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The Art of Communication: A Key to Effective Community Partnerships and Continuing Care

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Introduction

- Vancouver Center only BCCA center out of the 5 centers that have an inpatient unit
- 30 bed unit that serves the province and the Yukon
- Deliver chemotherapy and symptom management from disease and treatment modalities.



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Recognition and Thanks ...

To the people who live and die in our care

- For validating what we do well
- For teaching us what we still need to learn and improve upon

To the people who help make this presentation possible



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This presentation is a living work in progress.

“ I did then what I knew how to do. Now that I know better, I do better.”

Maya Angelou



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Why is this work necessary?

A story about a good care plan gone wrong:

“Grace”



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What were contributing factors?



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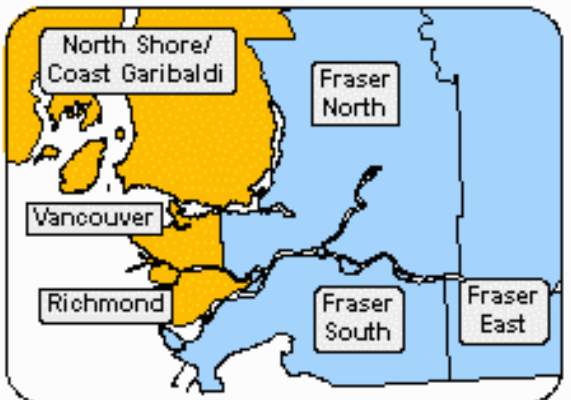
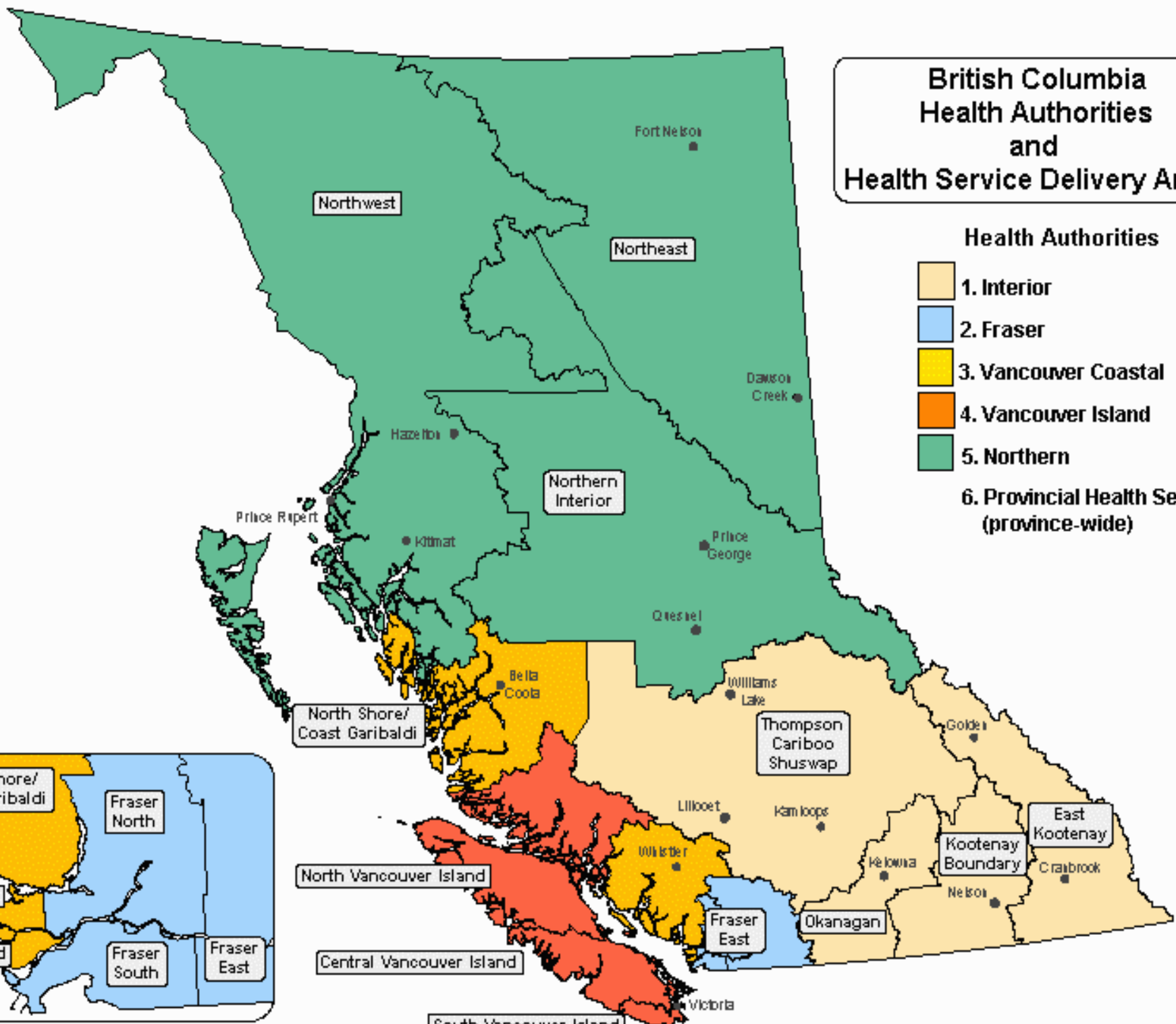
Communication

