Palliative Care Early and Systematic (PaCES)

Integrating an Early Palliative Approach into Advanced Colorectal Cancer Care
Faculty/Presenter Disclosure

**Faculty:** Aynharan Sinnarajah

**Relationships with financial interests:**

- **Grants/Research Support:** CIHR, Alberta Health, Canadian Frailty Network, MSI Foundation, University of Calgary
- **Speakers Bureau/Honoraria:** None
- **Consulting Fees:** None
- **Patents:** None
- **Other:** University of Calgary, Alberta Health Services
Mitigating Potential Bias

• Health system and research grants
• Low risk of potential bias
Agenda

• Background
• Kotter’s Leading Change
  – Sense of Urgency
  – Powerful Guiding Calition
  – Vision
  – Communicate Vision
  – Empower Others to Act on Vision
  – Short Term Wins
  – Consolidate and More Change
  – Sustain New Approaches
• Lessons Learned and Conclusion
Knowledge Translation Framework

1. Identify Problem
2. Review & Select knowledge
3. Assess Barriers to Knowledge Use
4. Select, Tailor and Implement Interventions
5. Adapt Knowledge to Local Context
6. Monitor Knowledge Use
7. Evaluate Outcomes
8. Knowledge Creation Funnel
9. Sustain Knowledge Use

Adapted from Graham et al. 2006
What do we mean by *early*?

A palliative approach to care that occurs concurrently with cancer treatment

- Early Stage Colon Cancer
- Early Stage Rectal Cancer
- Diagnosis of advanced colorectal cancer

Integrating an Early Palliative Approach into Advanced Colorectal Cancer Care

- Metastatic Colorectal Cancer
- No Remission and End of Life
- or
- Prolonged Remission
The hardest part is starting. Once you get that out of the way, you’ll find the rest of the journey much easier.

Simon Sinek
1. Problem
Local Context

- Alberta Health Services:
  - North Zone
  - Edmonton Zone
  - Central Zone
  - Calgary Zone
  - South Zone
- 5 Zonal Palliative programs
- 1 Provincial Cancer System
  - CancerControl Alberta
Initial Palliative Care – Death (mths)

Year: 2003 2004 2005 2006 2007 2008 2009 2010

Values: 1.8 2.2 2.1 2.4 2.4 2.3 2.0 2.2
Urgent Problem in Alberta

- 60-80% patients with advanced GI cancers have late PC <3 months from death or no PC referral
- Late or no PC is associated with lower patient quality of life and higher caregiver distress
- Late or no PC associated with death in hospital for 50% of patients vs. 25% receiving earlier PC
2. Coalition

Stakeholders

- Social Work
- Palliative consultants
- GI Medical Onc
- RN
- Community Services
- Palliative Homecare
- Hospice
- Rural Homecare
- AHS leaders
- Psychosocial
- Radiation Onc
- Transition services
- Care Coordinators
- Cancer Centre management
- Family Medicine
- Patient advisor
- Family Medicine
- Home Care
- Care Coordinators
3. Create a Vision

Palliative Care Early & Systematic (PaCES): Early palliative care pathway (processes and resources) for Albertans with **advanced colorectal cancer** (initially, as proof of principal)

**MISSION**

“To provide **early** and ongoing access to coordinated, comprehensive and compassionate palliative care to improve quality of life for Albertans with advanced cancer.”
Vision: Improving quality of life for Albertans with advanced cancer
4. Communicate Vision

- PaCES Collaborative (coalition)
  - Regular meetings
  - Executive Committee
  - Sub-WGs
  - Alberta Health Services Executive Advisory Committee
- Provincial GI Tumor Group
- Tumor Council
- Provincial Palliative Innovations Steering Committee
Processes mapped across the continuum

101 “pain points” or gaps identified

37 pages of solutions

7 Problem statements
5. Empower others

- Patient materials:
  - [https://www.albertahealthservices.ca/assets/info/cca/if-cca-systemic-treatment.pdf](https://www.albertahealthservices.ca/assets/info/cca/if-cca-systemic-treatment.pdf)
Clients do not have to have personal care needs to be eligible for home care services.

Early referrals can:

1. Establish a relationship
2. Access to home care professional services e.g. OT
3. Help clients and families navigate community care services
4. Assist with advance care planning conversations
5. Support clients and families in contemplating & sharing end of life planning.
6. Quick Wins

- PaCES Oncology Provider
- PaCES Rural
- PaCES Family Physician / SUPPORT-FM
- PaCES Health Resource

(First 3 done in 6 months, with last one in 12 months)
(posters)
### PaCES Oncology Providers

**Top 3:**
- My time with competing priorities
- Role confusion
- Lack of process for executing orders
7. More Change

Guideline & Pathway

Integrating an Early Palliative Approach into Advanced Colorectal Cancer Care

Effective Date: January, 2019
Essential Components of an Early Palliative Approach to Care

- Illness comprehension and coping
- Symptoms and functional status
- Advance care planning and patient’s preferred method of decision making
- Coordination of care
Step 1: Screen using Patient reported outcome Dashboard

Step 2: Identify Patient Needs

Step 3: Primary Provider Management of Unmet Needs

Step 4: Exploring End of Life Topics
Information located under “Gastrointestinal” and “Palliative & Supportive Care”
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 in remaining 6 GI clinics
- Phased change
Routine referral to PC nurse specialist

