Integrated Supportive Care

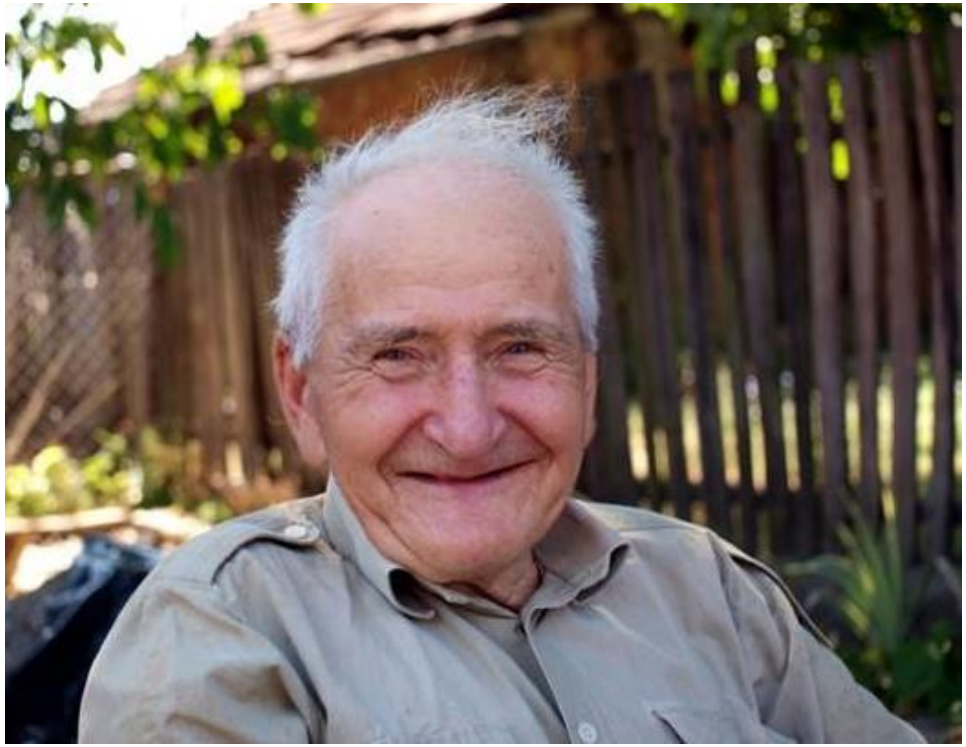
Improving care for patients with advanced chronic illness & cancer within their home communities

Dr. Sara Davison

- Professor of Medicine, University of Alberta
- Director, Kidney Supportive Care Research Group

Dr. Brad Bahler

- Primary Care Liaison, Primary Health Care Integration Network
- Medical Director ACTT Program – AMA & Primary Care Network Evolution



Purpose

- ✓ Generate awareness around Integrated Supportive Care
- ✓ Promote multi-disciplinary involvement
- ✓ Enhance system integration

Alberta Health Services

A working example is the on-line, interactive, co-designed Conservative Kidney Management Pathway

