Palliative Care Early and Systematic (PaCES) – Colorectal Cancer: GI Oncology Survey

Aynharan Sinnarajah, Madalene Earp, Marc Kerba, Patricia Tang, Jimena Arguello Rodriguez, Seema Rajani, Sharon M Watanabe, Jessica E Simon

EAPC 10th World Research Congress

PaCES
PALLIATIVE CARE EARLY AND SYSTEMATIC

Funding Acknowledgement

CIHR IRSC
Canadian Institutes of Health Research
Instituts de recherche en santé du Canada

Alberta Health

PaCES Team Acknowledgement

- Patricia Biondo
- Camille Bond
- Madalene Earp
- Kate Hardegger
- Marc Kerba
- Jessica Simon
- Amy Tan
- Patricia Tang
- Sharon Watanabe

Conflict of Interest

- No Conflict of Interest to declare
- No financial / commercial disclosures
- Grant support from CIHR, Canadian Frailty Network and MSI Foundation

Objectives

1. Introduction to Palliative Care Early & Systematic (PaCES)
2. GI Oncology Survey:
    1. Background
    2. Methods: Michie's Theoretical Domains Framework
    3. Results
3. Next steps

Alberta Health Services

UNIVERSITY OF ALBERTA

UNIVERSITY OF CALGARY

JOURNAL OF CLINICAL ONCOLOGY

Official Journal of the American Society of Clinical Oncology

This Journal | Enter search words / phrases / DOI / authors / keywords / etc.

Newest Articles | Issues | Browse By Topic | Special Conte | Authors | Subscribers | Abou

Integration of P tive Ca ard cology Care: American S Practice Gu

OPTIC

Expo

Trac

But, HOW!?

Recommend

Inpatients and ou l receive dedicated palliative care services, early in t se, co urrent with active treatment. Referral of patients to interdisciplin palliative care teams is optimal, and services may complement existing programs. Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services.

Alberta, Canada

Alberta - Size

Geographical Size:
661,185 sq km

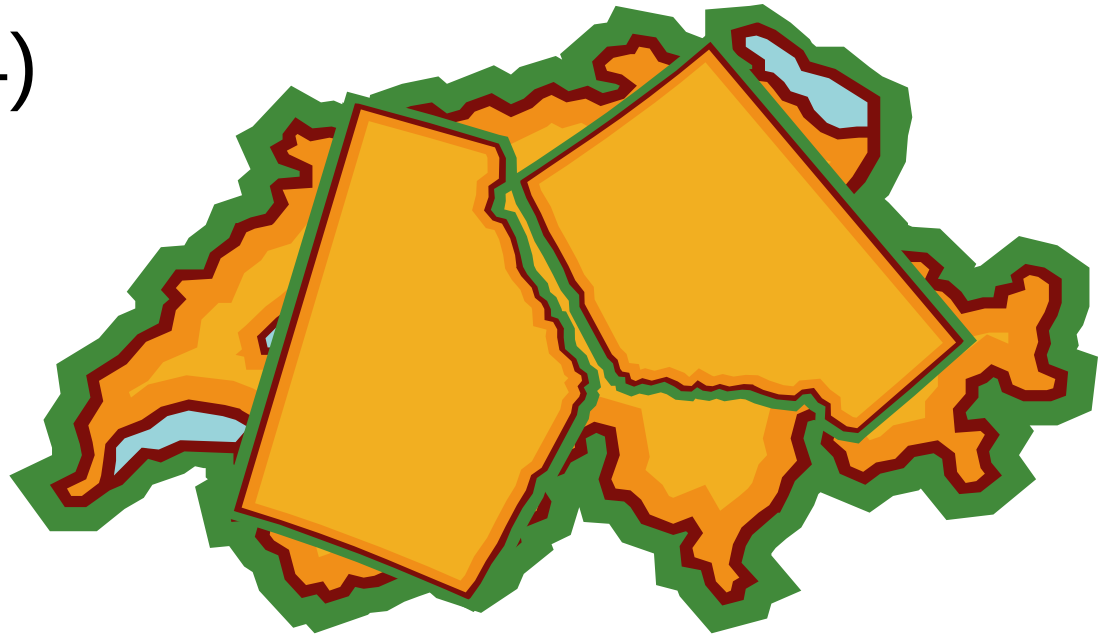
16 Switzerland = 1 Alberta

Alberta - Population

Population:

4,146,000 (2014)

(36,290,000 in Canada)



1 Switzerland = 2 Alberta

Alberta Health Services

UNIVERSITY OF ALBERTA

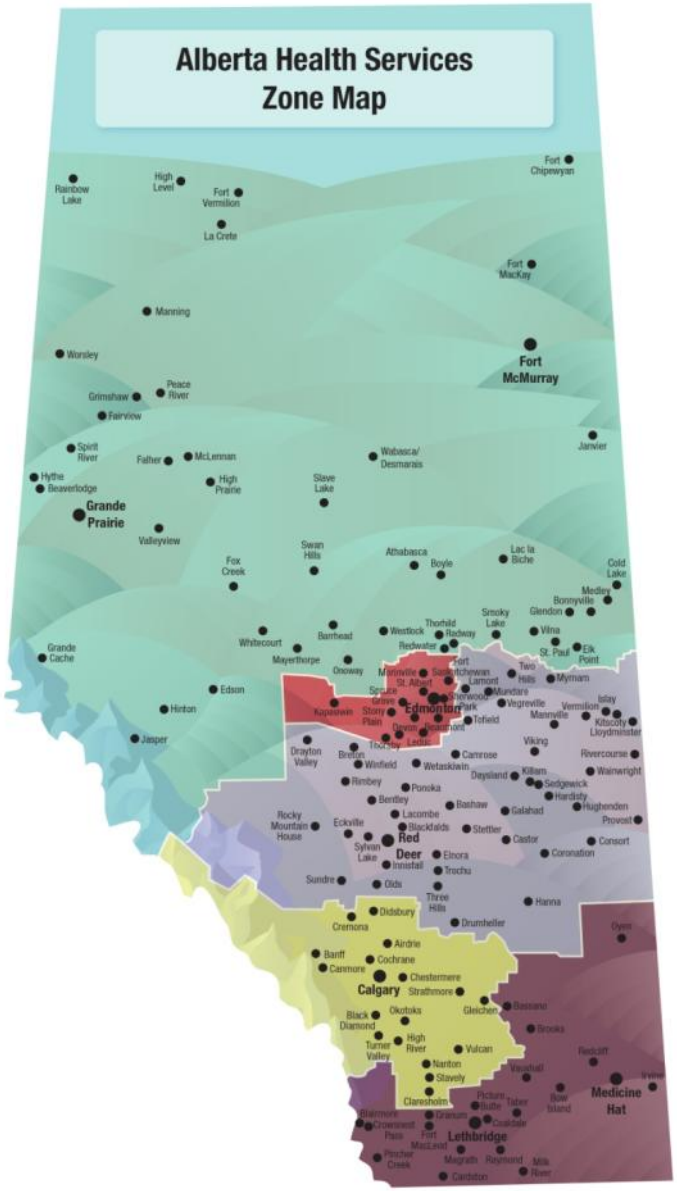
UNIVERSITY OF CALGARY

Calgary

Alberta Health Services

- Single provincial health system
- Cancer:
  - 17,985 new cancer cases
  - 5,869 cancer deaths
  - 25% of deaths due to cancer

- Colorectal cancer:
  - 2205 new cases
  - 632 deaths



PaCES
PALLIATIVE CARE EARLY AND SYSTEMATIC

P.a.C.E.S. PALLIATIVE CARE EARLY AND SYSTEMATIC

PATHWAY FOR CARE

1 Routine Identification

Routine identification and early referral of patients with incurable cancer to a Palliative Care clinician.

Routine Identification

Early Referral

2 Routine Screening

Oncology team members will **routinely screen for, and act on, the patient distress.**

Routine Screening

Act on Distress

3 Advance Care Planning

All teams engage in **"advance care planning"** but Oncologist will specifically share prognosis, outcomes of treatment options, and will discuss stopping disease modifying treatments.