- Complexity of information flow
 - BCCA- to – TST – to – Appropriate health unit
 - Electronic access is restricted
 - Between Provincial and Regional agencies
 - Between healthcare providers
- Processes for referrals are varied
 - Each region had developed its own process

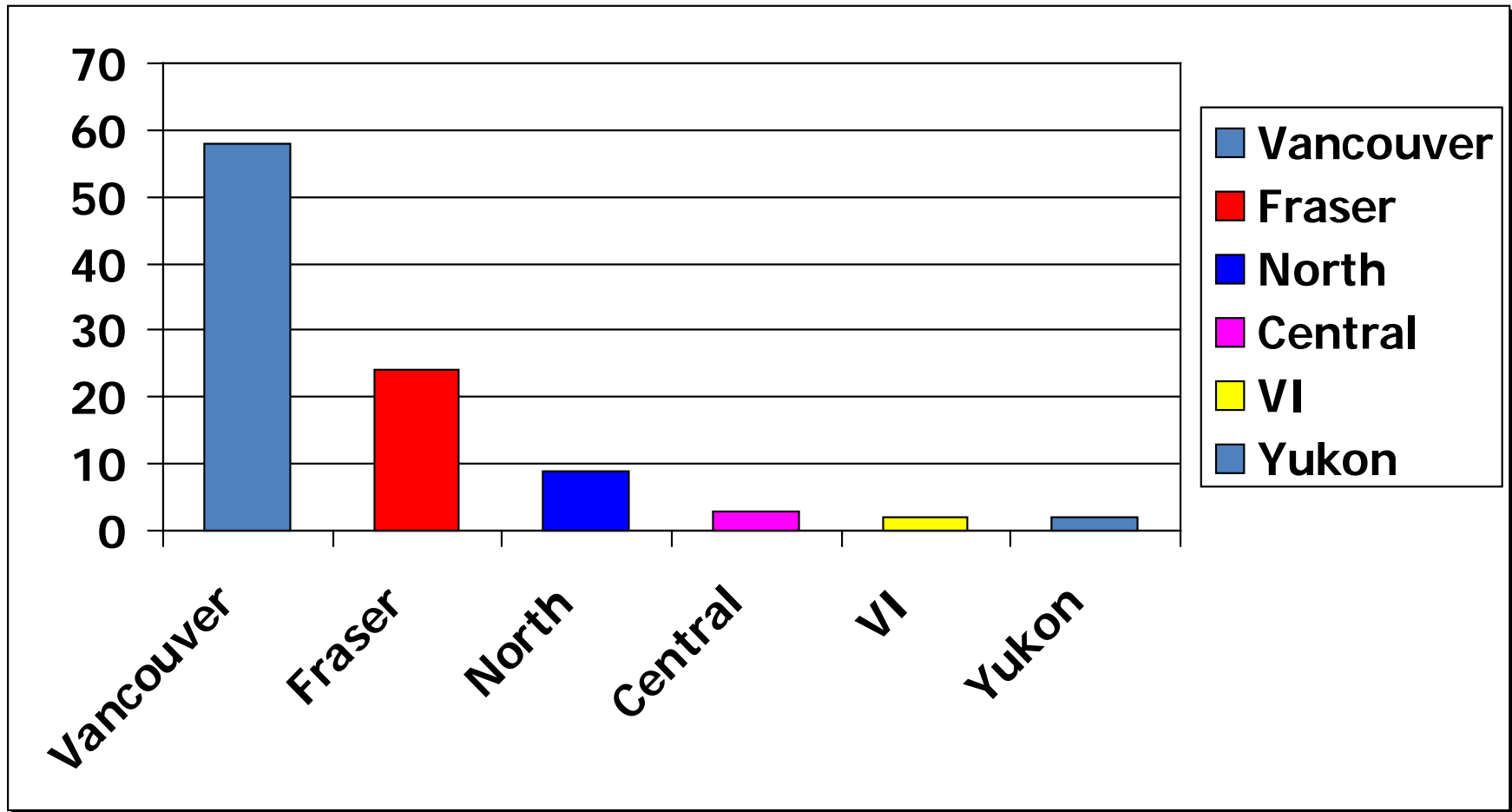
British Columbia Health Authorities and Health Service Delivery Areas

