Partnering to Improve the Patient Experience: After Hours Symptom Management Telephone Support

CQCO PROGRAMMATIC REVIEW
JUNE 2017
Background

Cancer Care Ontario
OCP IV

- Equity: Ensure health equity for all Ontarians across the cancer system
- Integrated Care: Ensure the delivery of integrated care across the cancer care continuum

Central Regional Cancer Program

- Committed to developing sustainable partnerships and the use of creative solutions to increase efficiencies and to maximize resources for the betterment of our patients

Bayshore HealthCare
CARE path™

- Ensuring clients receive advice, information, and support they need to navigate the health care system
Quality Improvement Project

Purpose
To implement a regional after-hours telephone support service for patients receiving systemic therapy in order to:

i. improve access to side effect management
ii. improve patient satisfaction with response times
iii. reduce unplanned patient Emergency Room visits/unplanned hospital admissions

Smart Goal
100% of Central LHIN new patients or patients re consulted who receive chemotherapy treatment will have access to an after-hours symptom management telephone support program serviced by specialized oncology registered nurses, activating patients to self-manage their symptoms at home
Solution: Creative Partnership

Partner with Bayshore HealthCare Limited, through their CAREpath™ division

- Over 10 years experience in oncology navigation in the private sector, employing experienced specialized oncology Registered Nurses

- Originally, a 9-month pilot project, after-hours only (1800-0800 hours), use of 1-800 central contact number, sufficient staff to ensure response time to patients no longer than 15 minutes (if not immediate)

- Adoption of COSTaRS tool for telephone triage, a set of evidence-based guidelines written by Canadian oncology nurses, based on Cancer Care Ontario algorithms and provincially agreed upon best practices

- Reporting to Cancer Centre of patient symptoms and health care advice/intervention provided by 0830 hours following morning

Phase I: Stronach Regional Cancer Centre
Phase II: All cancer programs in the Central Regional Cancer Program
Phase III: Pilot Expansion to interested Level 2 and Level 3 facilities
RCP Implementation: Process Flow Map

Patient provided with information on after hours support line & reasons for use by RN within hospital clinic

Patient experiences symptoms after hours & calls 1-800# provided by hospital

Patient is connected to CAREpath RN through call centre; RN requests permission to ask questions

If new patient, RN obtains consent; then proceeds with questions re patient concerns

Does patient require symptom management?

RN utilizes COSTaRS protocols for most problematic symptoms using RN best judgement to triage patients

RN reviews patient information & self management strategies with patient; seeks agreement with plan

If symptoms are severe, RN may advise patient to see medical attention or proceed to ED

RN summarizes plan, completes COSTaRS document, efaxes report to hospital point of contact by 0830 next morning

RN reviews pump/PICC/CVAD/catheter or other issue, troubleshooting with patient

Hospital clinic RN follows up with patient next morning re ongoing plan & treatment review

RN may advise patient to proceed to ED if unable to resolve
Patient Education

All patients are given a 2 page document explaining the scope and hours of the program.
Patients are also given a brief information sheet with data specific to their condition to share with the CAREpath™ RN.
CAREpath™ Reports

Reports are generated monthly using mutually agreed-upon indicators:

- **Cancer type, symptoms (reason for service), severity level**
- **Date/time of call**
- **Number of calls (per patient; total per month overall)**
- **Advice provided to patient & outcome**
  - No health service
  - Call oncologist and/or RN next day
  - Proceed to ED
- **Patient satisfaction with service & experience of care**

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Symptoms</th>
<th>Severity Level</th>
<th>Date of Call</th>
<th>Time of Call</th>
<th>Disposition</th>
<th>Outcome</th>
<th>Time to Call (s)</th>
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<td>Gastrointestinal</td>
<td>Vomiting</td>
<td>Moderate</td>
<td>5/1/2017</td>
<td>10:30</td>
<td>Call oncologist</td>
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<td>Dysphagia</td>
<td>Severe</td>
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<td>Emergency visit</td>
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**Central Regional Cancer Program**

**in partnership with Cancer Care Ontario**
Pilot Results (to April 2017)

Number of sites: 6
(as of May – 2 additional sites)

Aug 2016-Apr 2017:
Total calls = 460

% of patients proceeding to ED = 7%
**Pilot Results (to April 2017)**

Aug 2016-Apr 2017:
- Total calls = 460
- % of patients proceeding to ED = 7%

Jan 2017-Apr 2017:
- 80% of patients advised to seek ED attention received an intervention/were admitted
Pilot Results: Public/Private Partnership

Challenges

- Obtaining buy-in from clinical team and from patients, no pre-existing trusted relationship with on-call nursing staff at Bayshore
- Reliability of service to provide timely intervention unknown to start
- Variation in existing models of care delivery within other cancer programs & whether new program would complement approaches in place
- Developing a sustainable financial model for delivery of services

Benefits

- Willingness to explore innovative care delivery models between partners to improve patient experience
- Access to funding opportunities outside of traditional health care models, allowing public sector to concentrate on clinical services & private sector on efficiencies in project delivery
- Availability of oncology subject matter experts in non-traditional setting of telephone triage
- Flexibility in adapting model to suit changing patient needs
Key Features of Pilot to Spread & Sustain

- **Process:** single model replicated at each site
  - Standardized plan, protocols, escalation procedures, evaluation criteria/metrics – easily adaptable to local variability/complexities
  - Clear communication plan to staff, physicians, patients re: goal, structure, flow map, benefits and quality outcomes anticipated

- **Organization:** congruent visions
  - CCO (OCP IV), Central RCP and Bayshore
  - Easily adapted/adopted by each RCP or Level 3 centre

- **Staff:** strong leadership & engagement strategy
  - Appointment of pilot plan champions – manager, educator, physician lead, clinic-based nurses
  - Education on, and adoption of, COSTaRS protocols for all RNs in clinics

NHS Institute Model of Sustainability
Pilot Results

Successes

- Patients are triaged in timely manner, noting relief of anxiety with symptoms and reduced need for trip to ED after hours – *value for the patient*
- Reduced next day nursing telephone voicemail volumes from current patients (15%), with improved confidence in process – *value for the provider*
- Ongoing collaboration with CAREpath™ team to improve documentation, process, and reporting in this public-private partnership – *value for the system*

Next Steps

- Extension of pilot (including additional RCPs and Level 3 sites) until end September to increase data power
- Refine data collection – quantitative and qualitative measures
- Explore funding models in short & long term for sustainability across province
Questions?

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