Integrating an Early Palliative Approach into Advanced Colorectal Cancer Care

PaCES
PALLIATIVE CARE EARLY AND SYSTEMATIC

HPCO
Hospice Palliative Care Ontario

Annual Conference
April 28-30, 2019

Faculty/Presenter Disclosure

Presenters: **Ayn Sinnarajah and Camille Bond**

Relationships with financial sponsors:
Dr. Sinnarajah has grant funding from:
CIHR
Alberta Health
Canadian Frailty Network

Disclosure of Financial Support

Dr. Sinnarajah has grant funding from:

CIHR

Alberta Health

Canadian Frailty Network

C. Bond's position is paid through grants from CIHR and Alberta Health

HPCO
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Mitigating Potential Bias

Grants are for research and explicitly to conduct PaCES project.

Objectives

1. Learn about using a Knowledge Translation framework to implement best evidence on early palliative care.

2. Practice how to start this work and engage stakeholders.

3. Identify challenges and barriers.

Change Experiences

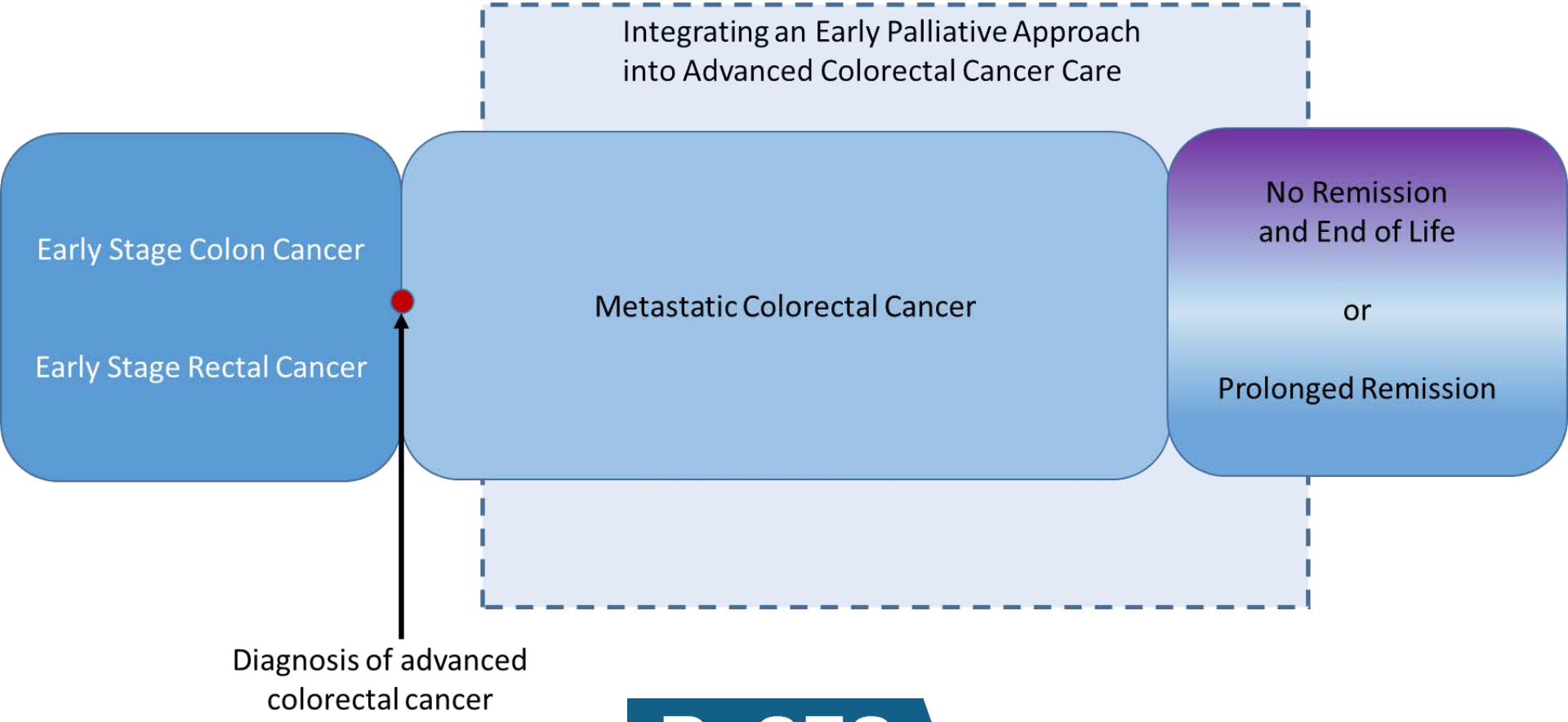
- What palliative care changes have you been involved in before?

- How did the change **feel**?

Introducing Palliative Care

What do we mean by 'early' palliative care?

A palliative approach to care that occurs concurrently with cancer treatment



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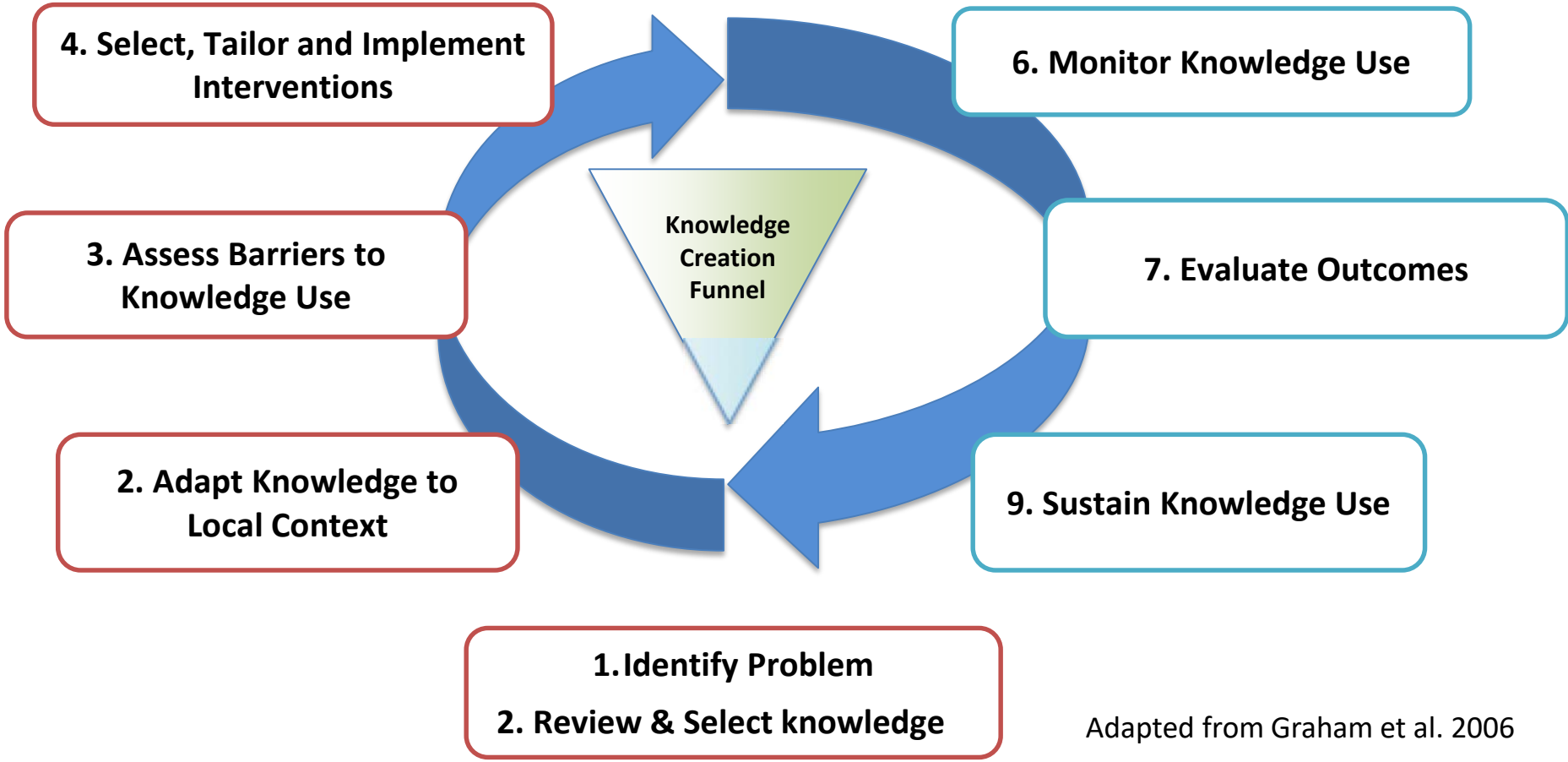
Knowledge Translation Framework



