INTEGRATE Project

Integrating a palliative care approach earlier in the disease trajectory

Dr. Anita Singh, INTEGRATE Palliative Care Physician Lead
South West Regional Cancer Program

South West Hospice Palliative Care Summit
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Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

South West Hospice Palliative Care Network

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Dr. Anita Singh has not had a financial interest, arrangement or affiliation with one or more organizations that could be perceived as a direct or indirect conflict of interest in the content of this presentation.

Objectives

1. Provide a brief overview of the current landscape of palliative care

2. Palliative care earlier in disease – why it matters

3. Introduce the INTEGRATE project
   - History
   - Current progress
   - Next steps

Motivation for Change

Dying in Place of Choice

When asked, the majority of patients state they would like to die at home surrounded by loved ones.

According to 2015/2016 SW LHIN data:

- **45%** all deaths took place in an acute care hospital
- **54.5%** of patients coded “palliative” died in acute care hospital

Health Care Use at the End of Life in Western Canada
Canadian Hospice Palliative Care Association Fact Sheet: Hospice Palliative Care in Canada
OPCN’s capacity planning tool containing the 15/16 regional data

OPCN's capacity planning tool containing the 15/16 regional data

Use of Hospital Services

- **62%** of patients coded "palliative" visited the Emergency Department in their last month of life
- **69.2%** of patients coded "palliative" were admitted to an acute care hospital in their last month of life

Access to Palliative Care Resources

The leading causes of death in Canada are:

29.8% - Neoplasms
25.1 % - Diseases of the circulatory system
4.7 % - Respiratory system

Cancer patients represent 28% of Canadian deaths (Statistics Canada, 2005), they make up 80-90% of home-care clients receiving end-of-life care from Home & Community Care services.

Stats Can 2013; Seow H. et al. 2009 Dissertation; QHPCCO -Creating an Integrated Hospice Palliative Care System in Ontario setting the stage for change 2010

Advance Care Planning

Benefits:

- More likely to have end-of-life wishes known and followed
- Family members have less stress and anxiety
- Patients and families are more satisfied with care
- Patients have better quality of life and death
- Patients are less likely to be hospitalized and or admitted to an intensive care unit

96% **of Canadians believe it is important to have conversations with their loved ones about their wishes for care**

73% **Want more information from their doctors so they can plan and begin these important conversations**

13% **Have completed an Advance Care Plan**

Wright AA et al. JAMA 2008, Detering KM. et al. BMJ 2010, Zhang B et al. Arch Intern Med 2009, The Way Forward: An integrated palliative approach to care

Advance Care Planning

Patients with a life-threatening illness who recalled having an end-of-life discussion with their physician:

Patient	% that had end of life discussion
Cancer Patients (N=151)	26%
CHF (N=99)	14%
COPD (N=115)	9%
Cirrhosis (N=47)	21%

