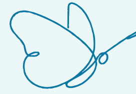


Building Operational Excellence

Home-Based Palliative Care

HIGH IMPACT PRACTICES

Evidence-informed practices in home and community care that result in better care, better outcomes and better value.

Whole Community Palliative Rounds

An innovative approach to inter-professional care planning and delivery in Interior Health

Whole Community Palliative Rounds is a strategy to enable rapid clinical problem-solving for symptom burden in high-risk individuals, purposeful and timely communication, shared decision-making and collaborative care planning among members of an inter-professional care team. **This High Impact Practice showcases how Interior Health in British Columbia has successfully implemented this strategy.**

BACKGROUND

People with palliative needs and their families often experience periods of escalating and fluctuating symptom burden[i] as their illness advances. Responding to the complex needs of the individual's physical and psychological symptoms requires coordinated and active involvement between the person, their caregiver(s) and an inter-professional health and social care team. Lack of communication structure, inadequate sharing of clinical information, poor reconciliation of medicines and duplicate or missing assessments are among the operational gaps that leave many people with palliative needs and their caregivers experiencing fragmented and poorly integrated care.[ii]

Ensuring responsive, coordinated care for individuals receiving palliative care throughout the Interior Health (IH) region is a challenge given the large geography (215,000 sq. km) and low population density (3.5 people per sq. km) In 2017, the population of the region was 749,853 (15% of the BC population), with an average life expectancy of 81 years. With a 21% expected growth rate for individuals aged 75+ and a 17% expected growth for individuals aged 85+, the demand for quality palliative care services in the area will increase over the coming years.[iii] In anticipation of this challenge, IH has embraced a primary generalist palliative model with consultation services to serve the majority of people living in small communities.

The BC Ministry of Health's *2018/19-2020/21 Service Plan*[iv] emphasizes the importance of transformational health system redesign across metro, urban, rural and remote communities. Creating team-based care with linkages to specialized services was identified as a key priority. In response to this strategic directive, IH committed to an inter-professional integrated approach to care. Specific to palliative care, this emphasizes active symptom management for individuals and their families. Whole Community Palliative Rounds (WCPR) is one of the strategies IH has developed and implemented to meet this goal.

This inclusive approach reflects the reality that we all experience and define our lives within the context of our relationships. Professionals from various health sectors and programs, as well as community partners are all included. The goal is to encourage collaborative input into the discussion and management of an individual's symptom burden and ultimately their quality of life and well-being.

Under the guidance of the IH Regional Palliative and End -of-Life Care Team, the concepts of "whole community" and "palliative rounds" were adapted to meet the needs of the palliative population, particularly for rural and remote areas.

"Whole Community"
Recognizes the inter-relationship and connections between formal and informal care (volunteers, family, friends) across all care settings.

"Palliative Rounds"
An expanded inter-professional team (circle of care) across health sectors, programs and disciplines focused on providing the best supports for the palliative population.

Canadian Home Care Association
canadienne de soins et services à domicile

Building Operational Excellence: Home-Based Palliative Care builds on "The Way Forward: An Integrated Palliative Approach to Care" by identifying innovative operational practices to address specific service gaps and improve the quality, efficiency and accessibility of home-based palliative care. The project is supported through a health funding contribution agreement from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

DEVELOPMENT

Building on previous provincial and IH strategic work, the WCPR model evolved to address identified gaps in care and communications across sectors, programs, and providers. Fundamental elements of the WCPR include:

- **Redefining the "circle of care"** to include sharing of information cross-sector, cross-program and with all members of the health care team located internally or externally to the health authority. IH's Department of Privacy, Policy and Risk Management reviewed the privacy legislation (Freedom of Information and Protection of Privacy Act - FIPPA) and provided guidance on how to redefine the circle of care. The new WCPR guidelines were widely shared and posted on IH's "insideNET" for permanent reference.

- **The WCPR Guideline** details the vision; goals and purpose; roles and responsibilities; referral criteria; and practical guidance on how to conduct efficient weekly rounds that are collaborative and inclusive.

- **Clinical decision support tools** ensure accurate recording and sharing of information and include a referral form, a Physician/ Nurse Practitioner Communication Sheet, and a Palliative Rounds Tracking Record.