Adapted from Graham et al. 2006

Kotter's Leading Change

1. Establish a Sense of Urgency
    - "We must do something now"
2. Form a Powerful Guiding Coalition
    - Assemble group with shared commitment and enough power to lead change effort
    - Engage the "right people" with right combination of skills
3. Create a Vision
    - Help direct change effort and strategies for achieving that vision

Kotter, P. Leading Change. 1996

Kotter's Leading Change

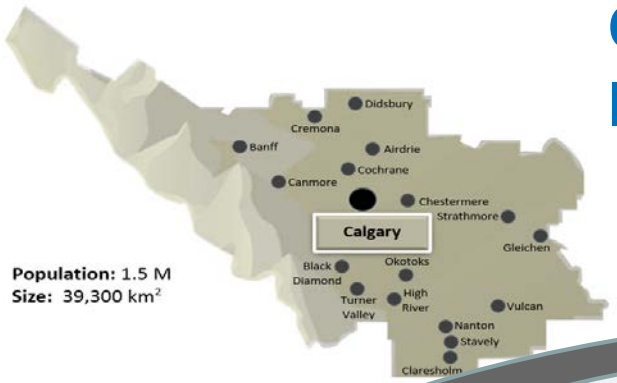
4. Communicate the Vision
    - Able to communicate to someone in 5 mins or less and get a reaction that signifies both understanding and interest!!!
5. Empower Others To Act on the Vision
    - Remove / Reduce obstacles (e.g. lack of information, wrong performance measurement, lack of self-confidence, disempowering bosses)
    - Encourage risk-taking and nontraditional ideas, activities and actions

Kotter's Leading Change

6. Plan for and Create Short Term Wins
   - Produce sufficient short-term wins to energize change helpers, enlighten pessimists, defuse cynics and build momentum
7. Consolidate Improvement and Produce More Change
   - Use increased credibility from early wins to change systems, structures, and policies to achieve vision
   - Reinvigorate with new projects and change agents
8. Institutionalize New Approaches
   - Make change stick
   - Ensure changes embedded in culture of organization

Case Study- Calgary

Calgary Zone
Palliative and End of Life Care (PEOLC)



Population: 1.5 M
Size: 39,300 km²


Home Care


Rural


Outpatient Clinics

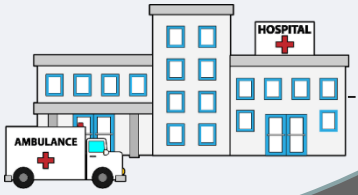

Hospices

PATIENT & FAMILY

Palliative Home Care


Care Centres


Supportive Living



Acute Care

Intensive Palliative Care Unit

Palliative Care Consult Service

Hospice Operations & Hospice Access

Advance Care Planning & Goals of Care

Grief Support

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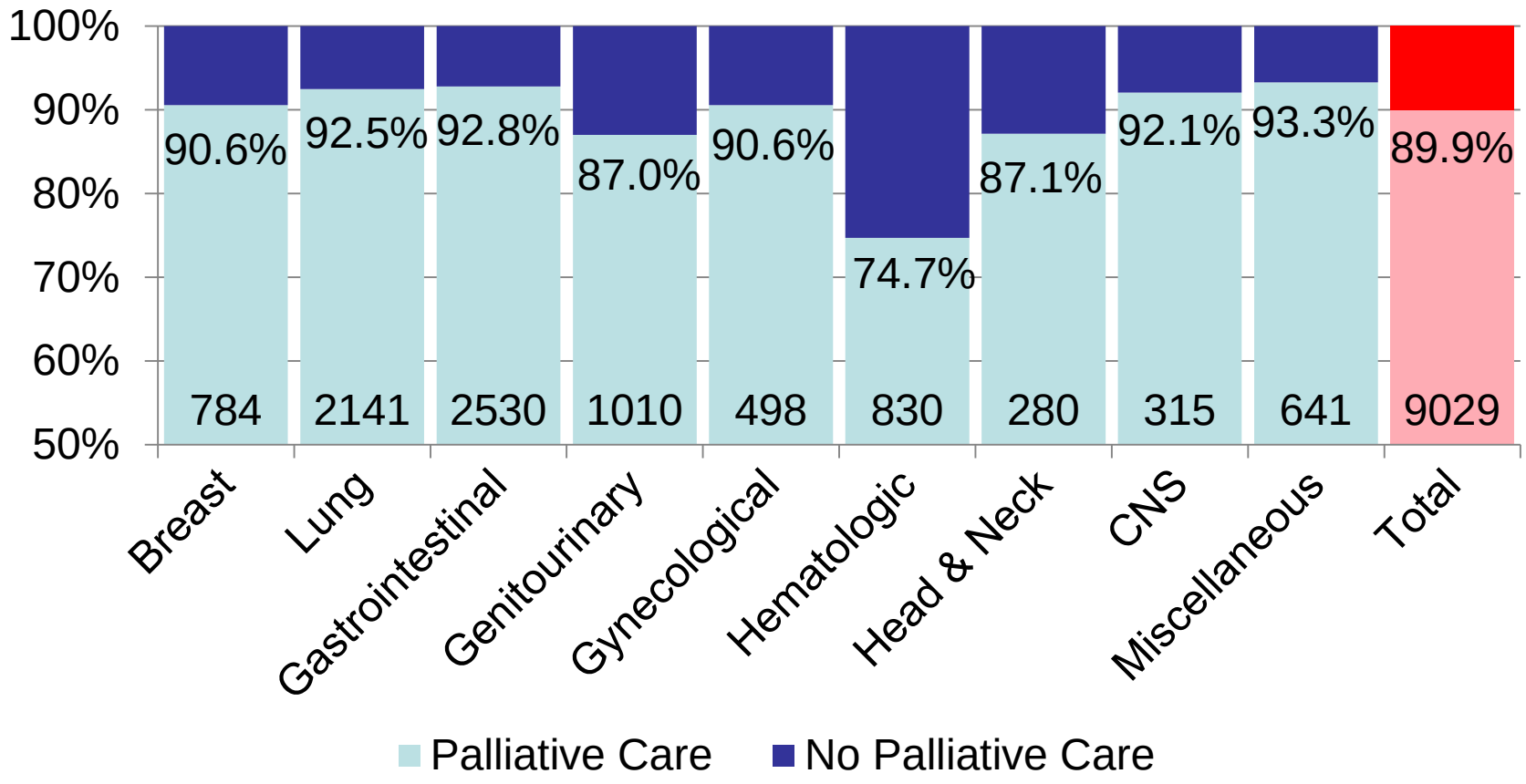
Palliative Care – Tumour Type



Initial Palliative Care – Death (mths)