Health Authorities

- 1. Interior
- 2. Fraser
- 3. Vancouver Coastal
- 4. Vancouver Island
- 5. Northern
- 6. Provincial Health Service (province-wide)



In Patient Discharge Destination



April 2009 to March 31,
2010



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Honouring what “Grace” taught us

Collectively nurses from BCCA, Vancouver
Community and TST wanted better
continuity of care

...and so did others



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Group Representation for Systems Perspective and Agents for Change

- Manager, Vancouver Community Palliative Care Services VCH
- Director, of Clinical Operations Systemic VCC BCCA
- Social Services / Counseling BCCA
- Nursing leaders; BCCA, Vancouver Acute and Vancouver Community and Transition Services Team (TST)
- Physiotherapy BCCA
- Medical Records Dept BCCA



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Our working group





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Working Group Goals

1. Identify process/steps for patients with simple to complex discharge needs
2. Clarity on who is responsible throughout each discharge process step
3. Obtain the right information and get it to the right source

Start discharge planning as early
in the patient process as possible!



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Working Group Tools

- Used LEAN Methodology (Poslinsky 2010)
 - Mapping current state of care and discharge planning
- Used standardized measurements
 - Palliative Performance Scale : PPS
 - Eastern Cooperative Oncology Group Performance Scale : ECOG
 - Edmonton Symptom Assessment Scale : ESAS
- Interdisciplinary participation in care planning
 - Fitch. Supportive care Framework: a foundation for person-centered care. 2009.



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Discharge/Transition Plan Documentation Requirement

- Where will the patient next be receiving care?
- What documents are required
- What information is most appropriate now?
- Who is responsible for communicating the information
- What processes are needed to follow through with discharge information

imProve Model for BC Cancer Agency Patient Transitions

BCCA Target Population Model:

- Ambulatory Care
- Inpatient
- Transitions

Approaches

- Determine goals of care at every level, including language/cultural diversity aspects
- Anticipate needs
- BCCA and community partners communication re patient admission to other facilities or death
- Advance care planning at every level

Client Acuity Level

Intensity needs of client

- PPS ≤50%
- ECOG 3-4
- Co-morbidities: requires involvement of other specialists
- ESAS >7 for single symptom, or >4 for multiple symptoms

- Symptom management:** intensive & ongoing complex intervention
- Psychosocial support:** intensive & ongoing complex intervention
- Care plan requirements:** significant support up to 24/7

- PPS 50%-70%
- ECOG 2
- Co-morbidities: requires active management
- ESAS persistent >=4 to 7 for => one symptom

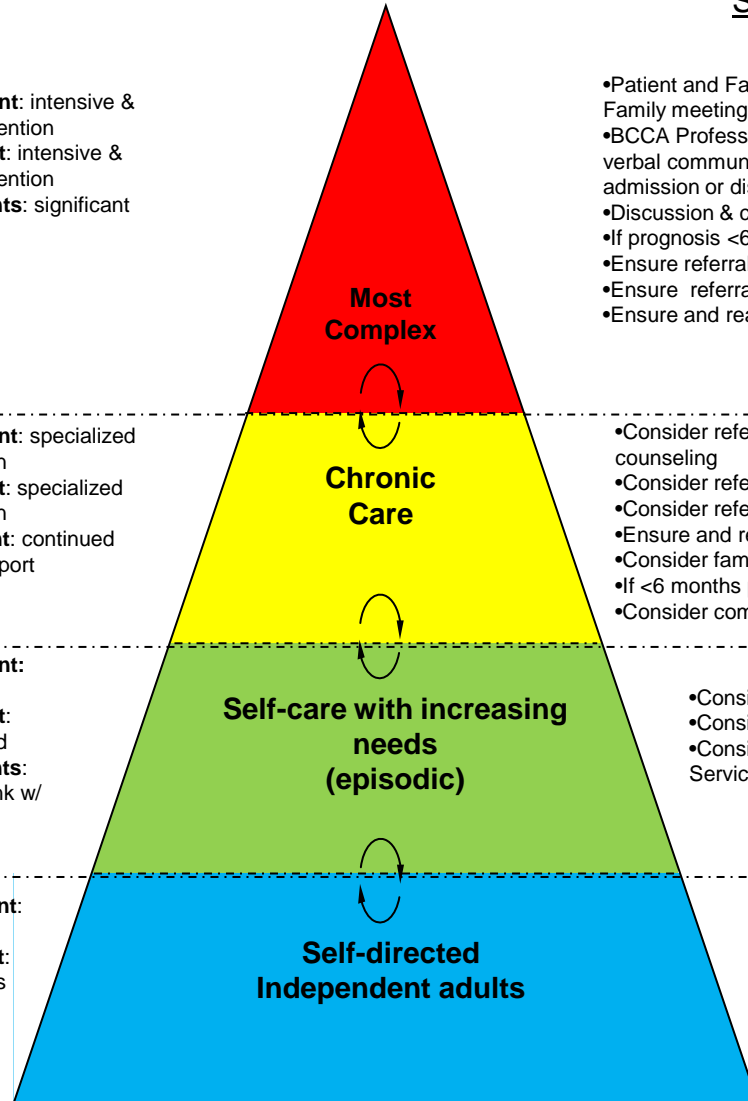
- Symptom management:** specialized professional intervention
- Psychosocial support:** specialized professional intervention
- Care plan requirement:** continued monitoring & active support