Heyland DK et al. Open Medicine 2009

Opportunity for Change

Palliative care earlier in the disease trajectory

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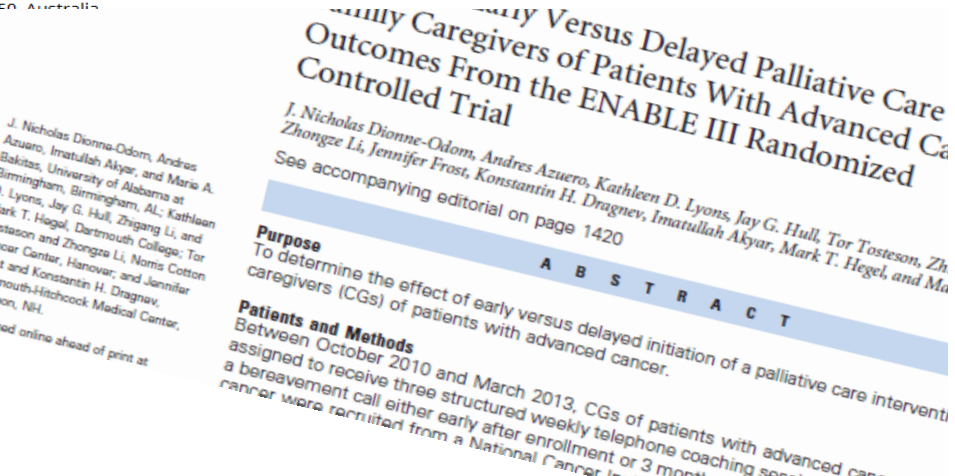
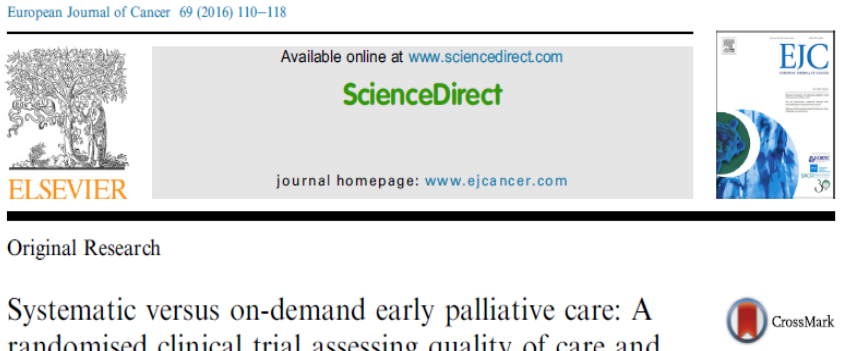
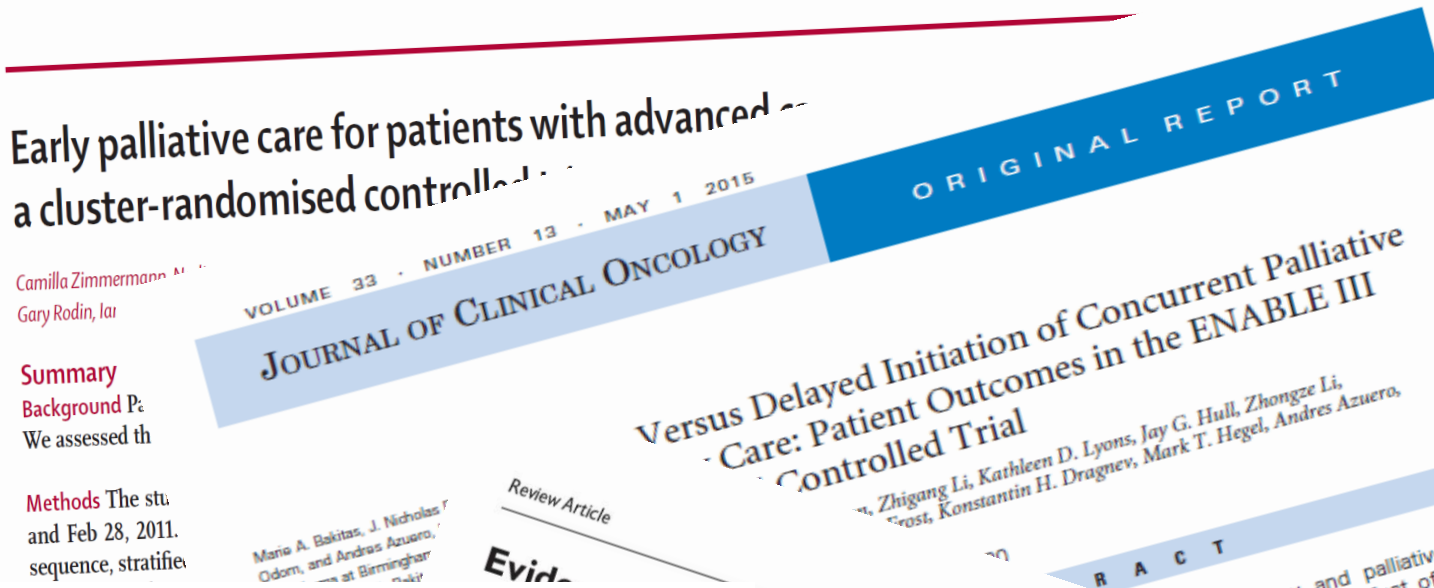
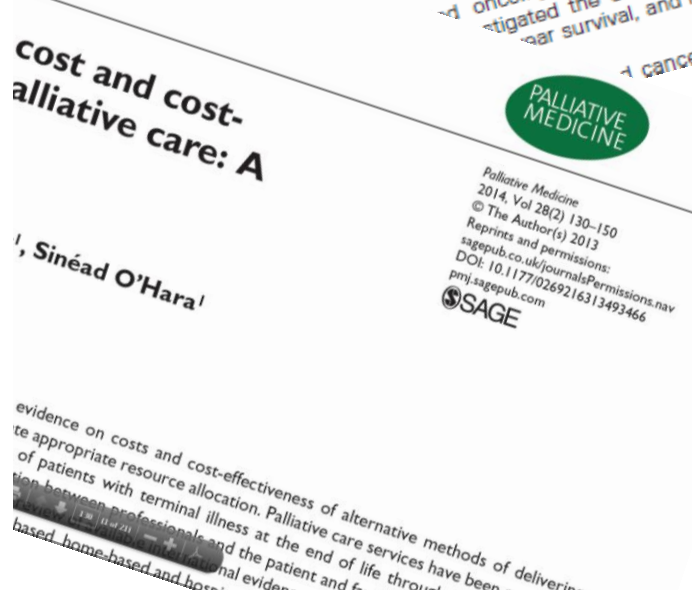
Palliative Care is no Longer just End-of-Life Care









Earlier Palliative Care Interventions - The Benefits

Patient

- Reduced symptom burden
- Less anxiety and depression
- Less caregiver burden
- Better quality of life
- Less aggressive treatments
- Longer life expectancy

System

- More appropriate referral and use of palliative resources
- Decreased Emergency Department visits
- Admission avoidance
- Measurable hospital savings through significant reductions in pharmacy, laboratory and intensive care costs

