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Changing Culture to Improve Care

- Deborah Dudgeon
- Provincial Program Head, Palliative Care, Cancer Care Ontario
- Palliative Care Medicine Program,
- Queen's University

- June 2010

Better cancer services every step of the way

"Making Change in a System: Measuring Outcomes"

- Review factors that support/impede innovation spread
- Outline Key Features of Cancer Care Ontario's Palliative Care Strategy
- Discuss spread of the Ontario Cancer Symptom Management Collaborative

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Factors that support/impede change/innovation spread

- External context
- Readiness for change
- Characteristics of the innovation
- Organizational communication, influence and linkages
- Dissemination & assimilation processes
- Organizational culture

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External Context

- Cancer Care 2000
- Canadian Hospice/Palliative Care Association
- Senate Reports
- Secretariat on Palliative and End-of-Life Care
- Federal Reports

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Cancer Care 2000: Expert Panel on Palliative Care

- Palliative care & control of suffering an essential 4th phase of cancer control
- Radical shift of cancer resources
- Major shift of resources into the home
- Government reimbursement to family for lost income
- Accreditation of cancer centres based on ability to relieve pain & PC delivery
- Development of at least 16 Regional Palliative Care Centres for teaching, research, consultation and base for specialized palliative home care
- Development of Divisions of Palliative Oncology in every Regional Cancer Centre

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Canadian Hospice/Palliative Care Association

- Established 1991 CPCA, 2001 new name
- Patron: Madame LeBlanc
- 2002: A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice
- Ongoing advocacy

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Senate Reports

- 1995: "Of Life and Death" – Report of the Special Committee on Euthanasia & Assisted Suicide
  - Governments make PC programs a top priority in restructuring
  - Development & implementation of guidelines & standards
  - Training of health professionals
  - Integrated approach to delivery
  - Research should be expanded and improved
- 2000: "Quality End-of-Life Care: The Right of Every Canadian"
  - Strongly recommended federal leadership & collaborative development of a national strategy to improve PEOLC

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Secretariat on Palliative and End-of-Life Care

- 2001 - Senator Carstairs: Minister with Special Responsibility for Palliative Care
- Canadian Strategy on Palliative & End-of-Life Care
  - Best Practices & Quality Care
    - Accreditation Canada
  - Education for Formal Caregivers
  - Public Information & Awareness
  - Research
  - Surveillance

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Federal Reports

- Romanow Commission Report 2002
  - Provide Canada Health Act coverage for palliative home care services
- The Health of Canadians: The Federal Role (Kirby) 2003
  - Need for National Palliative Home Care Program
  - Examine feasibility of Compassionate Care Benefit

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Ontario's Ministry of Health and Long-Term Care

- End-of -Life Care Strategy (2004)
  - $115.5 M (US $) over 3 years
  - To shift care from acute care settings to appropriate alternate settings of choice
  - To enhance client-centered & interdisciplinary service capacity
  - To improve access, coordination and consistency of services and supports

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Cancer Care Ontario

- Provincial Government's chief cancer advisor
- Directs nearly $700 Million
- Mandate to develop an integrated cancer system with coordinated cancer services
- Works with regional providers to plan and improve services
- Ontario Cancer Plan: Palliative Care a priority

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Readiness for Change

- More than 25,000 people in Ontario die with cancer each year
- 80-85% of people seen by palliative teams have cancer
- Patients experience significant physical, psychological, social & spiritual distress & suffering as a result of a cancer diagnosis
- Wide variations in access & quality across the province

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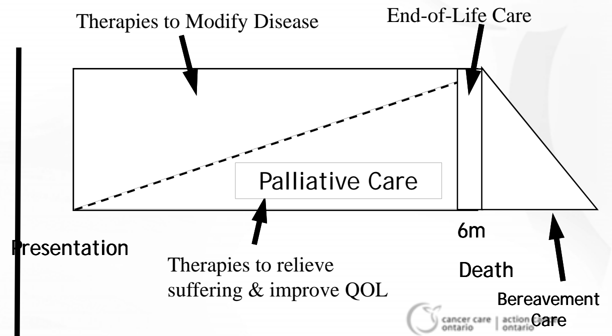
Palliative Care Program Vision

Every person living in Ontario, when faced with a cancer diagnosis, should have the opportunity to live life fully, to receive optimal symptom management, to be supported with dignity and respect throughout the course of his/her illness, and in the face of incurable disease, each person should have the opportunity to live and die in a setting of his/her choice.