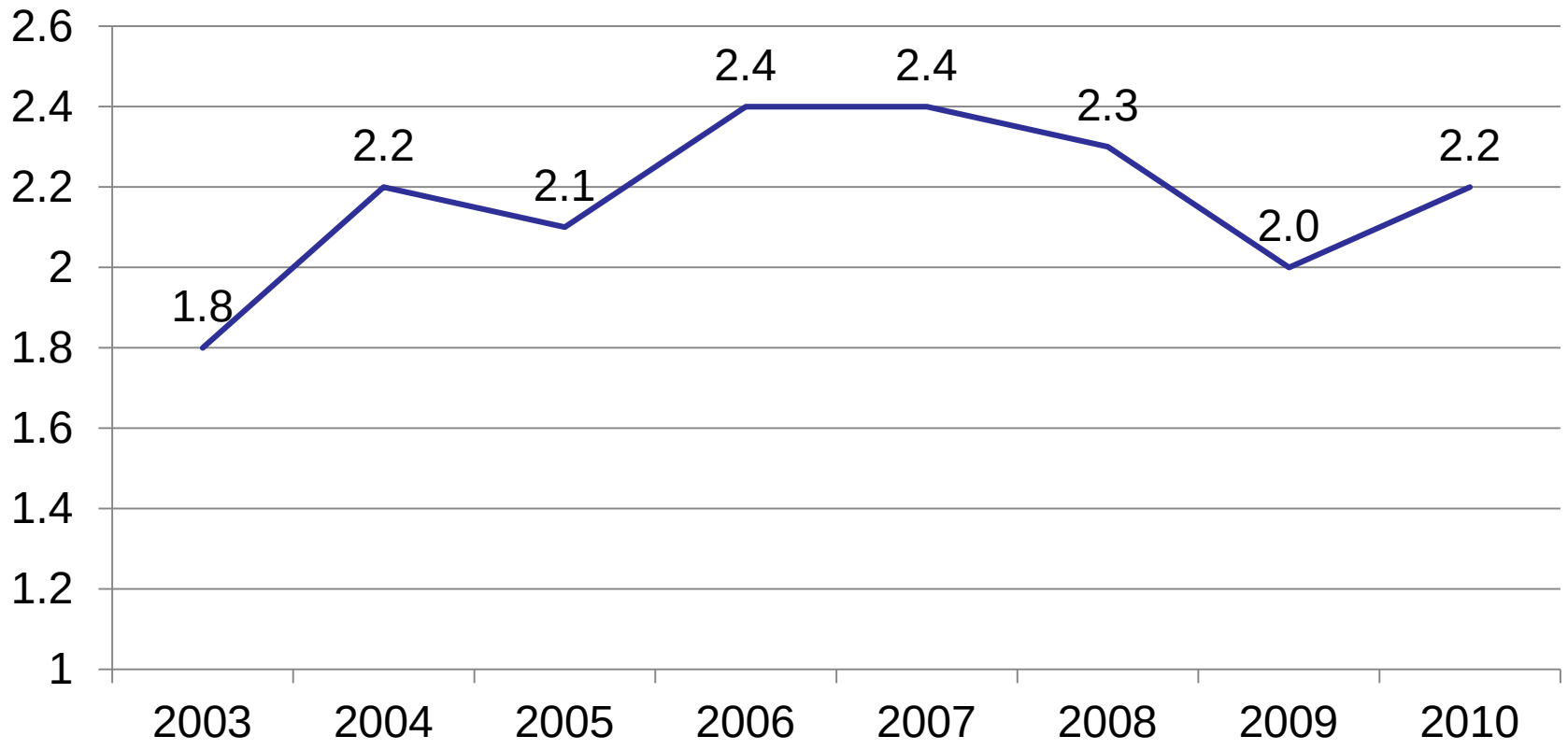


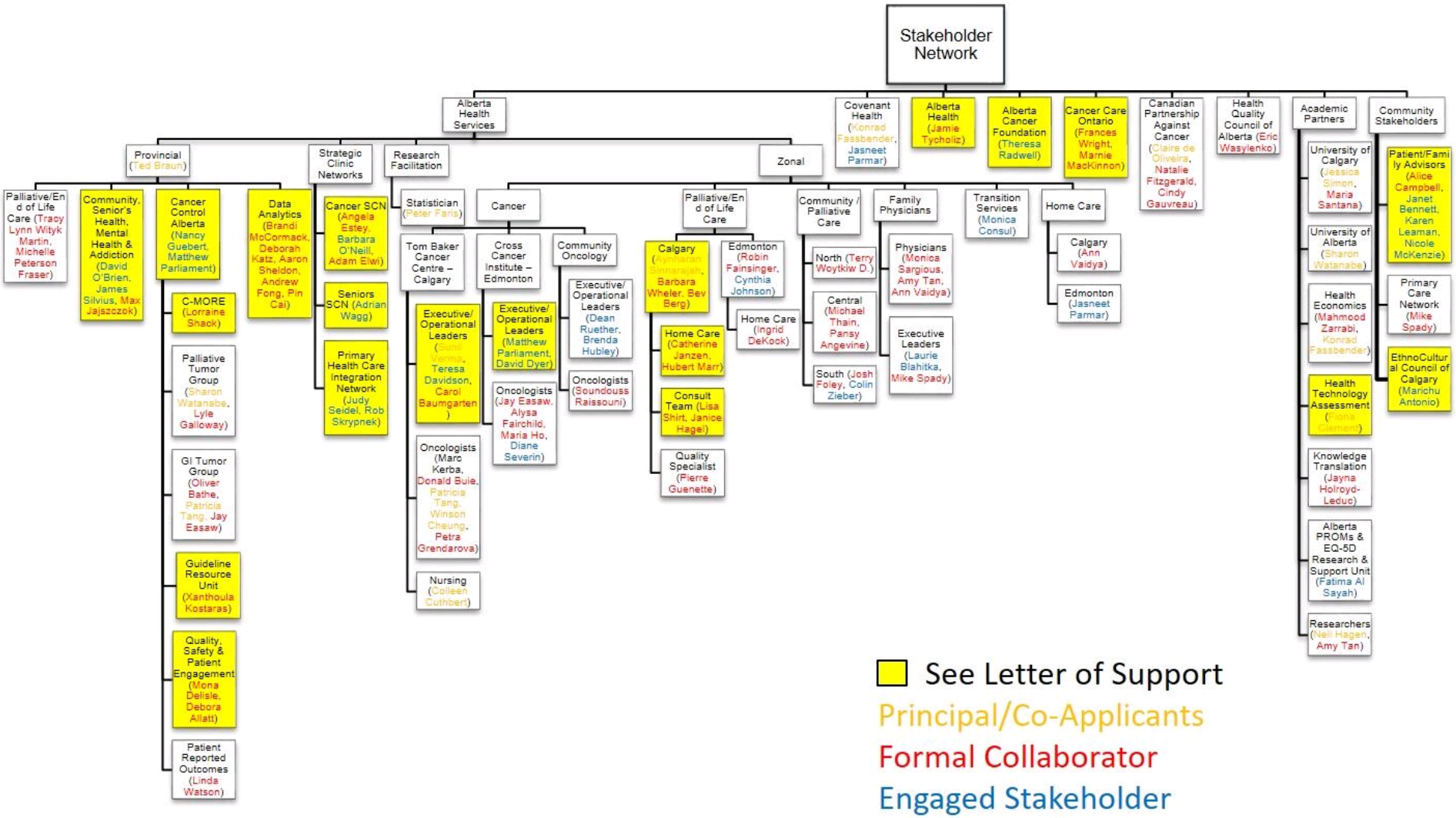
Table Talk

Coalition of the willing for palliative care

- Who are your stakeholders?
- Who else should be in your coalition?

A stakeholder is either an individual, group or organization who is impacted by the outcome of a project. They have an interest in the success of the project, and can be within or outside the organization that is sponsoring the project. Stakeholders can have a positive or negative influence on the project.

PaCES Coalition



Stakeholder Groups

Clinical areas:

– Oncology (Medical, Radiation etc), Palliative Care, Home Care, Family Physicians

Roles:

- Patient / Family advisors
- Front line clinicians
- Health System leaders / managers: Provincial, Regional, Local
- Researchers
- Knowledge Translation / Implementation experts
- Data Analytics
- Quality and Safety
- Education (Patient, Health Care provider)

