Capital Health Integrated Palliative Care Service (CHIPCS) Evaluation

Team Members: Dr. Paul McIntyre, MD CCFP, **Peter MacDougall,** RN, BScN, **Caroline Martin,** MSW, **Joanne Babin,** RN, **Michelle Baker,** BSc. MHA, **Pat Bell, Kris Dove,** P.Eng., **Andrea Leonard,** BN, **Beverly Lyttle,** RN, CHPCN, **Louise MacNeil,** RN, CHPCN, **Marie Claire Chartrand,** MTS RSW, **Dr. Lynn McAslan,** MD, CCFP, **Angela McFadden,** RN, **Barbara Stewart,** RN, CHPCN, **Mary Wylde,** RN

PLAN

Since 2004, the Capital Health Integrated Palliative Care Service (CHIPCS) has functioned as a partnership between Capital Health and the Continuing Care branch of the Department of Health.

The CHIPCS Quality Committee undertook an evaluation of the integrated service model using existing administrative data and data collected from several quantitative and qualitative audits undertaken for this report.

Focus: Evaluate integrated model via the Accreditation Canada Performance Indicators & Quality Dimensions.

Service Model Across Care Settings

Capital Health Integrated Palliative Care Service

- **Primary Team**: Family MD, Continuing Care
- **Consult Team**: Palliative Care RN / MD

↔ **Specialist**: Services / Programs

Accreditation Canada Quality Domains

1. Population Focus
2. Accessibility
3. Continuity
4. Effectiveness
5. Efficiency
6. Client-Centered Services
7. Worklife
8. Safety

Accreditation Canada Palliative Care Performance Indicators

1. Availability of hospice palliative care services
2. Continuity of care
3. Degree and management of symptom distress
4. Family and caregiver satisfaction
5. Documentation of patient and family service goals

DO

Admin Data

Health services utilization was assessed using the CHIPCS and other databases.

Chart Audits

Thirty charts were analysed for performance indicators. (Fig. X)

Process Mapping

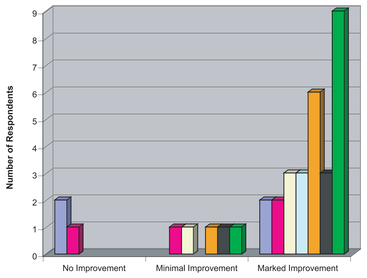
A full process review was undertaken to understand linkages among service providers & to identify gaps. (Fig. Y)

Family Satisfaction Survey

One hundred families were asked to complete the FAMCARE survey tool. (Fig. Z)

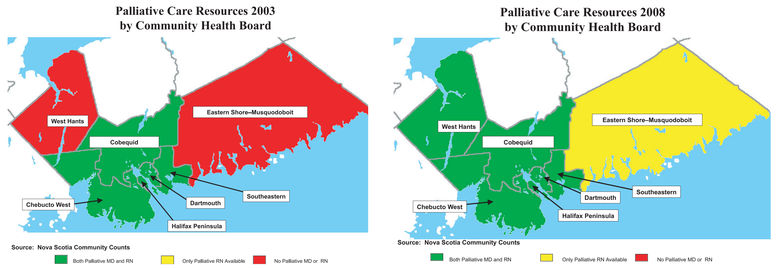
Conversation Café

70 community attendees provided feedback which was themed.



MUSIC THERAPY AUDIT

STUDY



CHIPCS is significantly more district-wide than 2004.

Elderly, especially in nursing homes, or living in rural area, are less likely to be enrolled in CHIPCS.

