Taking Ownership : a Primary-Level Palliative Care Capacity-Building Project in the Ottawa

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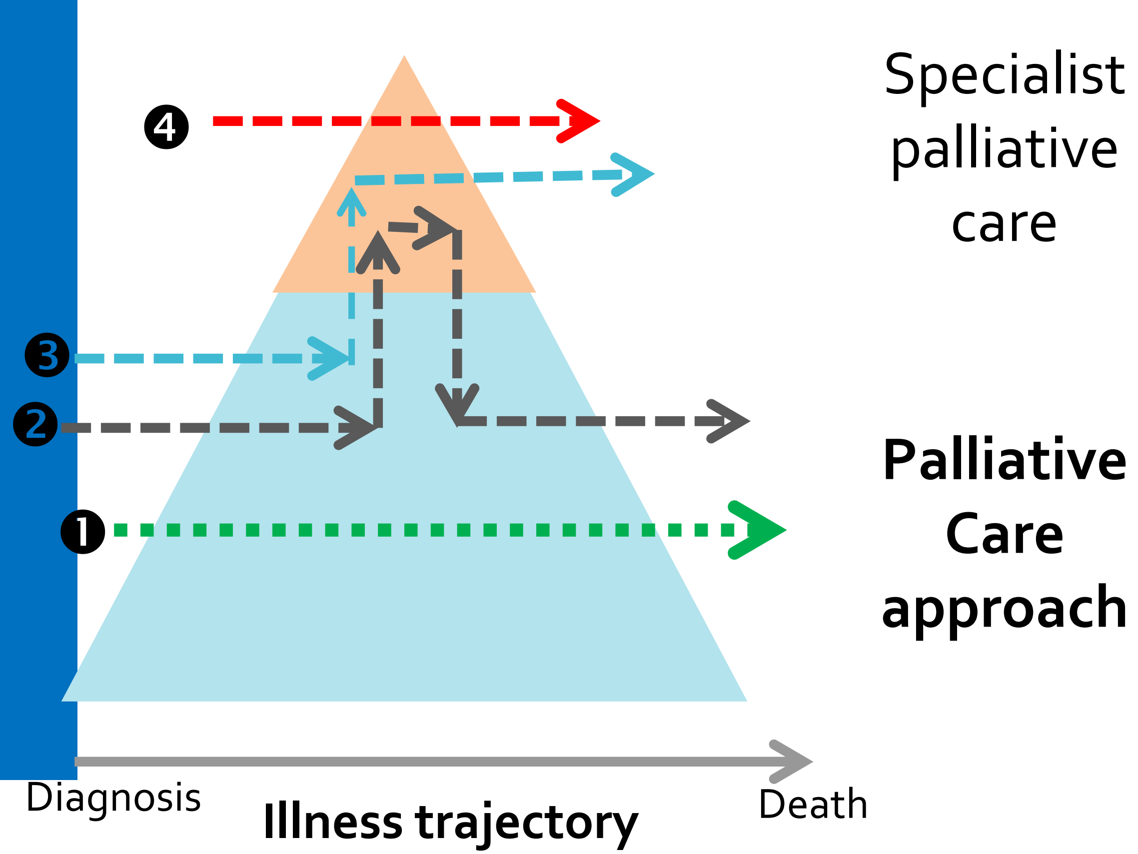
Background

Background

- Primary-level palliative care is a component of the comprehensive, continuous, community-based care provided by family medicine.
- For a number of reasons, many family physicians and family health clinics in urban Ontario settings have not provided primary-level palliative care (aka *the palliative care approach*) to their own patients, particularly when home or hospice care is required.
- This was the case with two academic FHTs (four clinics) in Ottawa prior to this project.