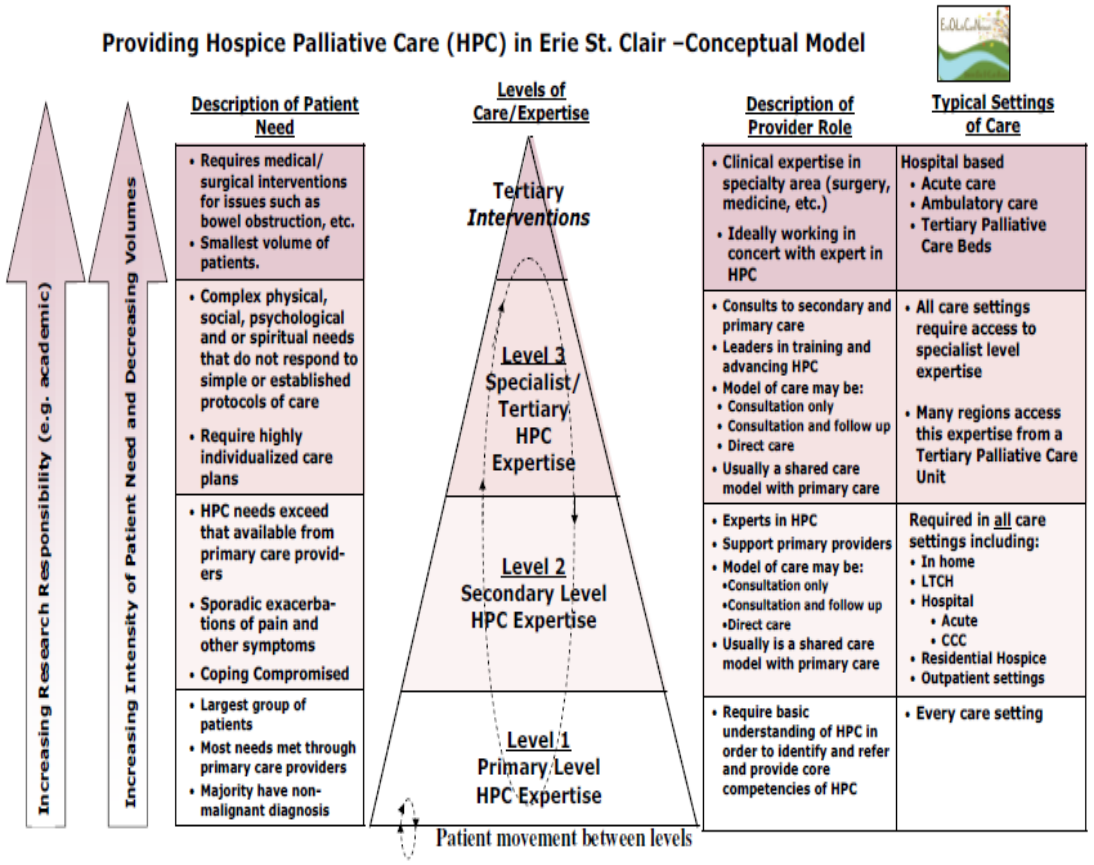
Early Home Care Supports

- Patients admitted six months before death had a 35% lower probability of hospitalization than those admitted three to four weeks before death
- Patients receiving more than seven nursing hours per week had a 50% lower odds ratio of being hospitalized
- Patients receiving personal support for more than seven hours per week had a 35% lower odds ratio of being hospitalized

Barbera L. et al. CMAJ 2010


Reactive
Proactive

Shared Care Model



Palliative care should be a two-pronged approach:

- Primary care delivery
  - Create necessary tools for support
- Specialist palliative care support

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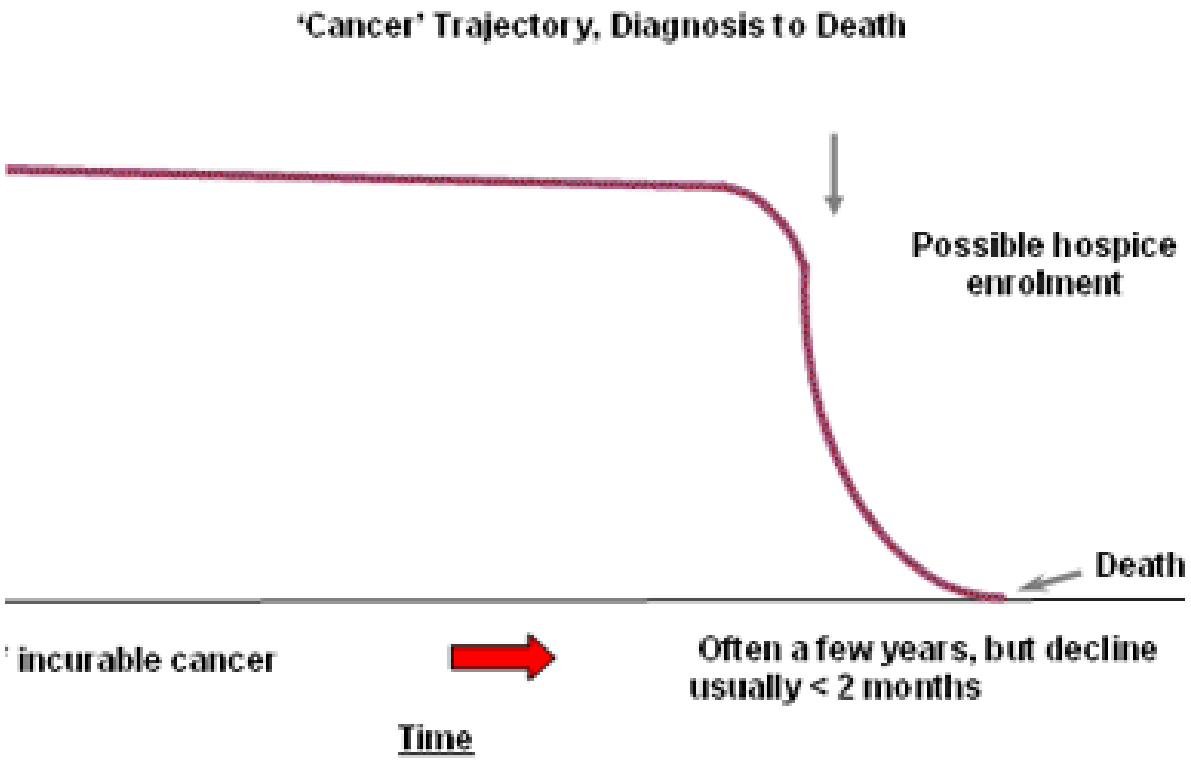
How Early?



