

PHSA QI: ONCOFERTILITY

Dr. Nicole Todd MD FRCSC

**PEDIATRIC AND ADOLESCENT GYNECOLOGY
UBC DEPARTMENT OF OBSTETRICS & GYNAECOLOGY**



DISCLOSURE

- Faculty: Nicole Todd
- Relationships with commercial interests:
 - Bayer – Received honoraria
- Employee of PHSA, VCH
 - Cross appointment within Department of Family Practice
- Off label medication list will be clearly marked with Asterix

DISCLOSURE

- Faculty: Nicole Todd
- Managing Potential Bias
 - I will not be speaking about medication use

BACKGROUND

- **Nearly 80% of children and adolescents are surviving childhood cancer**
- Second to mortality, future fertility is a great concern for patients and their parents
- Cancer treatment can affect a young woman's future childbearing potential
- Fertility treatments are advancing, and pregnancy outcomes are equivalent between frozen eggs and frozen embryos
 - While urgency of cancer treatment may preclude initial fertility preservation, treatment should not preclude the discussion
- Currently, urgent fertility consultations are at the discretion of the treating physician, and the consultant chosen based on a priori knowledge
- **This is not providing best practice in care**

PROJECT AIM

- **To improve access to Oncofertility counselling and Oncofertility follow up in women under the age of 19 years treated for cancer at BC Children's Hospital**

ONCOFERTILITY QI PROJECT CHAMPIONS & TEAM MEMBERS

- **Dr. Jeff Roberts, Reproductive Endocrinology and Infertility**
- **Dr. Kristin Marr, Pediatric Oncology**
- **Dr. Caron Strahlendorf, Division Head, Pediatric Oncology**
- **Dr. Mohammed Bedaiwy, Division Head, Reproductive Endocrinology and Infertility**
- **Dr. Debra Millar, Pediatric and Adolescent Gynaecology**
- **Dr. Stephanie Rhone, Senior Medical Director, Ambulatory Care Programs, BCWH**
- **Natasha Prodan-Bhalla, Nurse Practitioner**
- **Christine Tulloch, Patient Champion**
- **Bethina Abrahams, PQI Manager**

CURRENT STATE ANALYSIS

- **Pediatric Oncologists**
 - **Benefits:** coordination, patient centred, centralized information
 - **Barriers:** physician bias, patient/family stress, patient illness, cost, counsellor coverage, knowledge of what each service is already doing, uncertainty as to who to refer, knowledge of procedures offered
- **Counselling needs to be unbiased, flexible to serve patients in different phases of their journey: diagnosis, treatment, long-term follow up, relapse**

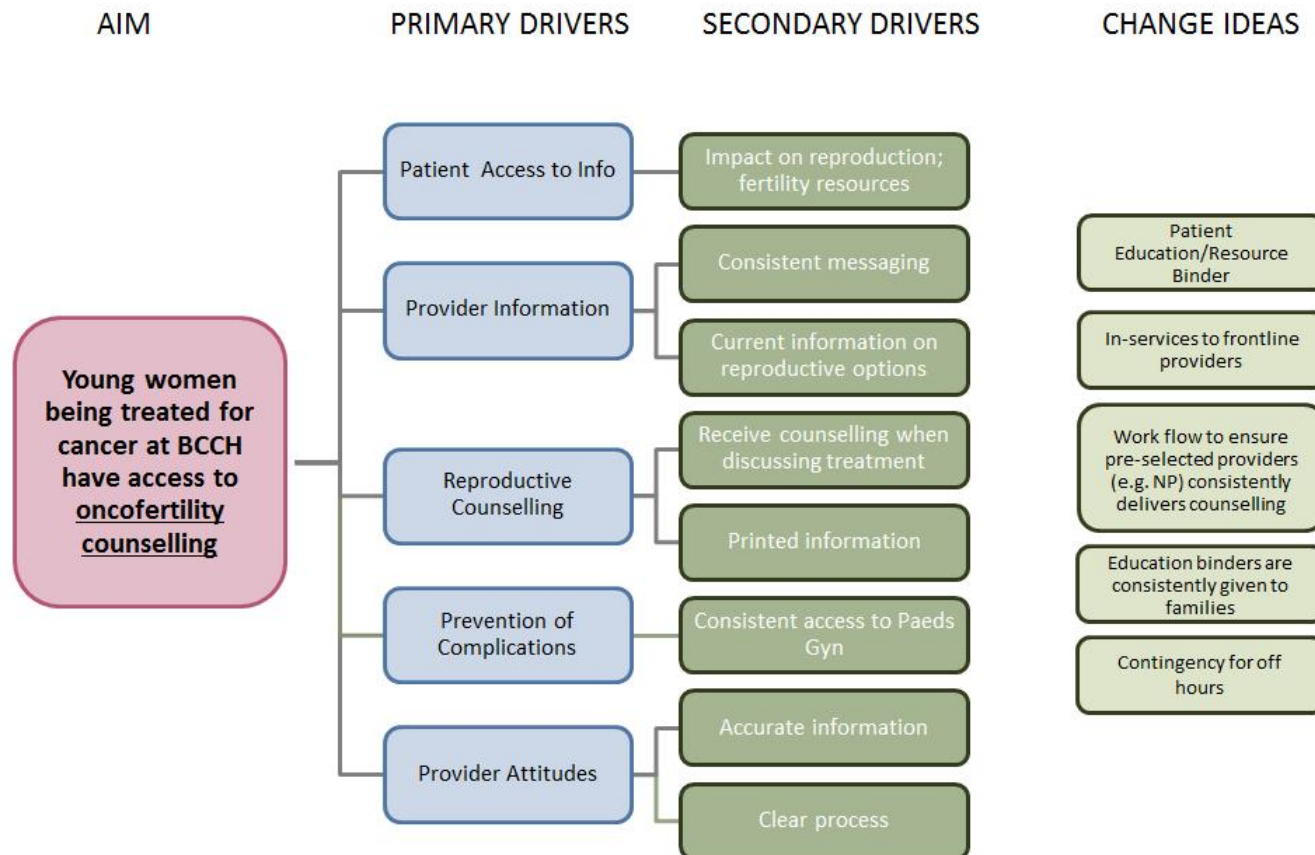
CURRENT STATE ANALYSIS

- **Reproductive Endocrinology and Infertility Physicians**
 - **Benefits:** universal, streamlined process (time to consult, access to Fertile Futures), consistent counselling, improved teamwork, research
 - **Barriers:** Cost, providers
- **Cost to fertility treatments Is a perceived barrier**
 - **patients should be connected to Fertile Futures, non-profit organization that can provide financial assistance**

