



The North Simcoe Muskoka Integrate Project

Early identification and management of patients who can benefit from a palliative care approach across settings

Patient & Provider Perspectives

“I don’t always know what is happening to my patient while they are undergoing treatment, whether curative or palliative. When my patient comes back to me I don’t feel equipped to provide palliative care.”

– Primary Care Provider

“We receive referrals to close to the end-of-life not allowing us to provide the care the patient and family needs.”

- Community Provider

“I don’t always know the services available for patients outside of the cancer centre.”

– Oncology

“No one told me my treatment was non curative. There was no team approach and we needed to repeat our story many times.”

- Patient/family member

INTEGRATE Background



Cancer Care Ontario
Action Cancer Ontario

- June 2013: CCO submitted INTEGRATE Project proposal in partnership with Champlain, NSM, Toronto Central and Quebec
- October 2013: CCO INTEGRATE Project accepted
- January 2014: INTEGRATE Project kicked off

The INTEGRATE Project spans 2014 – 2017 with \$1M awarded from CPAC and significant in kind funds put forward from partners

The NSM INTEGRATE Project is a partnership between:

•Barrie and Community Family Health Team



Barrie and Community
Family Health Team

•Hospice Simcoe



•North Simcoe Muskoka Community Care Access Centre



•North Simcoe Muskoka Hospice Palliative Care Network



•Simcoe Muskoka Regional Cancer Program at Royal Victoria Regional Health Centre



CPAC – INTEGRATE Overview

GOAL: Enable identification and management of patients to benefit from a palliative care approach early and across settings

1

Adapt and Implement Provider Education

Engage, adapt, implement and evaluate education for primary level providers (PCP, oncology, community) in **Ontario and Quebec**

Engage **First Nations, Inuit and Metis** to identify opportunities and barriers, develop, adapt, implement and evaluate

2

Implement Integrated Care Models

Implement and evaluate early identification campaign and linkages to community resources in **cancer centre setting**

Implement and evaluate early identification campaign and linkages to community resources in **primary care setting**



CANCER CENTRE SETTING

6 Goals of SMRCP Referral System:

1. Multidisciplinary group - not silos
2. Scalable and transferrable throughout region
3. One common referral point for wide range of referral sources
4. Single referral form to guide process
5. Effective feedback loop
6. Use and strengthen existing resources wherever possible

Thoracic and GI
Multidisciplinary
Cancer Conference
(MCC)

“Report to Primary Care”



Primary Care
Provider



“Navigator at the Network”