Plan

Step 1

Choosing CKM

If your patient requires support, consider using the Patient Decision Aid

Step 2

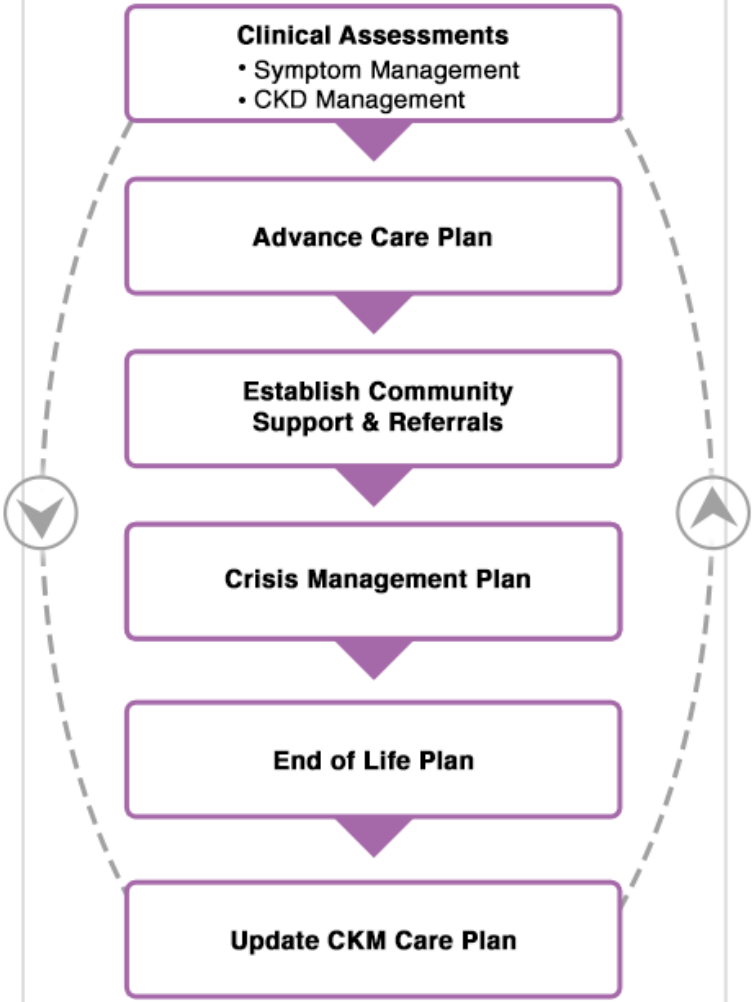
Initiate Care Planning

- Care Plan
- Engage Primary Care

Manage

Step 3

CKM Care



Support

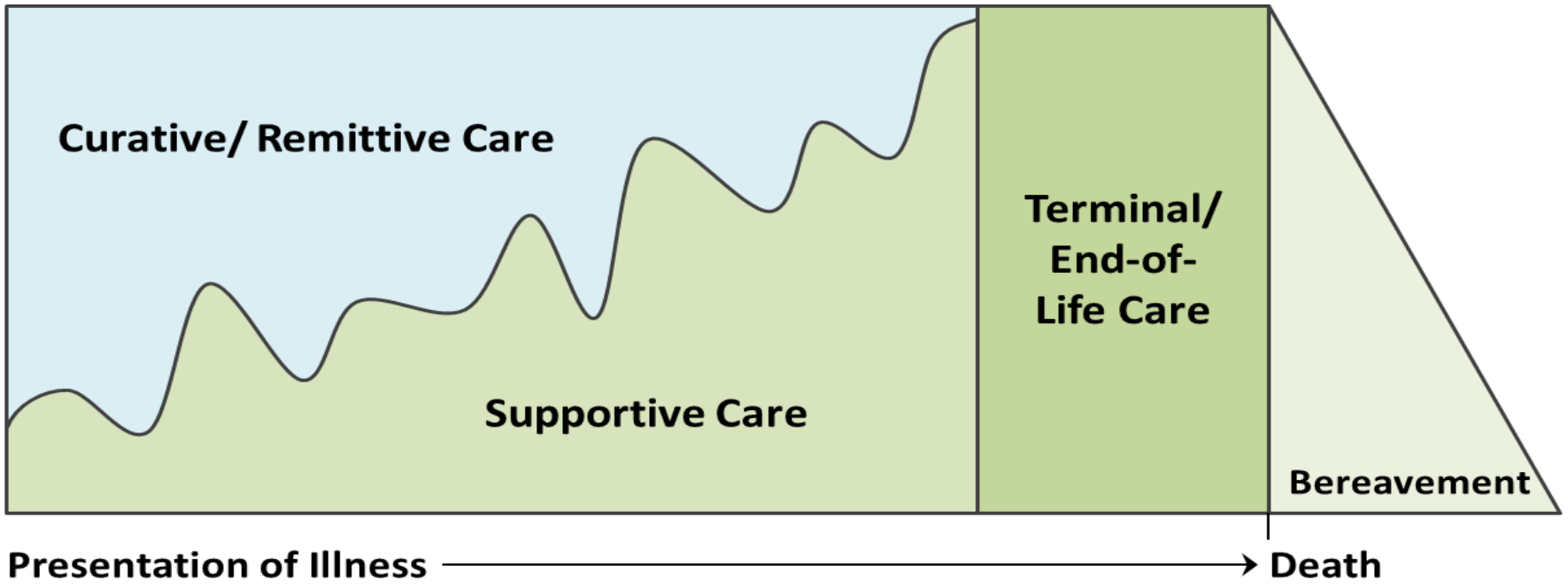
Step 4

Grief & Loss

CONSERVATIVE KIDNEY PROFESSIONALS PATHWAY

Integrated Supportive Care

The guiding principle in CKM is that all investigations and management are aligned with the patient's **preferences**, **goals** & **disease trajectory**



The Reality & Challenges for Primary Care

"Approach Conflict"

