

# INTEGRATE Project

## Integrating a palliative care approach earlier in the disease trajectory

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South West Regional Cancer Program**

South West Hospice Palliative Care Summit  
October 26, 2017



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





## 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

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



# 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



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

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 **Journal of Palliative Care & Medicine**

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Research Article

## Early Contact with Palliative Care Services: A Randomized Trial in Patients with Newly Detected Incurable Metastatic Cancer

Martin HN Tattersall<sup>1\*</sup>, Andrew Martin<sup>2</sup>, Rhonda Devine<sup>3</sup>, Joan Ryan RN<sup>4</sup>, Jesse Jansen<sup>5</sup>, Lucy Hastings<sup>6</sup>, Michael Boyer<sup>7</sup>, Paul Glare<sup>8</sup>, Martin Stockler<sup>9</sup> and Phyllis Butow<sup>10</sup>

<sup>1</sup>Professor of Cancer Medicine, Sydney Medical School, Blackburn Building, DO6, University of Sydney, Australia

<sup>2</sup>Statistician, NHMRC Clinical Trials Centre, University of Sydney, Australia

<sup>3</sup>Research Nurse, Department of Medical Oncology, Royal Prince Alfred Hospital (RPAH), Missenden Road, Camperdown, Australia

## Early Versus Delayed Palliative Care Outcomes From the ENABLE III Randomized Controlled Trial

J. Nicholas Dionne-Odom, Andres Azuero, Kathleen D. Lyons, Jay G. Hull, Tor Tosteson, Zhongze Li, Jennifer Frost, Konstantin H. Dragnev, Imatullah Akyar, Mark T. Hegel, and Maria A. Bakitas

See accompanying editorial on page 1420

**ABSTRACT**

**Purpose** To determine the effect of early versus delayed initiation of a palliative care intervention on quality of life and outcomes of patients with advanced cancer.

**Patients and Methods** Between October 2010 and March 2013, CGs of patients with advanced cancer assigned to receive three structured weekly telephone coaching sessions or a bereavement call either early after enrollment or 3 months after enrollment were recruited from a National Cancer Institute Cancer Therapy Evaluation Program (NCT01100060) study.

online ahead of print at

## Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial

Camilla Zimmermann<sup>1</sup>, Gary Rodin, Ian

**Summary**  
**Background** We assessed th

**Methods** The stu and Feb 28, 2011. sequence, stratified

European Journal of Cancer 69 (2016) 110–118



Available online at [www.sciencedirect.com](http://www.sciencedirect.com)

ScienceDirect

journal homepage: [www.ejancer.com](http://www.ejancer.com)



Original Research

Systematic versus on-demand early palliative care: A randomised clinical trial assessing quality of care and treatment aggressiveness near the end of life

Marco Maltoni<sup>a</sup>, Emanuela Scarpi<sup>b,\*</sup>, Monia Dall'Agata<sup>b</sup>, Stefania Schiavon<sup>c</sup>, Claudia Biasini<sup>d</sup>, Carla Codecà<sup>e</sup>, Chiara Maria Brogna<sup>f</sup>, Elisabetta Sansoni<sup>a</sup>, Roberto Bortolussi<sup>g</sup>, Ferdinando Garetto<sup>h</sup>, Luisa Fioretto<sup>i</sup>, Maria Teresa Cattaneo<sup>j</sup>, Alice Giacobino<sup>k</sup>, Massimo Luzzani<sup>l</sup>, Giovanna Luchena<sup>m</sup>, Alice



VOLUME 33 • NUMBER 13 • MAY 1 2015

**JOURNAL OF CLINICAL ONCOLOGY**

**ORIGINAL REPORT**

**Versus Delayed Initiation of Concurrent Palliative Care: Patient Outcomes in the ENABLE III Controlled Trial**

Zhongze Li, Kathleen D. Lyons, Jay G. Hull, Tor Tosteson, Zhongze Li, Jennifer Frost, Konstantin H. Dragnev, Mark T. Hegel, Andres Azuero, J. Nicholas Dionne-Odom