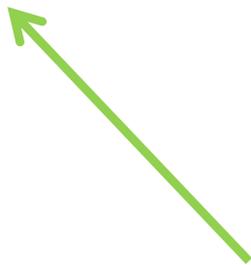


NSM CCAC

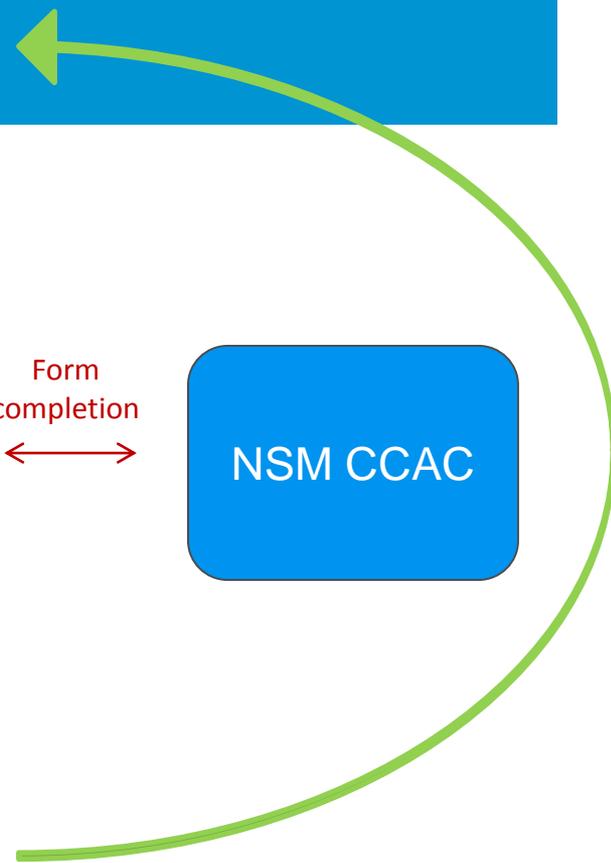


6 Community
Palliative Rounds (Orillia,
Barrie, Collingwood,
Huntsville, Midland,
Bracebridge)

Community
Rounds Report



Community
Rounds Report



NSM Integrate Project Palliative Care Process Map
– Cancer Centre Setting

SMRCP Results to date

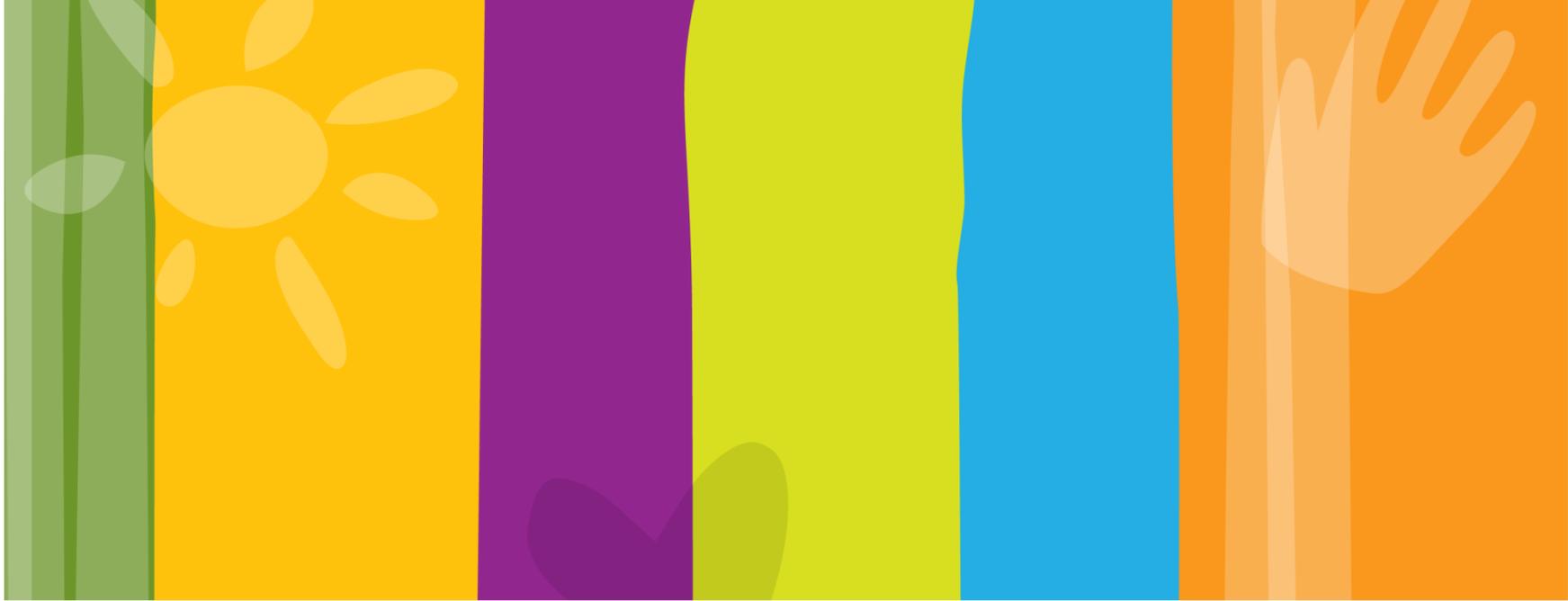
LEAP Oncology Provider Education: 1 Session, 25 Attendees held the evenings of Jan 13th and 20th

- 12 oncologists/oncology surgeons (plus one oncologist from Odette)
- 9 RN (5 from CCAC)
- 1 SW
- 2 'other' (Aboriginal patient navigator, radiation technologist)

SMRCP Data

(End of Feb to end of July)

