Integrating palliative care into the health care system

Maryse Bouvette & Dr. José Pereira

Disclosure

Relationship with Commercial Interest:	**Commercial Support:**	**Mitigating Potential Biases:**
Nil to disclose]	• No Industry funding	Nil to report

None

Learning objectives

At the end of this session, you should be able to:

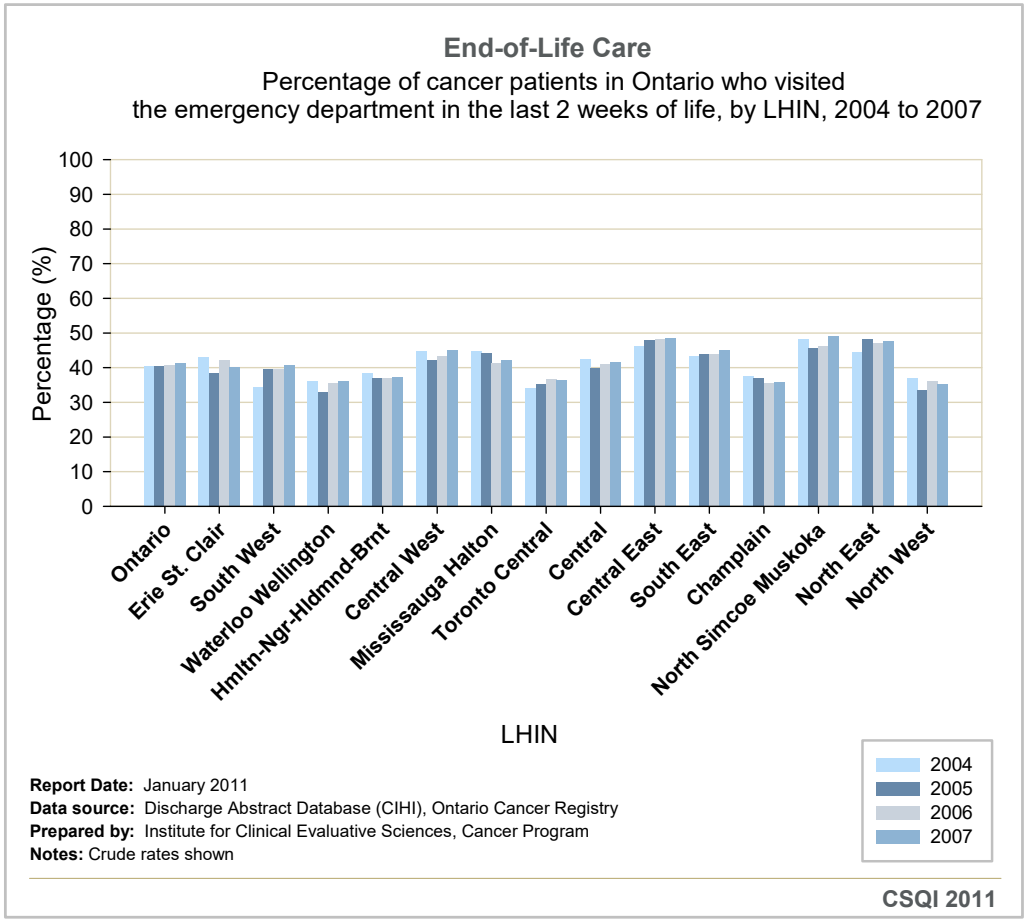
- Describe the different levels of palliative care services needed in a health care system
- Describe the different settings of care that palliative care is needed in.
- List essential palliative care services