Identifying the Problems and Building Solutions

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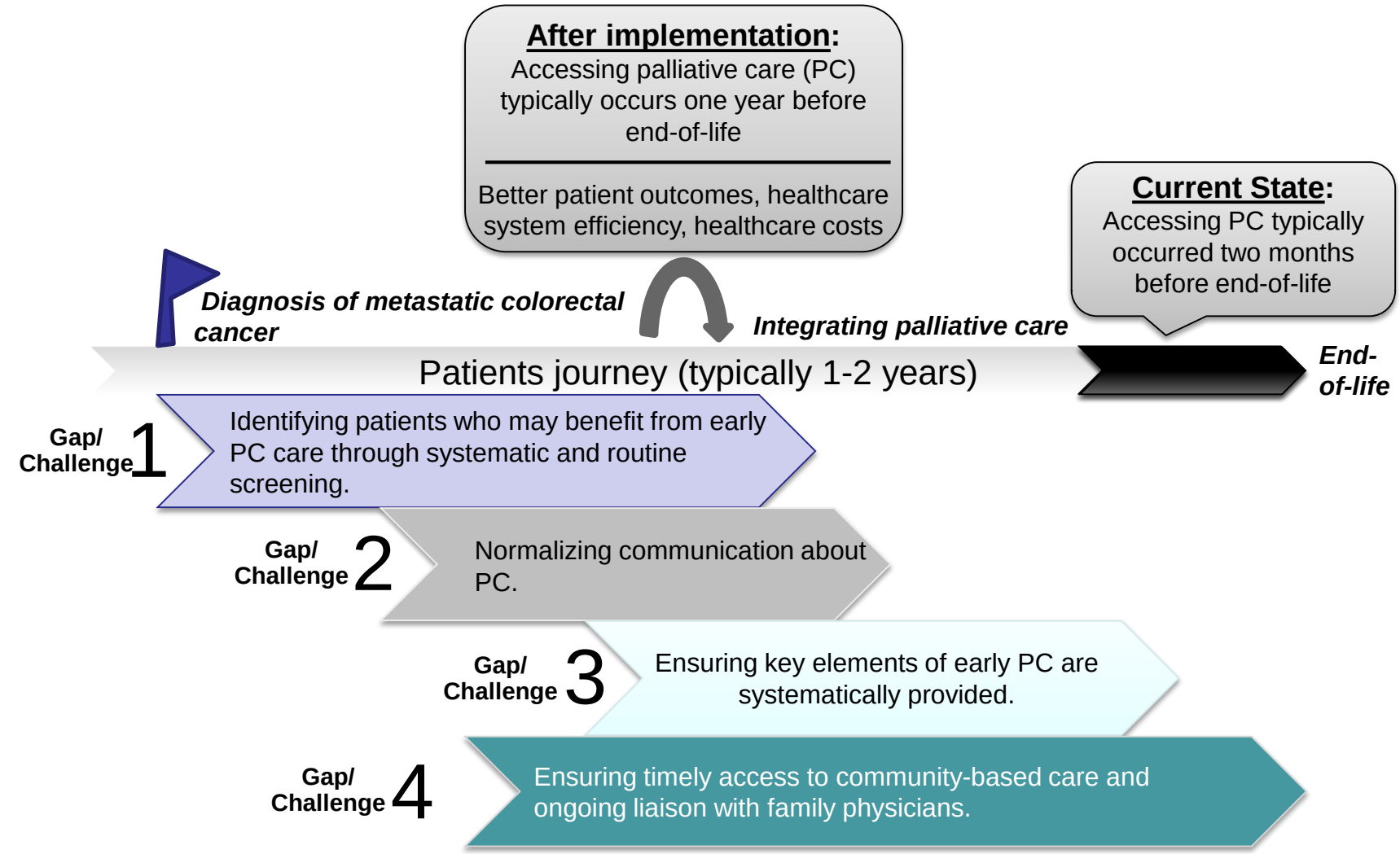
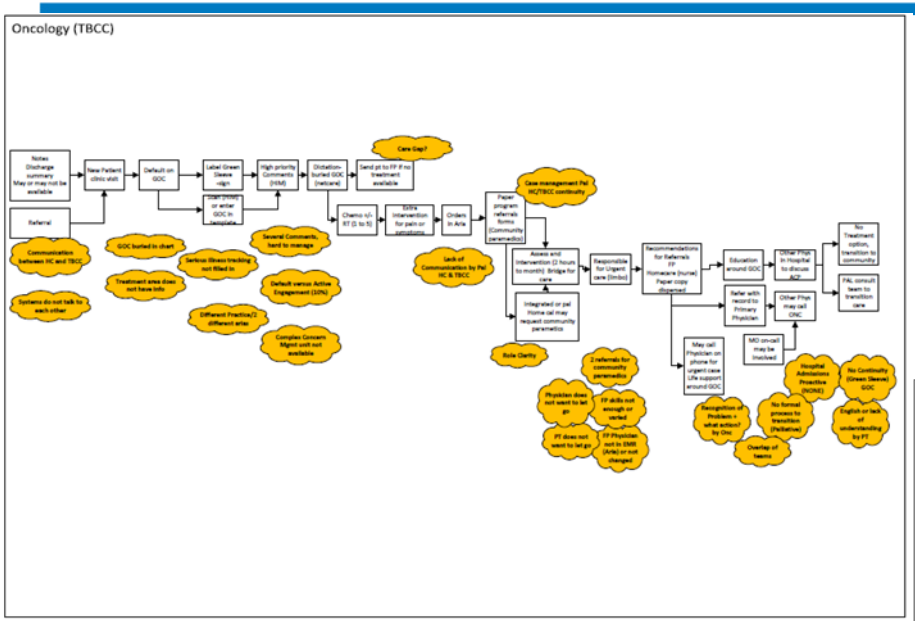
Outline

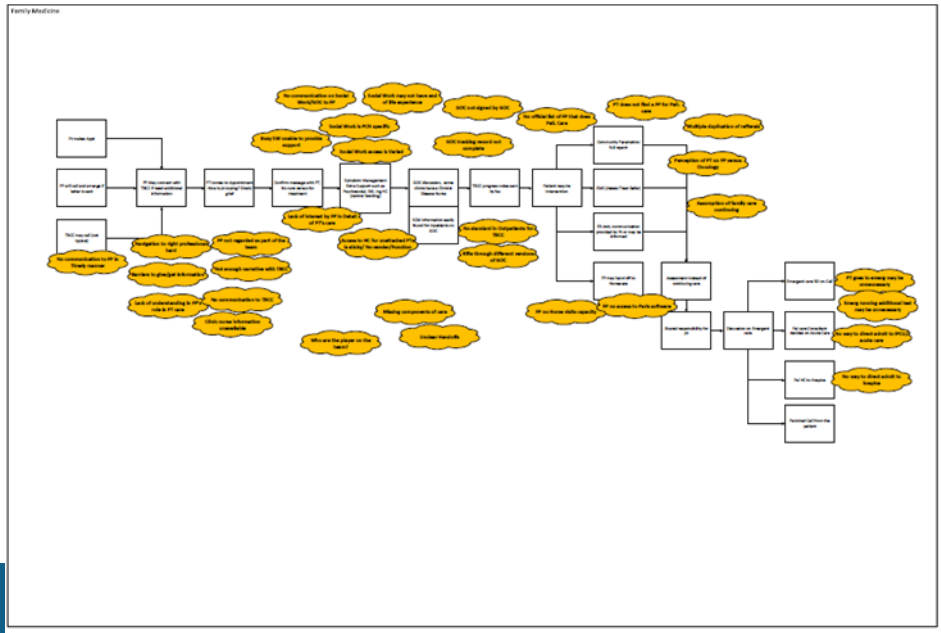
- Current state analysis
  - Gaps and barriers
- How solutions were generated
- Building on pre-existing processes


After implementation:
Accessing palliative care (PC) typically occurs one year before end-of-life
Better patient outcomes, healthcare system efficiency, healthcare costs
Current State:
Accessing PC typically occurred two months before end-of-life
Diagnosis of metastatic colorectal cancer
Integrating palliative care
Patients journey (typically 1-2 years)
End-of-life
Gap/ Challenge 1
Identifying patients who may benefit from early PC care through systematic and routine screening.
Gap/ Challenge 2
Normalizing communication about PC.
Gap/ Challenge 3
Ensuring key elements of early PC are systematically provided.
Gap/ Challenge 4
Ensuring timely access to community-based care and ongoing liaison with family physicians.

Process Mapping as a Foundation

Process Mapping as a Foundation





101 pain points or gaps identified

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Open session

- What do you think the probable pain points are in palliative care?