Advance Care Planning

Share Treatment Options

4 Communication Between Teams

The pathway for care will address: **role clarity,** standardized three-way **communication** between teams (Family Medicine, Oncology, Palliative Care), **coordinated care and symptom management.**

Communication Between Teams

Coordinated Care and Management

5

The palliative care clinician will ensure every referred patient has had **the following 5 key items** addressed to fill in any gaps:

1. **Illness Understanding**
2. **Symptom Management**
3. **Decision-Making**
4. **Coping With Life-Threatening Illness**
5. **Coordinated Referrals/Prescriptions**

Clinician Ensures Palliative Pathway is Addressed

	Smooth Transition Along the Illness Trajectory	Integrated Cancer, Family Medicine and Palliative Care	Clear Sense of Emergency Contacts	Prepared for Illness Deterioration	Optimized Symptom Management	Efficient and Appropriate use of Other Health Care Sectors	24/7 Palliative Physician On-Call Support
Proposed Pathway	✓	✓	✓	✓	✓	✓	✓
Current Pathway	✗	✗	✗	✗	✗	✗	✗

IMPROVEMENTS FROM CURRENT STATE

- Less Unwanted Aggressive Care
- Education and Resources for Clinicians & Patients
- Earlier Referral to Palliative Care Nurse
- Peace of Mind
- Less Redundancy
- Less Gaps in Care
- Money Saved by Healthcare System
- More Satisfied Clinicians and Patients

Oncology barriers to PC

Literature:

- Communication within & between teams
- Accurate prognostication
- Discomfort engaging patients in difficult conversations
- Patient acceptance of PC
- Insufficient resources

- BUT, Which is Most Important?
  - What actually leads to Behavior Change?

Intervention Development

- NICE Behaviour Change Guidance
  - National Institute for Health and Care Excellence
- Behaviour Change Wheel
  - Michie et al, Implementation Science, 2011
    - Michie's Theoretical Domains Framework (TDF)
  - www.behaviourchangewheel.com

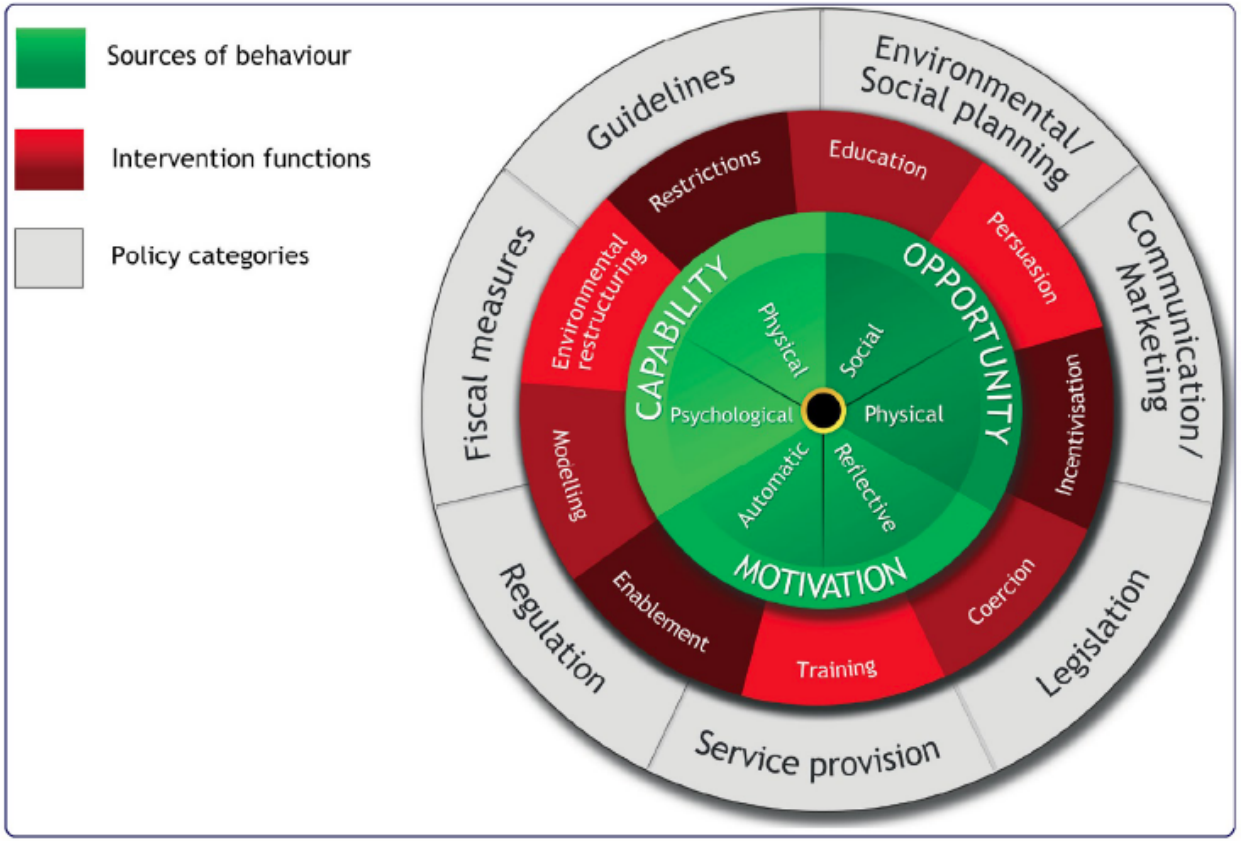
- What 3 conditions need to exist, for behaviour to change?