If a patient is spending more than 50% of their time in bed/lying down, prognosis is estimated to be three months or less

Surprise Question

"Would you be surprised if your patient died in the next year?"

Initiate a palliative approach to care

Adapted from the Gold Standards Framework (GSF) Prognostic Indicator Guidance tool

Surprise Question

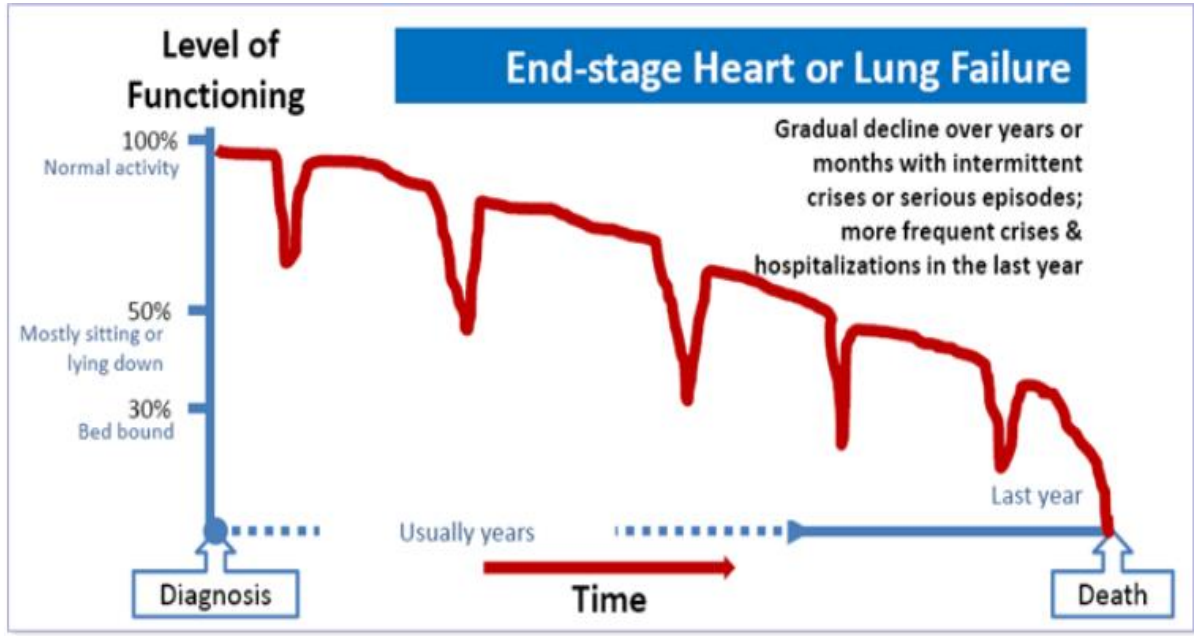
Advantages:

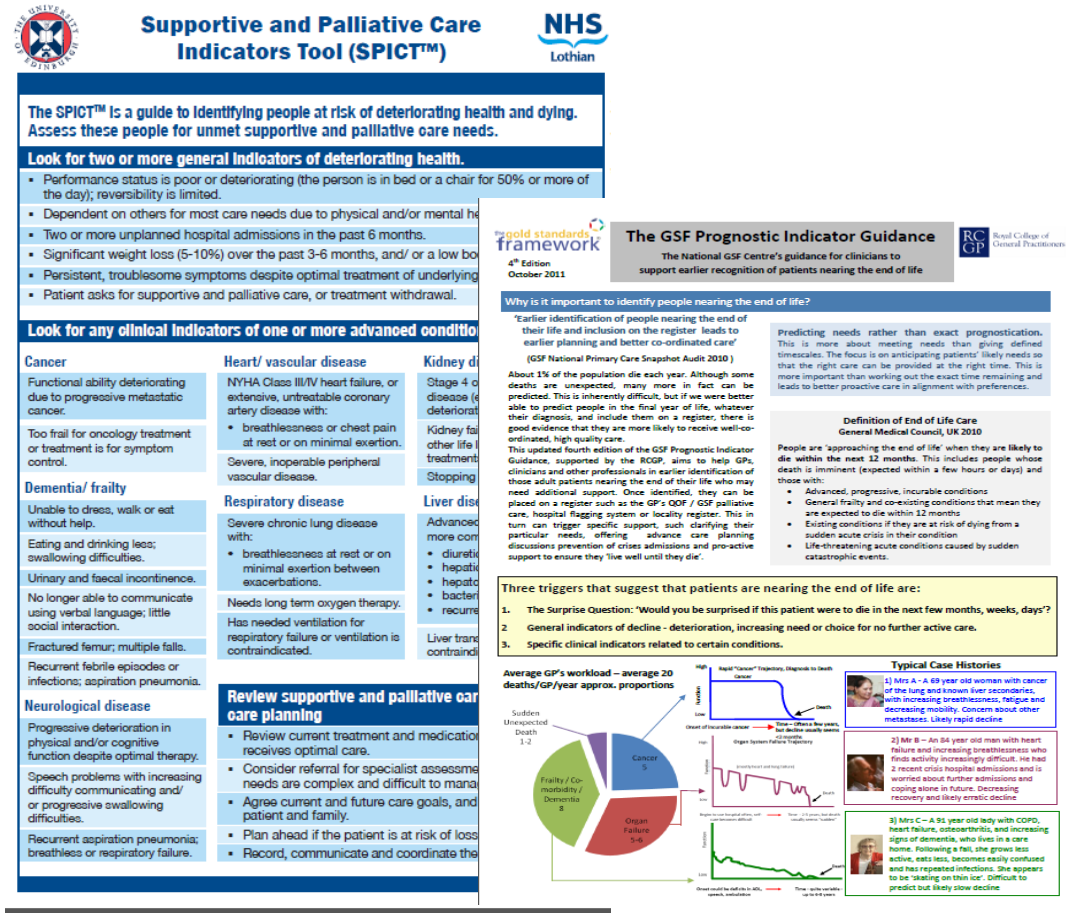
- Simple to implement – supports clinician buy-in
- Data to support its use in oncology and nephrology
- Has gained acceptance and traction