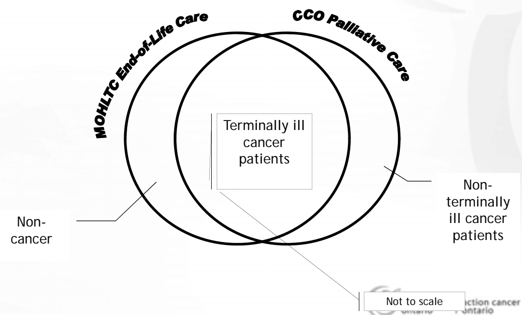
Simultaneous Model of Care



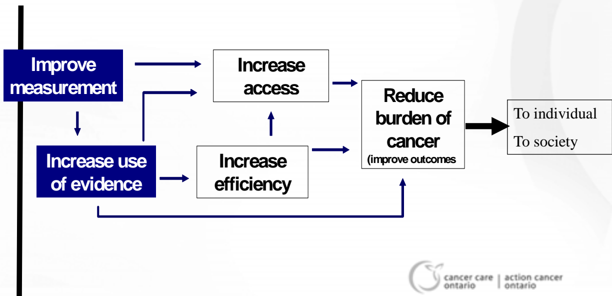
Objectives

- Accurate data is available to plan services and guide quality improvement
- Evidence-based clinical practice guidelines and organizational standards for palliative care delivery are utilized to ensure palliative care services are of consistently high quality
- Patients are identified and referred to appropriate services as soon as the need arises
- Patient assessment and patient-related communication is standardized according to best practice

Scope



Strategy for Quality Improvement In Palliative Cancer Care



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Reduce Burden of Cancer

To the Individual:

- early detection & management of symptoms
- Smoother "transitions" & improved continuity of care between sites
- Improved quality of life
- Improved satisfaction with care
- Live and die in setting of choice

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Reduce Burden of Cancer

To Society:

- Decreased acute care hospital days
- Decreased emergency room visits
- Decreased ICU days and deaths
- Decreased use of ineffective treatments

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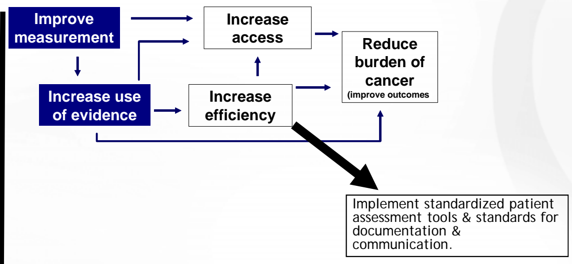
Strategy for Quality Improvement In Palliative Cancer Care



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Increased Efficiency

- Broker knowledge re Simultaneous Model of Care, ESAS & PPS
- Develop standards for documentation & communication
- RVP or designate on Regional EOLC networks
- Each region has appointed a palliative care physician to work with EOLC networks and sit on executive team of RCP

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Assessment Tools

- Palliative Performance Scale (PPS) (Hospice Victoria Society)
  - For all palliative patients
- Edmonton Symptom Assessment Scale (ESAS)
  - For all cancer patients

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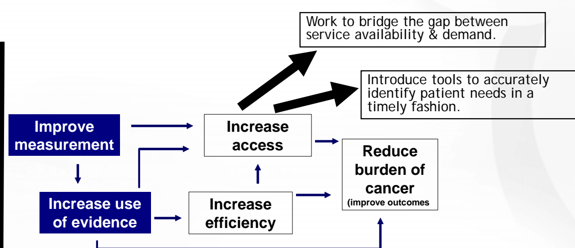
Strategy for Quality Improvement In Palliative Cancer Care