- **Physician engagement** begins with the identification of Palliative Medical Leaders with existing or desired formal expanded palliative knowledge and skills. Engaging physicians through sessional remuneration contracts enables the provision of medical leadership for the weekly WCPR. Practitioners are supported through IH's Regional Palliative and End-of-Life Care Medical Directors, an IH Executive Medical Director, and other local palliative care leaders. Palliative Medical Leaders may provide direct and in-direct person consult in follow-up to the WCPR when requested by their physician colleagues, and then directly bill the BC Medical Services Plan.

- **Promotion and education** enable updates and new information on the WCPR to be shared consistently across the region. The concepts of 'whole community' and 'upstream approach' to palliative care are supported through IH's palliative knowledge translation strategy for primary curricula (Learning Essential Approaches to Palliative Care (LEAP) and the Canadian Hospice Palliative Care Association). In-person WCPR education sessions for IH staff and community partners includes an overview of the concept and purpose, logistics, partner engagement, and anticipated outcomes. Recorded sessions are available through IH's "insideNET".

"All people deserve to have palliative care and we can provide the very best palliative care in a team environment. To do that we need to come together and communicate and work from each other's strengths."

—Karen Peterson, Clinical Practice Educator for Palliative Care in IH West

IMPLEMENTATION

Identifying the appropriate lead, the right participants, location and format all affect successful implementation and sustainability.

A designated rounds facilitator (permanent or rotating) is responsible for: ensuring the expanded inter-professional team includes the appropriate internal and external representatives; the rounds start and end on time and have a clear purpose; discussions are documented and ethically shared; and appropriate follow-up occurs. The designated facilitator also manages the local palliative registry either through the on-line system (Meditech) or a local spreadsheet. While the local registry provides a comprehensive listing of all known local persons with palliative needs who are registered in the IH Regional Palliative and End-of-Life Care Program, only individuals with unstable complex symptom burden issues are referred and presented in the weekly WCPR.

Referrals to WCPR are identified by health care providers in various care sectors (community care, acute, long-term care) and forwarded to a local administrative assistant for addition to the weekly WCPR agenda. Referral criteria includes persons and their families who:

- present with transitioning or unstable physical symptoms (e.g. ESAS-r 4 or greater)
- are experiencing challenges with care management and planning
- present with psychosocial, emotional, spiritual, financial or other care needs that are complicated and require an inter-professional solution-oriented approach
- are transitioning between sectors of care and require planning and communication from a whole community approach.

Participants in the WCPR are involved in active discussions and bring their professional lens, relevant experience and knowledge to inform decisions about care planning and resource alignment to improve care and respond to identified needs. Attendance varies from 5 to 20 participants, depending on the complexity and number of cases, the size of the community and the number of presenting issues. The person's Most Responsible Practitioner (MRP) is invited to attend WCPR however their attendance is not a requirement to proceed. The team's recommendations are communicated to the MRP through standardized communication tools. Team members participating in a WCPR may include (but are not limited to):

- nurses (generalist and palliative care nurse specialists)
- medical palliative leaders
- family physicians and nurse practitioners
- Aboriginal health partners
- community paramedics
- therapists (OT, PT, RT)
- dietitians
- social workers
- hospice volunteer coordinators/representatives
- pharmacists
- spiritual health professionals

Whole Community Palliative Rounds

An innovative approach to inter-professional care planning and delivery in Interior Health

Hosting and coordination of a WCPR can be done in a variety of ways. A physical meeting space enables participants to meet face to face. Connectivity through secure technology (teleconference, video conferencing, One Note) supports coordination and enables broader access. WCPR are pre-scheduled and use a structured guideline for content and flow. The length of WCPR varies between under 1 hour (5-7 cases) up to 1.5 hours (14-18+ cases).

Documentation and linkages: The coordination and communication of decisions and recommendations made within the WCPR are documented and provided to the clinical primary setting using tracking or communication sheets, updated charts and verbal hand-over.

OUTCOMES

The use of WCPR enhances the recognition that palliative needs are complex, require active care, and that it takes a team to provide the best possible care. Since its inception, the number of communities hosting a WCPR ("hubs") throughout IH has grown from four to nine, with an additional eight communities exploring possible development and implementation. Consistent and ongoing attendance at the weekly WCPR from internal and external health care team members reinforces the value and usefulness of this strategy. The increasing number of weekly referrals is a clear indication of greater clinical recognition of people who are suffering and who might benefit from WCPR consultation. The enhanced circle of care (resulting from the WCPR development) is a leading practice within IH and has influenced other practice environments and populations.

