

KEY MESSAGE

This knowledge translation project will study methods to adapt and implement evidence-based practices for **delivering early and systematic palliative care (PC)** to patients with metastatic colorectal cancer (mCRC).

OBJECTIVE: Improve patient outcomes while increasing healthcare system efficiencies and/or reducing costs.

KEY OUTPUTS

- A cross care sector (oncology, palliative care, primary care) **pathway** for the early and systematic delivery of PC to mCRC patients.
- An evidenced **change package**: how to effectively implement, monitor, and sustain use, for scale and spread in other cancer populations and regions.

PROJECT OVERVIEW

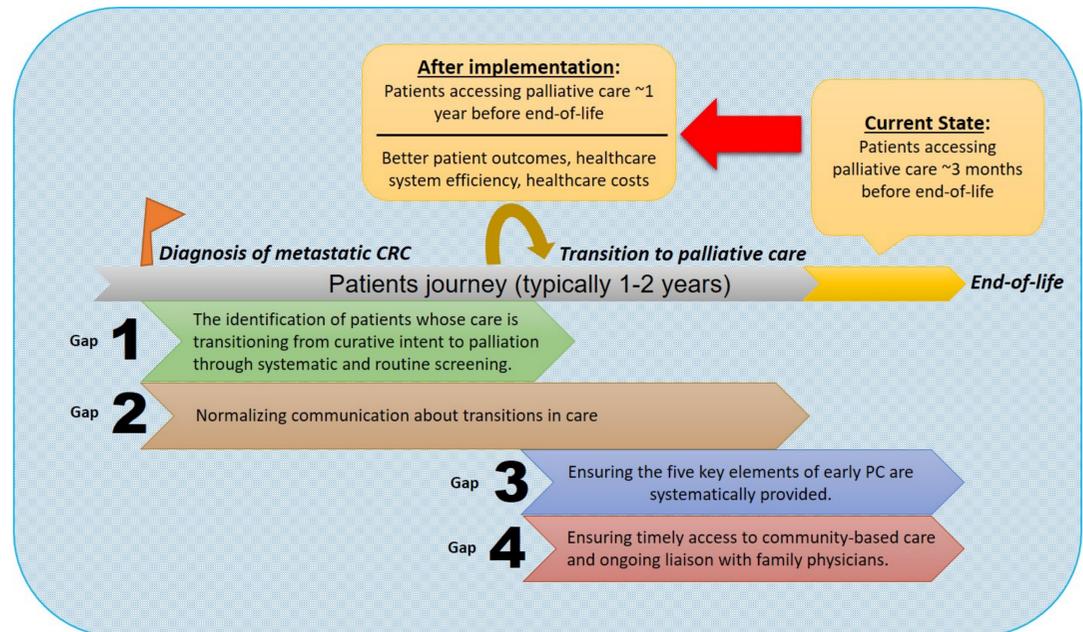


FIGURE 1. Plan for addressing gaps in care. Our work with patients, clinicians, and administrative knowledge users identified 4 major “gaps” hindering the delivery of early and systematic PC for patients with mCRC. Proposed interventions aim to close these gaps and ensure continuity of care.

Gap 1. Routinely identifying patients appropriate for early PC using clinician independent and dependent methods.

Gap 2. Increasing the quality of patient-clinician communication of care preferences by implementing the “Serious Illness Conversation Guide” process⁴.

Gap 3. Ensuring five key elements of early PC are systematically provided using a homecare PC specialist nurse.

Gap 4. Ensuring ongoing liaison with family physicians and timely access to PC services at home, using communication templates.

BACKGROUND

PROBLEM

- Late or no PC use is associated with lower quality of life, increased caregiver distress, and aggressive/costly end-of-life care.
- In Calgary (Alberta, CA), 60% of patients with mCRC have late (<3 months from death), or no, referral to PC¹. Of these, 50% receive aggressive care (e.g. admission to intensive care or death in hospital), compared to 25% of those referred to PC.

EVIDENCE-BASED SOLUTIONS

- There is strong evidence that early PC improves patient outcomes¹. Early PC is now recognized and recommended in national guidelines.
- Temel *et al.*² demonstrated that providing five elements of care: 1) illness understanding, 2) symptom management, 3) decision-making, 4) coping with life-threatening illness, and 5) coordinating referrals/prescriptions, improved patient and caregiver outcomes.
- In our own PC-oncology needs assessment³ patients and families told us transitions in care are enhanced by: 1) timely access to specialized PC, 2) greater continuity of care, and 3) increased opportunities to discuss care preferences.

HYPOTHESIS

By implementing earlier ‘first contact’ with PC providers (see Figure 1) and increasing the number of mCRC patients referred to PC (from 40% to >60%), we will improve patient outcomes and increase healthcare system efficiencies.