- PPS >60%, <80%
- ECOG 0-1
- Co-morbidities: episodic management
- ESAS >= 4 to 7 for one or more symptoms

- Symptom management:** episodic management
- Psychosocial support:** occasional support req'd
- Care plan requirements:** Monitor at intervals & link w/ appropriate resources

- PPS ≥80%
- ECOG 0
- Co-morbidities: Stable; self-care or minimal management
- ESAS <4

- Symptom management:** minimal management
- Psychosocial support:** aware of avail resources
- Care plan requirements:** able to manage self care



Strategies

- Patient and Family Counseling-Interdisciplinary Family meeting (inpatient, ambulatory)
- BCCA Professional to Community Professional verbal communication at "transitions" upon admission or discharge
- Discussion & completion of No CPR form
- If prognosis <6 months complete BCPCB form
- Ensure referral to Nutrition Services
- Ensure referral to PT/OT/SLP Services
- Ensure and reassess referrals to Home Care

- Consider referrals to PFC for transitional counseling
- Consider referral to Nutrition Services
- Consider referral to PT/OT/SLP Services
- Ensure and reassess referrals to Home Care
- Consider family meeting
- If <6 months prognosis, complete BCPCB form
- Consider completion of no CPR

- Consider referral to Home Care
- Consider referral Nutrition
- Consider referral to PT/OT/SLP Services

- Education, relevant info & navigation
- Basic emotional support
- Good communication & symptom management

Transition Plan ¹

- Home w/ Home Care
- Acute Hospital Transfer
- Complex Residential Care (LTC/CCU)
- Hospice
- PCU

- Home w/ Home Care
- Acute Hospital Transfer
- Complex Residential Care (LTC/CCU)
- Transition Care Unit
- PCU

- Home w/ or w/o Home Care
- Acute Hospital Transfer
- PCU

- Home

¹ Refer to "Discharge/Transition Plan Documentation Requirement"

Discharge Planning Decision Making Tool

Instructions: Circle the appropriate selection based on your assessment or patient status for each category. Given the selection, determine the potential Client Status and Discharge/Transition plan. Refer to the "imProve Model for BC Cancer Agency Patient Transitions" model for treatment strategies and "Inpatient Documentation" to complete required documentation .

