Improving Continuity of Care for End of Life Patients

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Purpose

The purpose of this study was to seek feasible improvements in continuity of care for end of life patients in a region of British Columbia.

Continuity of Care is defined as the consistency and cohesiveness of care provided to an individual patient over time. It is a component of quality care, spanning organizations. Continuity is a challenge for patients with chronic conditions, such as many end of life patients.

Methods

- **34 participant interviews** (physicians, nurses, pharmacists and IT professionals) were conducted in two different communities.
- Interviews were structured around two **simulated patient cases** that allowed providers to describe care to these patients over the last year of life.
- **Rich Pictures** (4) were developed based on analysis of the interviews (one for each patient in each community).
- **Conceptual Models** (16) described the size and nature of each patient's **Circle of Care**, for each community.
- **Group discussions** reviewed gaps in continuity and suggested improvements.
- **Suggested improvements** were agreed to by participants and shared throughout the health region.

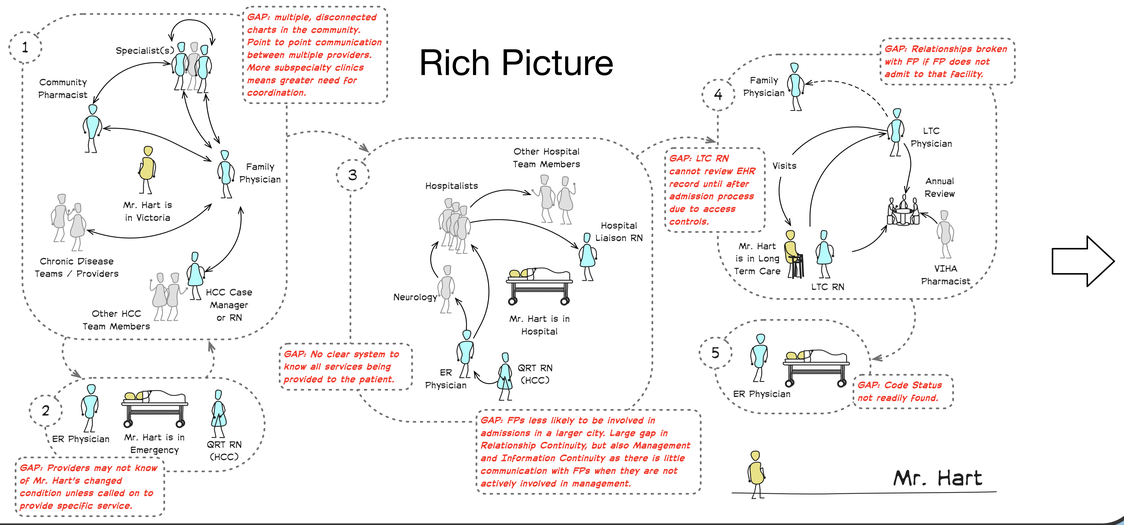
Types of Continuity

- **Information Continuity** - appropriate, seamless access to patient health information at the point of decision making, wherever that may be.
- **Management Continuity** - care provided is consistent between providers within the Circle of Care.
- **Relationship Continuity** - the personal relationship(s) between a patient and his / her providers, extending over time, providing a sense of predictability and trust.
- **Inter-Provider Continuity** - the relationships and trust between providers. Supports the other three types of continuity.

Example Simulated Patient Case: Mr. Hart's Last Year of Life

Mr. Hart is a 71 year old man with multiple chronic conditions, including: congestive heart failure, diabetes, hypertension. He has had two heart attacks. At the beginning of his story (1), he lives alone, just coping. He then has a small stroke (2). That is followed, months later, by a larger stroke and he ends up in hospital (3) and then is transferred to a nursing home (4). Finally, in the middle of the night, Mr. Hart has a final MI (5) and was rushed to Emergency.