CURRENT STATE ANALYSIS

- **Patient Advocate: Female, late teens with first cancer diagnosis, relapse in early adulthood**
 - **Desired information about future fertility at time of first treatment**
 - **Has regrets about actions not taken that could have protected her fertility**
 - **Found providers were dismissive of fertility concerns at the time of her cancer treatment**
 - **Has had to deal not only with impacts of cancer, but also with infertility, social and psychological implications**

Driver Diagram



APPROACH TO CHANGE

- **Forcing Function**: Education binder given to every female patient treated for cancer at BCCH: introduction, patient resources, financial assistance, clinic specific information
- **Consistent Message**: trained provider (goal: Nurse Practitioner) to deliver counselling
- Risk stratification process to provide initial improvement in access to counselling
- Work Flow process to ensure timely counselling delivery
 - **PDSA Cycle**: Work with Pediatric Oncology Champion to refine workflow and ensure timely counselling
- **Continuing Education**: Rounds to update providers on the current available fertility preservation techniques

PROPOSED PATIENT JOURNEY MAP - DIAGNOSIS



OUTCOME MEASURES

- **Referral for patient counselling**
 - **At present: Community Fertility Centres**
 - **Future: Oncofertility counsellor**
- **Patient and family satisfaction scores with education binder**
 - **Outpatient**
 - **Inpatient**
- **Oncofertility Counselling**
 - **Outpatient - Impact counselling had on treatment decisions**

NEXT STEPS

- **Chart Audit**
- **Pilot of formal Oncofertility program with single Pediatric Oncologist champion**
- **Develop training program for Oncofertility counsellor**
- **PDSA Cycle**
 - **Pediatric Oncology - champion**
 - **Pediatric Oncologist - new**

CONCLUSIONS

- **Centralized Oncofertility Program will improve timely access to assessment, counselling and possible fertility preservation to improve patient outcome and experience**
- **Our success to date has been limited by time, resources and network**
 - **This project has allowed for protected time for team members to collaborate at a clinical, administrative and research level**
- **Current state analysis has been instrumental to generate stakeholder buy in**
 - **Scaled roll out of the program key**
 - **Celebrate small successes!**

THANK YOU
NTODD@CW.BC.CA



Physician Quality Improvement (PQI) Rapid Fire- Patient as Team Members

Dr. Amrish Joshi
Palliative Care Team - Richmond, BC
November 2018

Disclosure

Presenter / Faculty	Dr. Amrish Joshi
Relationships with commercial interests:	
Grants / Research Support	None
Speakers Bureau/ Honoraria	None
Consulting Fees	None
Other	None

Managing Potential Bias

Not Applicable

Background

Serious Illness Conversation Guide- Simple tool to facilitate better care

Issues:

Cultural lens to wording

Lost in translation

Is it culturally neutral tool?

How does this cohort feel about SIGC

Aim Statement



“To improve the use of the Serious Illness Conversation Guide(SICG) to a target of 70% by gathering feedback from English speaking Canadians of Chinese ethnic origin, while also identifying areas for improvement with a cultural lens.”

Partners

Home Health Team - Nurses, SW...

Palliative Team - interdisciplinary team

The community - Chinese Advisory Committee, Community Engagement Project, Focus Groups

What Did We Do?

Knowledge from Community Engagement

Four Focus Groups - 27 participants

MD and Nurse demonstrated SICG

Quantitative and Qualitative Analysis

Intervention or Strategy for Change

Developed PEARLS from analysis

Share with Home Care Nurses

Measure success of documentation before and after- monthly analysis

Survey of value of PEARLS

Progress and Next Steps

Presented findings to 3 of 4 Focus groups

Presenting PEARLS in November

Working on survey for nurses

Scoring System for completion SIGC

A Qualitative Study Exploring the Beliefs and Understanding of Advance Care Planning or Advance Directives within Members of the Chinese Community from Richmond, British Columbia.

1. Awareness of Advanced Care Planning (ACP)/ Advanced Care Directives (ADP)

Age

Those Native born from the Chinese Ethnic Community were more aware of ACP/ACD. Individuals newly arrived as immigrants had less awareness of this topic- may never have heard the terminology of ACD/ACP. However, younger individuals are more comfortable with the SIGC- 'prepare for what is coming.'

The elders respect the healthcare professionals, and they will 'grab every word' the healthcare professional presents. This is an important dynamic in discussions within this cultural group

Education

Lower education achievement may result in words becoming 'Lost in Translation.' The severity of the medical condition may not be understood by the individual. The elders usually had lower lower academic achievements.

Religion

Christian or Buddhist followers were more open and accepting of a the SIGC. Those from a Christian faith used their religion as a source of strength when dealing with serious illness. The Buddhists accepted these discussions as part of the 'next stage.'

2. Façade

It is a taboo subject. Family and patients may be complicit in presenting a favourable image of the condition. It was an offensive topic for the adult children of elderly patients. It was perceived as failure for both groups: 1. The children had failed their parents and were burdened with guilt; 2. The failure as parents, with children discussing their deterioration in health in the context of a Serious Illness Conversation.

Presenting a favourable image- going as far as lying- was seen as compassionate care.

3. Family Centric

There is a hierarchy within the family, with greater influence among older members, and this includes expectations from other relatives. Patient wishes are recognised, but the family is a powerful partner in discussions about care. Those native born were more likely to acknowledge the importance of the patient over the family, but the family was still influential.

The family should be used to facilitate and 'buffer' difficult news, particularly for older patients. This approach acknowledges the importance of family and their role in caring for the patient.

4. Palliative Care Services

Anything to do with death is 'unlucky.' The service is perceived as having nothing to offer- the 'the outcome is death.' The patient and family want a 'fix.'

Individuals struggled with the questions exploring goals of care, perceiving them as pointless. It reminded the patient and the family of the poor situation, which generated distress.

5. Power of Words

Words have a 'positive or negative' impact on patients and family.