Section A

Curative Intent	Palliative Intent
Yes	Yes
No	No

Section B

Level	PPS	ECOG	Co-morbidities Management	ESAS/Canadian Problem list	Symptom Management	Psychosocial Support	Care plan requirements	Current client acuity level	Discharge/Transition Plan
	<i>Palliative Performance Scale (if Palliative within 1yr)</i>	<i>Symptom Management Guideline, RT Assessment, Falls assessment, PT Assessment, Dietitian Assessment</i>						<i>see imProve Model for BC Cancer Agency Patient Transitions</i>	
4	≤50%	3-4	Requires involvement of other specialists (Level 4)	>7 for single symptom OR >4 for multiple symptoms (Level 4)	Intensive and ongoing complex interventions	Intensive and ongoing complex interventions	Significant support up to 24/7	Most Complex	+Home w/ Home Care, +Acute Hospital Transfer, +Complex Residential Care (LTC/CCU), +Hospice, +PCU
3	50%-70%	2	Requires active management (Level 3)	Persistent >/= 4 to 7 for one or more symptoms (Level 3)	Specialized professional intervention	Specialized professional intervention	Continued monitoring & active support	Chronic Care	+Home w/ Home Care, +Acute Hospital Transfer, +Complex Residential Care (LTC/CCU), +Transition Care Unit, +PCU
2	>60%, <80%	0-1	Episodic management (Level 2)	>/= 4 to 7 for one or more symptoms (Level 2)	Episodic management	Occasional support required	Monitor at intervals & link w/ appropriate resources	Self-care w/ increasing needs	+Home w/ or w/o Home Care, +Acute Hospital Transfer, +PCU
1	≥80%	0	Stable; self-care or minimal management (Level 1)	<4 (Level 1)	Minimal management	Aware of available resources	Able to manage self care	Self-directed independent adults	+Home

Discharge Planning Decision Making Flow Sheet

Instructions:

- 1) Assess patient using "Discharge Planning Decision Making Tool", and fill in the respective level per date assessed
- 2) Add up all scores and indicate in total field
- 3) Refer to chart below in determining acuity level of care
- 4) Refer to "imProve Model for BC Cancer Agency Patient Transitions" for action strategies required

Patient Name: _____

Date:							
	Check Curative or Palliative						
Curative intent							
Palliative intent							
	Indicate level	Indicate level	Indicate level	Indicate level	Indicate level	Indicate level	Indicate level
PPS value							
ECOG value							
Co-morbidities Management							
ESAS (indicate level)							
Symptom Management							
Psychological Support							
Care plan requirements							
TOTAL							
Name of Assessor:							
Discipline:							

Total added value score:		
Palliative	Curative	Discharge/Transition Plan
22-28	19-24	Most complex
15-21	13-18	Chronic Care
8-14	7-12	Self-care w/ increasing needs (episodic)
0-7	0-6	Self-directed independent adults



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Pilot Study

- March 21, 2011 – April 21, 2011
- 5 West (7 bed unit)
- all new admissions n=9



Use of Model & Tools

Admission

- Patient arrives
- Team identifies discharge plan
- Patient/Family aware of plan



Treatment

- Patient receives treatment
- Patient & family involved in discharge plan



Discharge

- Patient discharged



Flow sheet	Documentation to assess patient and record levels per predictors to discharge planning
Decision Making tool	Definition of levels for each predictor as inputs to flow sheet
Model	Strategies and Discharge plan based on acuity level



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Results from Trial

The following were felt missing:

1. Despite having the flow sheet as a tool, team roles and responsibilities in D/C planning still weren't clear.
2. Having the right measurement predictors to assess patient readiness for discharge planning.
3. Flow sheet didn't adequately address gaps in discharge planning documentation.



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Results from Trial

While the model helped identify “the big picture” patient care needs, it was not useful in addressing the day-to-day care.

The model did not predict discharge readiness particularly when discussing at bi- weekly discharge planning rounds.



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Next Steps

- Form interdisciplinary focus team to address and resolve the gaps identified internally
- Meet q2weeks through summer 2011 and review



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Improve on Tools

- To analyze the tools with assembled team
- What are our predictors?
 - Some predictors are used for day-to-day care, some are used for future care planning
 - Mobility/Functionality/ADL
 - i.e. Braden score
 - Coping : ESAS and Canadian Problem Checklist
 - Understanding what the patient hears



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Documentation

- Having one place to communicate all goals of care
- Having one place for documenting discharge plan (i.e. from interdisciplinary rounds)



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Opportunities

- Development of a communication tool internally for team goals and concerns to be addressed and easily accessed
- Moving towards interdisciplinary progress notes for documentation
- E-health viewer



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Lessons learned:

The Model

- enables us to identify where are patients are currently at in terms of care needs
- identifies the resources required to effectively meet those needs

The invaluable role of verbal communication

Thanks to our Working Team:

- Janice Lochbaum, Manager
Vancouver Community
Palliative Care Services VCH
- Mary Flaherty, Director
Clinical Operations
Systemic BCCA Vancouver
- Andy Chow, LEAN Facilitator
- Glenda Christie, SW BCCA
- May Tuason, Manager
Transitions Services Team
Vancouver VCH
- Karen Janes, Professional
Nursing Practices Leader
BCCA
- Keith Gingerich casual BCCA
RN, Inpatient unit
- Suzanne Butler,
Physiotherapist BCCA
- Elizabeth Beddard-Huber,
Pain & Symptom
Management team
Palliative Care CNS BCCA