Disadvantages:

- Utility unknown in primary care and in patients with multiple comorbid illness
- Preliminary oncology and primary care data from Ariadne Labs shows that the surprise question misses approximately 40% of patients who die

Surprise Question





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The Palliative Intervention

Table 2. Key Elements of Palliative Care Visits

7 Key Elements
Relationship and rapport building
Addressing symptoms
Symptom assessment and review
Symptom management
Addressing coping
Ability to cope
Spirituality and faith
Emotional status
Referral to social work, psychiatry, or psychology
Establishing illness understanding
Information preference
Prognostic awareness
Current illness status
Discussing cancer treatments
Effect of cancer treatments
Decision making about cancer treatment
End-of-life planning
Resuscitation preferences
Hospice discussion or referral
Practical or personal plans
Health care proxy
Engaging family members

1. **Pain and symptom management including assessing and managing psychosocial needs**
   - ESAS
   - Functional status
2. **Serious Illness Conversations/Advanced Care Planning**
3. **Coordination of care**
4. **Ongoing monitoring**

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About INTEGRATE

- Early identification of patients who would benefit from a palliative approach is essential to ensuring that patients have access to the services they need, at the right time, at the right place, by the right care provider.
- Born out of a change idea from the London-Middlesex Collaborative expanding and building upon Cancer Care Ontario's framework to meet the needs of patients and care providers in London-Middlesex

- A collaborative effort between the South West Regional Cancer Program and the South West Hospice Palliative Care Network
- Initiated in the fall of 2016

About INTEGRATE

- Framework to help identify, assess, and plan for patients who would benefit from a palliative approach in primary and tertiary settings
- Focuses on on early identification interventions in:
  - Primary care
  - Tertiary care (oncology)
  - Aboriginal care each
- Tailored approach and evaluation metrics
- Based on system resources and capacity

INTEGRATE: London Regional Cancer Program

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Identification of Patients

- The GI Disease Site Team agreed to pilot early identification and a palliative approach to care at LRCP
- Surprise Question acts as the trigger (imbedded in GI Multidisciplinary Cancer Conference (MCC) electronic referral form)
- Patients who would benefit from a palliative approach are identified and information is dictated to an MCC note

London Health Sciences Centre
London Regional Cancer Program

This person has been identified as someone who could benefit from INTEGRATE

- ☐ Get verbal consent from patient/family to make referral to the SWLHIN (formerly CCAC).
- ☐ Complete Integrate Referral to SWLHIN Form.
- ☐ Begin Serious Illness conversations and document this in the chart.
- ☐ Review ESAS on every visit and manage symptoms.
- ☐ Complete Integrate update form with any change in status.
- ☐ Referrals to supportive care and or palliative care as required.

Palliative Alerts (based on Performance Status)

	ECOG	PPS %	Action to be taken based on functional status in context of progressive life-limiting illness (unless patient specifically requests otherwise; actions may be initiated earlier)
STABLE	0	100	☐ ESAS and PPS regularly ☐ Encourage patient to continue seeing family physician on a regular basis
	1	90	
		80	☐ ESAS and PPS at each visit
	2	70	☐ Explore patient's understanding of illness ☐ Discuss prognosis and goals of care. ☐ Discuss treatment options : benefits and burden
		60	☐ Increase frequency of clinical monitory ☐ Activate LHIN Home Care Services ☐ Initiate advance care planning discussions. ☐ Establish plans to deal with emergencies (avoid ED visits if possible) ☐ Explore community resources
TRANSITIONAL	3	50	☒ Move setting of care to home (or LTC, Residential Home) ☐ Ensure physician coverage in the home ☐ Discuss code status and establish DNR ☐ Discuss preferred and optimal place of death based on needs and circumstances
		40	
END-OF-LIFE	4	30	☐ Weekly Home visits ☐ Prepare family and caregivers (what to expect, signs of imminent death, what to do when person dies – do not call 911 but rather LHIN). ☐ Stop non-essential medications ☐ Review medications: discontinue non-essential meds, order parenteral (subcut) meds in case patient unable to swallow (e.g., opioid, haloperidol, glycopyrolate) ☐ Complete Expected Death in Home (EDITH) form ☐ Review again setting of death/care preference
		20	☐ Discontinue vital signs
		10	