'Fears and Worries'

Perceived as negative and culturally difficult to hear.

Conceptualising 'abilities'

A large number of participants found this word difficult to understand- an 'abstract concept.'

Delicate Negotiations

'Interventions to have more time' was a delicate question, particularly when presented to parents; it bordered on offensive and it was a challenge translating this question.

Strengths

The word 'strength' produced a good emotional 'vibe.' It was universally welcomed.

1. Awareness of Advanced Care Planning (ACP)/ Advanced Care Directives (ADP)

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My PQI Experience

Journey continues - other communities

Fluid project - remaining practical

Partnerships continue - Clinicians, Allied Health, and the community

‘Rich’ data from the users - guide to care

Sustainable

Readily usable

Continue to evolve

Review wording in our community

Other approaches Feedback from users

Poster Presentations- feedback from others



Connected Medicine Collaborative Team “RACE North”

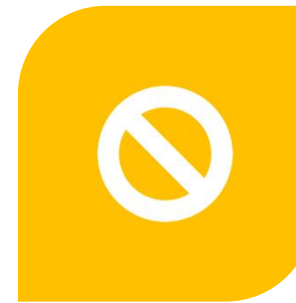
DISCLOSURE



PATIENT VOICES NETWORK
VOLUNTEER



PATIENT PARTNER WITH SSC-PQI
CFHI RACE NORTH TEAM
MEMBER



NO CONFLICTS TO DECLARE

What is Northern RACE?

Northern RACE has been simplified to connect you with specialists in the following categories (*the number corresponds with the option on the phone line*):

- | | |
|------------------------|--------------------------|
| 0. RACE support team | 7. Rheumatology |
| 1. Cardiology | 8. Pediatrics |
| 2. Nephrology | 9. Orthopaedics |
| 3. Infectious diseases | 10. Radiology |
| 4. Oncology | 11. Allergy & Immunology |
| 5. Gastroenterology | 12. Child Psychiatry |
| 6. Psychiatry | |

- **1-855-605-7223 (RACE)**
- Northern RACE (Rapid Access to Consultative Expertise) is an advice line to support primary care providers in Northern BC.
- Northern specialist physicians will provide telephone support for non-emergent, patient-related questions.
- 0900 -1600 Monday – Friday
- Calls are to be answered within 2 hours maximum

Project Background

- NPIC (Northern Partners in Care) funded by Shared Care, developed the Northern RACE line, but closed its operations two years ago.
- Northern Health assumed operation of the line at that point.
- We had an opportunity through CFHI Connected Medicine Collaborative to examine the current Northern RACE line, make improvements through a collaborative process and explore what else is needed to support PCPs and patients with access to timely specialist care.

AIM STATEMENT

By September 2018, we will increase NH physician use of RACE by 50%, from its current baseline of 49.4 calls per month to 74.1 calls per month.

Dr. Anurag Singh, Specialist Physician Lead

"Remote consults will prevent anxiety, travel and related costs to patients, burden on wait lists, and overall better patient and provider experience. Remote consults can also play a huge role to build relationships between providers which can improve patient experience and outcomes."



Dr. John Pawlovich, Primary Care Physician Lead



“The patients we serve do not always have the means or the desire to travel to larger communities to receive care. The RACE line prevents patients from having to leave home and allows the Primary Care Provider to have their questions answered quickly.”

Edwina Nearhood, Patient Advisor

“The RACE line would significantly improve the patient experience by allowing their Primary Care Provider to discuss the condition with a specialist without having to send the patient out of town.”



Specialist Champions



Dr. Abu Hamour



Dr. Haidar Hadi

"As the vast geography is a major challenge in Northern BC, remote consult will undoubtedly help bridge the gap in access to care. The anticipated improvement in the quality of care, patient and provider experience alike, and the possible saving in healthcare costs would all fit well with the triple aim strategy."

Reina Pharness,
Project Manager



Jessica Place,
Executive Sponsor



Tiegan Daniels,
Evaluations Lead



Janice Paterson,
SSC Lead



Jayleen Emery,
Physician QI Coordinator



Lee Cameron,
Quality Improvement Lead



IT Advisors

Andreas Hirt



Frank Flood



Leanne Nahulak,
RACE Line
Coordinator

The Project Goals

By November 2018, the RACE North project will aim to:	By:
1) Understand the needs of Primary Care Providers re: access to Specialist support	<p>Holding a variety of discussions (focus groups) and key informant interviews with PCPs. Developed standardized set of questions. Holding engagement and consultation sessions with PCP's in the North early on and continually throughout the project, gathering their feedback on the current system.</p> <p>March/ July 2018</p>
2) Make improvements to the Northern RACE line wherever possible (PDSA)	<p>Based on feedback from providers. Improvement ideas so far include: Specialist orientation for consistency in service. Creating an updated poster to distribute to Primary Care Provider offices.</p> <p>April – Oct 2018</p>
3) Improve provider's awareness of culturally sensitive care	<p>Providing Cultural Safety Training for our RACE North project team, and embedding this principle in our work and messaging. Explore ideas that support exposure to FN culture. Working with Central Interior Native Health to provide specialist clinics.</p> <p>April – Oct 2018</p>
4) Engage patients & providers in promoting the Northern RACE Line and increasing call volumes by 50%	<p>Mapping out the patient journey Engaging Indigenous populations: Discussing their experiences and collecting/sharing their stories. Create opportunities for patients to tell their story/ promote RACE Use physician champions</p> <p>June – Nov 2018</p>
5) Enhance relationships and collaboration between Specialists and Primary Care Providers	<p>Building on existing relationships, explore different forums for physicians across Northern Health to connect with local specialists. Understand what other organizations are doing ie Kootenay Boundary Division and IH. Explore feasibility for e-consults, align with secure texting project.</p> <p>June – Nov 2018</p>

What we've learned so far from our qualitative data collection:

Strengths:

- Structured access to SP advice
- 2 hr timeframe allows SP the ability to call back with advice that is well thought out
- Provides care closer to home
- Allows for joint decision making: patient involved with, PCP & SP
- Allows for educational opportunities
- Builds trust & relationships
- Opportunity for PCP to ask non-urgent questions

Weaknesses:

- RACE line is underutilized
- PCPs prefer more immediate answers
- Potentially bypass local SPs
- Local SPs potentially miss the referral opportunity
- Challenging to find the RACE number when needed
- Little opportunity to follow up with PCP
- Service can be inconsistent between SPs

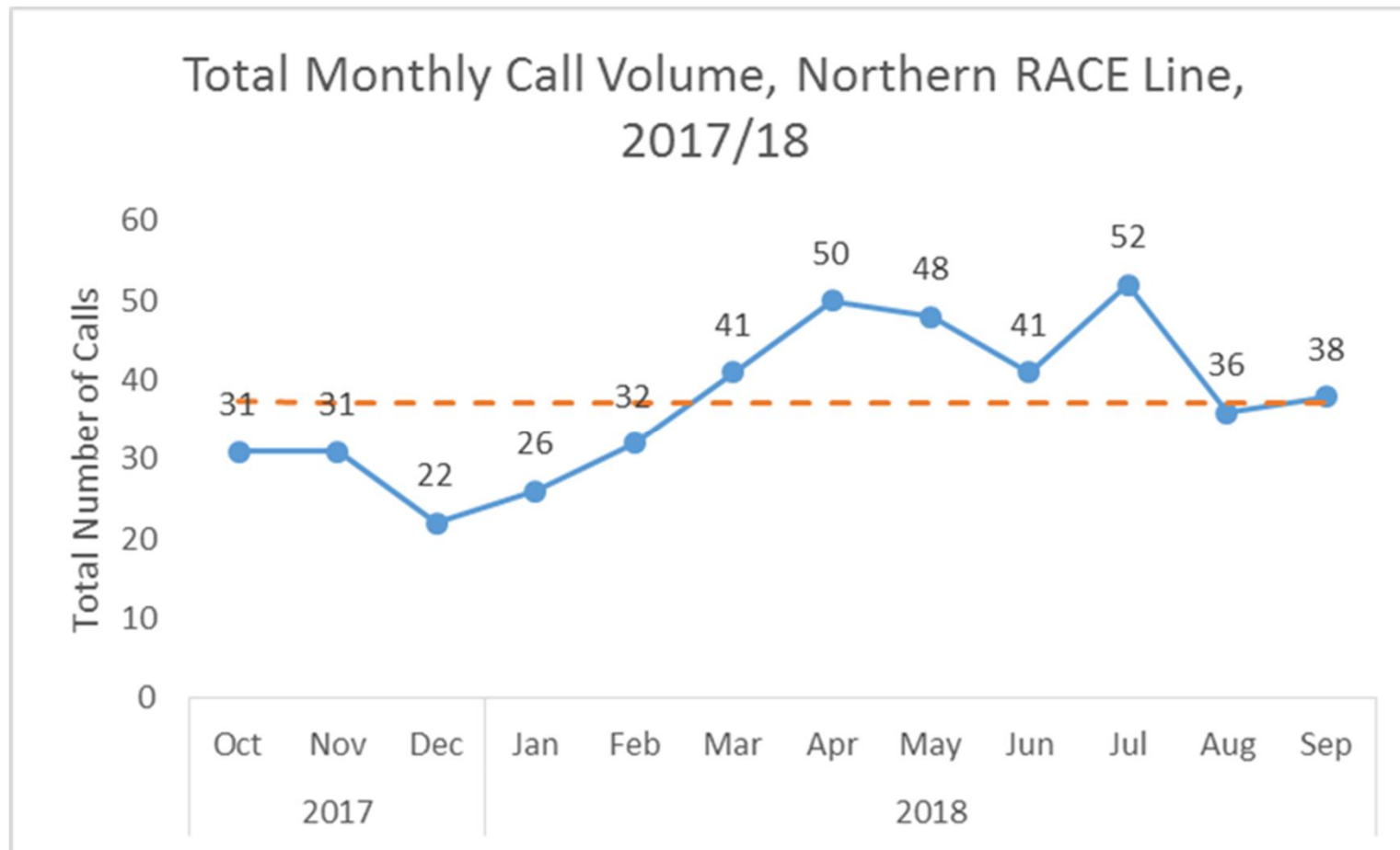
Opportunities:

- Alignment with a secure texting platform
- EMR integration
- Value added for CME, & outreach
- Regional RACE calls within HSDA
- Opportunity to increase awareness
- Inform patients of the service & encourage them to promote

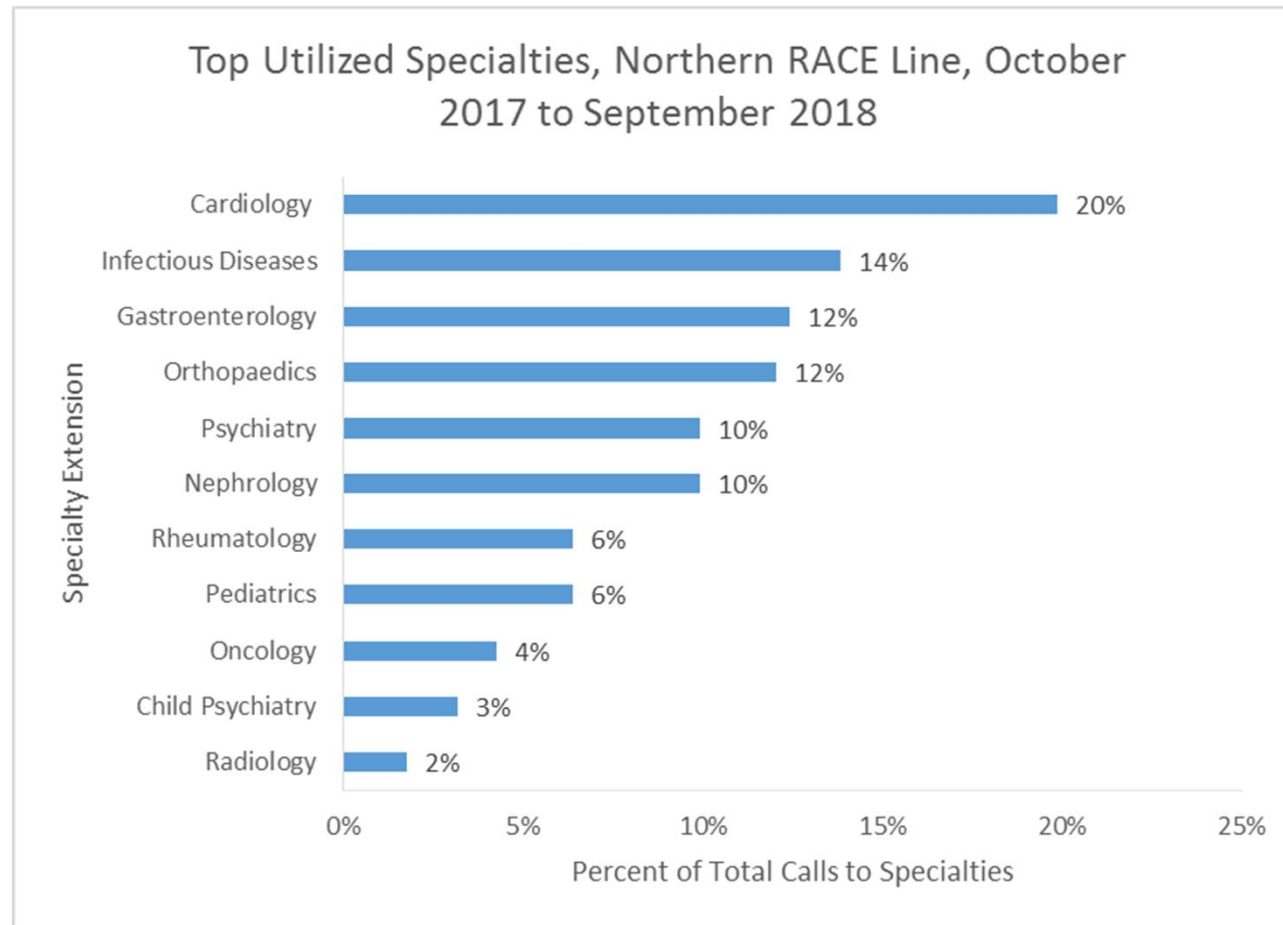
Challenges:

- PCPs prefer to consult directly with local SPs
- Other consulting networks: BC Cancer; Provincial RACE, Kelowna thoracics, BC Children's etc
- PCPs using switchboard to contact SP directly

RUN CHART



TOP UTILIZED SPECIALTIES



Next Steps:

Future thinking:

The Northern RACE Line will need to remain relevant as future technologies develop.

Next Steps:

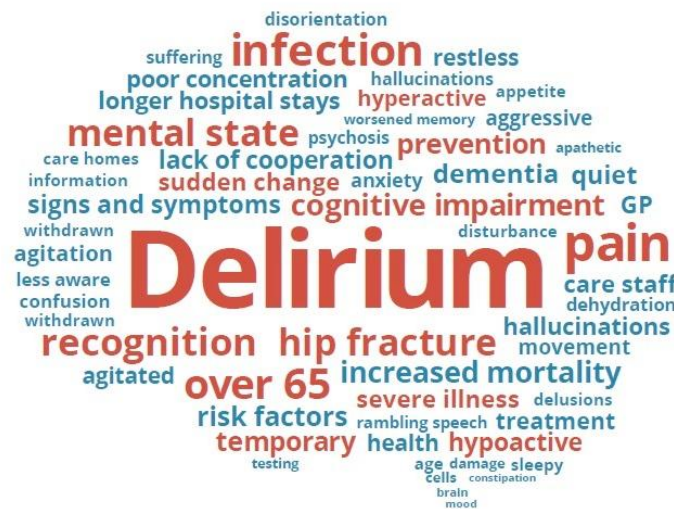
- Maintain the current operation of the Northern RACE Line and continue to make small improvements wherever possible.
- Continue to support reflective practice re: cultural safety.
- Support our patient partner in patient journey mapping training and create opportunities for her to share her story and promote the Northern RACE Line.
- To explore other Apps and technology platforms that support Primary Care Providers and Specialist communications.
- Work with the Provincial groups to explore possibilities for one system that includes the current regional components.



Patient Journey Map November 29th 1700-2130

Specialist Services Committee (SSC) will be reimbursing for physician time, dinner will be provided and CME credits will be available

Delirium: Decreasing the Distress



Disclosure

Presenter / Faculty	Dr. Jean Warneboldt
Relationships with commercial interests:	
Grants / Research Support	None
Speakers Bureau/ Honoraria	None
Consulting Fees	None
Other	None