Different needs, different levels of care



Palliative care is everyone's business

Specialist-level palliative care teams

Family physicians, primary care nurses, oncologists, internists, nephrologists, cardiologists, pharmcaists, etc

Palliative Care approach

Diagnosis

Illness trajectory

Death

SURVEY	CCO Ontario Survey[2]	National Physician Survey (NPS) 2010[3]
TARGET	**Clinic level** CHCs, FHTs, NPLCs, AHACs	**Physician level** Canadian physicians
RESPONSE RATE	31% (102/329)	19% (6602/34810)
Palliative care in clinic	83%	45.7% of FPs provide pall care 42.4% do home visit;
Palliative home visits	78%	
After-hours Palliative coverage	28% 30% of all responding clinics directed palliative patients to emergency rooms	

Project objectives

A. Increase the capacity of two academic FHTs to provide primary-level palliative care to their own patients;

B. Increase family residents’ exposure to palliative care learning opportunities.

C. Have FPs supervisors and clinics role model the palliative care approach

Project Context

- Two academic interprofessional FHTs in urban Ottawa, each with two clinics and family medicine residents.
- Provision of PalCare was the exception across all four clinics before the project (with some exceptions)
- Clinic physicians and nurses did not provide palliative care, including home- and hospice-based care.
- Transfer of care to community based palliative care physicians was common.
- The clinics had no on-call groups for a PalCare coverage.
- Exposure to PalCare and home visits for the family medicine residents linked to the clinics was often suboptimal.

FHT X	**CLINIC A**	**17 FPs, 1 NP, 3 RNs, 1 Pharm, 30 Residents**
	CLINIC B	8 FPs, 2 NPs, 3 RNs, 1 Pharm, 9 Residents
FHT Y	**CLINIC C**	12 FPs, 1 NP, 2RNs, 30 Residents
	CLINIC D	7 FPs, 1 NP, 2 RNs, 8 Residents

HT= Family Health Team NP = Nurse Practitioner RN = Registered Nurse

P= Family Physician Pharm = Pharmacist

lote: The exact number of FPs and Residents have fluctuated (± 2 in the smaller clinics and ± 4 in he larger clinics) over the course of the project (4 years: 2010 to 2014)

Interventions

- 4-year long multipronged QI approach
- Inspired by the work of Marshall et al (shared care model) but focused on a Consultation Role .
- The project was conducted in phases, starting in 2010 (with Clinic A), then Clinic B in 2011, followed by clinics C and D in 2013/2014.
- Funded for 3.5 years by the Ontario Ministry of Health and Long Term Care's Academic Hospitals Innovation Fund.
- The funding paid for a palliative care nurse part-time and part-time project coordination and research support.

Interventions

CLINICAL		EDUCATION	PROCESSES
Just-in-Time Support	**Clinical Aids**	**Lunch & Learns**	**Access to provide care in local Hospices**
• **24/7 just-in-time support from Palliative Care Consultation Team (Nurse & MD)** ○ Single pager access ○ Home & office visits ○ Telephone support ○ Joint visits ○ Palliative Team access to FHT EMR ○ Palliative care team remunerated by salary (not fee-for-service) ○ FHT FP remains most responsible physician.	• **Early identification of patients** "Surprise Question" • **Emergency supplies home kit** • **Clinical handouts** • **Pallium Palliative Pocketbook**	○ For all staff & residents ○ Topics included: ○ Palliative billing codes ○ Advance Care Planning ○ Symptom Management ○ Resources & tools	FHT FPs able to follow their patients into Hospice and also take on new Hospice patients.
			Palliative Care Registry
		Pallium LEAP modules	Each clinic maintains list of patients identified by "Surprise Question"
	Clinic On-call groups for Palliative Care	**Access to Pallium LEAP Core 2-day course**	**EDITH Protocol**
			Facilitate death certificate completion for home deaths.
	Home & Hospice visits by FHT FPs & RNs		**FP champions in clinics**

FP= Family Physician; EMR= electronic Medical Record FHT: FHT: Family Health Team
LEAP = Pallium Canada's Learning Essential Approaches to Palliative Care

Champlain Palliative Symptom Management Kit – Medication Order Form

Medical Pharmacy Group (8AM – 8PM) FAX: 613-244-4695 or 800-373-4945 PHONE: 613-244-4685 or 800-267-1069 X 5900
LHIN Fax: 613-745-6984 or 855-450-8569

Patient Name: ______________________ **Patient DOB (dd/mm/yy):** ____/____/____ **Patient OHIP#:** ______________________
Patient Address: ______________________ **Phone:** ______________ **Allergies:** ______________

MD/NP Instructions: Order Medications for a 24-72 hour period for the purpose of relieving anticipated or escalating end-of-life symptoms

1. Complete the patient demographics above.
2. Complete the order for each selected medication that corresponds with the Indications.
3. Write your initials in the Initials column for all medications you want included in the SMK.
4. To order a Foley catheter, tick the box located under the table of medications.
5. Complete your demographics at the bottom of the page.
6. Fax the completed form to the pharmacy (Medical Pharmacy Group) and to Champlain LHIN.