Behaviour Change (COM-B)

Capability	Opportunity	Motivation
Psychological	Physical environment	Reflective mechanism
Physical	Social environment	Automatic mechanisms

Behaviour Change Wheel

- Synthesis of 19 frameworks to classify interventions
- **Centre ring:** COM-B model
- **Inner ring:** 9 intervention elements
- **Outer ring:** 7 policy categories



(Michie et al., 2011)

Slide from Dr Jayna Holroyd-Leduc

TDF domains linked to COM-B components

Sources of behaviour

TDF Domains

Soc - Social influences
Env - Environmental Context and Resources
Id - Social/Professional Role and Identity
Bel Cap - Beliefs about Capabilities
Opt - Optimism
Int - Intentions
Goals - Goals
Bel Cons - Beliefs about Consequences
Reinf - Reinforcement
Em - Emotion
Know - Knowledge
Cog - Cognitive and interpersonal skills
Mem - Memory, Attention and Decision Processes
Beh Reg - Behavioural Regulation
Phys - Physical skills

From Michie, Atkins & West 2014

Understanding the barriers to Palliative Care

- Questionnaire developed based on Michie's TDF
  - 31 Questions (7 point ordinal scale)
    - Referring to PC?
    - Working with PC team members?
    - Managing patient's PC needs in clinic?
    - Recommending new routine PC pathway?
  - 4 Open-ended Qs

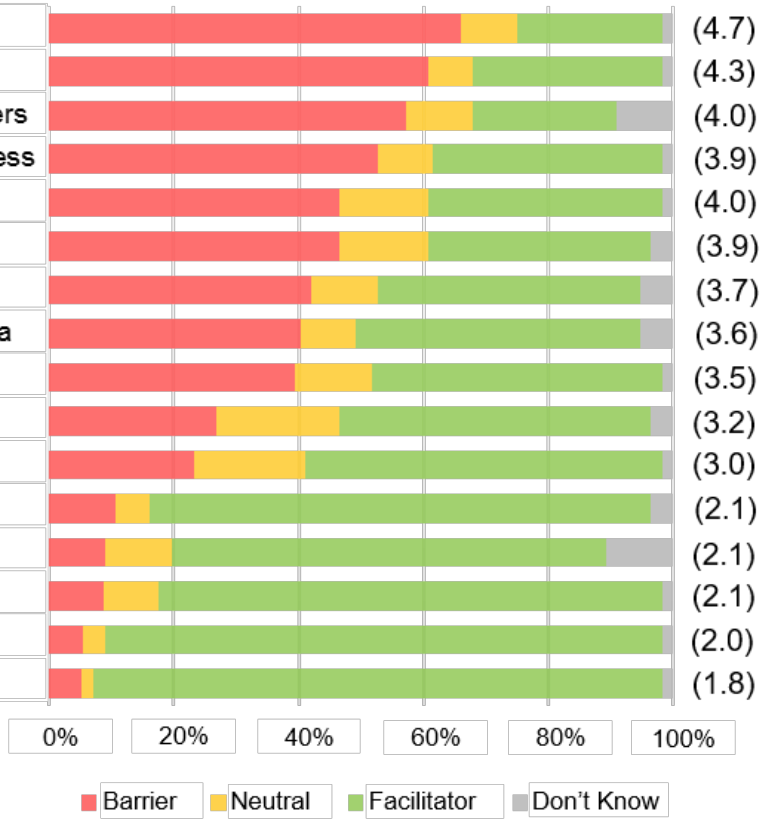
- All GI Oncology staff in Cancer Control Alberta
- Response rate: 40% (60/150)