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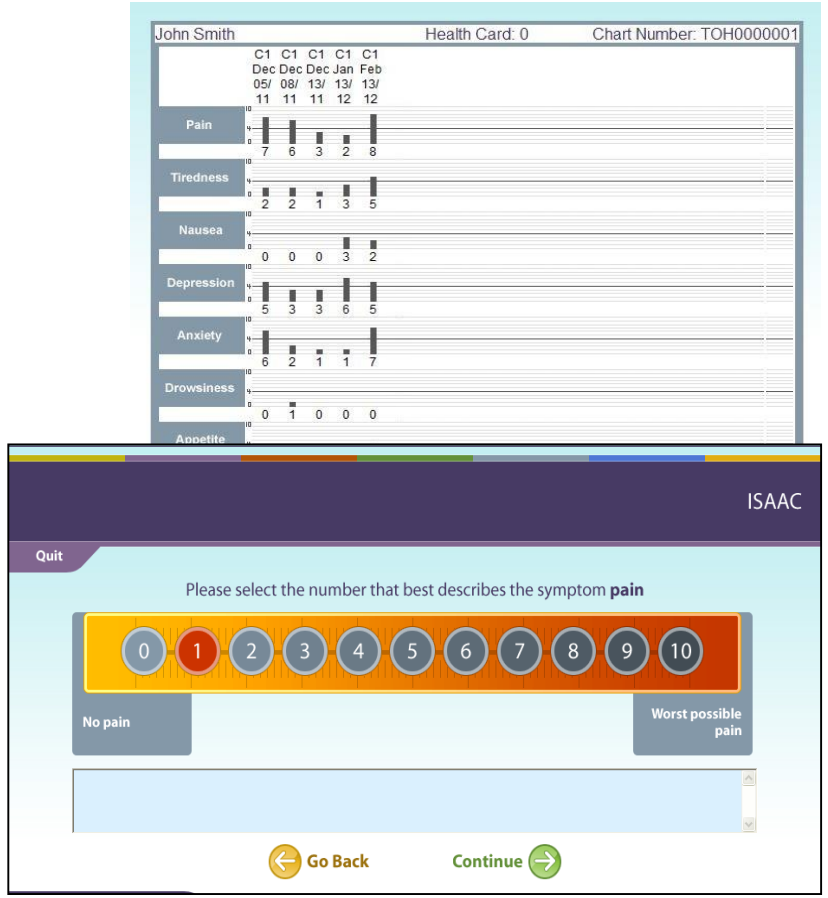
The Palliative Approach

1. Pain and symptom management:

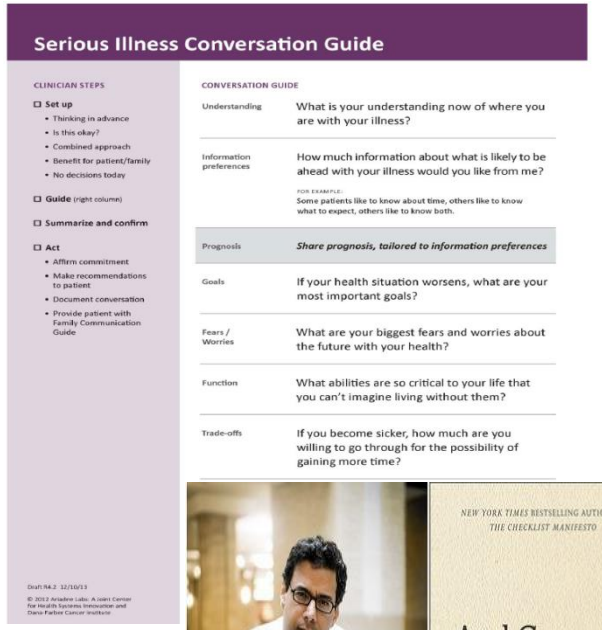
- Ontario Symptom Management Collaborative
- LRCP Steering Committee
- Screening tools (ESAS and PPS)
- Algorithms and symptom guides to practice

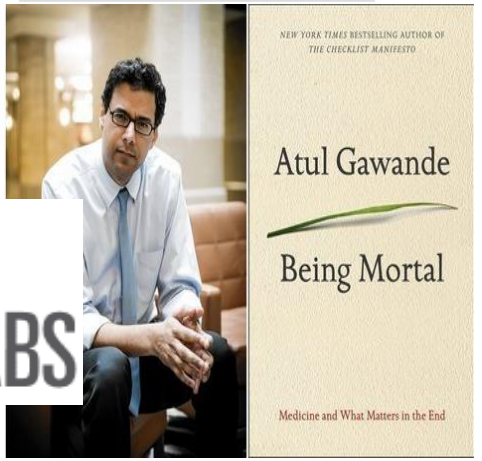


The Palliative Approach

2. Goals of Care/Serious Illness Conversation

- Serious Illness Conversation training provided ahead of the INTEGRATE project launch to support meaningful serious illness/goals of care conversations
- Full day workshop Sept 30, 2017
- Documentation of Serious Illness Conversation
  - Dictation Code
  - Serious illness conversation template in PowerChart
  - Common folder for all serious illness/goals of care conversations in PowerChart