Indications: Pain	Dyspnea	Agitation Delirium	Anxiety	Nausea Vomiting	Seizures	Upper Airway Secretions	Drug	Concentration	# Ampoules or bottles	Dose, Route, Frequency of Administration	MD/NP Initials
✓	✓	X	X	X	X	X	Morphine	☐ 2mg/ml ☐ 10mg/ml	10 x 1ml	______ mg Subcut q1hr prn LU 481	
							OR				
✓	✓	X	X	X	X	X	Hydromorphone (Dilaudid)	☐ 2mg/ml ☐ 10mg/ml	10 x 1ml	______ mg Subcut q1hr prn	
X	X	✓	X	✓	X	X	Haloperidol (Haldol)	5 mg/ml	5 x 1ml	______ mg Subcut q4hr prn	
X	✓	✓	✓	✓	X	X	Methotrimeprazine (Nozinan)	25 mg/ml	5 x 1ml	______ mg Subcut q4hr prn	
X	X	X	X	X	X	✓	Scopolamine	0.4 mg/ml	10 x 1ml	0.4 mg Subcut q4hr prn LU 481	
							OR				
X	X	X	X	X	X	✓	Glycopyrrolate	0.2mg/ml	10 x 1ml	0.4mg Subcut q2hr prn LU 481	
X	✓	✓	X	X	X	X	Midazolam	5 mg/ml	5 x 1ml	______ mg Subcut q30min prn LU 495	
seizures / catastrophic bleed / severe respiratory distress							Midazolam	5 mg/ml	5 x 1ml	______ mg Subcut stat LU 495 repeat every 5-10 minutes if event persists or sedation is not achieved, call MD/NP after first dose given	
indication:							Other:				
indication:							Other:				

☐ *** Insert Foley Catheter to straight drainage PRN, care and maintenance as per the Champlain LHIN Protocol ***

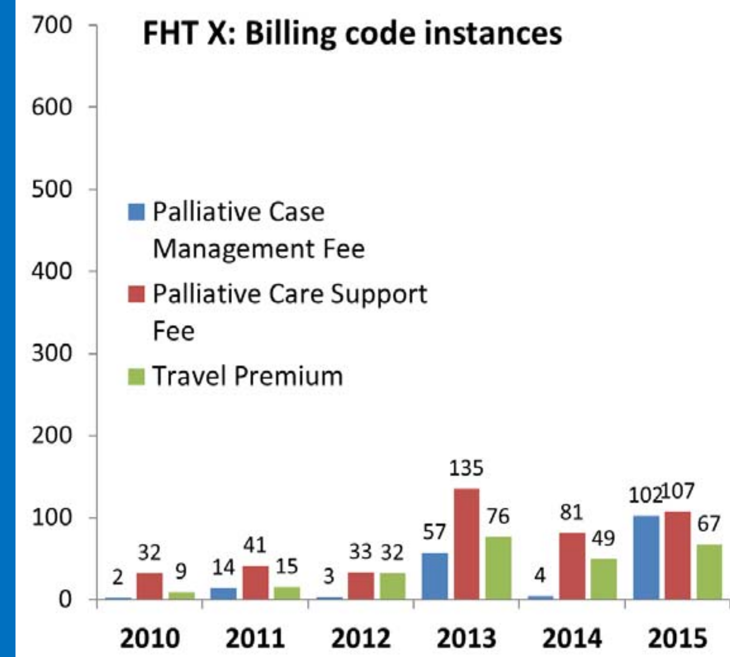
Physician/Nurse Practitioner Signature: ______ **Practitioner college#:** ______ **Phone Number:** ______
Physician/NP Address: ______ **Date requested:** ______ **Fax Number:** ______