**Review Article**

**Evidence**

**cost and cost-effectiveness of palliative care: A systematic review**

Sin  ad O'Hara<sup>1</sup>

**PALLIATIVE MEDICINE**

Palliative Medicine 2014, Vol 28(2) 130–150  
  The Author(s) 2013  
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DOI: 10.1177/0269216313493466  
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**SAGE**

evidence on costs and cost-effectiveness of alternative methods of delivering appropriate resource allocation. Palliative care services have been shown to be associated with improved quality of life and survival in patients with terminal illness at the end of life through the involvement of professionals and the patient and family in decision-making. Home-based and hospital-based palliative care services have been shown to be associated with improved quality of life and survival in patients with terminal illness at the end of life through the involvement of professionals and the patient and family in decision-making.



# 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



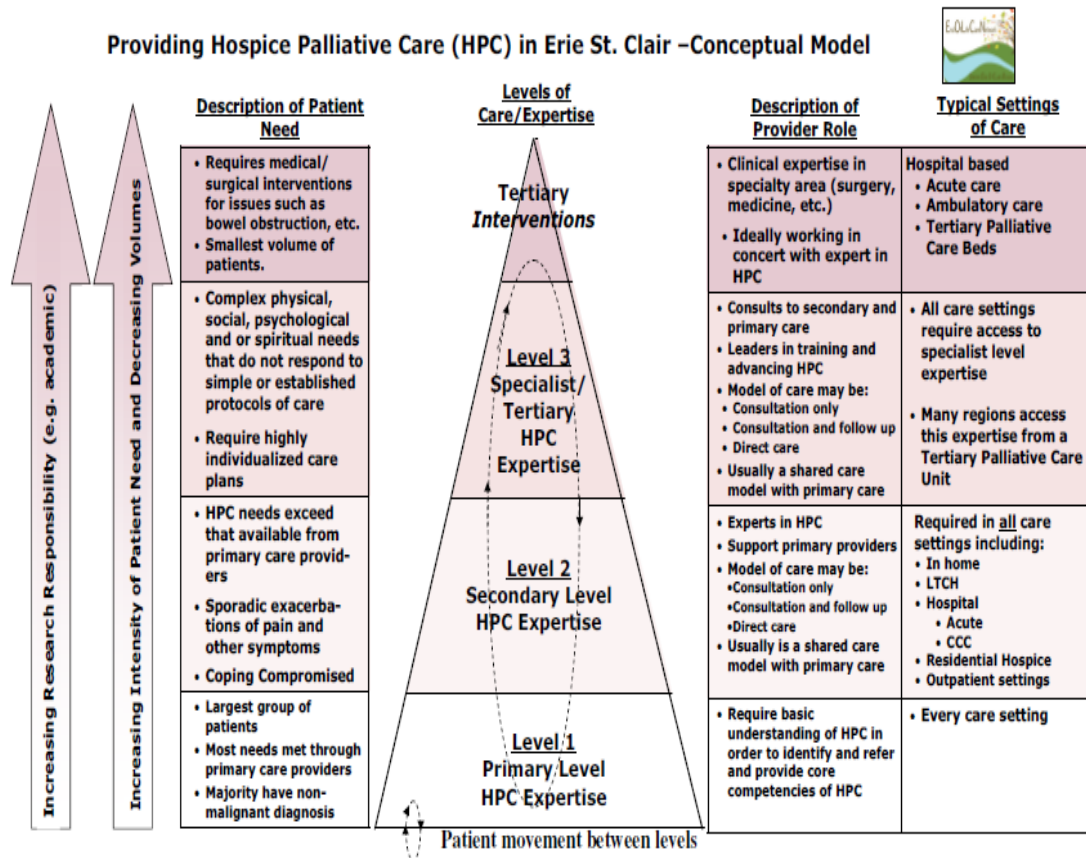
Barbera L. et al. CMAJ 2010



~~Reactive~~  
Proactive



# Shared Care Model



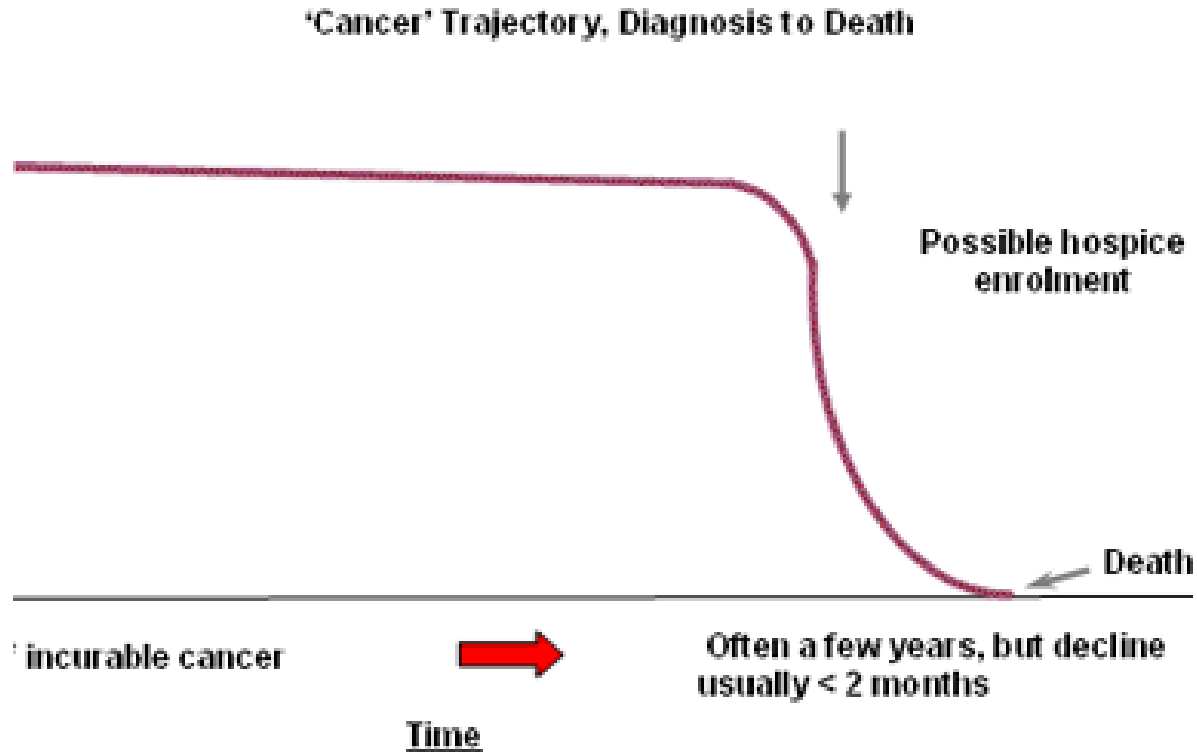
Palliative care should be a two-pronged approach:

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

Model developed for Erie St. Clair End of Life Care Network (ESC EOLCN), by Beth Lambie—Director ESC EOLCN (Sept. 2008, revised Dec. 2008, Jan. 2009)  
 This model incorporates concepts, design and content from: 1) Palliative care Australia—A Guide to Palliative Care Service Development (2005) pg. 14 & 15; 2) Unpublished work by Dr. D. Dudgeon (1992), 3) Chronic Disease Management Framework—ESC LHIN—Ralph Ganter (2008), 4) CHPCA Model (2002) pg. 56. 5) Cancer Care Ontario—Regional Models of Care—March 2009 (relating to research responsibility).  
 Note—Regional variations may result in: level 3 being subdivided to create a 4th level (quaternary level) or level 2 and 3 being merged to create a single level of specialist care.