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Increase Access

- Review service & infrastructure availability (ie # & type of pc services)
- Begin to establish planning standards
- Interprofessional education & mentorship re palliative care & collaborative practice

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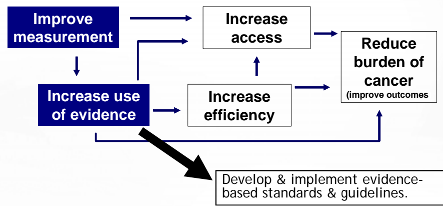
Strategy for Quality Improvement In Palliative Cancer Care



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Increase Use of Evidence

- Continue development of clinical practice guidelines for pain & other symptoms
- Support ongoing development & implementation of CCPs
- Broker knowledge re guidelines, CCPs & Accreditation Canada standards
- Seek opportunities to measure concordance with guidelines & standards

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Collaborative Care Plans

1. Generic Plan*:
   a) Stable (PPS 70-100)
   b) Transitional (PPS 40-60)
   c) End of Life (PPS 0-30)
2. Pain
3. Dyspnea

*Palliative Performance Scale identifies which generic plan is appropriate

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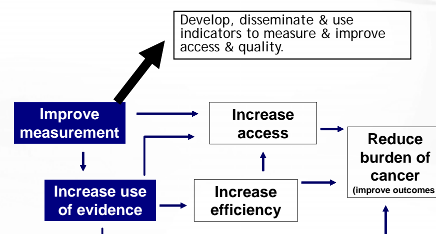
Strategy for Quality Improvement In Palliative Cancer Care



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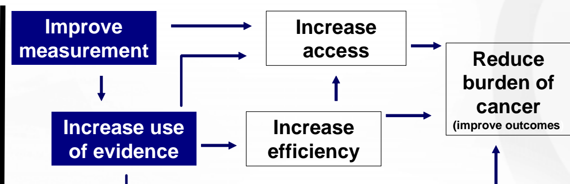
Improve Measurement

- Publish existing indicators in the Cancer System Quality Index
- Coordinate the identification of:
  - additional or alternative indicators
  - Information needs for planning
- Develop a data collection plan

Strategy for Quality Improvement in Ontario's Cancer System



Characteristics of Innovations with Successful Spread

- Simple
- Clinically useful
- Evidence-based
- Address a deficiency & have an impact on quality of care & patient satisfaction
- Potential to impact cost

Improving Access to Palliative Care

Development Of An Integrated Delivery System

Kingston, Frontenac, Lennox & Addington Palliative Care Integration Project

Issues Identified

- Lack of coordination of services
- Inadequate resources
- Inconsistent symptom management
- Few assessment tools
- Little evidence-based practice
- Under-utilization of expert resources
- Variable knowledge

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Palliative Care Integration Project

- Use of common assessment tools:
  - ESAS & PPS
- Development & Implementation of:
  - Symptom Management Guidelines
    - Pain, Dyspnea, Nausea/vomiting, Constipation, Delirium
  - Collaborative Care Plans
    - Stable, Transitional, End-of-Life

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PCIP Results

- Symptom documentation increased
- Acute Care deaths decreased: 65 – 59.6%
- Acute Care LOS/person yr decreased 22.69 – 22.26

Dudgeon, et al. JPC

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Provincial Palliative Care Integration Project

- Based on a successful & proven palliative care integration initiative from the South East Local Health Integration Network region
- Implementation in all 14 regions starting September 2006
- Funded by Ministry of Health and Long-Term Care and Cancer Care Ontario (CCO)
- The project consisted of:
  - Quality improvement framework
  - Multidisciplinary education
  - Cross sectoral collaboration
  - Common, evidence-based tools
  - Formal evaluation
- Will result in a system with integrated care across care sites & improved patient related outcomes