Pain Points- A Sampling

- Pt cannot find a Family Physician to work with Homecare/PC Consult team
- Duplicative referrals put in to prevent gap
- ER visits unnecessary but may be only place to go
- Family Physician with no capacity for home visits
- Not resourced for virtual remote care (e.g. rural)
- All Physician notes not avail (variety of systems involved, multiple services)
- Cross coverage of providers, who to go to for what?
- Role clarity
- Definition of Palliative care- different between providers and between providers and patients
- PC Consultants feel that there is an overall lateness to the referrals received (often when patient is in crisis)
- Barriers to giving and getting information (system issues)

Affinity Analysis

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1		What is the problem statement?	In scope?	Fishbone/5 whys?	Access	Communication	Patient Experience	Lack of System Capaci	Access to Info (Syster	Role Clarity	No Standard Practice / Conflicting Process for Some Processes	Standard Practice Not Followed for Some Processes	Skill Gap	local impact only
2	Many referrals put in to prevent gap (in multiple places: psychosocial, transition services receives duplicates for other services)		5	Unaware of what teams/consults are already involved; No 1 place to find these; once referral placed, unclear whether referral accepted and patient seen.	x	x		x	x		x		x	
3	Pall Consultants feel that there is an overall lateness to the referrals received (often when pt is in crisis) Note HC RN ref more than TBCC		5								x		x	
4	Definition of "Palliative Care"		5										x	
5	Not knowing resources is available at TBCC		5			x			x		x		x	
6	Lack of understanding of role of GP in pt care		5							x			x	
7	FP not regarded as part of team with oncology		5			x				x			x	
8	Case management Pall HC and TBCC continuity		5			x				x				

Problem Statements

Transitions

Role

Definition

Communication

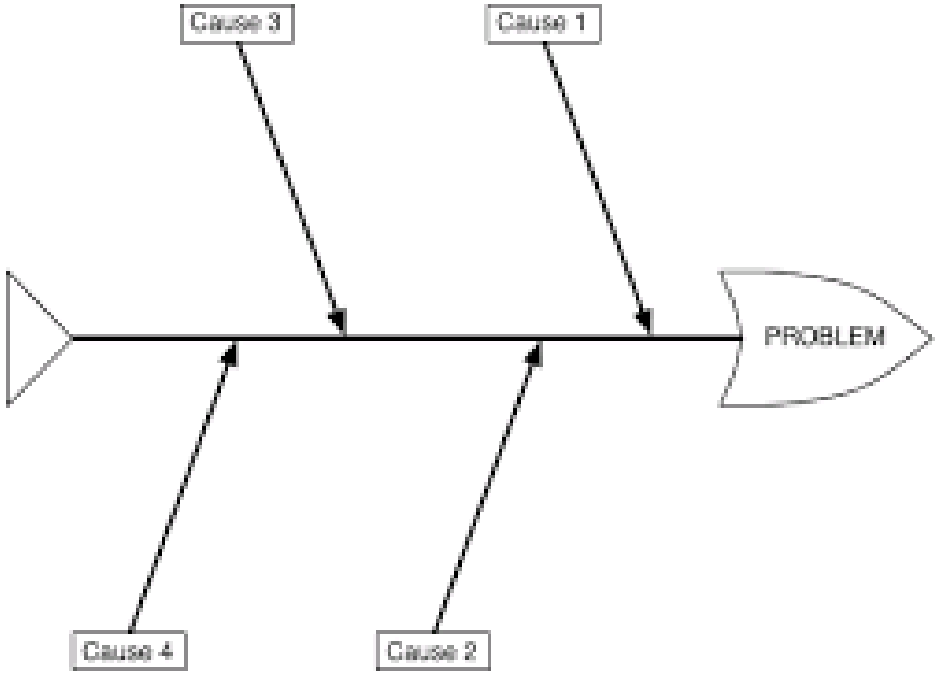
Patient Journey

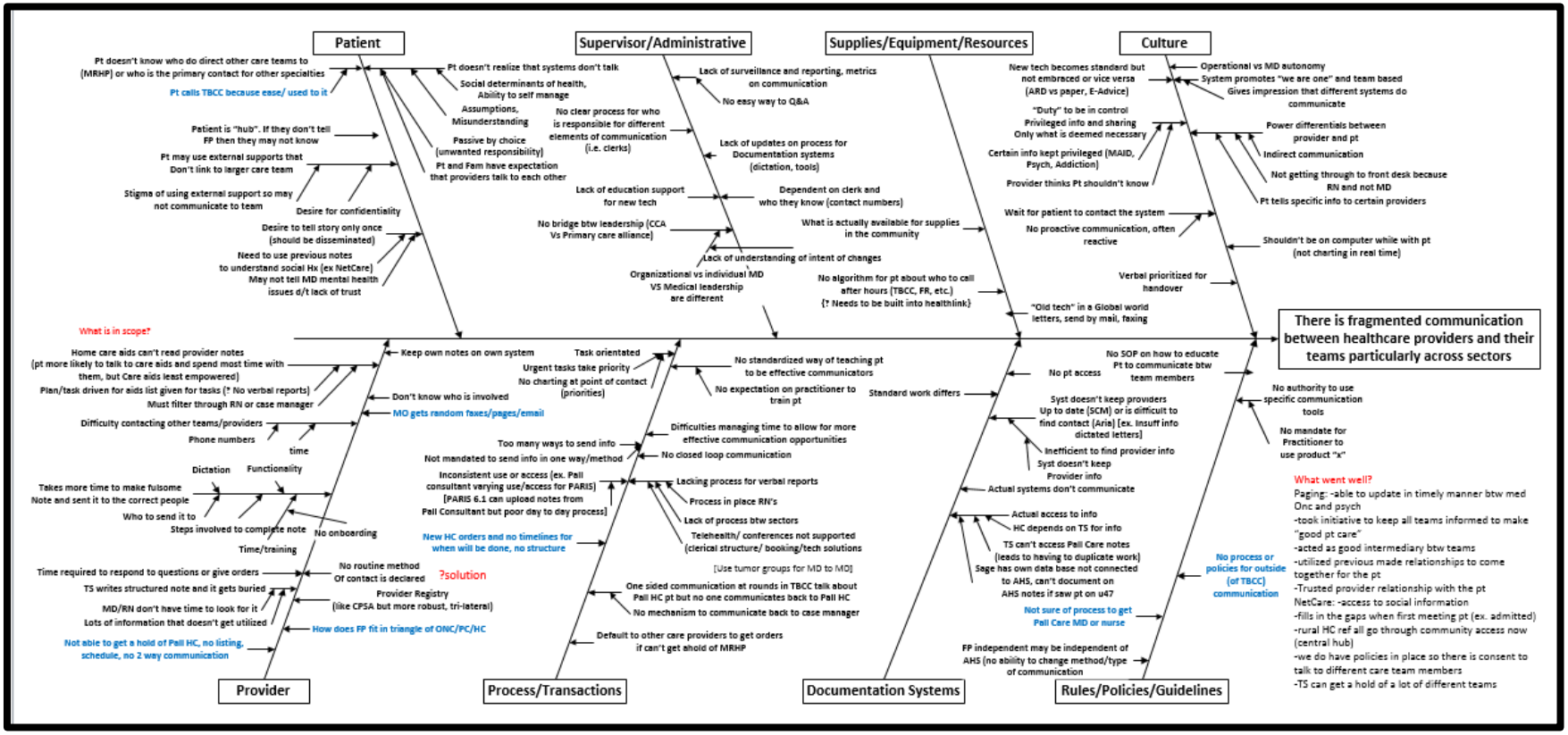
Standard Goals of Care Practice

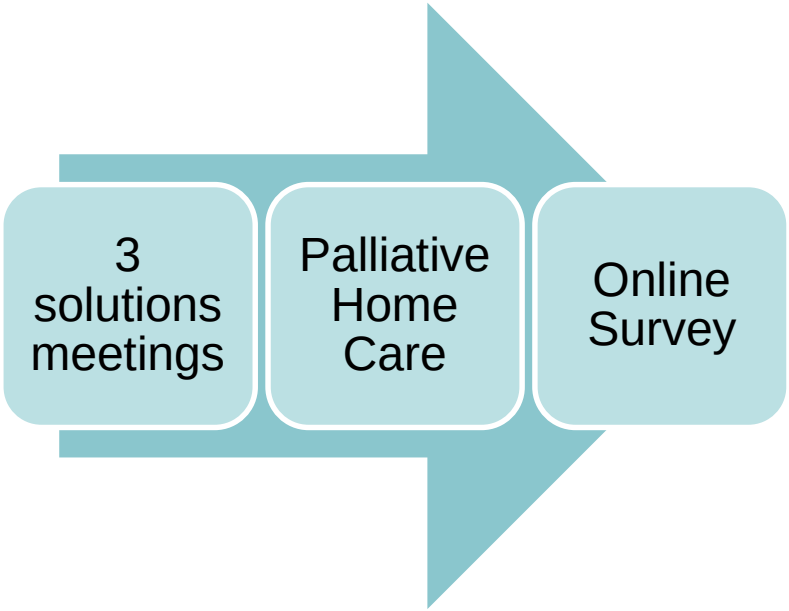
Varied Skills

Fishbone Analysis

- Patient
- Provider
- Supervision/Administration
- Rules/Policies/Guidelines
- Culture
- Process (Transactions)
- Documentation systems
- Supplies/Equipment/Resources (tangibles)