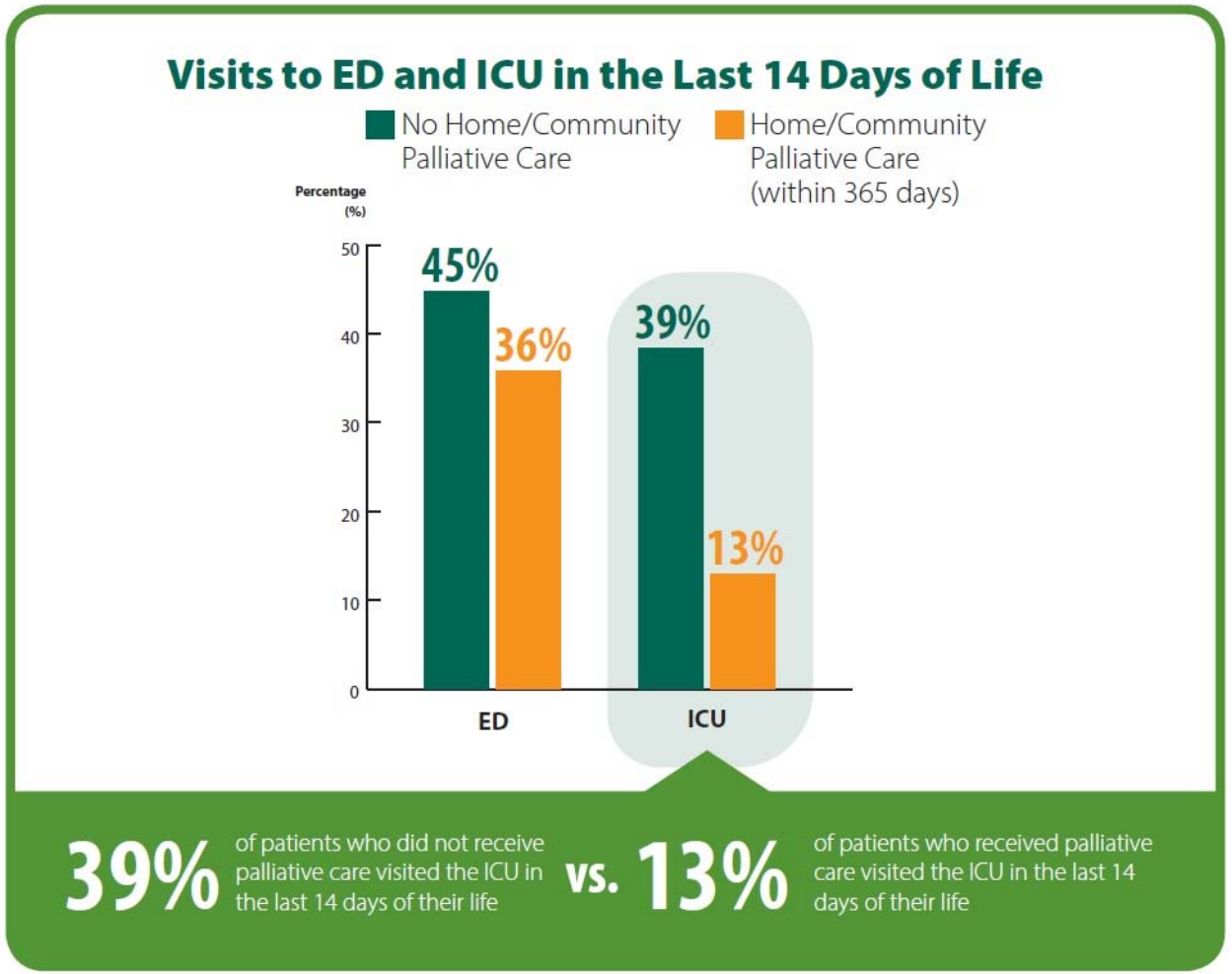
Only 15% to 30% of Canadians have access to Palliative Care