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Organizing for Improvement

- Volunteer involvement of all regions
  - Regional Cancer Programs, Home Care, EOL Care Networks
- Central support structure
  - Project plan, management & evaluation framework, common tools, expert coaching & guidance, data analysis, progress reporting & program evaluation
- Regional structure
  - RIC, Steering Committees, Improvement Teams
  - Regional Vice Presidents accountable for project
  - Clinical leadership: Palliative Care MD leads

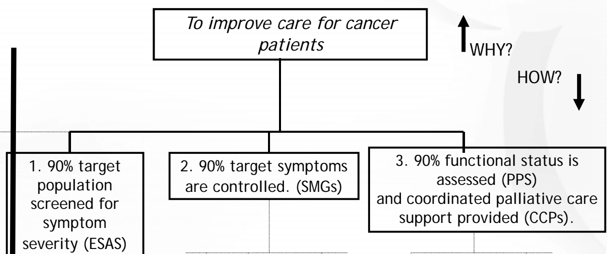
Dissemination Processes

- Learning sessions on quality improvement
  - Rapid cycles of Plan-Do-Study-Act (PDSA)
- IHI's Collaborative Model for Achieving Breakthrough Improvement
  - Weekly teleconferences between PIC & RIC's
  - Monthly teleconferences MD leads
- Provincial collaborative meetings

Project Aims

- Target population
  - all lung cancer and palliative care patients in Regional Cancer Centre clinics, and
  - all palliative care cancer patients in the home setting.
- Specific improvement aims developed

A Hierarchy of Improvement Aims



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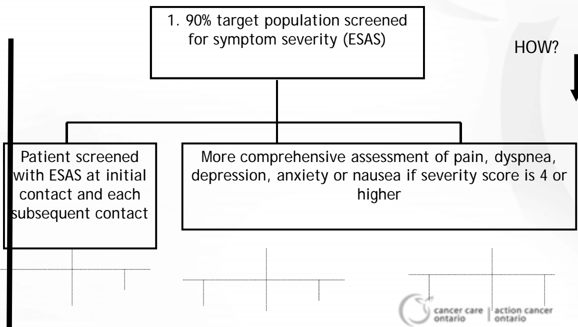

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Interactive Symptom Assessment and Collection (ISAAC)

✓	Accessible at the clinic via a touch-screen kiosk, or from home via the internet
✓	Tracks symptoms over time
✓	Puts patients in control of their own symptom assessment
✓	Results available to clinicians no matter where the patient completes the tool – in clinic, at home, or at another cancer centre
✓	Clinicians are notified by e-mail when the score exceeds certain parameters

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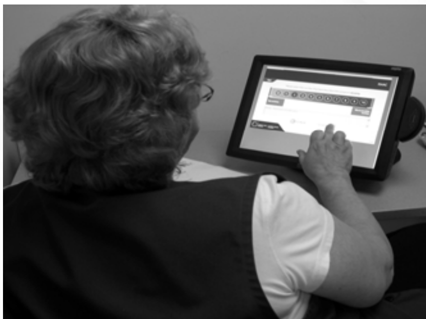
ISAAC Kiosk



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Patients assess their own symptoms using a proven tool

ISAAC
Quit
Please select the number that best describes the symptom **pain**
0 1 2 3 4 5 6 7 8 9 10
No pain
Worst possible pain
Go Back
Continue
ESAS

Patients are asked to rate the severity of nine common cancer symptoms using ESAS

A patient's perception of how they feel is the gold standard

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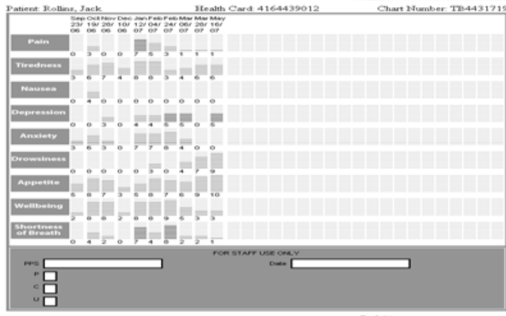
ISAAC Tracks Symptoms Over Time