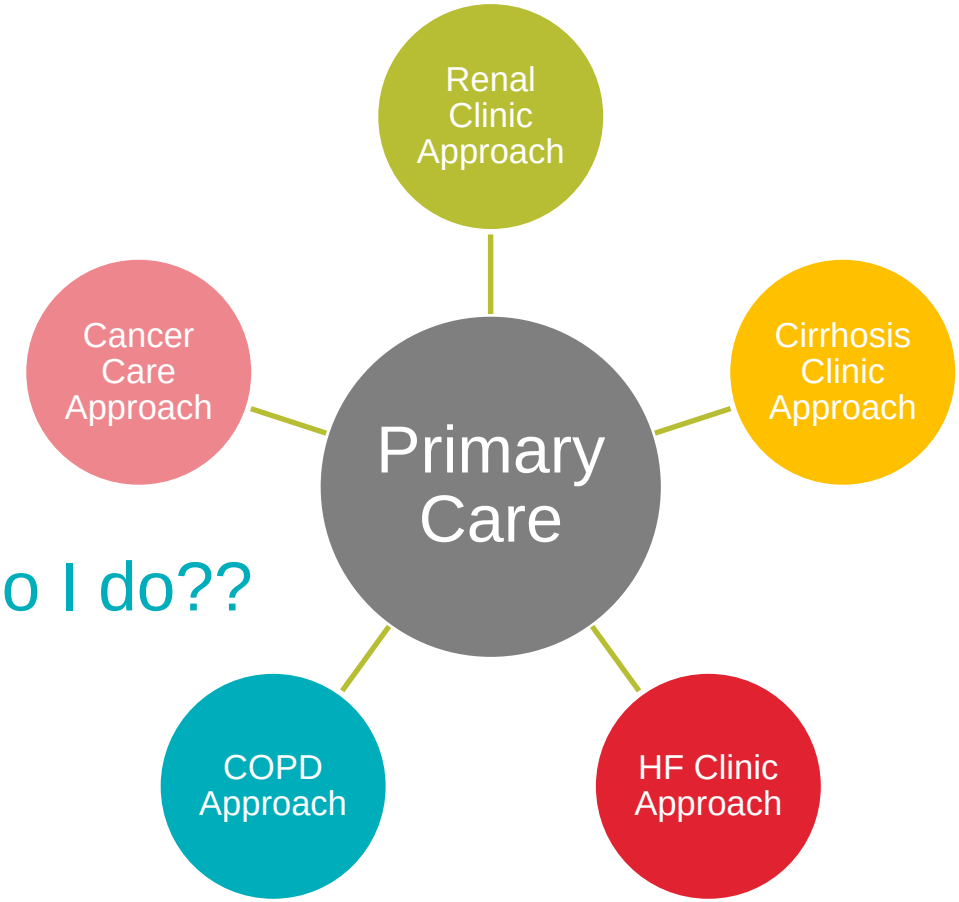
Communication Unclear

Responsibility Unclear

NO standardization

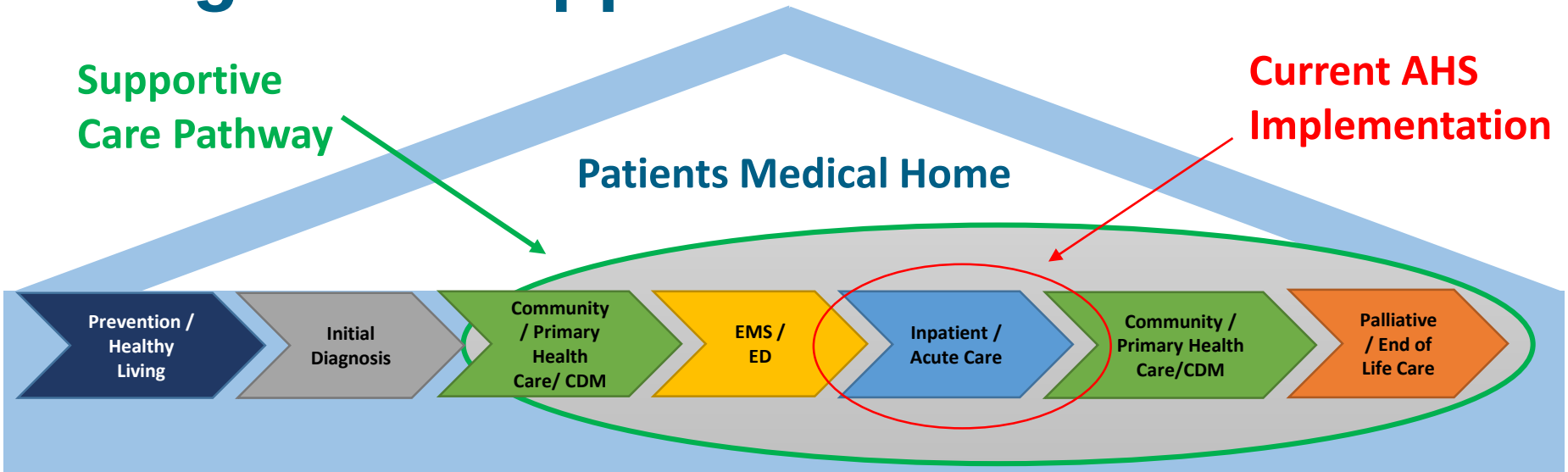
Tools Not Useful - What do I do??