Canadian Hospice Palliative Care Association. The Way Forward 2014

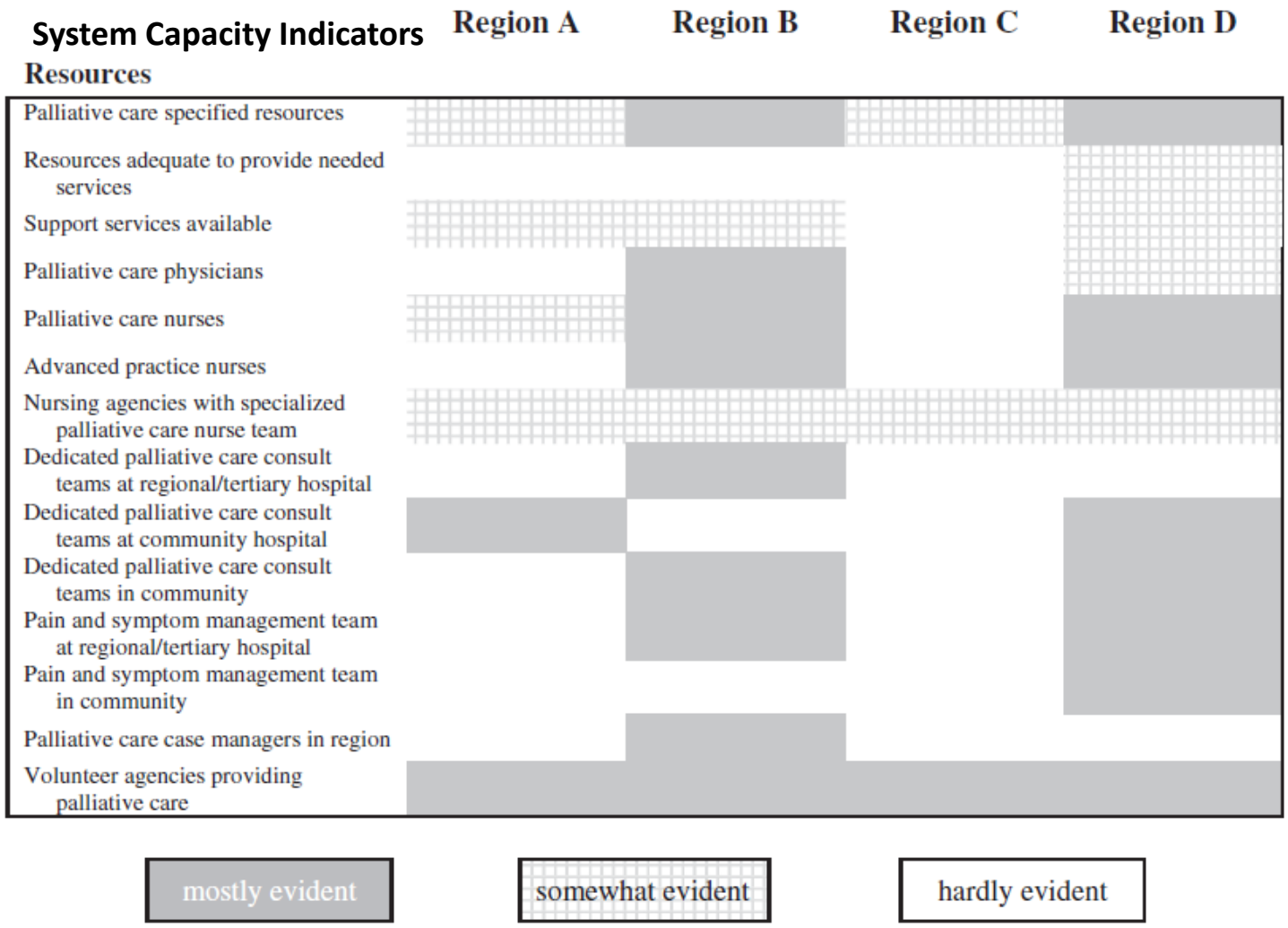
How do we get to 100%?

Cancer Care Ontario: Percentage of cancer patients in Ontario who visited the emergency department (ED) in the last 2 weeks of life, by LHIN, 2004–2007





2016-2019: Ontario Renal Network Palliative Care Report: Recommendations towards an approach for chronic kidney disease



Sussman J, et al. Pall Med 2011

How do we meet the needs?

Which of these patients might benefit from a palliative care approach?

Mrs. Mary T
66 years old. Advanced pancreatic cancer; liver metastases and cachexia. Disease progression despite chemotherapy.

Mr. Paul L
53 years old. Recent diagnosis of lung cancer with mediastinal metastases. Awaiting oncology consult regarding further treatment.

Mr. Morris C
73 years old. Advanced COPD; Lung function 30% normal. Shortness of breath on mild exertion.

- Video

Palliative Care: Early is better than late!