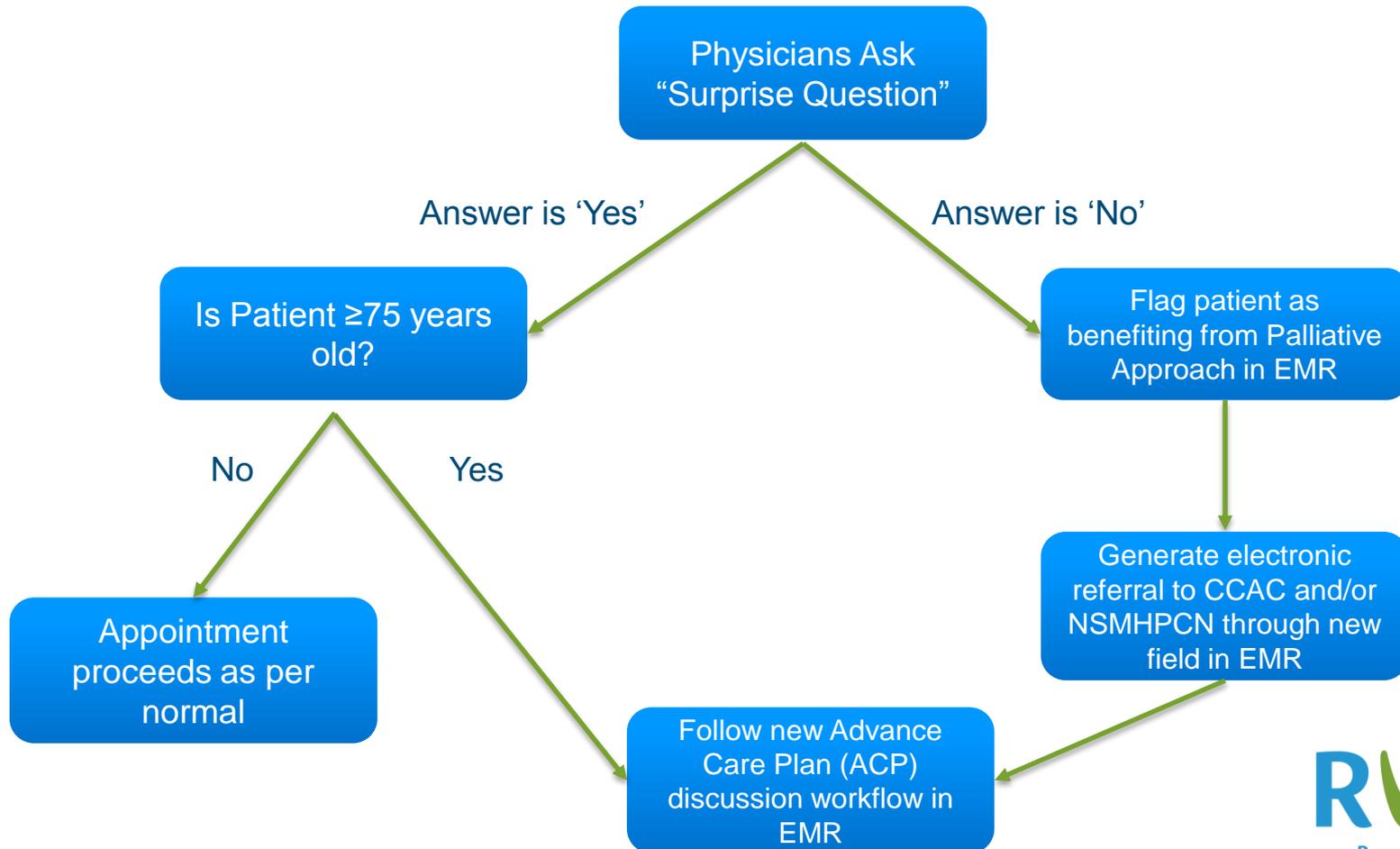
- Thoracic:
 - Discussed 87 patient cases
 - 28 (32%) Referrals Out for Palliative Care Approach in Community
- GI:
 - Discussed 145 patient cases
 - 26 (18%) Referrals Out for Palliative Care Approach in Community
- Under 4 days (average) from identification in MCC to faxing out of referral paperwork
- ~10 days (average) from referral out to discussion in local community rounds
- ~2 days (average) from discussion in community to Community Rounds Report received in SMRCP
- Summative duration (to complete loop) approx. 16 days



PRIMARY CARE SETTING

BCFHT INTEGRATE Process Map*

* Applied in **all** patient visits by participating physicians in BCFHT



BCFHT Results to date

- LEAP Provider Education: Three sessions, 60 attendees
 - 41 Primary Care Physicians
 - 14 RNs (4 CCAC, 5 NSMHPCN, 3 St. Elizabeth, 2 Hospice Simcoe)
 - 3 RPNs
 - 2 'other' (1 ICU physician)
- ACP QIP: FHO approval and 17 Physicians consented to participate (to date) with ongoing enrollment opportunities
- Tools Created in the EMR:
 1. ACP flow sheet including decision support links
 2. Instructional video and written educational materials created for participating physicians
 3. Palliative Care section in EMR with referral forms, flow sheets, billing info
 4. Data collection areas in EMR

NSM INTEGRATE Next Steps

- Expand ACP QIP and Asking of Surprise Question in BCFHT
- Communication Strategy for public, providers and LHIN administration; Patient Video
- Partnership with other Integrate Programs?
 - Out-of LHIN Integrate referrals coming in to NSM