Access Issues



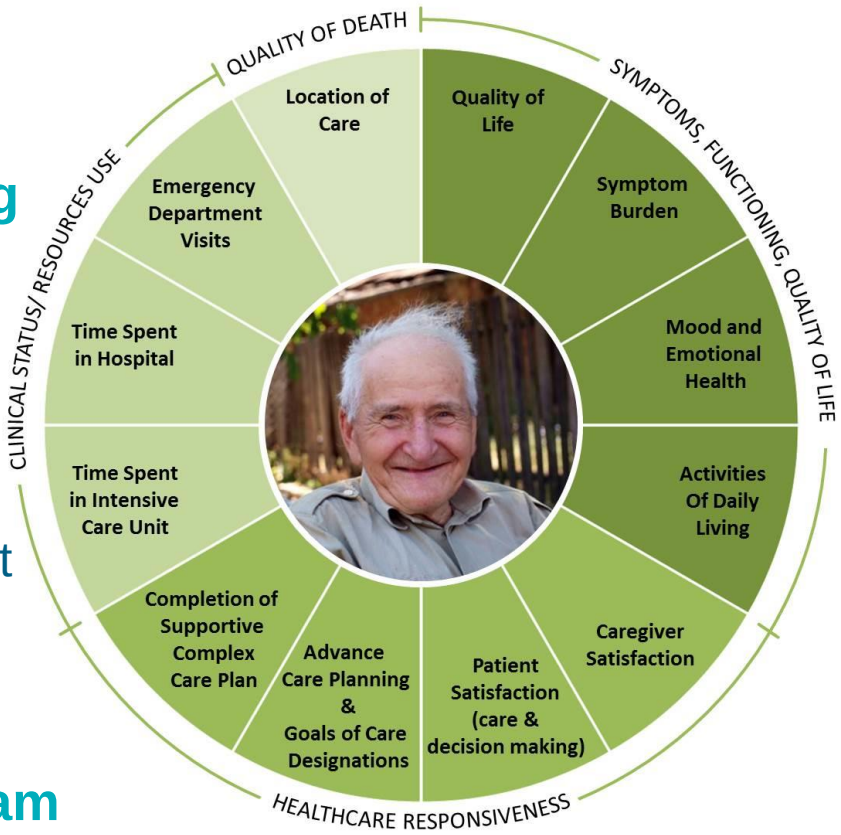
Our vision is a single supportive care pathway for all Albertans with advanced chronic illness

Integrated Supportive Care



- Disease inclusive – advanced chronic medical conditions
- PHCIN, Pan-SCN, provincial - acute, primary & community care
- Integrates current AHS pathways work – spread across continuum of care
- **Better support for patients in their medical home**

Patient First



Patient involvement in care planning to align patient preferences with actual delivered care

- ✓ Patient Decision Aids
- ✓ Patient-informed Care Plans
- ✓ Patient education & self-management

The right care, in the right place, at the right time, by the right health team

- ✓ Improve healthcare experience & patient satisfaction
- ✓ Improve communication between care providers, patients & family
- ✓ Integrated approaches to home & community-based care

Adapted from the International Consortium for Health Outcome Measures

Pathway Components

A co-designed, interactive pathway - operationalize care and key patient decision-points into 'how to' steps

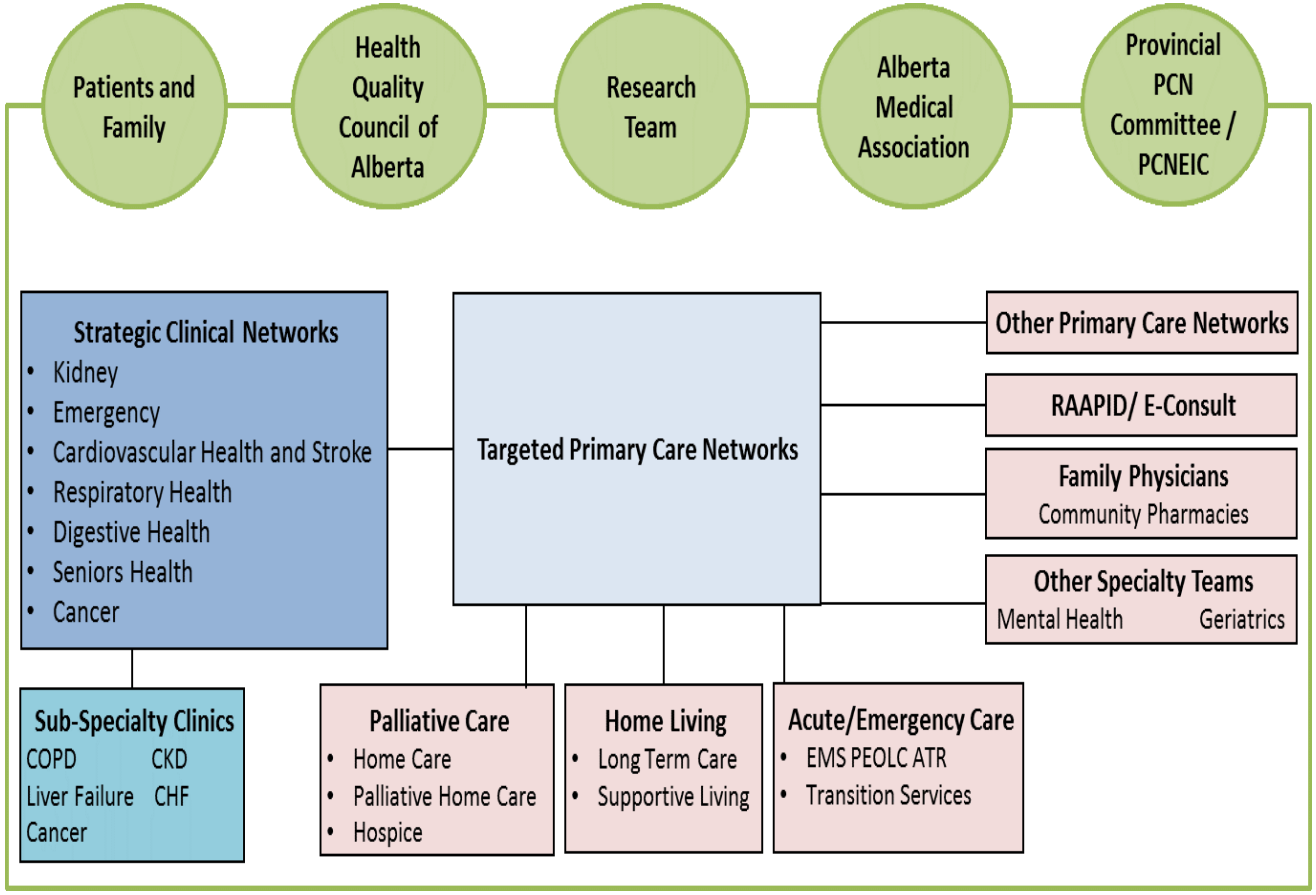
Health care provider portal

- Access for all multidisciplinary care providers
- Facilitate integrated & individualized care plans
- Enhance community supports & crisis management