- Compared to late referred patients, patients with early palliative care referrals had:
  - **Less depression & anxiety**
  - **Better quality of life**
  - **Lived longer (3 months)**

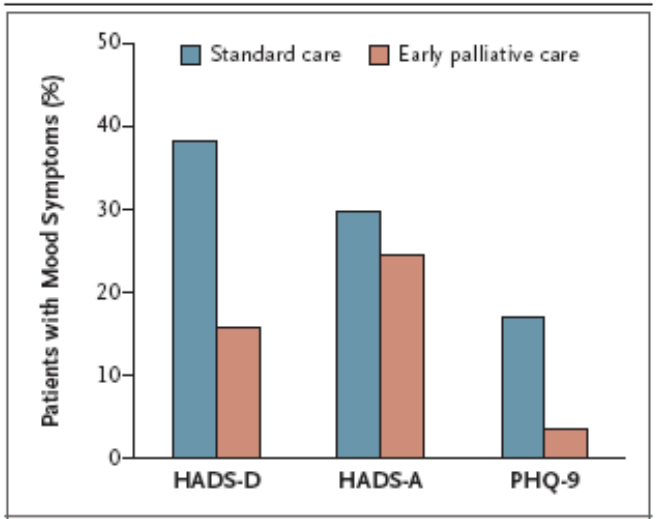
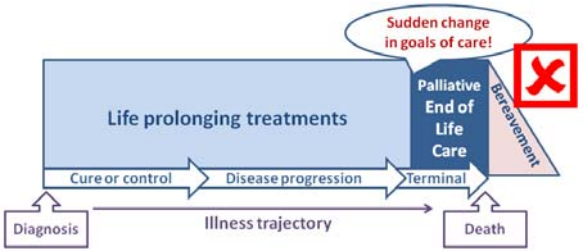


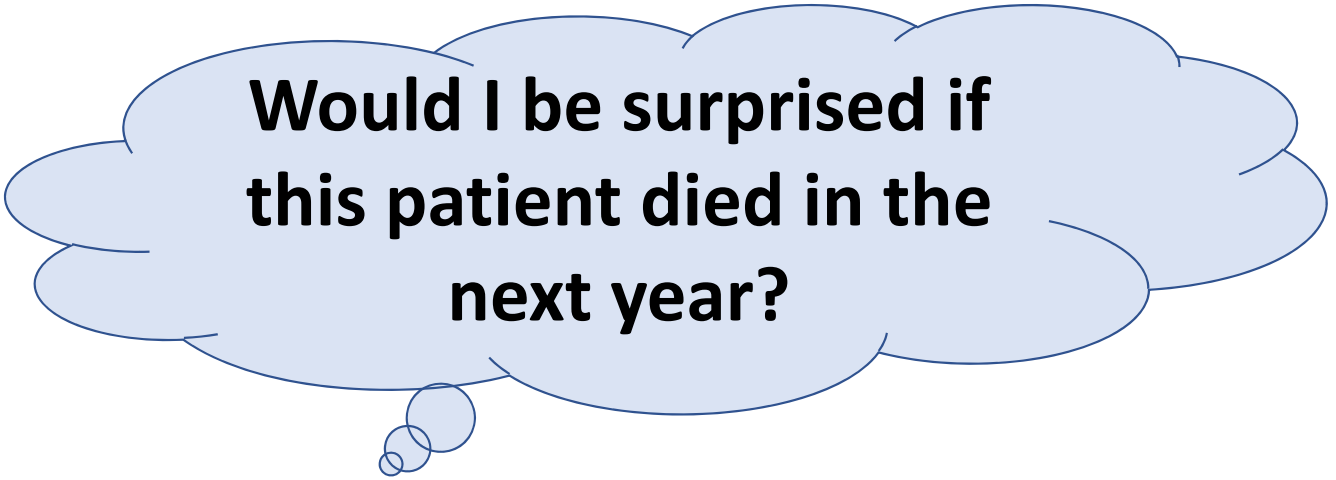
Figure 2. Twelve-Week Outcomes of Assessments of Mood.