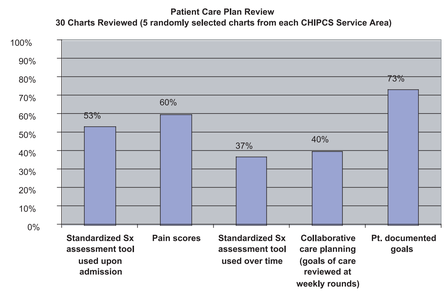


Fig. X: CHART AUDITS

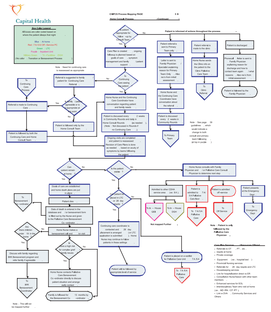


Fig. Y: SAMPLE PROCESS MAP

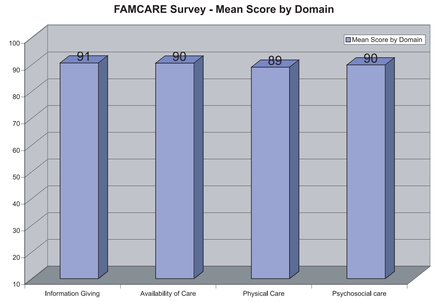


Fig. Z: FAMILY SATISFACTION SURVEY

MacDougall, Peter: Direct Team Report

		Total N	Percent Responding (%Favorable / %Neutral / %Unfavorable)	Distribution % 5	4	3	2	1	Mean
Joy									
	CDHA Overall	3,531	73% 17% 10%	24	49	16	8	2	3.85
	MacDougall, Peter Direct Reports	19	70% 24% 6%	24	46	24	4	2	3.86
Pride									
	CDHA Overall	3,531	80% 13% 7%	31	49	13	5	2	4.03
	MacDougall, Peter Direct Reports	19	79% 18% 3%	35	44	16	2	3	4.05
Trust Management									
	CDHA Overall	3,531	33% 31% 36%	3	30	31	24	12	2.87
	MacDougall, Peter Direct Reports	19	45% 42% 13%	1	43	42	12	1	3.32
Trust Peers									
	CDHA Overall	3,531	81% 11% 8%	23	58	12	6	2	3.95
	MacDougall, Peter Direct Reports	19	84% 8% 8%	33	51	8	8	0	4.09
Respect									
	CDHA Overall	3,531	61% 22% 17%	12	49	21	12	5	3.51
	MacDougall, Peter Direct Reports	19	66% 22% 13%	12	53	22	13	0	3.63
Engagement									
	CDHA Overall	3,531	43% 24% 33%	6	37	24	28	5	3.11
	MacDougall, Peter Direct Reports	19	38% 24% 38%	6	32	25	33	4	3.02
Patient Centeredness: Respondent Perspective									
	CDHA Overall	3,531	93% 5% 2%	47	46	5	1	0	4.38
	MacDougall, Peter Direct Reports	19	96% 4% 0%	46	51	4	0	0	4.42
Patient Centeredness: Climate									
	CDHA Overall	3,531	58% 28% 14%	15	43	28	11	3	3.56
	MacDougall, Peter Direct Reports	19	51% 30% 19%	7	44	30	18	2	3.37
Leader Being									
	CDHA Overall	3,531	43% 30% 27%	9	34	30	16	11	3.14
	MacDougall, Peter Direct Reports	19	65% 25% 10%	16	48	26	8	2	3.69

Powered by ClearPicture Corporation — March 19, 2009 — Page 3

CDHA WORKLIFE SURVEY

ACT

Recommendations

Population Focus

Build capacity to integrate a palliative approach in relevant population segments.

Develop a working relationship with CDHA Community Health Boards.

Accessibility

Develop a "quick response" model for end of life care in community.

Create ambulatory palliative care clinics at Cobequid Community Health Center and Dartmouth General Hospital.

Advocate for community-based hospice beds.

Continuity & Effectiveness

Implement and evaluate: standardized assessment and outcome tools.

Create dedicated community care teams, assigning them directly to communities where possible (DGH, Cobequid, ESM).

Implement standardized end of life clinical care pathway across care settings, including access after hours to med kits.

Develop shared care model via integrated teams in community & nursing homes.

Efficiency

Define optimal case loads for each role & monitor administratively.

Client Centered Services

Regular measurement of family satisfaction.

Increase awareness of bereavement service to grieving families.

Volunteers to be able to follow clients from community or LTC to hospital.

Expand access to music therapy beyond inpatient unit.

Improve communication between community care teams and family physicians.

Advocate for continuity of home care nurses.

Worklife & Safety

Monitor progress of CDHA pilot re implementation of survey results.

Review safety policies to ensure consistency between CDHA & continuing care staff.

Summary

Structure, process and outcome aspects were assessed.

Intended for CHIPCS Steering Committee to focus & prioritize quality improvement initiatives.

Relevant to Continuing Care devolution process by documenting strengths & weaknesses of an existing integrated model.