# 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?”**

**NO**

**Initiate a palliative approach to care**

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



# Surprise Question

## Advantages:

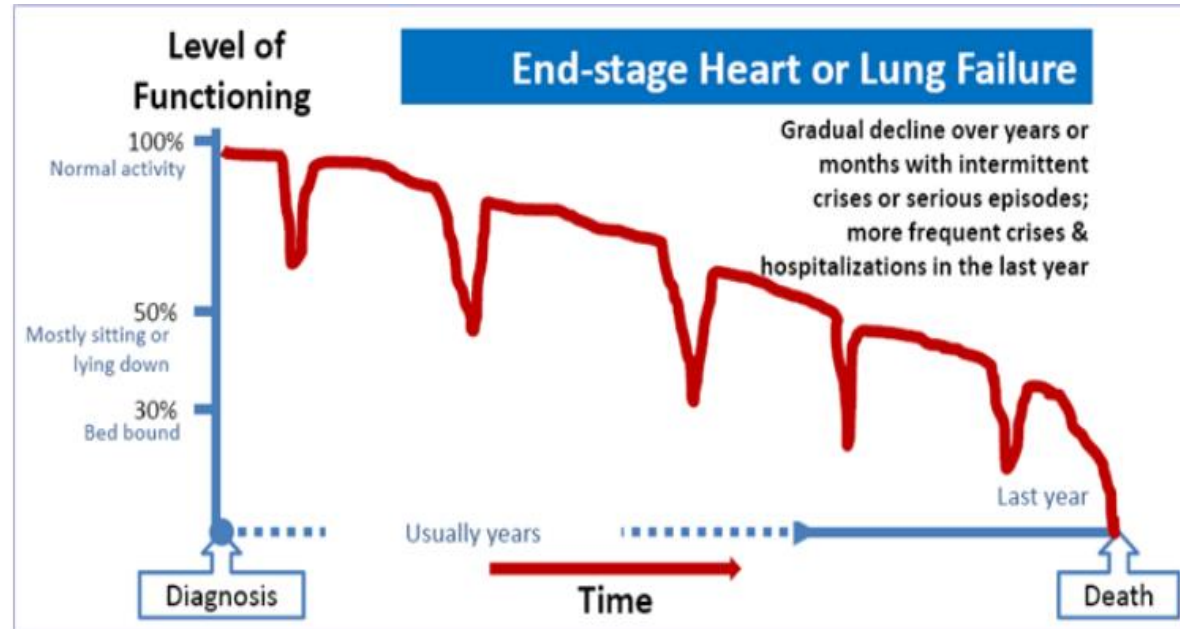
- Simple to implement – supports clinician buy-in
- Data to support its use in oncology and nephrology
- Has gained acceptance and traction

## 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



## Supportive and Palliative Care Indicators Tool (SPICT™)



The SPICT™ is a guide to identifying people at risk of deteriorating health and dying. Assess these people for unmet supportive and palliative care needs.

### Look for two or more general indicators of deteriorating health.

- Performance status is poor or deteriorating (the person is in bed or a chair for 50% or more of the day); reversibility is limited.
- Dependent on others for most care needs due to physical and/or mental health problems.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of underlying condition.
- Patient asks for supportive and palliative care, or treatment withdrawal.

### Look for any clinical indicators of one or more advanced conditions

|   |  |   |
|---|--|---|
| <b>Cancer</b><br>Functional ability deteriorating due to progressive metastatic cancer.<br>Too frail for oncology treatment or treatment is for symptom control.  | <b>Heart/vascular disease</b><br>NYHA Class III/IV heart failure, or extensive, unresolvable coronary artery disease with:<br>• breathlessness or chest pain at rest or on minimal exertion.<br>Severe, inoperable peripheral vascular disease.  | <b>Kidney disease</b><br>Stage 4 or 5 chronic kidney disease (eGFR < 30 ml/min/1.73 m²).<br>Kidney failure on dialysis.<br>Stopping dialysis.                               |
| <b>Dementia/frailty</b><br>Unable to dress, walk or eat without help.<br>Eating and drinking less; swallowing difficulties.<br>Urinary and faecal incontinence.<br>No longer able to communicate using verbal language; little social interaction.<br>Fractured femur; multiple falls.<br>Recurrent febrile episodes or infections; aspiration pneumonia. | <b>Respiratory disease</b><br>Severe chronic lung disease with:<br>• breathlessness at rest or on minimal exertion between exacerbations.<br>Needs long term oxygen therapy.<br>Has needed ventilation for respiratory failure or ventilation is contraindicated.  | <b>Liver disease</b><br>Advanced more common liver disease:<br>• jaundice<br>• hepatomegaly<br>• ascites<br>• recurrent encephalopathy<br>Liver transplant contraindicated. |
| <b>Neurological disease</b><br>Progressive deterioration in physical and/or cognitive function despite optimal therapy.<br>Speech problems with increasing difficulty communicating and/or progressive swallowing difficulties.<br>Recurrent aspiration pneumonia; breathless or respiratory failure.   | <b>Review supportive and palliative care planning</b> <ul style="list-style-type: none"> <li>Review current treatment and medication receives optimal care.</li> <li>Consider referral for specialist assessment needs are complex and difficult to manage.</li> <li>Agree current and future care goals, and patient and family.</li> <li>Plan ahead if the patient is at risk of loss of consciousness.</li> <li>Record, communicate and coordinate the plan.</li> </ul> |   |