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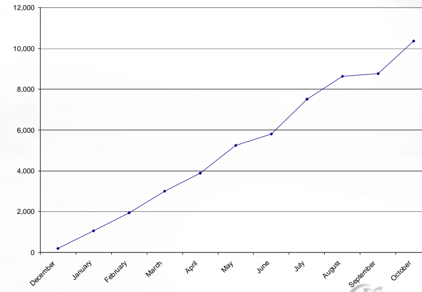
Data Show Encouraging Results



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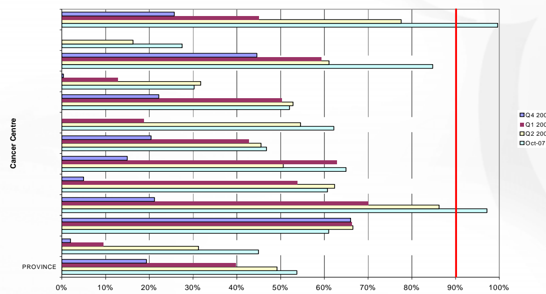
Progress on Symptom Screening



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Provincial Distribution of ESAS scores for 3 symptoms

	Moderate (4-6)	Severe (7-10)
Pain	19%	13%
Dyspnea	17%	12%
Depression	15%	8%

October 2007

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Percentage of Patients with a high symptom score with no evidence of further assessment

Pain	24%
Dyspnea	37%
Depression	46%

Sample of charts October 2007

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Improvement in ESAS scores within 72 hours

Change in Symptom Severity when a Subsequent Assessment is Completed in 72 hours

	Pain		Dyspnea	
Threshold				
Score 7 or higher	424	9%	391	9%
Score 6 or lower	4,042	91%	4,077	91%
Total	*4,466*	*100%*	*4,468*	*100%*
Subsequent Assessment conducted with 72 Hours				
Yes	170	40%	124	32%
No	254	60%	267	68%
Total	*424*	*100%*	*391*	*100%*
If Assessment Completed, was score 6 or below				
Yes	118	69%	39	31%
No	52	31%	85	69%
Total	*170*	*100%*	*124*	*100%*

* based on an analysis of September data across regions that had implemented across the continuum of care

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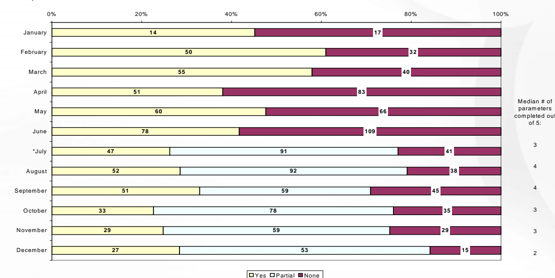
Progress on Pain Assessment

Aims Indicator: Percentage of patients with a pain score of 4 or greater who received a comprehensive pain assessment (based on a sample of charts)



* In July, the audit was further defined to check whether 5 specific parameters of the assessment were completed in order to qualify as a comprehensive assessment.

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Patient Satisfaction

- 407 patients completed a ‘User Satisfaction’ survey June – Sept 2007
- 85% thought ESAS was important to complete as it helped providers know how they were feeling
- 70% preferred the kiosk/internet version of ESAS over the paper tool
- 61% agreed that their providers took into consideration ESAS symptom ratings in developing a care plan

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Challenges to Implementation

- Lack of consensus re ESAS
- Resource constraints
- Resistance to change
- Terms "palliative" and "project"
- Challenged "traditional" model of care

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Essential Components for Success

- Centralized project management
- Dedicated RIC for local implementation
- Strong leadership support & clinical champions
- Data analysis to track implementation, monthly regional reporting & quality improvement methodology
- Coordinated implementation with regional flexibility