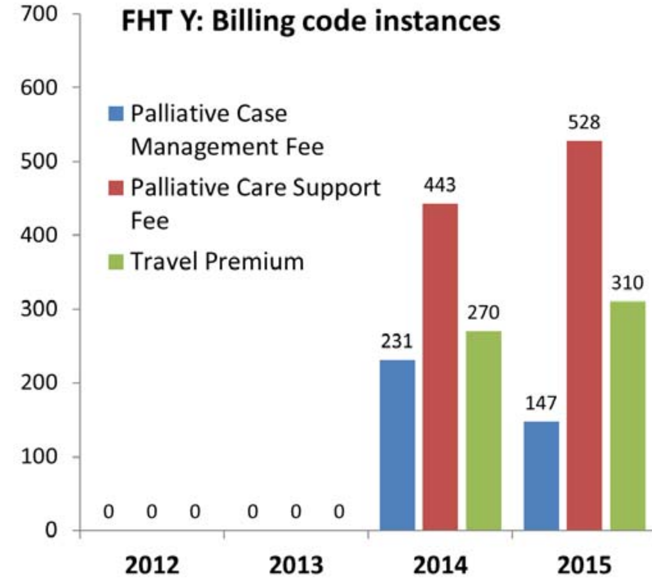
Evaluation Methods

- Action research and mixed methods approaches used.
- Approved by Bruyère & Ottawa Hospital Research Ethics Boards

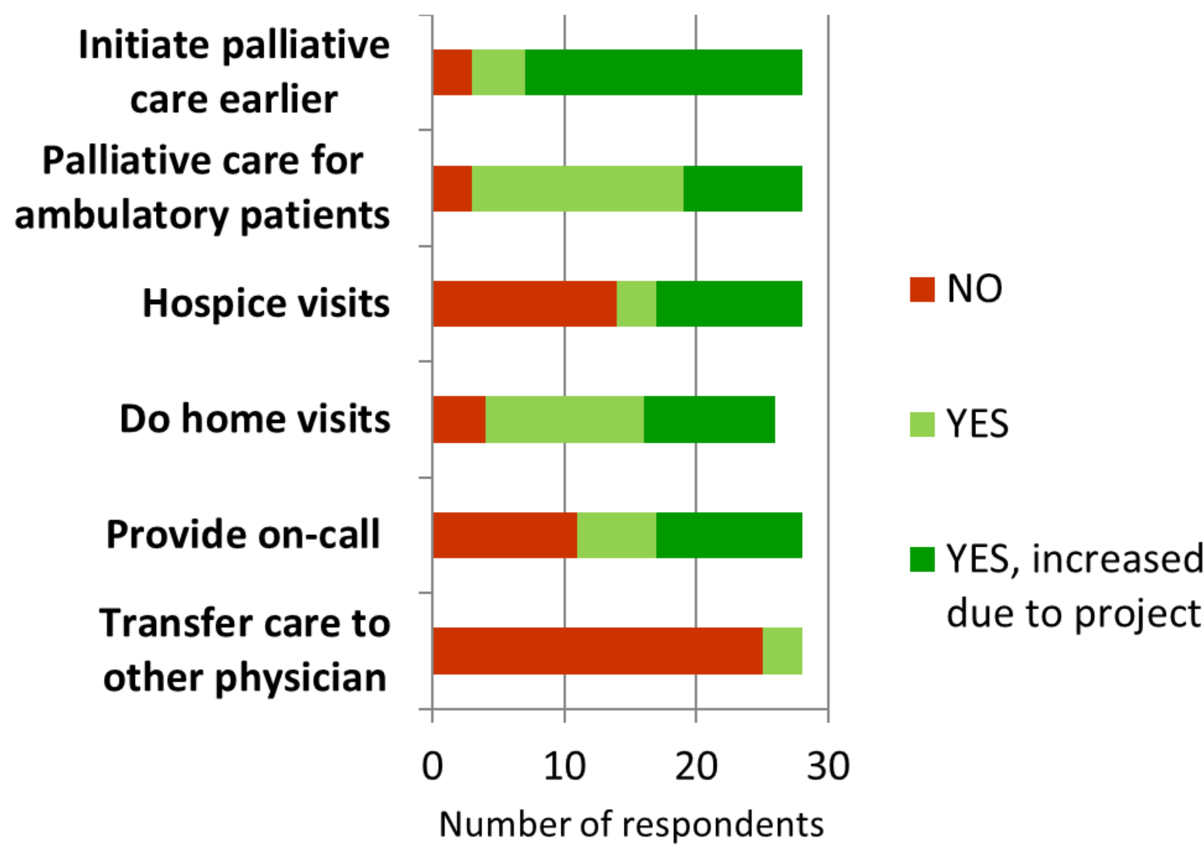
QUANTITATIVE	• Number of palliative care fee codes billed by FHTs FPs; • Pre- and post-project (exit) surveys of FPs and Residents; • Number of consults to the Palliative Consult Team.
QUALITATIVE	• Project exit interviews with FHT FPs (purpose sampling); • Interviews with PCT team (RN & MD); • Field notes kept by PCT. • Interviews with FPs on sub-project interventions (e.g. "Surprise Question" in clinical practice; Emergency Kit, Registry)