Patient
Supervisor/Administrative
Supplies/Equipment/Resources
Culture
Provider
Process/Transactions
Documentation Systems
Rules/Policies/Guidelines
There is fragmented communication between healthcare providers and their teams particularly across sectors
What is in scope?
What went well?
Paging: -able to update in timely manner btw med Onc and psych
-took initiative to keep all teams informed to make "good pt care"
-acted as good intermediary btw teams
-utilized previous made relationships to come together for the pt
-Trusted provider relationship with the pt
NetCare: -access to social information
-Fills in the gaps when first meeting pt (ex. admitted)
-rural HC ref all go through community access now (central hub)
-we do have policies in place so there is consent to talk to different care team members
-TS can get a hold of a lot of different teams



37 pages of proposed solutions or 700 individual comments

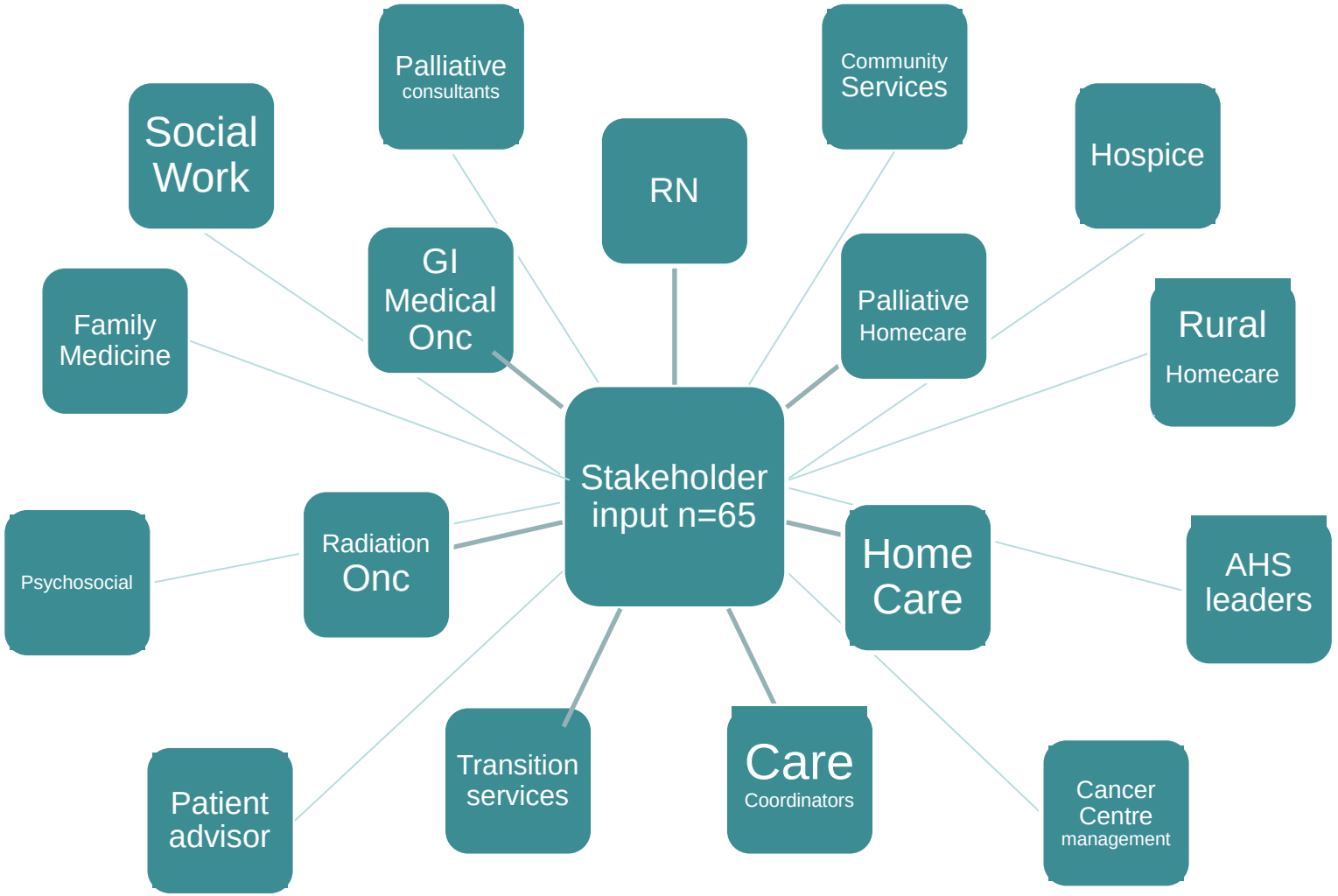

Palliative consultants
Community Services
Social Work
RN
Hospice
GI Medical Onc
Family Medicine
Palliative Homecare
Rural Homecare
Stakeholder input n=65
Psychosocial
Radiation Onc
Home Care
AHS leaders
Patient advisor
Transition services
Care Coordinators
Cancer Centre management

Table Talk: Problem Statements

Transitions: No formal transition process for patients with advanced cancer to be discharged that are “No Further Recall” (NFR) to community service providers and Family Physicians creates a care gap for the patient.

Role: It is not clear among health care providers (HCP), patients and their caregivers who is responsible for each aspect of patient care.

Definition: There is no shared definition of palliative care in the eyes of HCPs and patients and no common knowledge of the palliative care services available.

Table Talk: Problem Statements

Communication: There is fragmented communication between healthcare providers and their teams particularly across sectors.

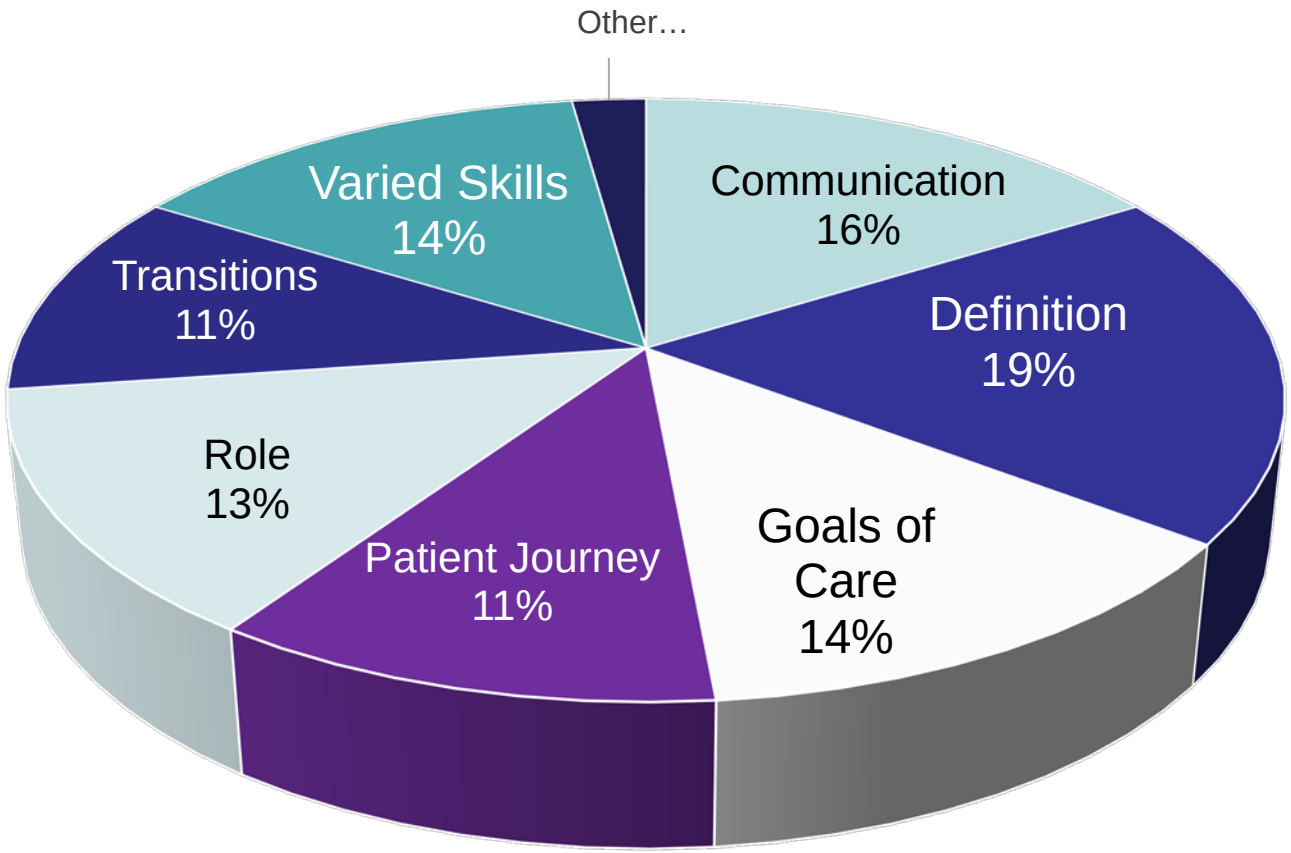
Patient journey: There is a lack of visibility of the patient's schedule and resources being used by that patient to various healthcare providers.

