Across disciplines
   - Across communities
   - More and timely care conversations;
   - Shared understanding of the goals of care;
   - Ability for different team members to take a similar approach to care conversations with people/families

2. Communication
   - Symptom Burden Relief;
   - Self management;
   - Improved options to stay home;
   - Family/Caregiver Support and Education;
   - Consistency of care and information from the team

3. Clinical Responsiveness and Flexibility
   - Real time clinical learning “in the moment”
   - Clinical problem-solving from a team perspective
   - Safe place to try out new assessment skills and knowledge;
   - Mentoring

4. Knowledge as Action
   - Awareness of people, roles and resources both within and external to the health authority.
   - Improved ability to network and refer outside of WCPR

5. Inclusiveness
   - Relationship building
   - Team development
   - New partnerships
   - Knowledge building
   - Connections and communication reinforced locally and geographically

6. Capacity Building
   - Best practice palliative care is fully supported;
   - Use of the BC Inter-professional SMG and standardized assessment tools;

7. Palliative Excellence

Whole Community Palliative Rounds

Every person matters
Summary of Key Findings

Whole Community Palliative Rounds
- is an effective strategy to enable rapid clinical problem-solving of symptom burden in people with advancing illness and palliative needs and to support them to self manage and remain at home

Expanded Inter-Professional Teams
- Enhances collaboration, communication, collegiality, appreciation of different roles and disciplines, improved palliative care knowledge, networking and quality of care delivery

Builds System Capacity
- WCPR is used as an intentional rural and remote strategy to reinforce and strengthen local primary generalist teams to deliver best possible, evidence-based palliative care.
Next Steps

Continued support to existing WCPR
- Reflective practice, quality improvements sought
- Greater consistency of member attendance, involvement

Formal evaluation of existing WCPR
- Pre/post surveys, FamCARE, PROMS, PREMS, sharing of results
- Social network mapping

Further development
- Establishment of new hub and spoke WCPR to cover all areas of IH
- Refining of guidelines and clinical decision support tools as needed

Enhancing Primary, Secondary & Specialist Linkages
- Stronger linkages and capacity building amongst and between WCPR members and between primary and specialized care programs (renal, heart failure, diabetes and oncology, etc)
- Possible Community of Practice for designated WCPR Facilitators
SPRINT-WCPR Implementation Collaborative

Download and complete the EXPRESSION OF COMMITMENT  -  **Deadline June 3**

Visit [https://www.homecarekn.ca/sprint-implementation-collaboratives/](https://www.homecarekn.ca/sprint-implementation-collaboratives/)

4 – 8 Successful Teams – Notified June 5

On-boarding/learning forum – June 24 & 25 (Toronto) (3 team members)

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<td><strong>Launch SPRINT-WCPR</strong></td>
<td><strong>JUNE 3</strong></td>
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<td><strong>OCT 9</strong></td>
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<td><strong>DEC 2 &amp; 3</strong></td>
<td><strong>NOV 2 &amp; 3</strong></td>
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<td>Deadline for submission of EXPRESSION OF COMMITMENT</td>
<td>Virtual Learning Session (1.5 hrs)</td>
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<td>Virtual Learning Session</td>
<td>Capstone Event 2 days (Location TBD)</td>
<td>1 year Check-in 2 days (Location TBD)</td>
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<td>JUNE 5</td>
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<td>Successful team notified</td>
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<td>JUNE 24 &amp; 25 On-boarding, learning forum 2 days (Toronto)</td>
<td>ACTION PERIOD (PDSA)</td>
<td>ACTION PERIOD (PDSA)</td>
<td>ACTION PERIOD (PDSA)</td>
<td>ACTION PERIOD (PDSA)</td>
<td>TEAM EXPERIENCES</td>
<td>NATIONAL SHARING</td>
<td>SUSTAINABILITY</td>
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VIRTUAL LEARNING SERIES

Question and answer session

Webinar participants – please post questions for our speakers in the ‘Questions and Comments’ chat pod to the left of the presentation.

Please tell us who your question should be directed to.

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