Patient portal

- Educational materials & patient decision aids
- Improve experience, satisfaction, communication, & health outcomes

How results will be achieved?



Stakeholder Engagement for the Supportive Care Pathway

Primary Care Priority Alignment

Continuity of care – relational, informational & management continuity for patients with advanced stage chronic diseases & cancer

Team-based care improvements – promotes effective use of clinical & extended care teams (PCN, AHS and community) in delivering coordinated, integrated, shared care

Evidence-based care – co-design of disease inclusive clinical decision supports

Transitions in care

Alignment of existing tools (e.g. EQ5D) to help build capacity & reach in practice

AHS

Priority Alignment

- Practice Variation
- Enhancing Care in the Community
- Specialty Access & Integration
- Accountability

Clinical Engagement for Co-design

Integrated Supportive Care

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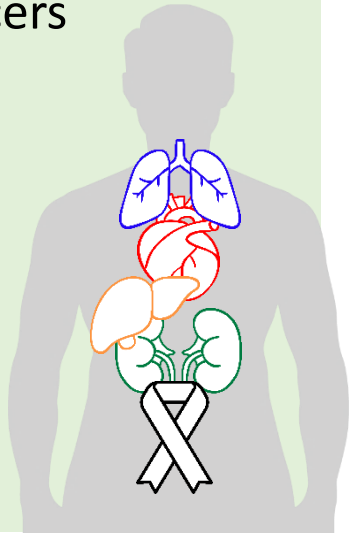
Two Sides of the Care Coin

SUPPORTIVE CARE KIDNEY RESEARCH GROUP

- ✓ **Primary Care** implementation
- ✓ Chronic diseases & solid organ cancers



Common elements

Integrated Care:

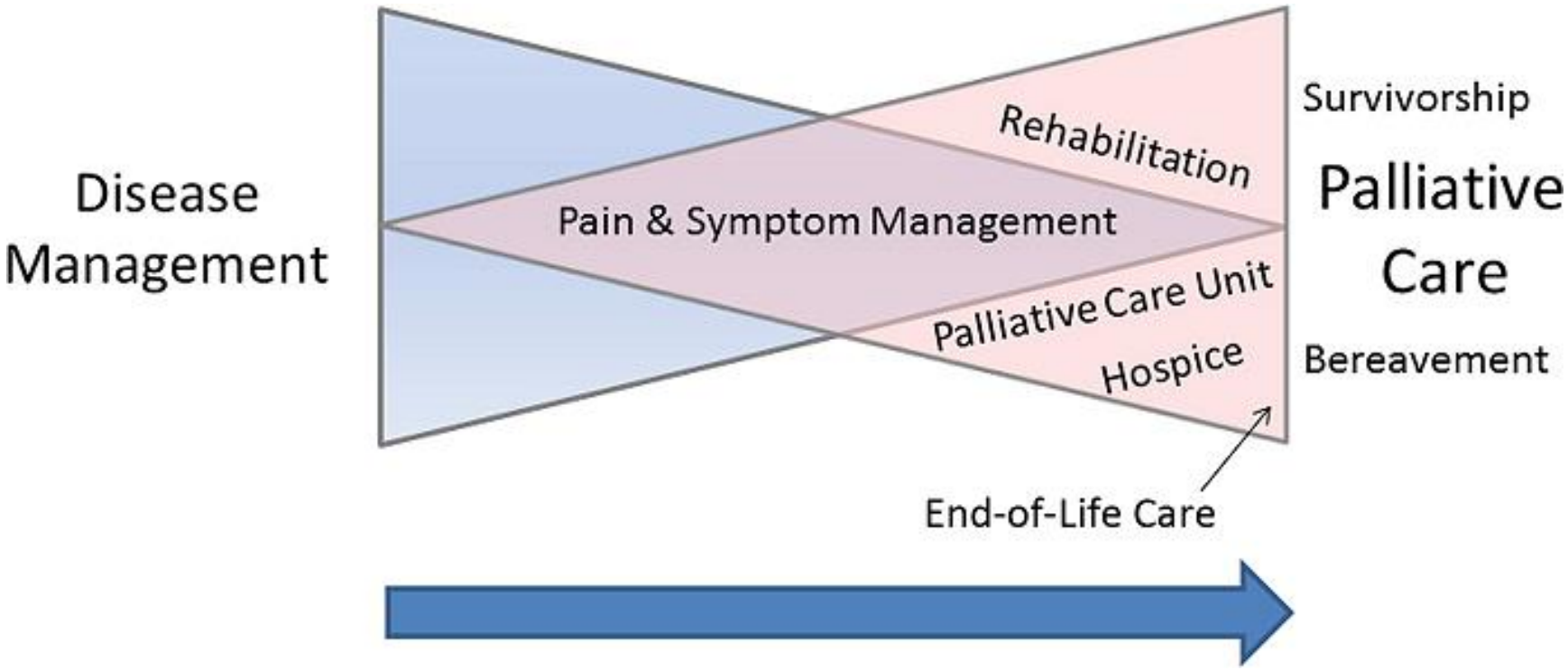
- ✓ Assessment
- ✓ Symptom Management
- ✓ Care Coordination
  - ✓ Shared care plans
- ✓ Crisis Management
- ✓ Appropriateness of Care