ARIADNE LABS

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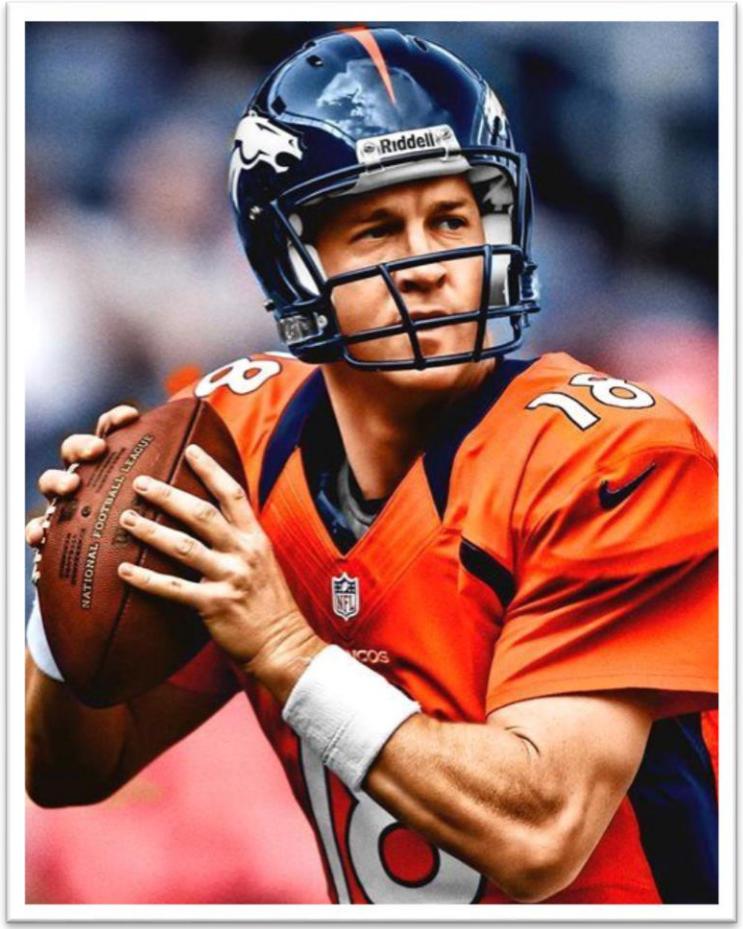
The Palliative Approach



3. Coordination of Care (quarterback)

- Early referral to Home and Community Care
- Complete the Coordinated Care Plan and share with broader team
- Request status updates from primary care/LRCP as required and communicate with the broader team
- Coordination of care plan
  - Follow up post-discharge from hospital/emergency department
  - Monitor regular performances (ESAS, PSS)
  - Connect patient/family to services

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800 Commissioners Road East, London, ON N6A 5W9

INTEGRATE LRCP to SW-LHIN

☐ **New Referral to INTEGRATE**
☐ **Status Update**

Telephone: (519) 000-0000 Fax: (519) 000-0000

ADDRESSOGRAPH

DATE OF REFERRAL:

REFERRAL SOURCE: ☐ LRCP ☐ SW-LHIN ☐ Primary Care ☐ Other:

PATIENT IDENTIFICATION

Patient Name:	Date of Birth:
LRCP Chart Number:	Health Insurance Number:

CLINICAL INFORMATION

Diagnosis:

SYMPTOMS OF NOTE: Please circle any symptoms that are NEW or REQUIRE MANAGEMENT

☐ Pain	☐ Tiredness	☐ Nausea	☐ Depression
☐ Anxiety	☐ Drowsiness	☐ Appetite	☐ Wellbeing
☐ Shortness of Breath	☐ Other (see comments)		

Comments: .....

.....

.....

FUNCTIONAL / PERFORMANCE STATUS:

PPS Level (ECOG):

☐ ≥ 80%	☐ 70%-60%	☐ 60%-50%	☐ 50%-40%	☐ 30%	☐ ≤ 20%
Normal activity, perhaps with some effort.	Full self-care to occasional assistance required.	Can no longer carry out normal work/hobby; normal or reduced intake.	Unable to do most activity; mainly in bed; extensive disease; normal or reduced intake; mainly assisted care.	Totally bed bound. Unable to do any activity; extensive disease; normal-reduced intake; total care.	Totally bed bound. unable to do any activity; extensive disease; minimal intake; total care.
0	ECOG 1	ECOG 2	ECOG 3	ECOG 4	

Supports Requested:

☐ Palliative Nursing Support	☐ Occupational Therapy	☐ Hospice Referral
☐ Palliative Physician Home Visit	☐ Social Work	☐ Requires Symptom Relief Kit
☐ DNR Status Discussion	☐ Complete EDITH	☐ No Home Support Required – Case Mgmt Only
☐ Increase Nursing Hours	☐ PSW Support	☐ Other .....

Additional Notes: .....

.....