Table Talk: Problem Statements

Standard Goals of Care: While a standard policy/procedure exists for the use of Goals of Care designation, the practice is varied and there are gaps in its application.

Skill Gap: Healthcare providers have varied skills in relation to providing a palliative care approach which leads to gaps in the patient experience and late referrals to palliative care services.

Actionable Solutions

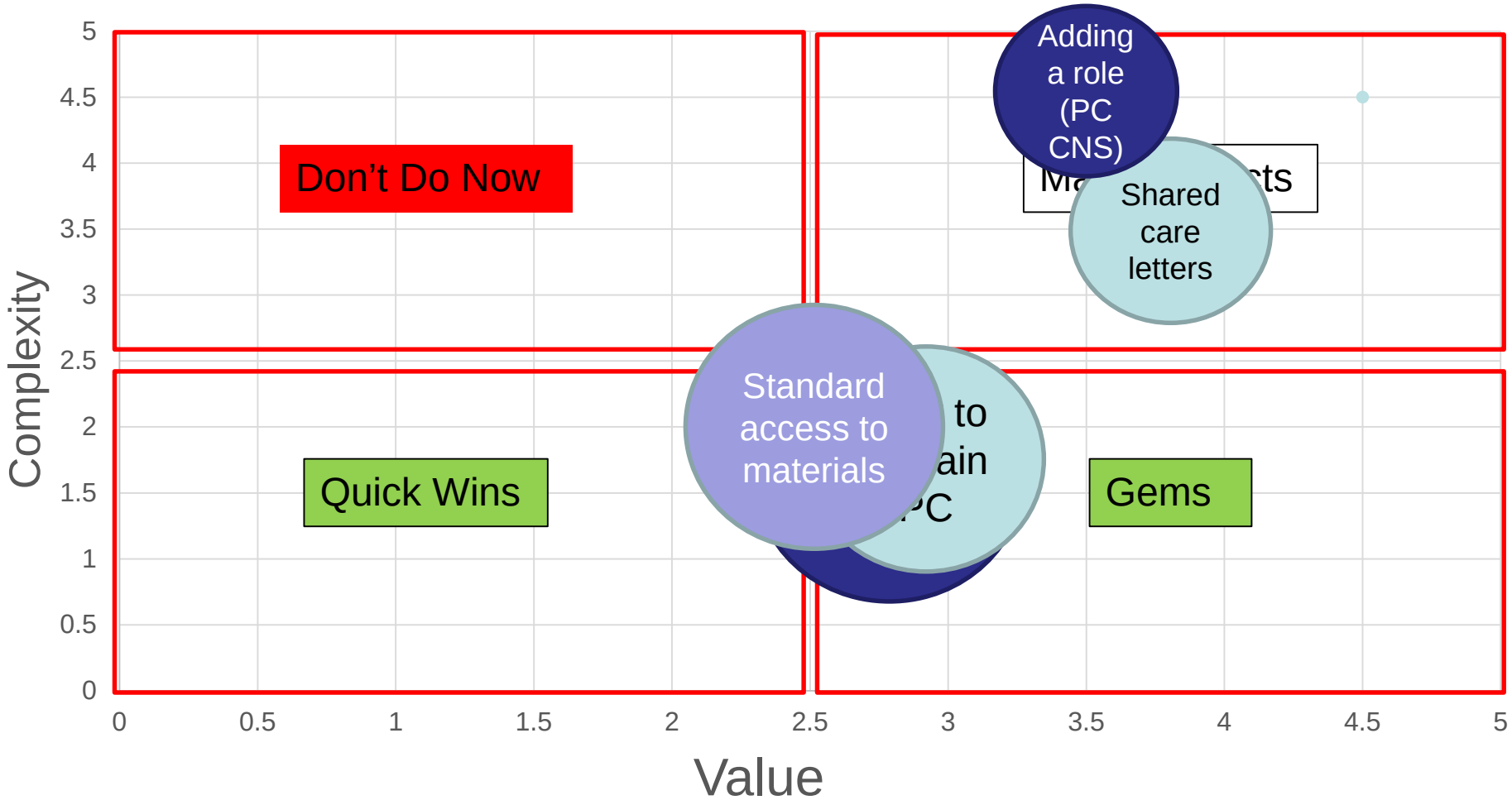


Alberta Health Services

UNIVERSITY OF ALBERTA

UNIVERSITY OF CALGARY

Weighted Ranking
Value vs Complexity vs Impact



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	SCORE	
Value	0	No value in relation to specific problem statement.
	1	Small Change - Difficult to Measure
	2	Measurable change in process/performance
	3	50% improvement in process/performance
	4	75-90% Improvement in process/performance
	5	Transformational value - 100% improvement for patient experience.
Complexity	0	No Change to current process
	1	Information based change
	2	Educational based change
	3	Change in how exisiting process/technology is used
	4	Modification to existing process/technology required
	5	New Process/Technology Required
# of PPL Impacted/Required by/for change	0	1 - 5 people
	1	5 - 20 people
	2	20 - 100 people
	3	100 - 500 people
	4	500 - 2000 people
	5	2000+ people

Solutions

TBCC change projects	Palliative care change projects	Knowledge/resources change projects
"Healthcare provider education" • Healthcare provider local training and education (grand rounds, simulation, courses, CME) • Communication technique- how to introduce pall care	"Healthcare provider education" • Healthcare provider local training and education (grand rounds, simulation, courses, CME)	"Healthcare provider resources" • Standard access to materials/ educational content (sharepoint, G-Drive, Websites) • Local Tips for providers • Symptom Summary tip sheets
"Referral process" • Create Standard Practice to consult pall care (business rules) • Palliative cluster elements of Patient Reported Outcomes (PRO) dashboard • "Concurrent" Chemo/Palliative treatment when on 2nd line chemo (like RT/Chemo concurrent tx)	"Referral process" • Change criteria to allow "well patient" access to home care services **Urban/rural Calgary zone • Palliative cluster elements of PRO dashboard	"Patient resources" • Definition of pall care- changing patient facing material **Provincial AND **Local • Normalizing pall care in CancerControl Alberta education material
"Transitions" • Dictation business rules (For MO), information sent to FP • Transition services- assessing process and addressing gaps • Transition package for non-curative (*shared care letters)	"Communication" • Home Care to fax/cc notes to Cancer Centre • Creation of business rules/guidelines for communication (Pall Care)	
Leadership surveillance and f/u with metrics/ audits (Local, cancer centre)	Leadership surveillance and f/u with metrics/audits (Local, cancer centre)	

Implementation Process

We are all human…change is hard.

Implementation Process

Pre Planning
- Learning from similar projects
- Input from front line staff and operations

Pilot
- Pilot in two oncology clinics
- Test and implement proposed changes

Refine
- Learn from pilot
- Refine process

Scale and Spread
- Implement refined process
- Phased change

Sustainability

- NHS Sustainability Model
- Stakeholder engagement
- Change Management Strategy
- Embedded in Alberta Health Services

Building on pre-existing processes

Poll

Do you currently intentionally practice early palliative care?

Do you believe early palliative care work should be led by Palliative Care providers?