PaCES

PALLIATIVE CARE EARLY AND SYSTEMATIC

- ✓ **Cancer Centre** Implementation
- ✓ Extend CRC guideline to all cancers

Integrated Supportive Care



Hawley PH. The Bow Tie Model of 21st Century Palliative Care. JPSM. Jan 2014

Integrated Supportive Care – Steering Committee

Primary Care
(Patient's Medical Home)

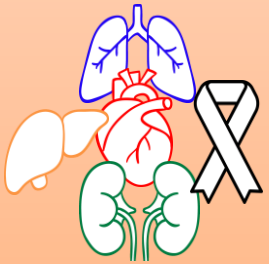
Common Elements of Care

Common Elements +Disease Specific Nuances

Disease Specific Guidelines

Integrated Shared Care Plan

- ✓ **Care Planning Tools (patient decision aids)**
- ✓ **Care Coordination**
- ✓ **Appropriateness of Care**

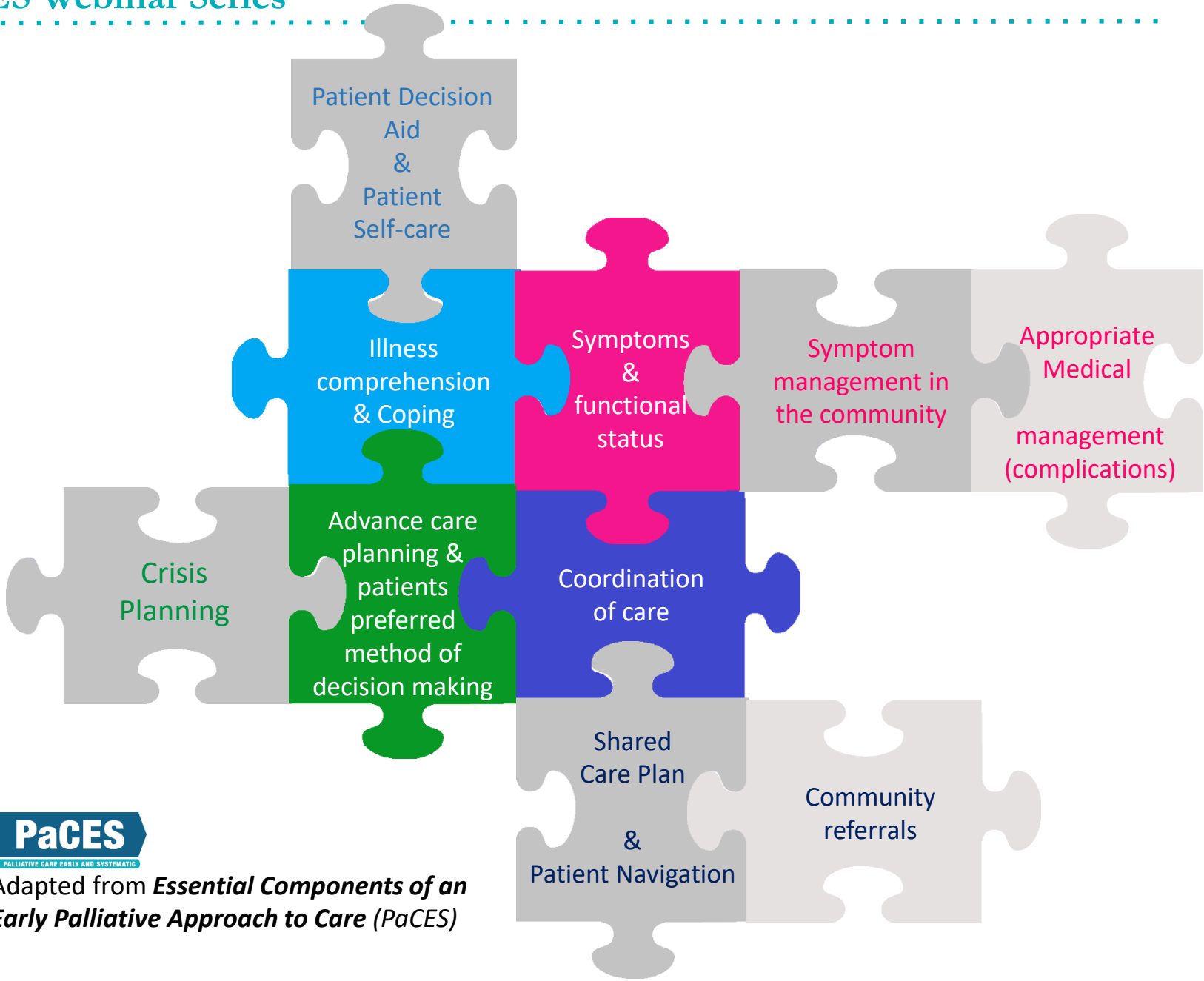


- Clinical Assessment
- Symptom Screening
- Advance Care Plan GCD
- Community Supports & Referrals
- Crisis Management
- Terminal care, Grief & Loss