PROJECT METHOD/APPROACH

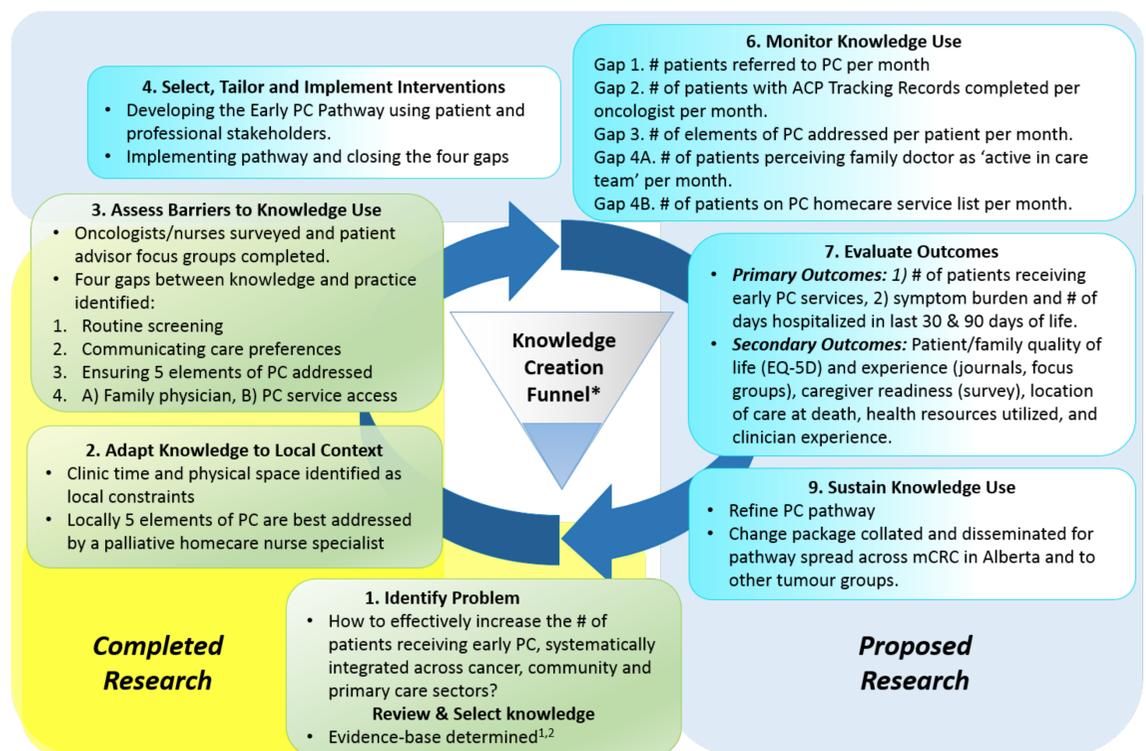


FIGURE 2. PaCES project mapped to the KTA cycle. Outcomes will be evaluated using Interrupted Time Series with an implementation site (Calgary, AB) and control site (Edmonton, AB).

STUDY POPULATION

WHY COLORECTAL CANCER ?

mCRC is as an ideal ‘demonstration condition’ because it is:

- Common (12% Canadians with cancer, 2,160 Albertans diagnosed and 750 died in 2015)
- Impacts genders equally
- Long survival relative to other metastatic cancers (12 month median from failure of first-line chemotherapy)
- Relevant to an aging demographic (70% mCRC >65 years)
- Frequently associated complications/distress and >50% of mCRC deaths are in hospital
- Existing trials evidence showing benefit of early PC.

REFERENCES

- Sinnarajah A, Murray, A., Wu J. Palliative Care & Resource Use at End of Life in Cancer Patients. In: Calgary Uo, editor.; 2016.
- Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 2010; 363(8): 733-42.
- Tom Baker Cancer Centre/Palliative Collaborative Project: Tom Baker Cancer Centre, Cancer Control Alberta; Alberta Health Services, Calgary Zone, 2013-2016.
- Bernacki RE, Block SD, American College of Physicians High Value Care Task F. Communication about serious illness care goals: a review and synthesis of best practices. *JAMA internal medicine* 2014; 174(12): 1994-2003.

PROJECT TEAM

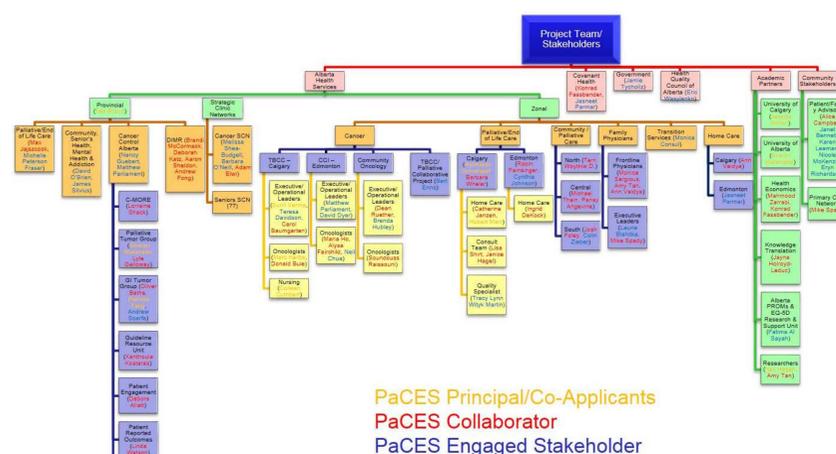


FIGURE 3. Overview of PaCES team. Our collaborative team includes oncology, palliative, primary care, and homecare senior mentors, leaders, clinicians, researchers and administrative knowledge users, patient/family advisors, and experts in health economics, health technology and policy, statistics, process improvement, and knowledge translation. The breadth of expertise, with representation from rural and urban Alberta, Canada, is necessary to develop a broadly applicable early PC pathway.