Lessons Learned

PC Nurse Specialist Routine Referral

- 25 referrals since January 7 2019
  - 5 deaths (1 home, 3 hospice, 1 hospital)
  - 4 transferred to full Palliative Homecare
  - 6 acute care admissions
  - 5 referrals considered “late” (estimated prognosis 3 months or less)
  - On average 5hrs spent per patient (independent of clerical work)

PC Nurse Specialist Routine Referral

- Most time spent on **illness comprehension and coping**, followed by symptom and functional status, Advance Care Planning/decision-making, then coordination of care.

- Referrals have all been needed and appropriate: all within weeks to < 1 year from end of life; all have had early PC needs.

PC Nurse Specialist Routine Referral

- Patients have been overwhelmingly grateful for PC support:
  - o “I wish you [PC] had been introduced to us at the very beginning.”
  - o “No one has asked me about time and the quality of my life before.”
  - o “I was afraid to ask about what was coming, but it helps to have it out in the open. I feel like I don’t have to push those thoughts away all the time.”

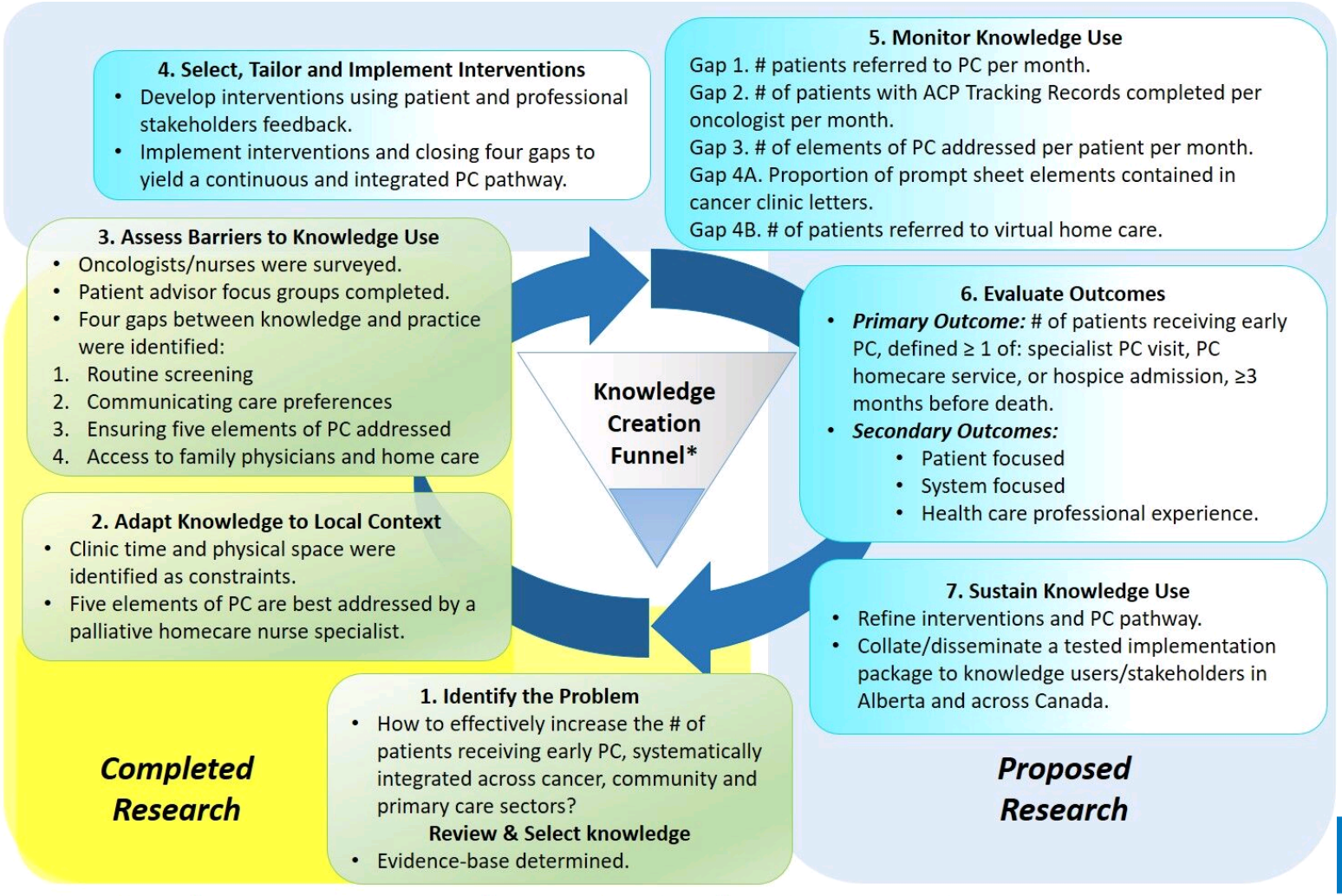
Living With Colorectal Cancer Study

	Calgary	Edmonton
Patients	41	98
Caregivers	23	37
as of April 12, 2019		

Interim analysis trends:

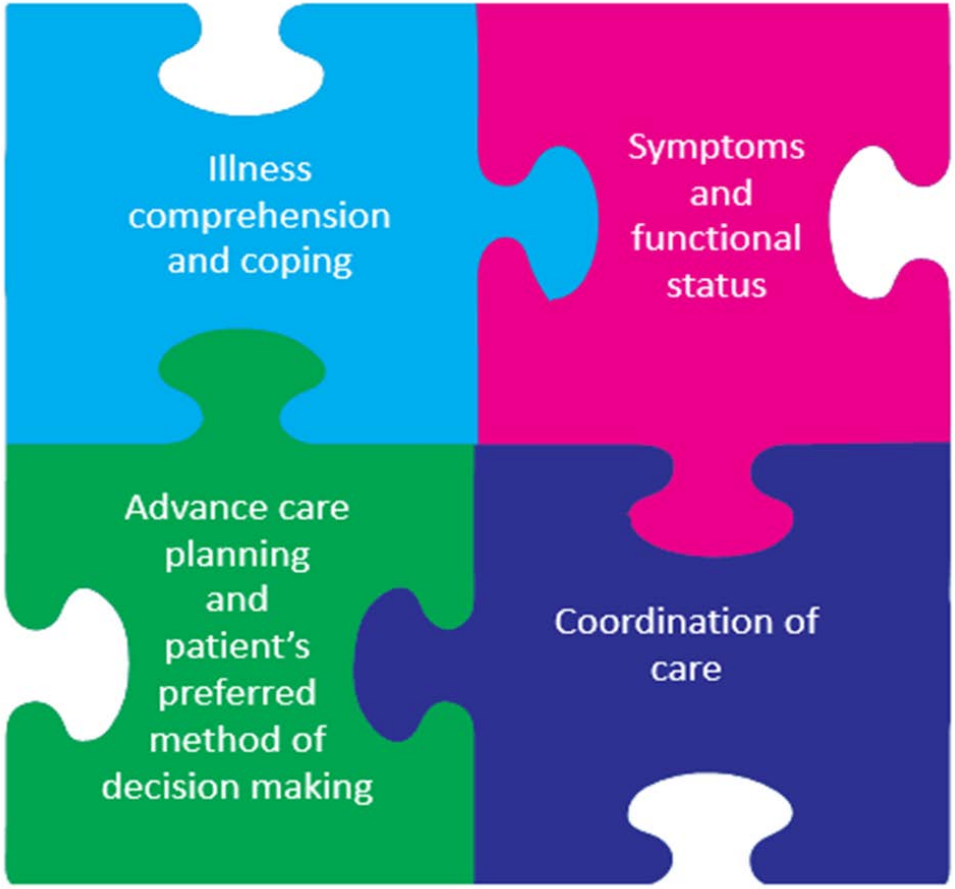
- Calgary patients report worse overall health when compared to Edmonton patients (at enrollment)
- ~40-60% of patients have a caregiver enrolled in the study
- Several participants expressed the desire to describe their experiences beyond what the surveys could accommodate
- Caregiver reported ‘preparedness for caregiving’ seems to decrease over time across all categories
- Caregivers report being the least prepared for the stress of caregiving and caring for the patient’s emotional needs and the most prepared for taking care of the patient’s physical needs

Knowledge Translation Framework



*Our tested implementation package (how to effectively implement, monitor and sustain the pathway) will be new knowledge created.

Essential Components of an Early Palliative Approach to Care



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Final Thoughts

Conclusion

1. Stakeholder engagement
2. Dedicated implementation / change management team
3. Funding for palliative clinicians to see earlier PC referrals