- Symptom Management
- Risk Stratification
- Frailty Assessment

Assessments

- Symptom Management
- Treatment Algorithms
- Key Decision Points



PaCES
PALLIATIVE CARE EARLY AND SYSTEMATIC

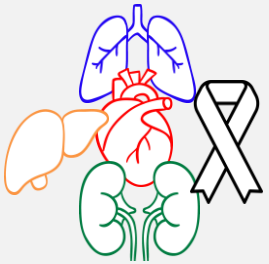
Adapted from ***Essential Components of an Early Palliative Approach to Care*** *(PaCES)*

Integrated Supportive Care – Steering Committee

Primary Care (Patient's Medical Home) | Common Elements of Care | **Common Elements** | Disease Specific Guidelines

Integrated Shared Care Plan

- ✓ Care Planning Tools (patient decision aids)
- ✓ Care Coordination
- ✓ Appropriateness of Care



Common Elements of Care

- Clinical Assessment
- Symptom Screening
- ACP/ GCD
- Community Supports & Referrals
- Crisis Management
- Terminal care, Grief & Loss

+Disease Specific Nuances

Symptom Management

- Constipation
- Diarrhea
- Cancer Pain
- Numbness/tingling
- Memory loss
- Insomnia

Risk Stratification

- Early Palliative Approach to Care
- Monitoring for Transition Points in Care
  - ✓ ESAS ≥ 7/10 / PRO Dashboard
  - ✓ ECOG ≥ 3

Frailty Assessment

Frailty & malnutrition screening

Assessments

Symptom Management

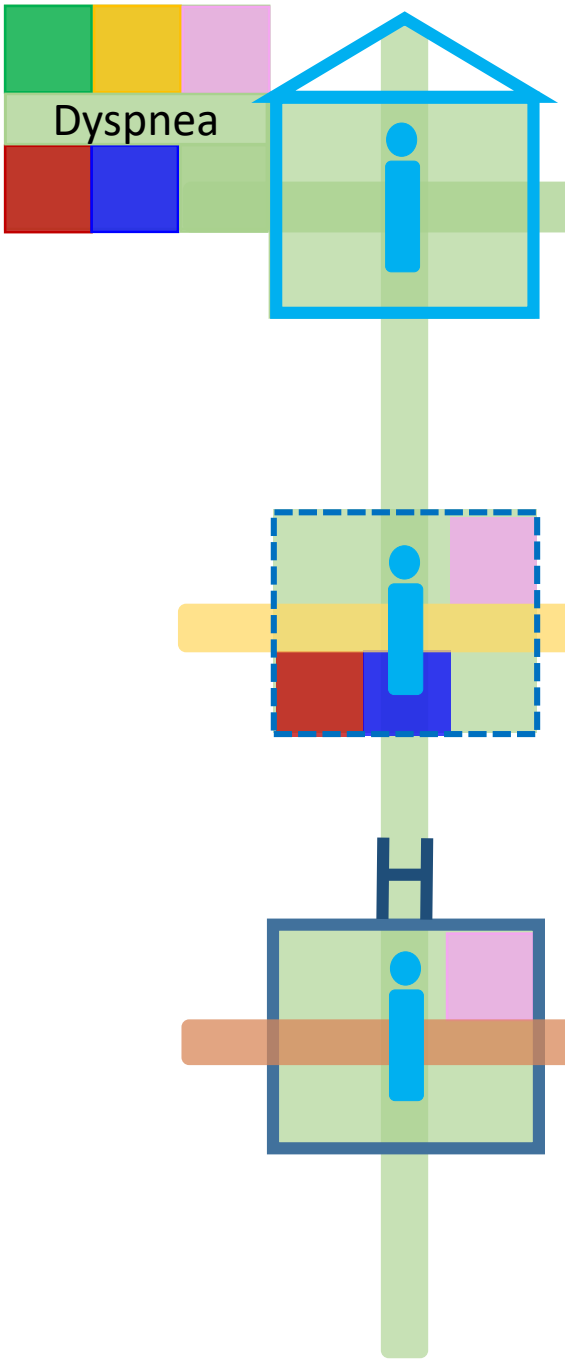
- Delirium
- VTE
- Tenesmus
- Hemoptysis
- Oral Care
- Febrile Neutropenia
- Appetite Loss/Cachexia
- Chemo Induced
- ✓ Peripheral Neuropathy
- ✓ Nausea/vomiting