## The GSF Prognostic Indicator Guidance

The National GSF Centre's guidance for clinicians to support earlier recognition of patients nearing the end of life



### Why is it important to identify people nearing the end of life?

Earlier identification of people nearing the end of their life and inclusion on the register leads to earlier planning and better co-ordinated care' (GSF National Primary Care Snapshot Audit 2010)

About 1% of the population die each year. Although some deaths are unexpected, many more in fact can be predicted. This is inherently difficult, but if we were better able to predict people in the final year of life, whatever their diagnosis, and include them on a register, there is good evidence that they are more likely to receive well-coordinated, high quality care.

This updated fourth edition of the GSF Prognostic Indicator Guidance, supported by the RCGP, aims to help GPs, clinicians and other professionals in earlier identification of those adult patients nearing the end of their life who may need additional support. Once identified, they can be placed on a register such as the GP's QoF / GSF palliative care, hospital flagging system or locality register. This in turn can trigger specific support, such as clarifying their particular needs, offering advance care planning discussions, prevention of crises admissions and pro-active support to ensure they 'live well until they die'.

Predicting needs rather than exact prognosis. This is more about meeting needs than giving defined timescales. The focus is on anticipating patients' likely needs so that the right care can be provided at the right time. This is more important than working out the exact time remaining and leads to better proactive care in alignment with preferences.

### Definition of End of Life Care

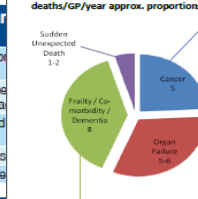
General Medical Council, UK 2010  
People are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events.

### Three triggers that suggest that patients are nearing the end of life are:

- The Surprise Question: 'Would you be surprised if this patient were to die in the next few months, weeks, days?'
- General indicators of decline - deterioration, increasing need or choice for no further active care.
- Specific clinical indicators related to certain conditions.

### Average GP's workload - average 20 deaths/GP/year approx. proportions



### Typical Case Histories

1) Mrs A - A 69 year old woman with cancer of the lung and known liver secondaries, with increasing breathlessness, fatigue and decreasing mobility. Concern about other metastases. Likely rapid decline

2) Mr B - An 84 year old man with heart failure and increasing breathlessness who finds activity increasingly difficult. He had 2 recent crisis hospital admissions and is worried about further admissions and coping alone in future. Decreasing recovery and likely erratic decline

3) Mrs C - A 91 year old lady with COPD, heart failure, osteoarthritis, and increasing signs of dementia, who lives in a care home. Following a fall, she grows less active, eats less, becomes easily confused and has repeated infections. She appears to be 'ticking on this ice'. Difficult to predict but likely slow decline



Ontario

Local Health Integration Network

Réseau local d'intégration des services de santé



South West Hospice Palliative Care Network



South West Regional Cancer Program  
in partnership with Cancer Care Ontario



# 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**



# South West INTEGRATE Project



# 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



# 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





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



# 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

John Smith Health Card: 0 Chart Number: TOH0000001

|            | C1<br>Dec 05/11 | C1<br>Dec 08/11 | C1<br>Dec 13/11 | C1<br>Jan 12/12 | C1<br>Feb 13/12 |
|------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Pain       | 7               | 6               | 3               | 2               | 8               |
| Tiredness  | 2               | 2               | 1               | 3               | 5               |
| Nausea     | 0               | 0               | 0               | 3               | 2               |
| Depression | 5               | 3               | 3               | 6               | 5               |
| Anxiety    | 6               | 2               | 1               | 1               | 7               |
| Drowsiness | 0               | 1               | 0               | 0               | 0               |
| Appetite   |                 |                 |                 |                 |                 |

