Conflict Disclosure Information

- Catherine A. Clelland, BMedSc, MD, CCFP, FCFP
  - Executive Director, Society of General Practitioners of BC
  - Chair, EOL PSP Module Development Working Group
  - GP Services Committee Staff Support

- There is no corporate or other potential conflict of interest in relation to this program/presentation
Objectives

- Background to the British Columbia (BC) provincial Practice Support module in End-of-Life (EOL) care.
- Clarify the components of a provincial model integrating home care, palliative care services with services being provided in General practitioners offices.
- Demonstrate the utility of the EOL algorithm
- Review the Early Evaluation findings
Practice Support Program:

BC Practice Support Program (PSP)

- Created to help family physicians in BC network with colleagues & learn how to integrate new ways of doing things into their clinical practices via a peer-to-peer teaching model.
- Expanding to include specialist physicians.
- Supported by the GP Services Committee, Specialist Services Committee & Shared Care Committee (partnerships between the Ministry of Health Services and the BC Medical Association, including the Society of General Practitioners) and Regional Health Authorities.
Structured Learning Collaborative

- Overall goal: To give participants tools they can use in their practice to improve care and to support them as they try to use these tools.
- **Structure:**
  - **Pre-work**
  - **3 Learning sessions:**
    - Half day sessions with GP/MOA teams, Specialists and Community Allied Health Professionals (possibly NGOs in some communities)
  - **2 Action Periods:**
    - Change concepts are implemented during the periods between learning sessions.
- Not CME, but eligible for CME Credits for both GPs and Specialists.

GP Champions

- **Champion [def’n]:** A peer who has special experience or skills and mentors others
- **Principle:** A teacher as similar to the student as possible

Role: To teach content/ change concepts to their peers at a local level.

Qualifications: Those who
- Enjoy teaching in an interactive & informal context
- Are passionate about the clinical topic area.

Supports for role:
- Champions are reimbursed for their time spent doing PSP work.
- Experienced PSP coordinators
PSP Coordinators

- Support content development
- Support physicians during action periods to ensure the role is manageable and not disruptive to clinical responsibilities.
- Facilitate communication among local providers/practice peers and care delivery across the continuum
- Ongoing support for practices with practice change and action periods
- Monthly phone calls
- List-serve to share learning as it happens

Team Functions:
Knowledgeable, local support available in all three domains: Clinical, Practice Management, & IMIT

Model for Improvement

<table>
<thead>
<tr>
<th>What are we trying to accomplish?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will we know that a change is an improvement?</td>
</tr>
<tr>
<td>What changes can we make that will result in improvement?</td>
</tr>
</tbody>
</table>

Act  Plan  Study  Do
Practice Support Program: End-of-Life Module

Module Aim

- Improve the care of patients and families living with, suffering and dying from life-limiting and chronic illnesses by:
  - Early Identification (Registry Building)
  - Enhance and Improve physician confidence related to End of Life care (e.g. care planning, forms, communication, resources)
  - Improve Collaboration (clarity of roles, appropriate resource referrals, network of community resources, etc)
  - Improve the experience of the patient, family, physician, MOA and healthcare providers in End of Life care.
Module Aim (continued)

To improve the care of patients and families living with, suffering and dying from life-limiting and chronic illnesses by:

Improving collaboration:

- Identifying and referring appropriate patients to specialty palliative care and others for consultation and services.
- Understanding provider needs, clarifying roles, tools and resources for practice support and collaboration.
- Improving collaborative care planning, coordination and communication with patients/caregivers and physicians and other local health care and community providers.

“Integration in Action”

Palliative Approach:
Care through all the transitions

McGregor and Porterfield 2011
Best practice: Collaborative and Interdisciplinary

Specialist palliative care service delivery based on a population based approach with four delineated levels of care

- **Complexity of patient need**
  - Complex
  - Intermediate
  - Primary care

- **Level and role of specialist palliative care**
  1. **Primary palliative care**
     - Provide learning and development opportunities for primary and secondary care providers
  2. **Consultation – liaison**
     - Provide consultation and advice to primary and secondary care providers
  3. **Shared care**
     - With primary and secondary providers
  4. **Direct care**
     - In the community and in designated beds

**Target Population**

- **Include patients with advanced disease:**
  - Cancer
  - AIDS
  - COPD and other chronic respiratory conditions
  - Chronic heart disease
  - Renal failure
  - Neurological conditions, including dementia
  - Frailty or multiple co-morbidities

- **Consider patients in residential care as a target population**
Who is the patient’s care team?

- Patient, family and informal network
- Family physician
- Specialist Physician (Oncology, IM)
- Community pharmacist
- Home Health / Community Care
  - Nurses/rehab/home support
- Nurse practitioners, community RT
- Disease specific consultants / services
- Hospice palliative care consult teams
**Collaboration with Home and Community Care/Palliative Care**

- Participation of Home and Community Care at Learning Sessions and Train the Trainer Sessions
- Creation of regionally-specific Integration material where applicable
- Development of learning objectives and action period activities for Home and Community Care staff
- Evaluation includes the input from Home and Community Care/Palliative Care staff

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**Who is involved in the PSP EOL module?**

- 500 GPs with MOAs (recent approval to increase to 900)
- 100 H&CC/palliative care staff ~ 1H&CC/PC: 5 GPs
- 30 - 50 specialist physicians
- 40-50 PSP Coordinators
Through the past year...