Treatment Algorithms

EOL Algorithms

Key Decision Points

- Paracentesis
- Thoracentesis
- Transfusions
  - ✓ Medications
  - ✓ Compound subcutaneous
- Hospice Referral



one : path

Core Symptom Guidelines

Primary Care

- ❑ Symptom Screening
  - ✓ Indicators/flags
  - ✓ Investigations
- ❑ General symptom management/monitoring
  - ✓ Non-pharmacological
  - ✓ Pharmacological & polypharmacy
- ❑ Patient education and self-care

Disease Nuanced Care

Shared Care

- ❑ Specialist treatment/care
  - ❑ Comorbidity mix
  - ❑ Treatment related
  - ❑ Complexity flagging
- ❑ Risk Stratification / prognostic indicators
  - ✓ Contraindications
- ❑ Specialist referrals (role negotiation)

Disease Specific Care

Specialist Care

- ❑ Pharmacological management
- ❑ Unique symptom management
  - ✓ Treatment Algorithms
  - ✓ Key decision points
  - ✓ Management referrals (i.e. pain clinic)

Implications to Community Services

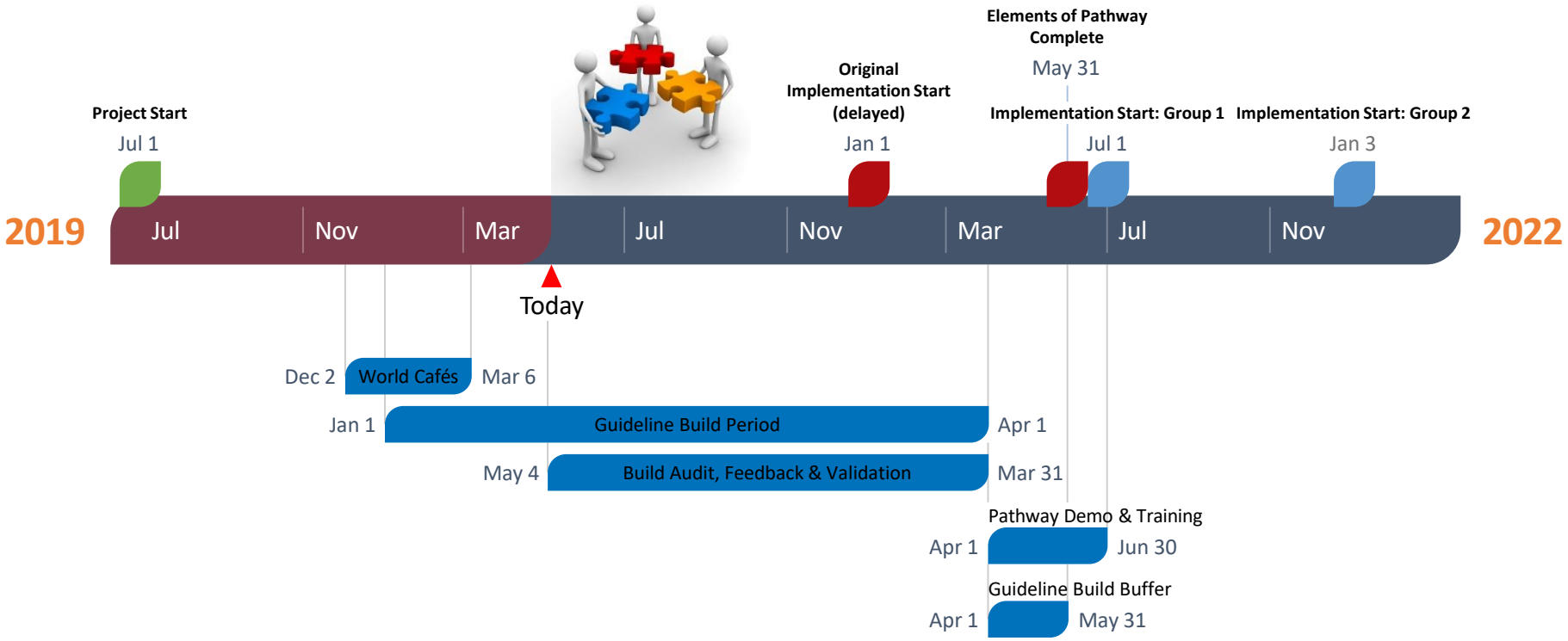
- ↑ demand on community services

- Expanded scope of practice

- Additional training required to support care delivery

- Coordinated shared care enhancements

Timeline: Integrated Supportive Care



Next Steps

- Identify individuals (primary care & specialists) to inform content
- Strike clinical working groups
  - ✓tumour teams
  - ✓specialty areas

Acknowledgements

Funders

Alberta Health Services

ALBERTA INNOVATES

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

Partners

ALBERTA MEDICAL ASSOCIATION

HQCA Health Quality Council of Alberta

EnACt

Primary Care Networks

UNIVERSITY OF ALBERTA

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Jessica Simon
Ayn Sinnarajah
Marc Kerba
Sharon Watanabe
Amy Tan
Patricia Tang

Strategic Clinical Networks

- ✓ Cancer SCN
- ✓ Cardiovascular Health and Stroke
- ✓ Digestive Health
- ✓ Emergency
- ✓ Kidney Health
- ✓ Respiratory Health
- ✓ Seniors SCN
- ✓ Primary Health Care Integration Network

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