Results - Demographics

Question	Category	Number of Respondents (n=57)	%
Professional Role	Physician	31	54
	Clinic Nurse	19	33
	Other Health Care Professional	3	5
	Nurse Practitioner	1	2
	Social worker	1	2
	Clerical	1	2
	Nurse Navigator	1	2
Cancer Centre	Cross Cancer Institute	22	39
	Tom Baker Cancer Centre	21	37
	Margery Yuill Cancer Centre	10	18
	Grand Prairie Cancer Centre	2	4
	Jack Ady Cancer Centre	2	4
Oncology Discipline	Medical Oncology	41	72
	Radiation Oncology	10	18
	Surgical Oncology	4	7
	Other	3	5
Number of patients seen	> 25 per month	22	39
	10-25 per month	18	32
	< 10 per month	17	30
Gender	Female	36	63
	Male	21	37
Years in Professional Role	>15 years	20	35
	>10-15 years	14	25
	>5-10 years	11	19
	>2-5 years	5	9
	0-2 years	7	12

Results

Survey section	Survey Question (abbr.)	Survey Results (Barrier Strength out of 7)	Behavioural Domain
Addressing PC needs myself	My time/competing priorities	(4.7)	Opportunity
Working with PC teams	Role confusion	(4.3)	
Working with PC teams	Lack of process for executing orders	(4.0)	
Referral to PC	My referral increases patient distress	(3.9)	Motivation
Working with PC teams	Lack of standard communication	(4.0)	Capability
Working with PC teams	Document transfer shortfalls	(3.9)	Opportunity
Referral to PC	Lack of PC providers/services	(3.7)	
Referral to PC	Referral pathway issues in my area	(3.6)	Capability
Addressing PC needs myself	My capability	(3.5)	
Addressing PC needs myself	Lack of leadership in my area	(3.2)	Opportunity
Addressing PC needs myself	Increases patient distress	(3.0)	Motivation
Addressing PC needs myself	Not my responsibility	(2.1)	
Working with PC teams	Bad previous experience	(2.1)	
Referral to PC	Referral not my responsibility	(2.1)	
Addressing PC needs myself	Perceive lack of benefit	(2.0)	
Referral to PC	Little benefit to patient	(1.8)	



Top 3 Facilitators

1. There is benefit to the patient (Motivation: Referral to PC)
2. There is benefit to PC (Motivation: Addressing PC needs myself)
3. Referral is my responsibility (Motivation: Referral to PC)

Top 3 Barriers

1. My time / Competing priorities (Opportunity: Addressing PC needs myself)
2. Role confusion (Opportunity: Working with PC teams)
3. Lack of process for executing orders (Opportunity: Working with PC teams)

Barriers to Early PC: PC Service

- PC Service:
  - Insufficient Resources
  - PC services perceived as sub-optimal

Currently, when I refer to PC, the patient is seen once or twice and then discharged from clinic once their symptoms are stable. There is no ongoing follow-up and they need to be re-referred if new symptoms develop. In patients with uncomplicated symptom issues, it is simpler to treat them myself. [Oncology MD]

Barriers to Early PC: Clinician

- Clinician:
  - Poor Communication
  - Professional Role Confusion
  - Confusion around PC Services
  - Difficult Conversation

The need for frank and open discussion starting with the primary doctors involved. Very difficult discussion for many oncology doctors. [Oncology RN]

There seems to be no clear role division. [Oncology RN]

PaCES
PALLIATIVE CARE EARLY AND SYSTEMATIC

Barriers to Early PC: Patient

- Patient:
  - Patient does not qualify for PC services
  - PC not needed
  - Patient declines

Sometimes I find I think that a patient would benefit, the patient agrees to the referral, and then when they are contacted the patient feels they don't need PC services [Oncology RN]

They are sometimes refused as we are told they are not yet a "suitable" client. [Oncology RN]

Integration of Early PC (1)

(Oncology Clinician Ideas)

- Processes:
  - Clinical Practice Guidelines
  - Standard processes for delivering PC
  - Standard communication to find PC treatment plans and changes
  - Need a Navigator

Integration of Early PC (2)

(Oncology Clinician Ideas)

- Education/Awareness
  - Patient/Families about PC early in their trajectory
  - Clinician education

- Resources
  - Increased PC resources

Survey findings summarized

- Oncology staff are motivated
- They mostly feel capable
- But we need better opportunities to provide great palliative care

Next steps

- Early Palliative Care pathway being developed
- Stakeholder engagement:
  - Process Maps
  - Pain points
  - Solutions
  - Prioritization of Solutions
- Sustainability

THANK YOU!!!