Evaluation: Early Learnings
Evaluation: Early Learnings

- **Two Surveys**
  - Baseline to April 30, 2012 (administered at beginning of LS1)
  - End-of-Module to August 31, 2012 (administered at end of LS3)

- **Three groups of survey respondents**
  - **GPs**
    - Baseline: N=308, response rate = 72.5%
    - End-of-Module: N=155, response rate = 48.7%
  - **MOAs**
    - Baseline: N=180, response rate = 62.9%
    - End-of-Module: N=67, response rate = 36.4%
  - **Home and Community Care and Palliative Care (HCC/PC) nurses**
    - Baseline: N=27, response rate = 23.4%
    - End-of-Module: N=7, response rate = 10.4%

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Satisfaction with the EOL Module

<table>
<thead>
<tr>
<th></th>
<th>GPs (N=155)</th>
<th>MOAs (N=67)</th>
<th>HCC/PC Nurses (N=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The material was clear and informative</td>
<td>87.0</td>
<td>89.0</td>
<td>100.0</td>
</tr>
<tr>
<td>The facilitators were well informed and knowledgeable</td>
<td>91.0</td>
<td>89.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Pacing of sessions was too slow</td>
<td>29.2</td>
<td>28.6</td>
<td>28.6</td>
</tr>
<tr>
<td>Respondent already knew much of the material</td>
<td>9.1</td>
<td>13.6</td>
<td>13.6</td>
</tr>
<tr>
<td>Networking and sharing of information was helpful</td>
<td>34.8</td>
<td>34.8</td>
<td>57.1</td>
</tr>
<tr>
<td>Required action period activities could be completed in time allocated</td>
<td>69.2</td>
<td>69.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Respondent learned something new that he/she incorporated into his/her practice</td>
<td>94.4</td>
<td>90.9</td>
<td>71.4</td>
</tr>
</tbody>
</table>

* Responses for questions with N<7 are not shown.
### GP’s Practices Changes Related to EoL Care Provision

<table>
<thead>
<tr>
<th>Practices Related to End of Life Care</th>
<th>N</th>
<th>Pre</th>
<th>Post</th>
<th>t- or z-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you currently have a registry for patients requiring end of life care?</td>
<td>213/106</td>
<td>9.4%</td>
<td>72.6%</td>
<td>z = 11.57</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Do you currently have an action plan for patients who require end-of-life care?</td>
<td>209/101</td>
<td>29.2%</td>
<td>69.3%</td>
<td>z = 6.70</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Do you currently participate in collaborative care with HCC and/or PC providers?</td>
<td>212/107</td>
<td>2.25</td>
<td>2.30</td>
<td>t = 0.46</td>
<td>.642</td>
</tr>
<tr>
<td>Do you generally follow the most recent clinical guidelines for palliative care?</td>
<td>202/100</td>
<td>64.9%</td>
<td>89.0%</td>
<td>z = 4.44</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Do you currently conduct home visits for patients requiring end-of-life care?</td>
<td>214/104</td>
<td>2.73</td>
<td>2.60</td>
<td>t = 0.98</td>
<td>.327</td>
</tr>
</tbody>
</table>

**Notes:**
1. The rating responses ranged from “always” (1) to “never” (5); thus smaller numbers indicate a higher frequency of occurrence.
2. The t-value is reported for the dependent-samples t-test on the means, with the degrees of freedom of (N-1).
3. The z-value is reported for a z-test on two proportions.
4. Statistically significant results, at the .05 level, are shown in bold.

### GP’s Changes in Confidence: Abilities Related to Providing EOL Care

<table>
<thead>
<tr>
<th>EOL-Related Targeted Abilities</th>
<th>Mean 1</th>
<th>t-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patients who may benefit from palliative approach to care</td>
<td>1.79</td>
<td>4.32</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Initiate a conversation about EOL care with a patient &amp; his/her family</td>
<td>1.89</td>
<td>4.98</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Guide the patient with regards to his/her goals of care at the end of life</td>
<td>2.05</td>
<td>4.94</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Develop an action plan for your patients requiring end-of-life care</td>
<td>2.42</td>
<td>7.37</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Communicate patient’s needs/wishes to other HCPs, as appropriate</td>
<td>1.94</td>
<td>4.14</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Participate in collaborative care with HCC nurses</td>
<td>1.84</td>
<td>2.14</td>
<td>.033</td>
</tr>
<tr>
<td>Access/refer patients toEOL specialists in the community, as needed</td>
<td>1.94</td>
<td>4.05</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Develop and maintain “shared care” relationships with non-PC medical specialists</td>
<td>2.06</td>
<td>3.78</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Support a patient during the terminal phase of his/her illness and address his/her concerns</td>
<td>1.87</td>
<td>3.84</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Support the patient’s family during grief and bereavement and address their concerns</td>
<td>1.86</td>
<td>3.09</td>
<td>.002</td>
</tr>
</tbody>
</table>

**Note:**
1. The rating responses ranged from “very confident” (1) to “not at all confident” (4); thus smaller numbers indicate a higher level of confidence.
Conclusion

- All groups of participants were satisfied with the EOL learning module
- The EOL module has had a positive impact on GP practices and patients
- GPs’ and MOAs’ confidence in addressing the concerns of EOL patients has increased, compared with baseline measures
- Preliminary results show that the relationships between general practices and the home and community care providers are improving, but there are opportunities to strengthen these further

Thank You