Oncology Team

Patient and Family

Family Doctor

GI CNS

Palliative Home Care
8. Sustainability

- Existing health system processes
  - Tumor Council
  - Patient Education
- PaCES guideline: Co-owned by GI & Palliative Provincial Tumor group
- Cancer Measurement, Outcomes, Research & Evaluation (e.g. build dashboard)
- Zonal Palliative Programs
- Letter in existing and future EMR
### Screen using existing PRO Dashboard

<table>
<thead>
<tr>
<th>Comments</th>
<th>Qtr Entry Date</th>
<th>Previous PPF Symptom Complexity</th>
<th>Home Care (PPF)</th>
<th>Palliative Home Care (db)</th>
<th>Request for Goals of Care (PPF)</th>
<th>GCD Order (ARIA)</th>
<th>Goals of Care Date (ARIA)</th>
<th>Weight Change(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 weeks f/u as per appt slip...pt aware...ss</td>
<td>2018-Dec-31</td>
<td>L</td>
<td>N</td>
<td>N</td>
<td>M1</td>
<td>03/10/2016</td>
<td>0.18%</td>
<td></td>
</tr>
<tr>
<td>f/u as per appt slip...pt aware...zg</td>
<td>2019-Jan-14</td>
<td>L</td>
<td>N</td>
<td>N</td>
<td>M1</td>
<td>16/02/2016</td>
<td>-2.04%</td>
<td></td>
</tr>
<tr>
<td>f/u as per appt slip.mailed...zg</td>
<td>2019-Jan-15</td>
<td>L</td>
<td>N</td>
<td>N</td>
<td>M1</td>
<td>16/02/2016</td>
<td>7.83%</td>
<td></td>
</tr>
</tbody>
</table>
Use Existing Tools

<table>
<thead>
<tr>
<th>Component</th>
<th>Assessment Tool</th>
</tr>
</thead>
</table>
| Illness comprehension and coping | Canadian Problem Checklist (CPC)  
Edmonton Symptom Assessment System- Revised: anxiety and depression scales (ESAS-r)  
Serious Illness Care Program (SICP) |
| Symptoms and functional status | ESAS-r  
CPC  
Eastern Cooperative Oncology Group (ECOG)  
Palliative Performance Scale (PPS) |
| Advance care planning and patient’s preferred method of decision making | ACP GCD Tracking Record  
CPC  
SICP |
| Coordination of care | PPF |
Wrapping up
Conclusion / Lessons Learned

1. Stakeholder engagement (easier)
2. Dedicated implementation / change management team (harder)
3. Funding for palliative clinicians to see earlier PC referrals (hardest)
Integrate palliative care earlier

Palliative Care is an added layer of support (not just for dying!)

Supports you can use: www.ahs.ca/GURU

Attend to 4 Elements

- Illness comprehension and coping
- Symptoms and functional status
- Advance care planning and patient's preferred method of decision making
- Coordination of care

Enhance Shared Care

- Shared Care Information Exchange
  - We are sharing the care of this advanced oncology patient. To foster collaborative care, we would like to provide you the opportunity to ask any questions and individualize the patient's care plan.
  - Please confirm your clinic is the patient's current medical home.
  - Please confirm you are managing new cancer-related concerns and medication refusal.
  - Comments:

- Please provide clinic contact information here, if the medical oncologist needs to contact you:

- Do you feel comfortable in participating in the palliative approach to care for our patient?
- Share care:
  - Yes
  - No
  - Comments:

- Navigation Movement: If a patient is transferred:
  - Please indicate if the patient's care has been transferred and includes the transfer date.

- Advance Care Planning: Are there any changes to the care plan?
  - Please indicate any changes to the care plan.

- Please fax this letter to: 403-283-1051.
  - Non-urgent messages for the oncologist can be left at: (Name and Phone)
About PaCES

Our Team

Our Stakeholders

Learn more about PaCES activities

- Measuring current healthcare use
- Engaging oncology clinicians
- Understanding the rural patient experience
- Developing our early palliative care pathway
- Evaluating our early palliative care pathway

VISION:

Improving quality of life for Albertans with advanced cancer

MISSION:

To provide early and ongoing access to coordinated, comprehensive and compassionate palliative care to improve quality of life for Albertans with advanced cancer

WHAT IS PaCES?

The Palliative Care Early and Systematic (PaCES) Project is a province-wide team of researchers and knowledge end-users working together to develop and deliver an early and systematic palliative care pathway for advanced colorectal cancer.

"I will be forever grateful for the many acts of kindness, both big and small — that reassured both of us that we weren't alone, that others cared, and that her life was honoured and respected to its end."

(PaCES Patient/Family Advisor, on her mother's journey with cancer)
Continuing the journey.....
PaCES at CCRC 2019: Posters

- Impact of specialist palliative care delivered over three months prior to death on a colorectal cancer patient’s risk of experiencing aggressive end-of-life care
- Feasibility of collecting survey-based patient reported outcome measures (PROMs) from patients living with advanced cancer: emerging findings from the Living with Colorectal Cancer study
- SUPPORT-FM: supporting family physicians to provide community-based primary palliative care for their patients (PI: A Tan)
- Palliative Care Early and Systematic (PaCES): assessing patient and caregiver preferences for early palliative care delivery in rural Alberta
- Barriers to providing palliative care to patients with advanced cancer: a provincial survey of oncology clinicians
Let us know what you’re thinking

Ayn.Sinnarajah@ahs.ca

Thank you!
Summary: Integrating Palliative Care

• Quadruple Aim - Improves Outcomes:
  – Patient / caregiver experience
  – Population health
  – Health System efficiency
  – (Health care professional)
• Primary Care are key partners
• Care Coordination is unspoken foundation
• Change Management