ENABLERS FOR SUCCESS

WCPR are gaining momentum because they are an effective whole community-based primary care strategy that leverages the expertise and strengths of health care professionals and the experience and knowledge of local community resources. Members learn from each other and the learning from one WCPR has relevance to the next, deepening both clinical knowledge and practice.

Palliative medical leaders are essential to the success of WCPR. These local palliative care champions provide support to the weekly WCPR and act as a resource for local family physicians.

The **IH Regional Palliative and End-of-Life Care Team** has led the development, standardization, implementation, education and expansion of the WCPR strategy across the health authority. Subsequently formed Whole Community Palliative Teams are operational enablers that identify local system gaps/barriers and support front-line clinicians. An organizational culture that supports dedicated clinician time and resourcing of WCPR is essential to success.

Internal and external partner collaboration and inclusion are essential for building positive relationships, enhancing awareness of community capacity, developing and enhancing "compassionate communities", facilitating access and providing new opportunities for cross-sector referrals and collaboration.

Strategic and ongoing communication is necessary to build awareness of the new approach to support inter-professional care collaboration across IH. This requires various communication strategies to introduce the concept, reinforce the benefits and provide a reference source for new communities and team members as the concept grows.

Benefits for individuals with palliative needs and their caregivers

More timely interventions address symptom burden and ease suffering

Enhanced communication and greater consistency of care during transitions

Better understanding of the person and their caregiver's needs and supports

Increased ability to self-manage palliative care needs at home due to options and support provided by local care teams

Benefits for the health care team members

Enhanced trust and improved relationships across traditional and non-traditional teams

Enhanced clinical problem-solving and application of evidence-informed support tools such as the "BC Inter-professional Symptom Management Guidelines"

Clinical and relational learning through open discussions and structured communications

More efficient and focused use of health care resources (e.g., avoid unnecessary emergency room visits)