ISAAC

Quit

Please select the number that best describes the symptom **pain**

0 1 2 3 4 5 6 7 8 9 10

No pain Worst possible pain

Go Back Continue



# The Palliative Approach

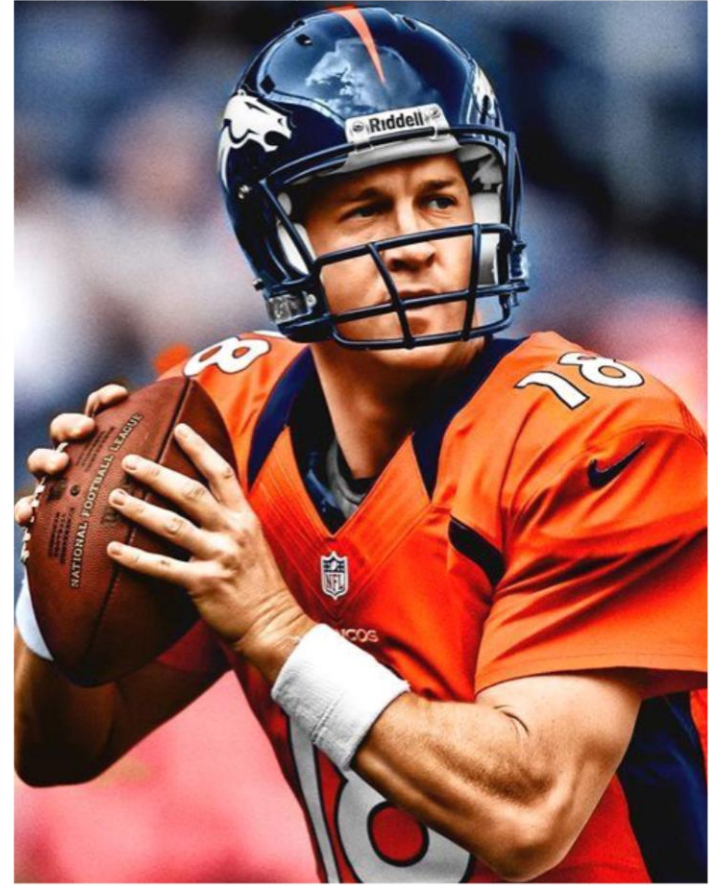
## 2. Goals of Care/Serious Illness Conversation