Email: ayn.sinnarajah@ahs.ca

Twitter: @DrASinnarajah

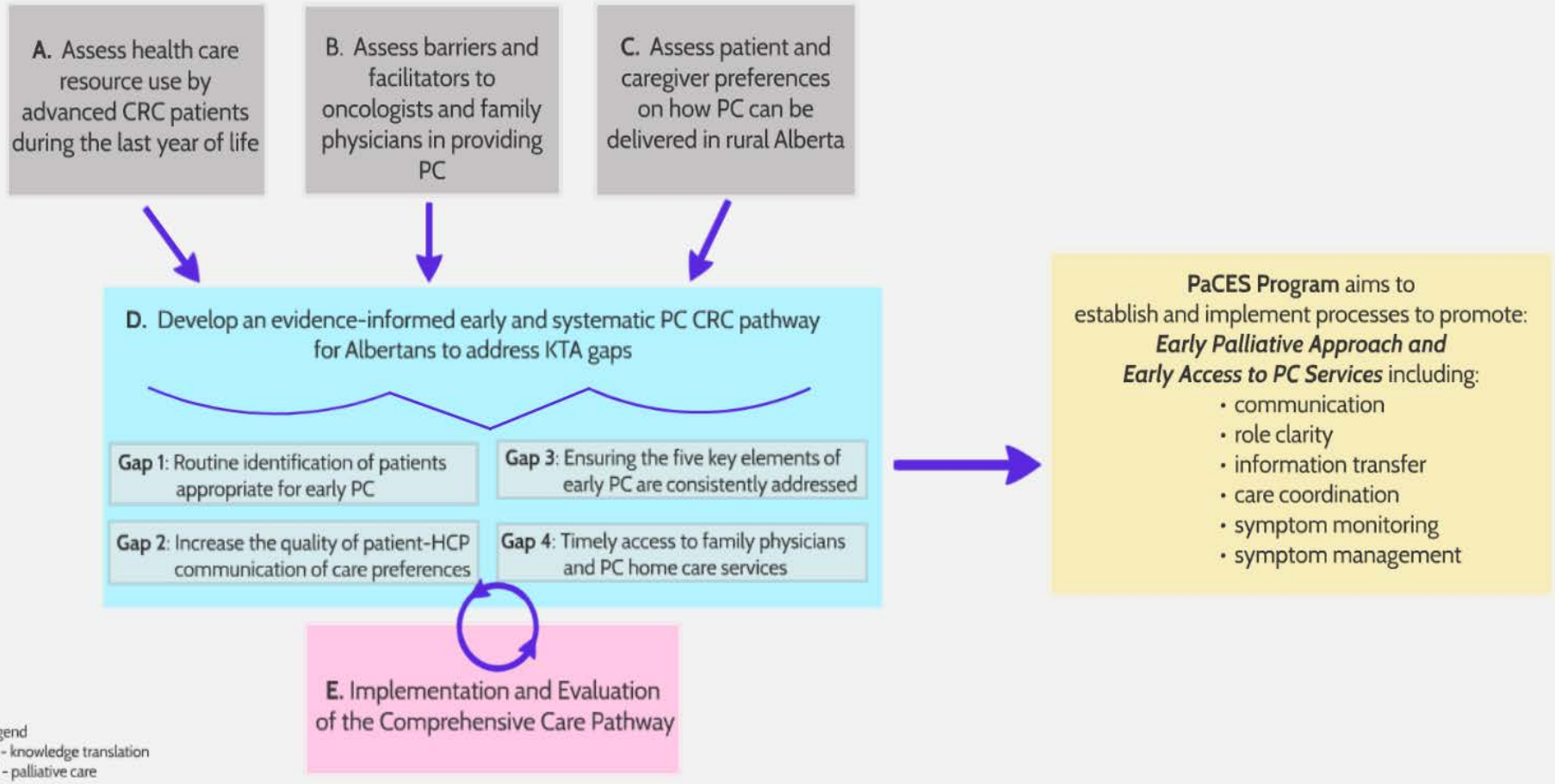
PaCES

PALLIATIVE CARE EARLY AND SYSTEMATIC

PaCES - Colorectal Cancer

Palliative Care Early & Systematic Program

A comprehensive program incorporating research, clinical analysis, and KT to understand and improve palliative care in Alberta



Legend
KT - knowledge translation
PC - palliative care
CRC - colorectal cancer
HCP - health care provider
KTA - knowledge-to-action

Table 2. Clinician identified barriers to providing early, systematic, and oncology-integrated palliative care for advanced colorectal cancer patients.