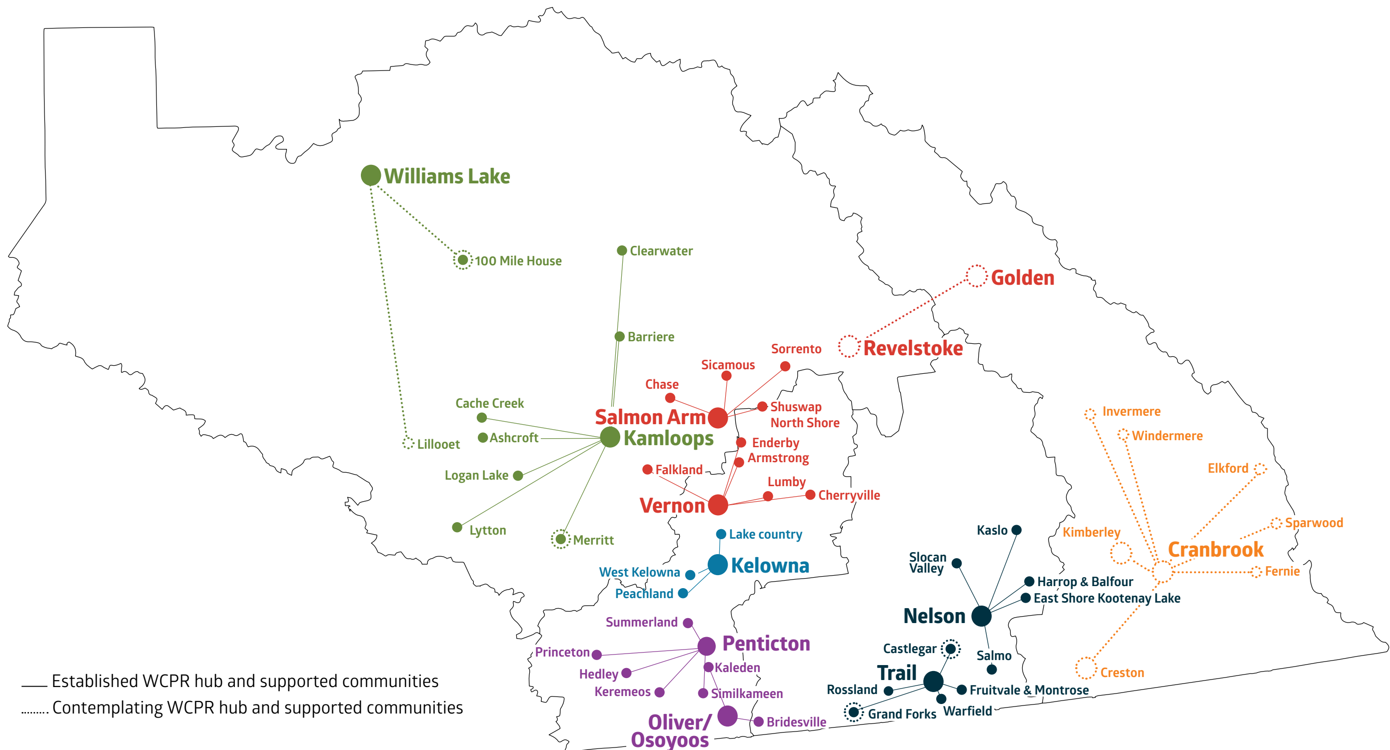
NEXT STEPS

The WCPR has expanded and evolved in concept and use since the early application began in 2017.[v] At that time, two site locations had implemented clinical rounds with a limited scope and membership to address specific issues such as discharge and bed utilization for individuals with palliative needs.

There are currently nine well-established WCPR in IH that act as a reference hub to support 36 smaller outlying ("spoke") communities. These smaller communities call in to the WCPR for consultation and palliative information on an as-needed basis.

An additional eight communities in Interior Health are in varying degrees of discussion and/or development to establish their own local WCPR strategy. They may potentially provide support to an additional 10 outlying communities.

WCPR add value for the clinicians who participate because they enhance the quality of care. Practical and individualized care solutions arise from inter-professional discussions. A formal evaluation of WCPR (e.g., social mapping, quantitative and qualitative surveys) is a future consideration.



REFERENCES

i Symptom burden is defined as suffering in the physical, psychosocial, emotional, sexual, cultural and spiritual domains that directly impacts quality of life.

ii Geneva: World Health Organization (2018), Geneva: Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services. Licence: CC BY-NC-SA 3.0 IGO.

iii Interior Health Profile (2017), https://www.interiorhealth.ca/AboutUs/QuickFacts/PopulationLocalAreaProfiles/Documents/Interior%20Health%20Authority%20Profile.pdf

iv BC Ministry of Health (2018), 2018/19 – 2020/21 Service Plan (2018): , Available at: https://www.bcsc.bc.ca/uploadedFiles/About_Us/Publications/BCSC_Service_Plan_2018-2021.pdf.

v Kamloops formally began their inaugural Whole Community Palliative Rounds on June 17th, 2017, and Penticton modified their existing weekly palliative rounds to more widely include internal and external health partners as of October 18th, 2017.

The CHCA Would like to extend a special thank you to the IH Regional Palliative and End-of-Life Care Program Team Contributors:

Elisabeth Antifeau, Regional Clinical Nurse Specialist, Palliative and End-of-Life Care
Karyn Morash, Director, Palliative and End-of- Life Care
Dr. Douglas Smith, Executive Medical Director,Long-Term Care, Palliative and End-of-Life Care, and Medical Assistance in Dying
Vicki Kennedy, Regional Clinical Nurse Specialist, Palliative and End-of-Life Care
Janine Carscadden, Program Lead, Palliative and End-of-Life Care
Ruth Shirley, Administrative Assistant, Palliative and End-of-Life Care

Interior Health (IH) is mandated by the Health Authorities Act to plan, deliver, monitor, and report on publicly funded health services for people that live within the Southern Interior of British Columbia. Its vision is "to set new standards of excellence in the delivery of health care".

The Canadian Home Care Association (CHCA) is dedicated to ensuring the availability of accessible, responsive home care to enable people to safely stay in their homes with dignity, independence and quality of life. Our vision is an integrated health and social care system that provides seamless patient- and family-centred care that is accessible, accountable, evidence-informed, integrated and sustainable.

www.cdnhomecare.ca @CdnHomeCare ©Canadian Home Care Association April 2019