Rich Picture

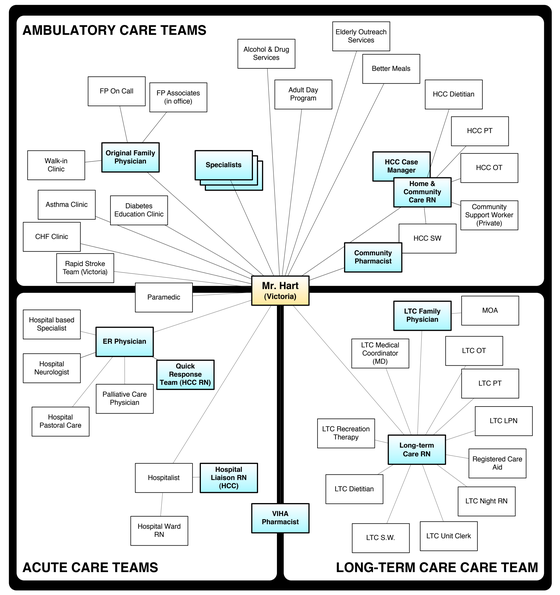


Findings and Suggested Improvements from the Study

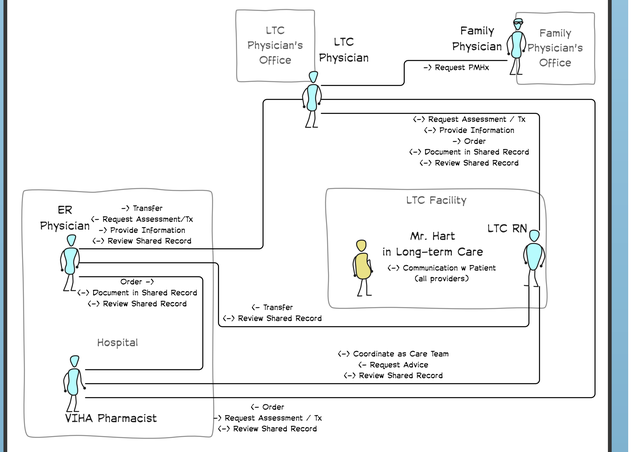
Gaps in Continuity	Suggested Improvements	Alignment with Infoway Blueprint
Insufficient access to existing clinical information systems, lack of information impacts care.	Improve provider access to select Clinical Information Systems (CIS).	Standardized access to some existing content through the EHR.
Advance directives not available or easily accessible when needed, such as in the ED.	Develop an electronic advance directives repository in main regional CIS.	*Advance directives not currently included in EHR messages.*
Unclear to providers, especially for unplanned care, who is involved in the patient's Circle of Care.	Electronically document patient-provider relationships in regional CIS.	*EHR blueprint does not include patient-provider relationship repository.*
Providers within Circle of Care not aware of patient transitions, such as admissions & discharges.	Develop automatic notifications to key providers for patient transitions.	*EHR is a repository of information. Providers would need to look up admissions / discharges proactively.*
Case conferencing in limited use, geography / travel a common barrier.	Improve use of virtual case conferences, to reduce travel issue (tele or video).	Telehealth program, supported by Infoway may improve virtual case conferencing.
Communication mostly 1:1 and ad hoc (phone, fax), other members of Circle of Care often aware of changes in care plans.	Design a regional clinical communication tool with historical repository.	*Infoway EHR does not include a clinical messaging tool or repository.*

Mr. Hart's Circle of Care Models

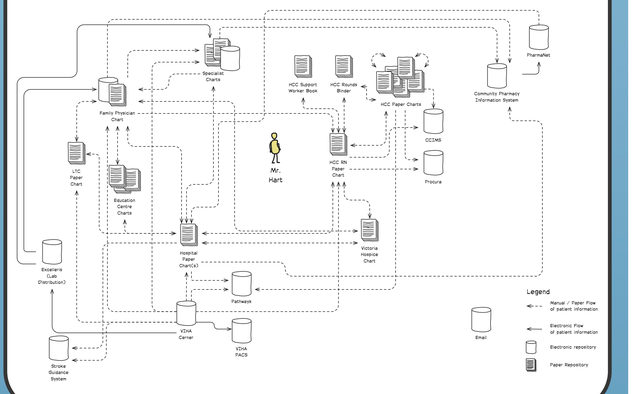
Provider View



Communication Patterns



Information Repositories



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