Category	Theme	Exemplar Quote
PC SERVICE	INSUFFICIENT RESOURCES	Not enough nursing support for effective symptom control management and follow-up. Not enough clinic room/time to see, follow-up, patients in a timely fashion. [Physician 1, TBCC]
	PC SERVICES PERCEIVED AS SUB-OPTIMAL	Currently, when I refer to PC, the patient is seen once or twice and then discharged from clinic once their symptoms are stable. There is no ongoing follow-up and they need to be re-referred if new symptoms develop. In patients with uncomplicated symptom issues, it is simpler to treat them myself. [Physician 2, CCI]
CLINICIAN	POOR COMMUNICATION	All teams are excellent, it is the fact that no one cooperates together. The [patient] and family have to retell their story and journey over and over. They need one point of contact! [Nurse 1, MYCC]
	PROFESSIONAL ROLE CONFUSION	There seems to be no clear role division. [Nurse 2, TBCC]
	CONFUSION AROUND PC SERVICES	I feel staff need to understand that the PC program is not only for patients who are going to pass in "a week". It is for patients who may have months or years to live but need extra services for example, pain control, home care, etc. [Nurse 3, MYCC]
	DIFFICULT CONVERSATION	The need for frank and open discussion starting with the primary doctors involved. Very difficult discussion for many oncology doctors. [Nurse 1, MYCC]
	PATIENT DOES NOT QUALIFY FOR PC SERVICES	They are sometimes refused as we are told they are not yet a "suitable" client. [Nurse 4, TBCC]
PATIENT	PC NOT NEEDED	Active treatment continues until end of life. [Other healthcare professional, Other site]
	PATIENT DECLINES	Sometimes I find I think that a patient would benefit, the patient agrees to the referral, and then when they are contacted the patient feels they don't need PC services. [Nurse 5, CCI]

Abbreviations: PC, palliative care; TBCC, Tom Bake Cancer Centre; CCI, Cross Cancer Institute; MYCC, Margery Yuill Cancer Centre.

Table 3. Oncology clinicians' ideas for improving the integration of early palliative care within cancer care for advanced colorectal cancer patients.

Theme	Theme Description	Exemplar Quotes
PROCESSES	Need clinical practice guidelines in the management of palliative care patients in the province	Establish clinical practice guidelines in the management of palliative PC in the province. [Physician 3, TBCC]
	Need process map for delivering standardized PC	I think a process map for the [outpatient department] to start the process helps. And a chronological communication sheet that we can quickly refer to rather than trying to piece together all the steps that have been addressed. i.e. Looking through paper chart...then ARIA® [oncology information system] notes...then talking to clinic nurse.....or talking with doctor. A lot of time wasted trying to figure things out [Nurse 6, CCI]
	Need standardized communication processes (chronological communication sheets) to easily find PC treatment plans and changes	
	Patients need one point of contact, a person who is well informed and knows the process and how care teams are integrated	One point of contact. Integrate home care and teams to give patient and family a primary contact and a family conference immediately. [Nurse 1, MYCC]
EDUCATION /AWARENESS	Systematically educate patients/families about PC early in their disease trajectory	Standardized patient information to give to all metastatic patients about the role of PC and the services they offer. [Physician 4, JACC]
	Systematically educate clinicians about PC: established practice guidelines, established process map	Education, communication and review for all staff members (nurses). This would have everyone using the same message and patients will not become confused or have different messages from staff. [Nurse 3, MYCC]
RESOURCES	Increase PC resources so that more patients can be seen	Finding the time and space to conduct the referral. [Physician 5, TBCC]

Abbreviations: PC, palliative care; TBCC, Tom Bake Cancer Centre; CCI, Cross Cancer Institute; MYCC, Margery Yuill Cancer Centre.