CONNECTING SOUTH WEST ONTARIO

Benefits Realization: Integrated community Hospice Palliative Care

Benefits evaluation is an important component of the connecting South West Ontario (cSWO) Program that helps to support and demonstrate the realization of health system benefits through the adoption of an electronic health record (EHR). By pursuing the measurement of organizational value (improvements in the efficiency of care delivery such as time-savings and redirected resources) and clinical value (patients undergo fewer unnecessary tests, patients have improved access to care) ultimately, patients benefit from higher quality, better informed clinical decision-making.

The cSWO Benefits Realization program uses a research-based approach to identify areas of clinical best practice that are affected by the use of the EHR, and works collaboratively with clinicians to understand the value of the EHR. This formative evaluation process informs change management and adoption, and enables clinicians to use the EHR more effectively. This research does not include the use of any personal health information.

The document is one in a series of case studies which describe the clinical value of the EHR in different clinical settings and contexts, particularly with respect to clinical best practices. The work of the cSWO Benefits Realization program is ongoing; in some cases, these cases raise questions for further investigation, and clinicians are invited to participate in benefits evaluation to continue to develop these answers.

Value statement

Hospice Palliative Care in the community is improved when care providers are able to understand various components of disease progression to inform person-centred care for patients in their homes.

Community Hospice Palliative Care (HPC) teams provide integrated, appropriate care

Developing practice expectations related to the management of palliative patient care have recommended integrated, in-home care. Brumley et al. (2007) found in their randomized, controlled trial that patients receiving in-home care were 2.2 times less likely to die in hospitals when compared to patients who received care from a conventional hospital-based approach. The authors also found significantly higher patient satisfaction with care provided through an in-home palliative care model.

The Canadian Hospice Palliative Care Association (CHPCA) released a national framework for the Canadian context that has heralded the same merits for more community care for our aging population. The model, proposed for wider implementation, is to lower system costs and better patient outcomes. Community integrated palliative care:

> "provides key aspects of palliative care at appropriate times during the person's illness, focusing particularly on open and sensitive communication about the person's prognosis and illness, advance care planning, psychosocial and spiritual support and pain/symptom management. As the person's illness progresses, it includes regular opportunities to review the person's goals and plan of care and referrals, if required, to expert palliative care services" (CHPCA, 2015).

As a patient moves through a disease and life stage progression, they interact with multiple clinicians and caregivers, and there are many elements of which to keep track and manage across personal, emotional, spiritual and physical domains. Clinical information is currently being shared across organizations in south west Ontario via the Regional Clinical Viewer, ClinicalConnect™. Appropriately informed clinicians are able to ask clarifying questions of their colleagues and provide integrated and appropriate care in residents' homes.

Waterloo Wellington Community Hospice Palliative Care (HPC) teams

Waterloo Wellington residents dealing with progressing chronic diseases that could lead to death are referred to the Community Care Access Centre (CCAC) to access the Community HPC Care team. Primary care physicians, nurse practitioners, nurses and spiritual care providers with expertise in palliative care, work with care coordinators to create collaborative care plans and deliver in-home care to residents in alignment with the palliative care philosophy outlined in the CHPCA framework. To deliver appropriate care, community teams can access patient information through ClinicalConnect. The most current integrated cross sectoral/organizational personal health care information from acute care hospitals, regional cancer programs, CCACs, community and public laboratories and diagnostic image repositories enables the team to be informed of the needs of patients receiving hospice palliative care, and provide the most appropriate treatment advise based on "real time" patient information.

Enabled care occurs as a result of two processes. First, the community team interprets implications of disease from **the care that has already taken place in a different setting to create effective care plans**. Second, because HPC teams understand common disease trajectories and can anticipate complications/signs of progressive disease, **care can be directed to the most appropriate provider/setting avoiding emergency department visits and unnecessary admissions (Figure 1)**.

For instance, some patients experience progressive pain as a result of advancing disease. The patient may have been told by a different clinician that the disease might progress in a way that could lead to that pain, but may not recall the details of the particular discussion. Patients may not understand how disease progressions impair systems (i.e. nervous, vascular, respiratory) and without enabled in-home support, patients may need to make an emergency department visit. Using ClinicalConnect, care teams see radiology reports that could identify the metastasis likely causing increased pain. This knowledge enables better inter-professional communication between clinicians and better translation for patients by palliative teams as it relates to key assessments in palliative care (pain, nausea, depression, anxiety, tiredness, drowsiness, appetite, shortness of breath, well-being).