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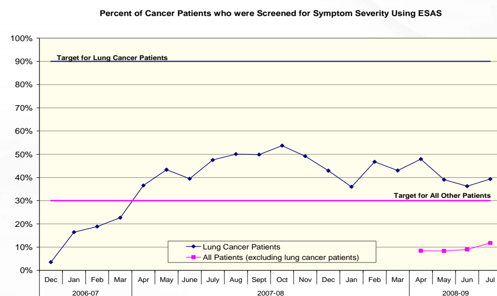
% Lung & All Cancer Patients



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Notes for Palliative Care Graphs:
- Southlake and RVH population data are self-reported as CCO data is unavailable.
-Source: Cancer Care Ontario, ISAAC database (ESAS and PPS data) and Activity Level Reporting (Population data)

Reorganization for Expansion & Sustainability

- Ontario Cancer Symptom Management Collaborative
- Central support reorganized
- Regional Vice Presidents accountable through quarterly reviews
- Public Reporting – Cancer System Quality Index
- Tele-ISAAC, electronic interface with institutions' electronic health records
- OICR investment in more kiosks

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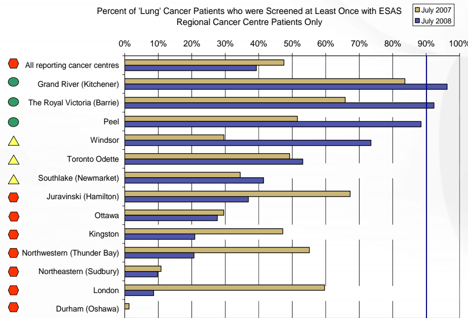
July 2007 and July 2008 Results



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To Achieve Screening Aims

- Examination of roles, reorganization of workflow & responsibilities, changed booking times
- Involvement & education of all team members
- Engagement of clinical champions – "pull"
- Development of Symptom Guides & algorithms
- CPAC funding for 14 satellite sites

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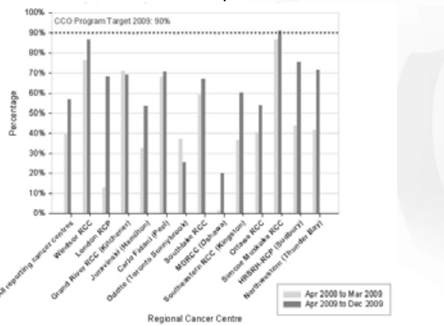
Percentage of Lung Cancer Patients Screened at least once per Month



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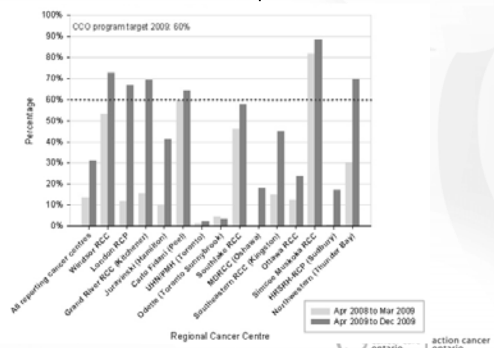
Percentage of Non-Lung Cancer Patients Screened at least once per Month



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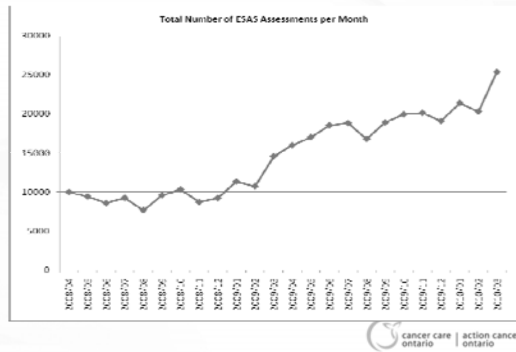
Total ESAS Assessments by Month



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Measurement

- Improved symptom management and QOL for patients and families through early identification and management of symptoms
- Data to develop business case to match resources to need
- Improved outcomes: decreased ER visits, LOS, etc

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Culture Change

- Patient-centered
- Standardized objective measure
- Measurement focuses quality improvement
- Opportunity for research
- Determine best practices
- Opportunity for evaluation of concordance with guidelines

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