Home Based Primary Care Program; Quality Improvement in Palliative Care

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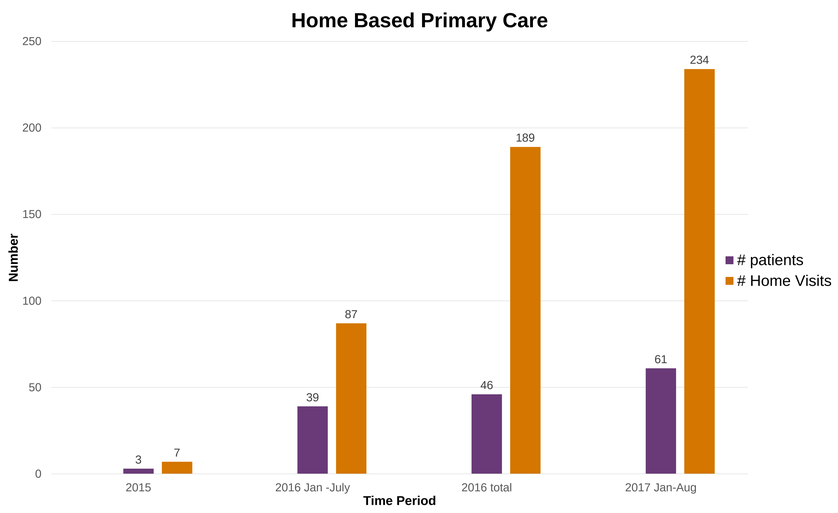
HBPC Program Overview

Thames Valley Family Health Team (TVFHT) is one of the largest Family Health Teams in the province. TVFHT is made up of over 15 physical locations, over 115 primary care physicians, and 110+ interdisciplinary health professionals providing care for over 155,000 patients.

The Home Based Primary Care (HBPC) provides comprehensive interdisciplinary care to individuals with complex medical and social needs that focus more on ensuring patients independence rather than acute care (Akhtar& Pham 2015).

The Middlesex Center of Family Medicine Clinic (MCMFC) with partnership of Thames Valley FHT developed the HBPC program. This multifaceted program aims to improve access to care for those patients and their care givers that cannot access care at the family physicians' office due to physical and/or mental health barriers. Secondly, HBPC aims to foster a safe and supportive teaching environment for medical residents to improve exposure to home-based care and improve residents' skills, confidence and comfort when providing this type of care.



Problem Statement

1. Patients and their care givers are not engaged in the shared decision making regarding their care, especially end of life.
2. Family Physicians did not have a systematic approach to home visits.

"70% of decision at end of life are not made by the patient" (Advanced care planning.ca)

AIM Statement

80% of Patients in the MCFMC will have ACP discussion and death in preferred location by 2017.

Driver Diagram

Primary Drivers

- Improved resident participation
- Improved Patient identification and Communication
- Improved coordination

Secondary Drivers

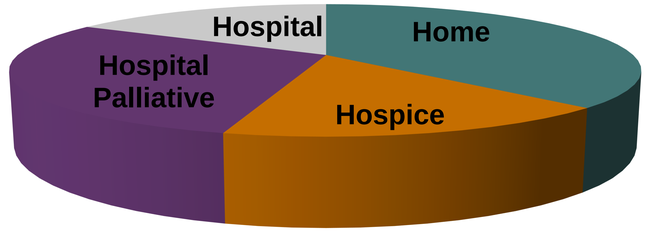
- Joint visits with resident, RN, and lead GP
- Referral process " would you be surprized if patient dies in next year"→ Surprise Question
- Information sessions for residents, patients and family
- Communicate with community partners and participate in Coordinated Care Planning
- Coordinate a simple point of contact for patient/family as a Substitute Decision Maker
- Coordinator to set up visits for resident and GP.

Change Ideas/ Lessons learned with PDSA cycles

1. One on call number for patients to call for assistance
2. New documentation tool for Advance Care Plan and template for documentation for HBPC team
3. Joint visit and support for resident and patient continuity
4. Advance Care Plan information sessions for all patients and families
5. Care partners CCAC, Nursing, Family in CCP section of EMR
6. Document goals of care (GOC) in CCP section of EMR.

Results

Palliative Outcomes: Location of Death



Lessons Learned

- Patients are not attending Advance Care Plan Education sessions; need to restructure.
- We need to improve communication between primary care sector and specialist/hospital sector.
- Medical Assistance in Death (MAID) new option for patients 3 requests 1 completed need to be clear on process.

To learn more about the program or how to implement it at your FHT, please contact us.

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References

1. Akhtar S & Pham T (2015) A Canadian Provider's Handbook to Home based care.
2. 2. Advanced Care Planning.ca and Myers, Jeff MD CCFP 2015 NOSM Palliative Care Conference Rethinking Advanced Care Planning: It's all about Values.
3. The Improvement Guide (2009) Langley, Moen, Nolan, Nolan, Norman and Provost