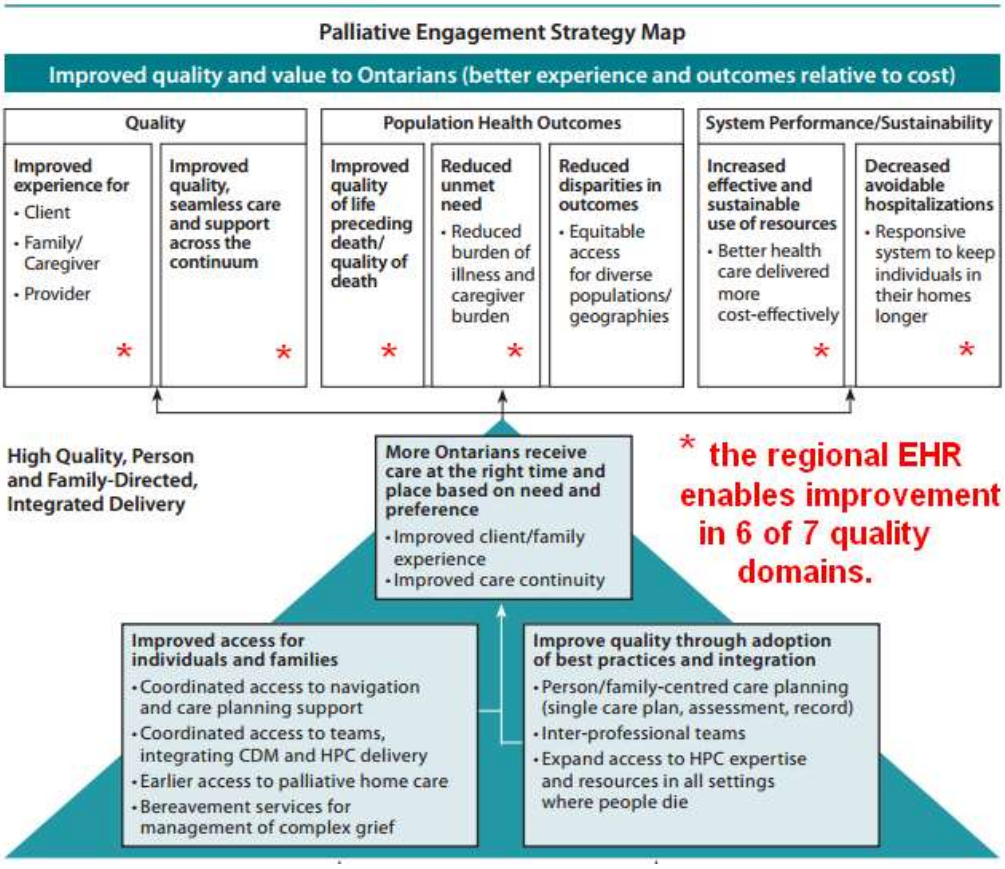

Figure 1. Excerpted and modified from: Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action. Page 22 (LHINs & QHPCCO, 2011)

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Testimonials

"ClinicalConnect allows me to access patient information including assessments, treatments and medical impressions in real time. Having access to a patient's most recent health information allows me, as a nurse practitioner, to see the big picture of the care plan and intervene accordingly with new or revised interventions. It means I can better anticipate and plan for risks and potential complications; this often results in a reduced need for patients to go to the Emergency Department. For health care providers, it means better job satisfaction because it allows me to create a positive experience for patients."

Cindy Shobbrook, Nurse Practitioner, Waterloo Wellington CCAC

"ClinicalConnect allows me to really understand a patient's needs by providing a secure and efficient way to share patient information. It provides access to health care provider's notes, lab work and radiology reports; critical information that helps me to understand the care a patient has received, and where they received their care. This information helps to inform the patient's palliative care plan, reduces duplication of health care services, and supports greater collaboration among the patient's health care providers. For patients and families, ClinicalConnect means less instances where they have to re-tell their story, which can help to alleviate some of the stress that patients and families naturally experience during this stage of their health care journey."

Jennifer Armitage, Team Assistant, Waterloo Wellington CCAC

Questions

For questions, comments, or to participate in cSWO Program's Benefits Realization program, please contact:
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Sources

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Published: May 2016

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