# **Cancer Care** Ontario **Action Cancer** Ontario

# Advanced Care Planning: A Quality Improvement Plan Toolkit for Primary Care Teams

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#### **Presenter Disclosure**

#### **Relationships with commercial interests:**

Not applicable

#### **Potential for conflict(s) of interest:**

Not applicable

#### **Overview**

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# Background on the Advanced Care Planning (ACP) Quality Improvement Plan Toolkit

MOHLTC introduced Quality Improvement Plans (QIP) to the primary care sector in January, 2013 The following are required to develop and submit a QIP to Health Quality Ontario (HQO) by April 1 of each year: Aboriginal Health Access Centres (AHACs) Community Health Centres (CHCs) Family Health Teams (FHTs) Nurse Practitioner Led Clinics (NPLCs) Community Care Access Centres (CCACs) CCO has developed a toolkit for those practices that decide to include ACP as part of their QIP The ACP toolkit makes it *quick, easy and simple* to implement the QIP

# Implementing the ACP Toolkit Within Your Practice

#### **Five-Step Plan Checklist:**

- 1. Identify team members
- 2. Fill out the Planning Tool
- 3. Fill out the Measurement Tool
- ☐ 4. Orient staff who will be involved in the initiative
- 5. Make staff and patients aware of initiative

# **Planning Tool**

	AIM				MEAS	URE					CHANGE		
QUALITY DIMEN- SION	OBJECTIVES 1	MEASURE / INDICATOR	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT OR BASELINE PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFI- CATION	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS 5	PROCESS MEASURES	GOAL FOR CHANGE IDEAS	COMMENTS
Patient- centred care	All patients over 50 years old have an ACP or it is documented that they did not wish to have an ACP .	population who have participated in an ACP education session or	Target population identified by the care practice (i.e. all patients over 50 years old)	Patient list generated from existing data set over duration of project (i.e. billing data/ EMR)		If documented and data obtainable, identify how many patients have been offered an ACP discussion or consultation and how many have participated.	If current state is known (documented and data available) calculate the % of the target population that has been offered an ACP discussion or consultation and how many have participated.  Set a target for improvement.	Based on how many people are in the target group and the capacity of staff to provide the consultation	1. Staff will receive opportunities to learn about ACP and health care consent.  2. ACP will be introduced to all people within the target population or those identified through the surprise question.	access to educational resources Introduce ACP to patients within the	learned about ACP  Number of ACP consultations offered.  Documentation of patient response in patient record (EMR) (refused, not sure,	All eligible staff learn about ACP  All eligible patients in target population are identified.  Targets for offering ACP discussions or consultation and documenting response are met.	

### Sample Workflow

### Supporting patients through ACP

Identify patients
within your
practice to
target for the
ACP initiative

Invite patients to attend an ACP education session Conduct ACP
education
session and
provide patient
education
materials

If required, provide patient with support as they develop their ACP

If patient has shared an ACP, document it in their chart

#### **Measurement Tool**

#### **Part A: Performance Measurement Planning**

#### 1. Indicator Selection

- What is/are the indicator(s)/outcome measure(s) of this initiative? How is/are the indicator(s)/outcome measure(s) going to be calculated? What is the baseline?

Indicator(s)	Methodology (determined by the	Baseline Value	Target Values	
	practice)			
e.g., Percentage of the	Numerator: (e.g., number of patients	e.g., 50 patients/400 total	(as stated in QIP)	
target population who	who have been invited to attend group	patients who fall within the	e.g., 25%	
have been invited to	education session or ACP	target population = 12.5%		
attend ACP education	consultation)			
session as documented in	Denominator: (e.g., total number of			
their chart	patients identified within the target			
	population and invited to consult)			

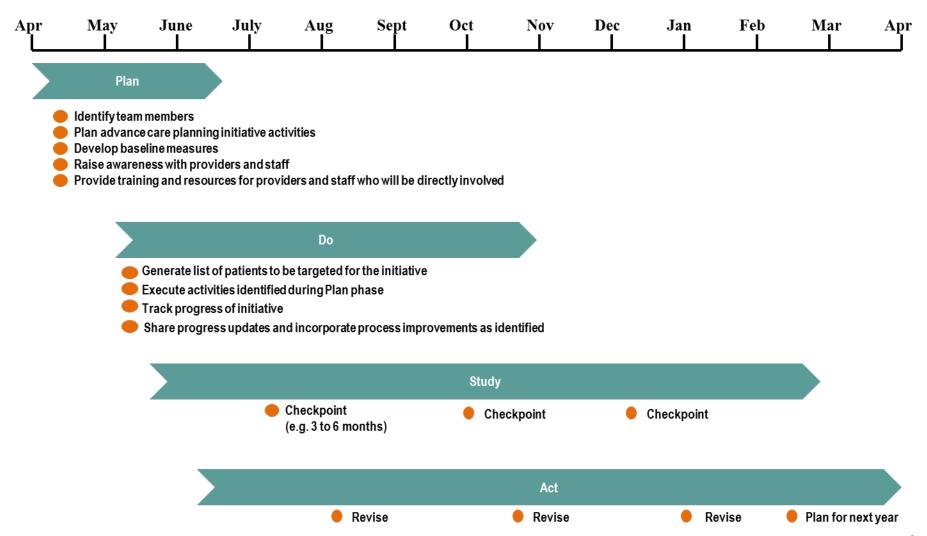
2. Process Measure Selection					
Process Measure(s)	Methodology				
e.g., Patient identified as within target group	e.g., Develop list and flag chart (patient record) that patient				
	should be offered a consult				

#### 3. Period Duration

- How often will the checkpoints occur?

e.g., every quarter/month/week

### **Example Timeline**



# **Experiences from the**Jane Finch Family Health Team

## Background

- ACP Program began on April 1, 2013
- 168 Face To Face counselling sessions
- 3 outreach sessions:
  - FHT referred clients
  - Senior's Group
  - Vulnerable Women's Group

### Important Considerations/Discussions with Clients

- Substitute Decision Maker
- Power of Attorney
- Cultural and religious beliefs
- Normalize the process for clients

#### Resources

- ACP Toolkit link on CCO website: http://www.cancercare.on.ca/pcs/primcare/qitoolkit/
- ACP resources created by CHPCA: www.advancedcareplanning.ca
- Ontario Seniors Secretariat: www.seniors.gov.on.ca/en/advancecare/
- Canadian Virtual Hospice: www.virtualhospice.ca
- Ontario Attorney General: www.attorneygeneral.jus.gov.on.ca
- Hospice Palliative Care Ontario: alecoche@hpco.ca
- Canadian Hospice Palliative Care Association: www.chpca.net