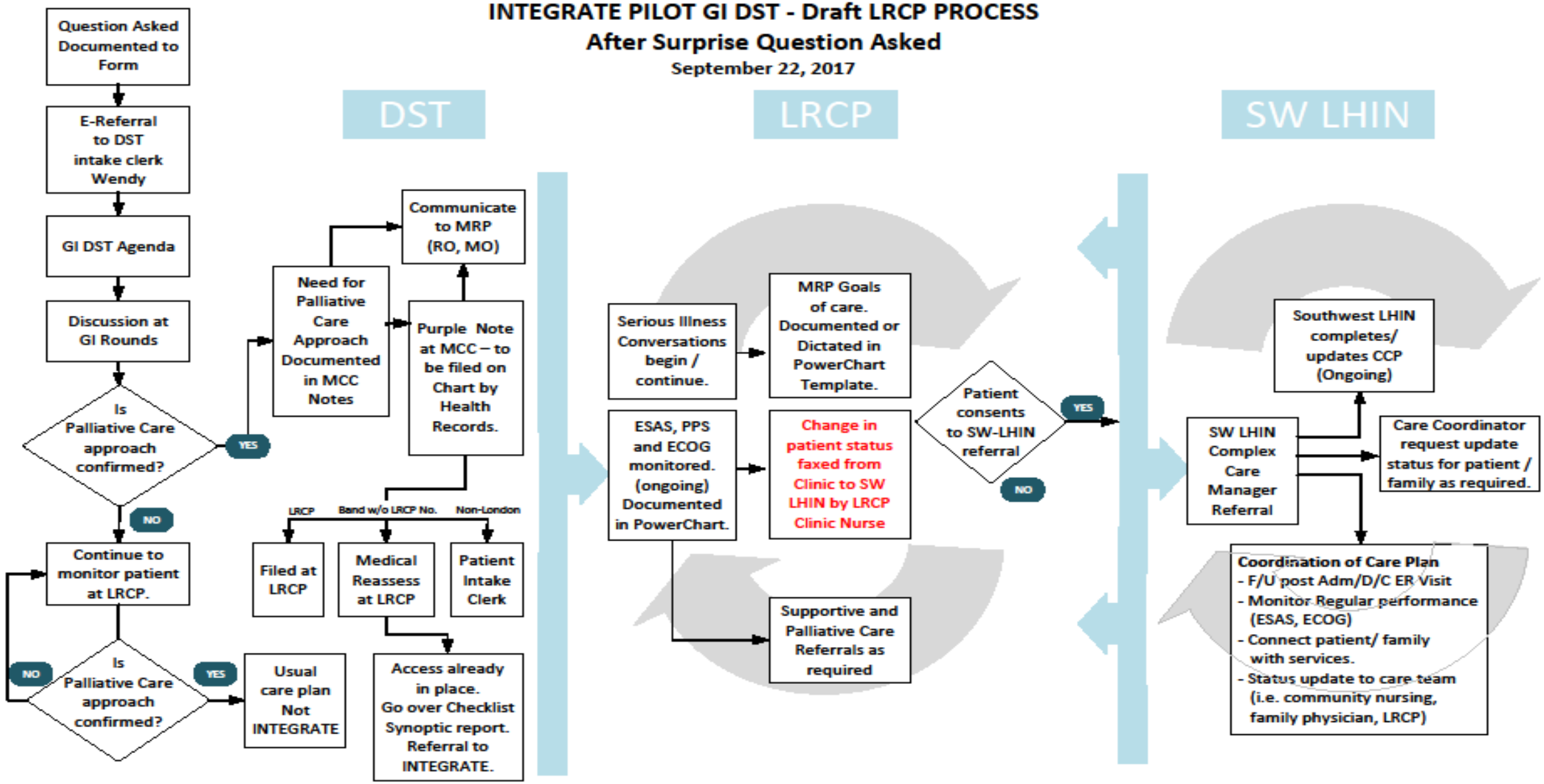
.....

☐ Changes in Goals of Care / Advance Care Planning Documentation	☐ Attached ☐ CPP and/or PowerChart
Date Discussion Initiated:	☐ Patient aware of INTEGRATE referral to Home and Community Care
Status Update Documented by: (Print Name)	Signature:

**** FAX COMPLETED FORM TO NURSING AGENCY AND PRIMARY CARE DOCTOR ****

July 14, 2017

INTEGRATE PILOT GI DST - Draft LRCP PROCESS
After Surprise Question Asked
September 22, 2017



Implementation

Based on system resources and capacity, **250 patients** will be identified to participate in this approach over the course of one year.

- Launched October 1, 2017
- Serious Illness Conversation Workshop completed
- Dictation codes and template – live!

Outcome Measures

Primary outcome measures

- Visits to hospital
- Visits to Emergency Department
- Deaths in place of choice
- Goals of Care discussions

Serious Illness Conversation Workshop

- Qualitative study

INTEGRATE: Primary Care and Aboriginal Care

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Primary Care

- Byron Family Medical Centre
- Development of a quality improvement project that will improve communication about goals of care and encourage/initiate advanced care planning
- All patients 75 and over screened with “surprise question”
- Those who respond “no” to surprise question will follow a similar pathway as LRCP (early referral to Home and Community Care)
- Development of patient information sheets on advanced care planning and home care
- Launched on October 16, 2017

Primary Care

- Two LEAP Mini Courses offered to the Department of Family and Community Medicine in 2016
  - interdisciplinary
  - academic and adjunct faculty

- Byron Family Medical Centre staff invited to attend Serious Illness Conversation Workshop

Aboriginal Care

- Initial focus was on Indigenous cultural safety training
- Two different education opportunities available to primary care physicians in the South West:
  - Nine E-learning Mainpro+ accredited modules to strengthen knowledge of First Nations, Inuit and Metis history and culture to improve health outcomes and person-centred care
  - South West LHIN Indigenous Cultural Safety Training – Mainpro+ accredited facilitated online training program
- Learning Essential Approaches to Palliative Care (LEAP) course planned for February 2018

Next Steps

- Monthly evaluation of identified patients, referrals, and serious illness conversations
- Monitor existing LHIN metrics (ED admission, place of choice, etc.)
- Review of project resource impact – SW LHIN Home and Community Care
- Closeout report

Looking to the future…

- Continued support for Serious Illness Conversation program – LRCP and beyond
- Continued support for Home and Community Care involvement – development of a business case to expand service regionally
- Roll out of palliative approach to other disease sites at LRCP
- Expand to include other Family Health Teams and primary care settings
- Development of a formal education/engagement plan

From entrepreneurs to social movements, politicians to philanthropists, events to inventions. People and their beliefs are upsetting the orthodoxy for better or worse... changing how we live, our sense of ourselves, and society.

Questions?

anita.singh@lhsc.on.ca