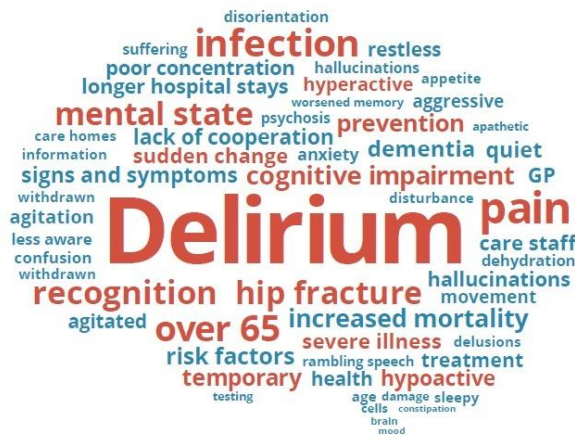


Managing Potential Bias

Not Applicable

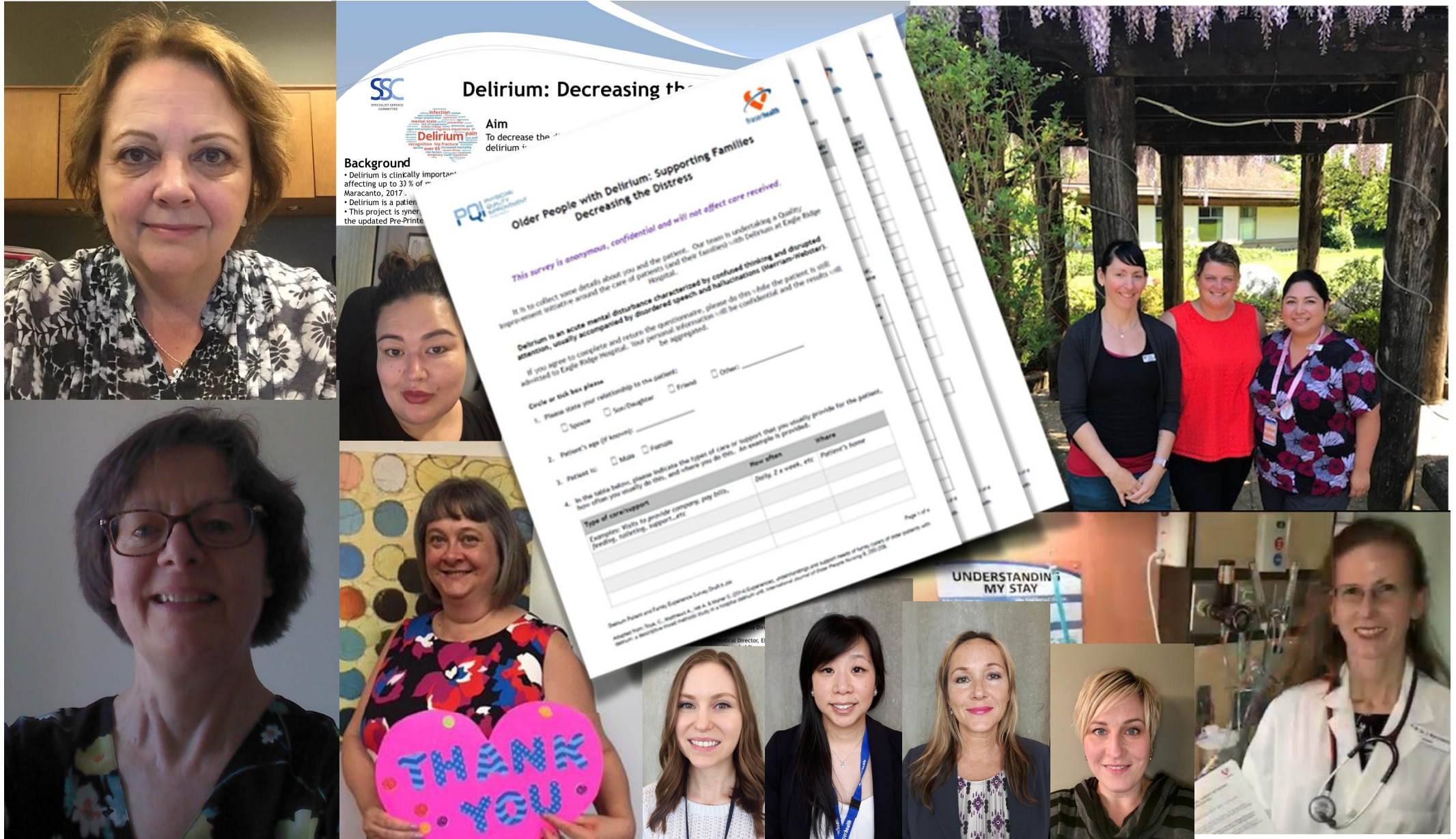
Delirium: Decreasing the Distress Aim

To decrease the distress of delirium
experienced by patients and families
on Eagle Ridge Hospital acute medical wards
by 30% by June 2018.



Delirium: Decreasing the Distress

Guiding Principles



Delirium: Decreasing the Distress

Outcome Measures:

Family Surveys (experience with team and awareness of delirium)
Length of Stay

Process Measures:

PPO use
Hospitalist Survey (practice patterns)
Nursing Surveys

Balancing Measures:

Re-admissions

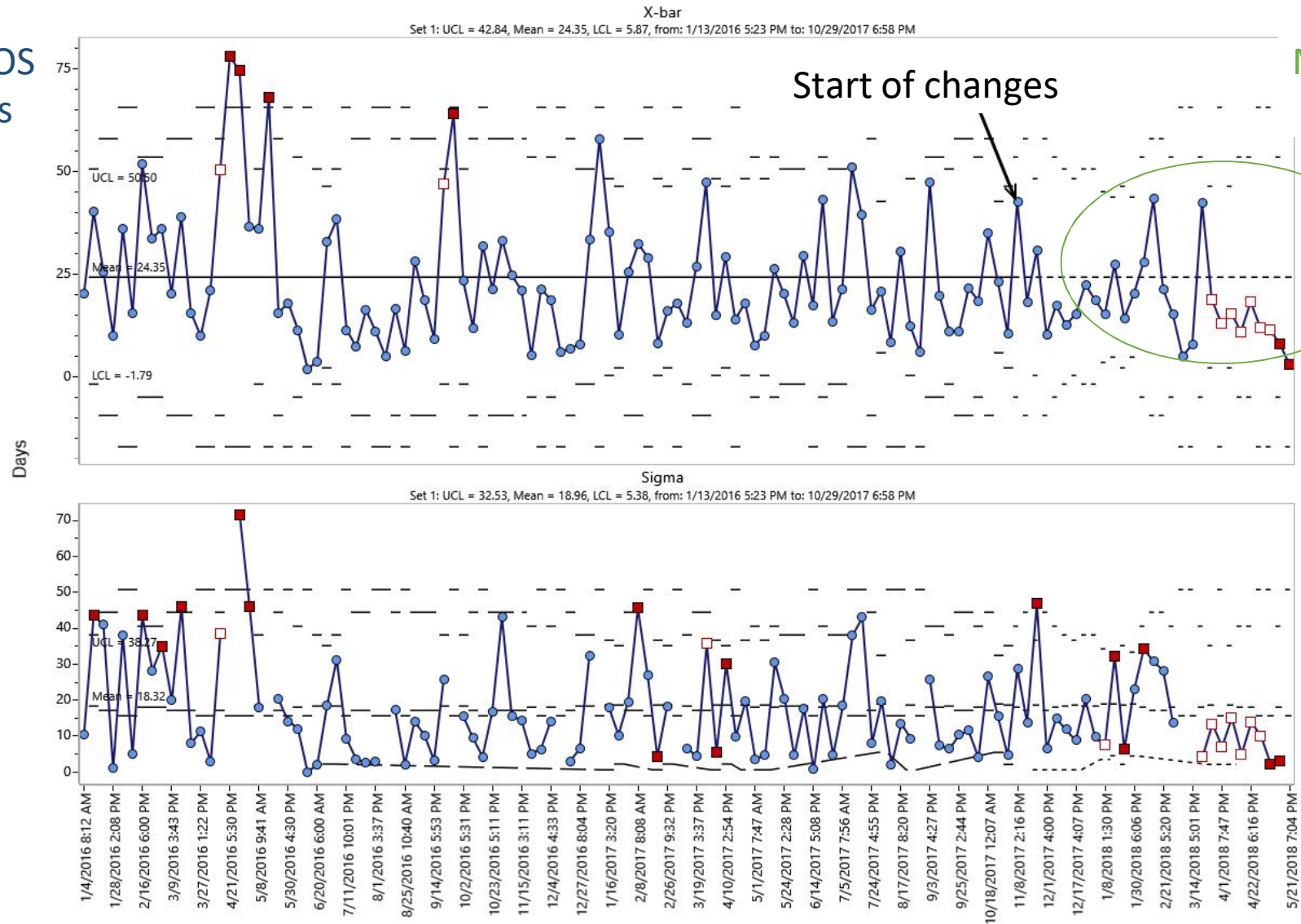
Change Ideas

- CNE Roving Carts
- Bathroom Posters
- Sticker Campaign
- Nursing Education Days
- Nursing Surveys (Hickin 2017)
- Increase use of Evidence-Based, Standard of Care tool = PPO
- Family and Caregiver Survey (Toye 2013)
- Allied Health Lunch and Learn
- Regular Hospitalist Updates
- Hospitalist Surveys
- Provide Brochure

Days to Return Home (Not LTC) ERH Delirium Coded Patients

Mean LOS
24 days

Mean LOS
12 days



Delirium: Decreasing the Distress Caregiver Survey Results

Themes:

- Experience with staff Positive
- Obtaining information about delirium Negative

More than half of family members
did not recognize
they had received the Delirium brochure

Delirium: Decreasing the Distress

Key Outcomes

Delirium care at ERH has been improved by:

- Increasing usage of the PPO
- Reducing LOS
- Integrating patient voices
 - patient partners on our team
 - family survey as a key metric

[illegible]

Delirium: Decreasing the Distress Parting Values

"Together, we can reduce the delirium impact to our community"

- Wendy Alston

References:

Fraser Health Authority. (2014). www.fraserhealth.ca

Gesin, G., Russell, B., Lin, A., Norton, H., Evans, S. and Devlin, J. (2011). Impact of a Delirium Screening Tool and Multifaceted Education on Nurses' Knowledge of Delirium and Ability to Evaluate It Correctly. *American Journal of Critical Care*. 21(1). e1-e11.

Hickin, S., White, S. and Knopp-Sihota, J. (2017). Nurses' knowledge and perception of delirium screening and assessment in the intensive care unit: Long-term effectiveness of an education-based knowledge translation intervention. *Intensive and Critical Care Nursing*. 41. 43-49.

Law, T.J., Leistikow, N.A., Hoofring, L, Krumm, S.K., Neufeld, K.J., Needham, D.M. (2012). A survey of nurses' perceptions of the intensive care delirium screening checklist. *Dynamics*, 23(4), 18-24.

Maracanto, E.R. (2017). Delirium in hospitalized older adults. *N Engl J Med*. 377. 1456-66.

Toye, C., Matthews A., Hill A. & Maher S. (2013). Experiences, understandings, and support needs of family carers of older patients with delirium: a descriptive mixed methods study in a hospital delirium unit. *International Journal of Older People Nursing*. 9. 200-208.

Warneboldt, JA., Chorny, I., O'Connor, MP., Lee, S., Cumberworth, H. (2013). Geriatric delirium quality improvement project. *Can. Hosp. Conf.* poster.

Thank-you to the Team

Key members of our innovation:

- Executive Sponsor: Lisa Zetes-Zanatta (Executive Director Eagle Ridge Hospital) and Anita Wempe (Acting ED ERH)
- Medical Sponsor: Dr. Julia Morley (Medical Director Eagle Ridge Hospital)
- Physician and Project Lead: Dr. Jean Warneboldt
- Clinical Nurse Educators and Co-Leads: Gilma Johnston, Jennifer Brett, Tricia Mcaloney
- Patient Voices Network: 2 Patient Partners
- Research Support: Mariam Manna (Physician Student Volunteer Simon Fraser University)
- Allied Health Practice Leaders: Shannon Maclean & Nadine Butzelaar

Key supporting organizations include:

- ERH Administration
- FH Regional Delirium Steering Committee
- FH Physician Quality Improvement Special Services Committee Initiative
- Patient Voices Network
- Simon Fraser University VSP