- 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





# 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





South West  
Regional Cancer Program  
In partnership with Cancer Care Ontario

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: <input type="checkbox"/> LRCP <input type="checkbox"/> SW-LHIN <input type="checkbox"/> Primary Care <input type="checkbox"/> Other: |   |  |   |   |  |
| <b>PATIENT IDENTIFICATION</b>   |   |  |   |   |  |
| Patient Name:   | Date of Birth:  |  |   |   |  |
| LRCP Chart Number:  | Health Insurance Number:  |  |   |   |  |
| <b>CLINICAL INFORMATION</b>   |   |  |   |   |  |
| Diagnosis:  |   |  |   |   |  |
| SYMPTOMS OF NOTE: Please circle any symptoms that are <u>NEW</u> or <u>REQUIRE MANAGEMENT</u>   |   |  |   |   |  |
| <input type="checkbox"/> Pain   | <input type="checkbox"/> Tiredness  | <input type="checkbox"/> Nausea  | <input type="checkbox"/> Depression   |   |  |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Drowsiness   | <input type="checkbox"/> Appetite  | <input type="checkbox"/> Wellbeing  |   |  |
| <input type="checkbox"/> Shortness of Breath  | <input type="checkbox"/> Other (see comments)   |  |   |   |  |
| Comments: .....   |   |  |   |   |  |
| .....   |   |  |   |   |  |
| <b>FUNCTIONAL / PERFORMANCE STATUS:</b>   |   |  |   |   |  |
| PPS Level (ECOG):   |   |  |   |   |  |
| <input type="checkbox"/> ≥ 80%<br>Normal activity, perhaps with some effort.  | <input type="checkbox"/> 70%-60%<br>Full self-care to occasional assistance required. | <input type="checkbox"/> 60%-50%<br>Can no longer carry out normal work/hobby; normal or reduced intake. | <input type="checkbox"/> 50%-40%<br>Unable to do most activity; mainly in bed; extensive disease; normal or reduced intake; mainly assisted care. | <input type="checkbox"/> 30%<br>Totally bed bound. Unable to do any activity; extensive disease; normal-reduced intake; total care. | <input type="checkbox"/> ≤ 20%<br>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:   |   |  |   |   |  |
| <input type="checkbox"/> Palliative Nursing Support   | <input type="checkbox"/> Occupational Therapy   | <input type="checkbox"/> Hospice Referral  |   |   |  |
| <input type="checkbox"/> Palliative Physician Home Visit  | <input type="checkbox"/> Social Work  | <input type="checkbox"/> Requires Symptom Relief Kit   |   |   |  |
| <input type="checkbox"/> DNR Status Discussion  | <input type="checkbox"/> Complete EDITH   | <input type="checkbox"/> No Home Support Required – Case Mgmt Only                                       |   |   |  |
| <input type="checkbox"/> Increase Nursing Hours   | <input type="checkbox"/> PSW Support  | <input type="checkbox"/> Other .....   |   |   |  |
| Additional Notes: .....   |   |  |   |   |  |
| .....   |   |  |   |   |  |
| <input type="checkbox"/> Changes in Goals of Care / Advance Care Planning Documentation   |   |  | <input type="checkbox"/> Attached <input type="checkbox"/> CPP and/or PowerChart  |   |  |
| Date Discussion Initiated:  |   |  | <input type="checkbox"/> Patient aware of INTEGRATE referral to Home and Community Care   |   |  |
| Status Update Documented by: (Print Name)   |   |  | Signature:  |   |  |
| <b>** FAX COMPLETED FORM TO NURSING AGENCY AND PRIMARY CARE DOCTOR **</b>   |   |  |   |   |  |