Results





Results:
Project exit survey of FHTs family physicians (n=28)



Results: qualitative data

- Several domains were covered in the exit interviews, including: a) impact of the project, b) factors for success (enablers), c) barriers to providing this care, d) challenges experiencing during the project, and e) things to change in the future.

Results

- On-call rosters were established in 3 of 4 clinics.
- 15 family physicians participated in the exit interviews. Participants came from all 4 clinics and represented various levels of palliative care activity.

Results: themes emerging

Theme	Quotes
More palliative care being done, including home visits.	*“For myself, the numbers show that from May 2012 to April 2013 I saw 2 palliative care patients and from May 2013 to April 2014- the following 12 months- I saw 20…. So in the last year has been a significant increase as a group; we saw fifty palliative care patients the previous year and 93 this year. …” [P5]* *“Some of [the residents] were graduating never having done a home visit and so the concept of looking after at home was completely foreign.” [P9]* *“We looked at this, our billings have gone way up, the number of faculty at our site who are now getting their palliative care bonus from the province…” [P2]*
Increased work satisfaction	*“What the project did was increase peoples’ commitment and buy-in and satisfaction with the kind of work they were doing so as a group we could do it much better.” [P4].*

Results: themes emerging

Improved residency education	*"Some of [the residents] were graduating never having done a home visit and so the concept of looking after at home was completely foreign." [P9]* *"The other thing that we've done is we have a palliative care curriculum that we did not have before." [P13]* *"[Residents] got to see that this is something that you can do in primary care, embedded in primary care, and you can manage it within a practice." [P4]* *"It's really enabled residents to feel like they could see themselves doing this in the future, and that's really, really positive for the field." (P2)*

Results: themes emerging

Enablers	• Just-in-time access to Palliative Care Consultation Team • Consultation model that kept family physician as MRP • Providing care in local hospices (for 3 of 4 clinics); • Focus of project on residency training was transformative; • Competitive fee codes for billing
Challenges	• Time pressures in practice • Urgent house calls (role for practice's nurses?) • Ongoing lure to have Palliative Care Consult Nurse to stay indefinitely involved and to take on most responsible role.

Results: Reflections of the consultant team

- Importance of visibility and presence in the clinics
- Need to maintain consulting role (temptation and pressure to switch to take over model)
- Sometime shared care model, but limit this

Ottawa Academic FHTs Palliative Care Project (2010-2015)	Doing palliative care? 2011	2014
CLINIC A	✖	✓
CLINIC B	✖	✓
CLINIC C	✖	✓
CLINIC D	✖	±

Conclusions

- A culture shift occurred as a result of this project; the family physicians in this project took ownership of providing primary-level palliative care.
- This project demonstrates that urban family health clinics and family physicians, with the necessary support and resources, are able to provide high quality primary-level PalCare, including care in hospices and the home.
- A multi-pronged approach that includes just-in-time clinical support, clinical decision-aids, education and improved processes is required, as well as time.

Conclusions

- Project enablers included just-in-time access to a Palcare consultation team, a focus on improving residency training , fair remuneration fee codes for this type of work. The clinical and education support increased physicians' comfort levels providing this work.
- Next steps requiring studying the impact of the project on health service parameters such as length patients stayed at home, ED visits, hospitalizations, etc