Woman-centered care in Early Pregnancy Loss

Patient Voices inform a new approach to care

November 19, 2018


Maki Ikemura MD

Cowichan Maternity Clinic, Duncan BC





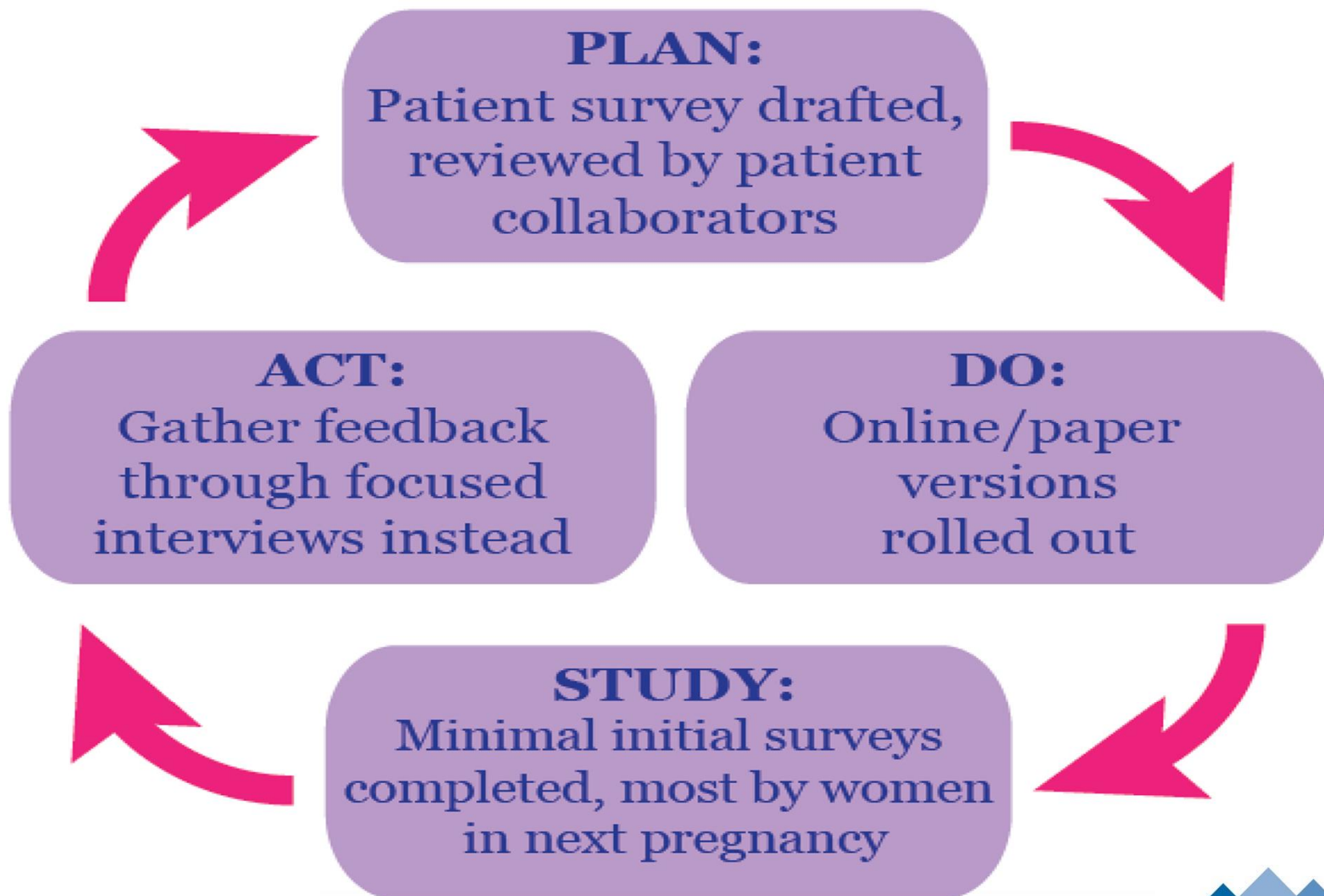
DISCLOSURES - NONE



25% of women
experience
miscarriage











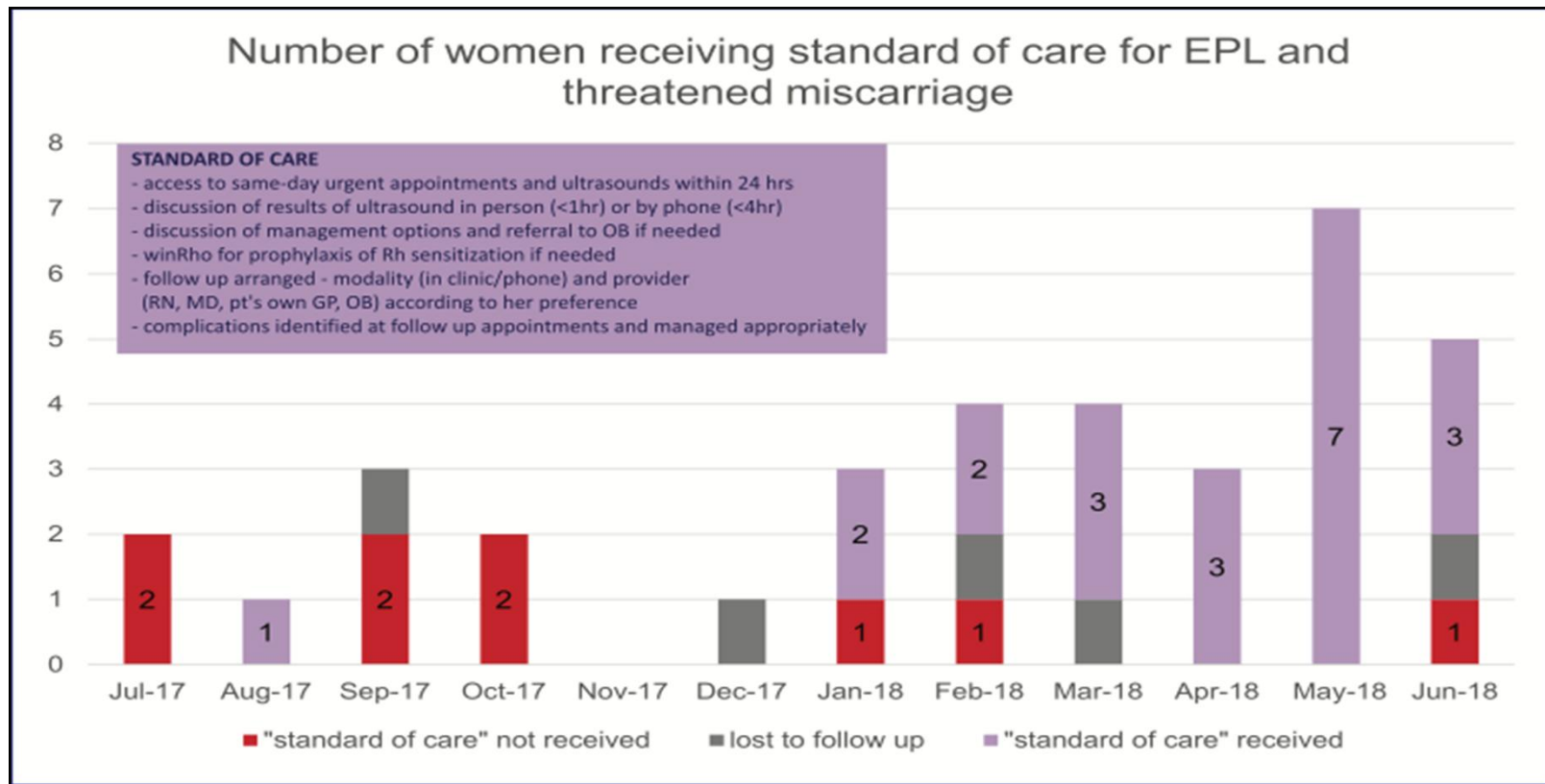
Welcome Visit





FINDING #1:

More women are receiving standard of care



FINDING #2:

More women are being seen for pregnancy loss concerns