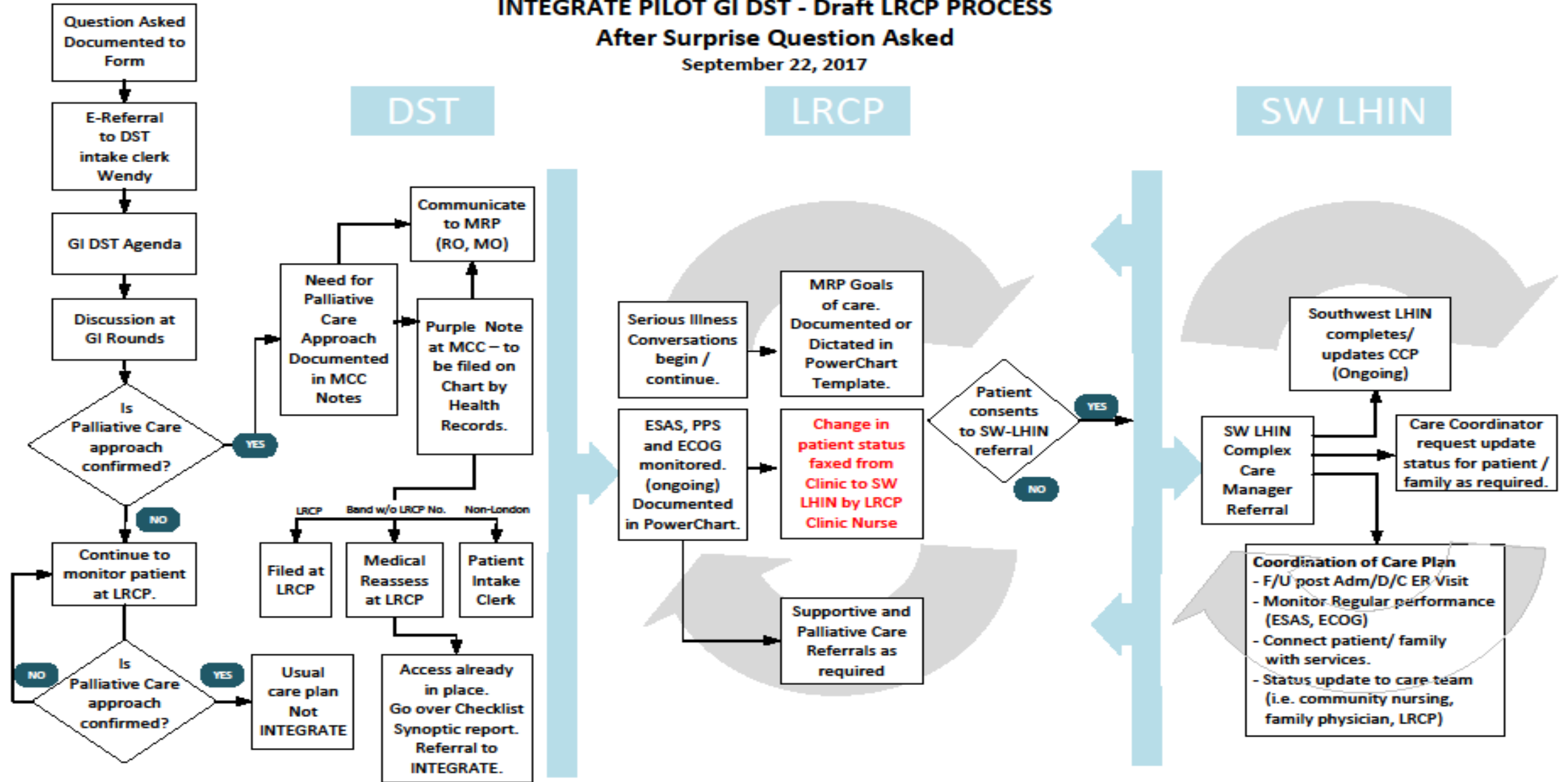


# INTEGRATE PILOT GI DST - Draft LRCP PROCESS After Surprise Question Asked September 22, 2017

DST

LRCP

SW LHIN





# 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



# 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





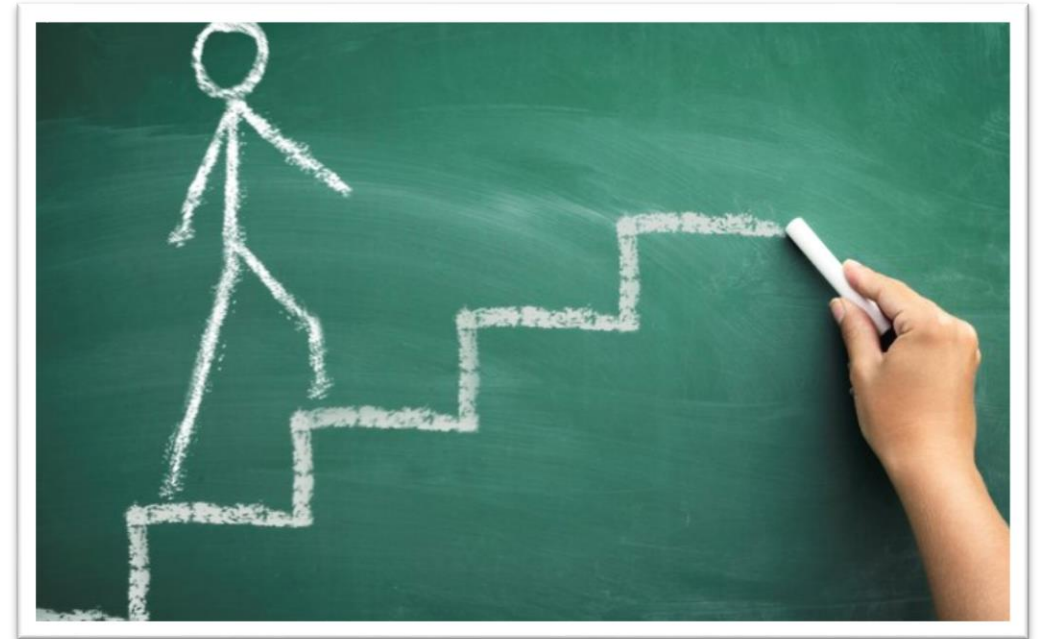
# Aboriginal Care

- 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



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# The Current

with Anna Maria Tremonti

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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?

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