Temel J et al. NEJM 2010

Out with the old and in with the new



“Ask the question”



- Joanne Lynn. RAND Lecturer USA and senior advisor on end-of-life care
- Gold Standards framework, UK.
- You JJ, et al. CMAJ 2014

Gold Standards Framework: General and Disease-specific indicators: Indicators of approaching end-of-life

General Indicators of Decline
■ **Performance status declining** (PPS ≤ 50% or ECOG ≥ 3) ■ **Progressive weight loss** (≥10%) over past 6 months ■ **Two or more unplanned admissions to hospital** in past 6 months because of disease-related complications ■ **A new diagnosis of a progressive, life limiting illness** ■ **Repeated unplanned/crisis admissions to hospital** ■ **Sentinel event (serious fall)** ■ **Serum albumin < 25 g/l** ■ Two or more advanced conditions (co-morbidity)

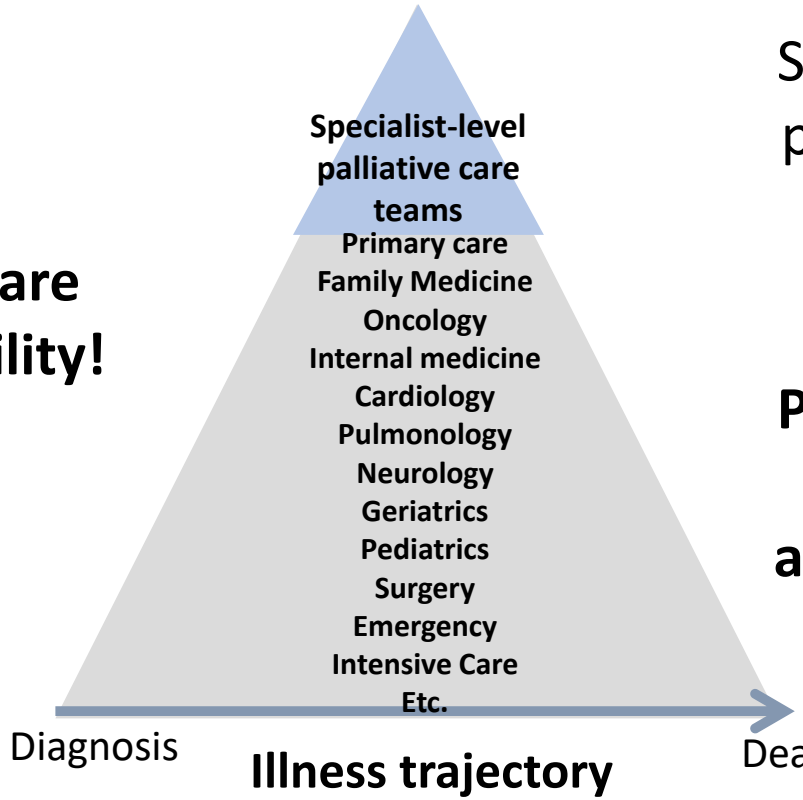
Disease-specific Indicators of Decline	
Cancer ■ Performance status deteriorating due to metastatic cancer (PPS ≤ 50% life expectancy in order of only a few months) ■ Metastatic disease ■ Significant weight loss due to primary cachexia ■ Refer to prognostic indicator tools (PPS, PaP, PPI): can help but do not refer to them blindly	**Neurological disease** ■ Progressive deterioration in function despite optimal therapy ■ Symptoms which are complex and difficult to control ■ Dysphasia leading to recurrent aspiration pneumonia; sepsis, dyspnea, breathless or respiratory failure ■ Speech problems with increasing difficulty communicating and progressive dysphasia
Renal disease Stage 4 or 5 chronic kidney disease (CKD)(eGFR < 30 ml/min) with at least 2 of the following indicators: ■ "No" to Surprise question ■ Patient chooses "no dialysis" option, discontinuing dialysis or not opting for dialysis if transplant failed ■ Difficult physical or psychological symptoms despite optimal tolerated renal replacement therapy ■ Symptomatic renal failure	**Respiratory disease** (≥ 2 of following) ■ Severe airway obstruction (FEV1 < 30%) or restrictive deficit (VC < 60%) ■ Meets criteria for long term oxygen therapy (Pa02 < 7.3kPa) ■ Breathless at rest or on minimal exertion between exacerbations ■ Persistent severe symptoms despite optimal tolerated therapy ■ Symptomatic right heart failure ■ Loss of appetite and weight ■ Recurrent hospital admissions (≥ 3 in last 12 month) due to disease

Gold Standards Framework

Who provides palliative care?

Palliative care: It is everyone's business

We all share responsibility!

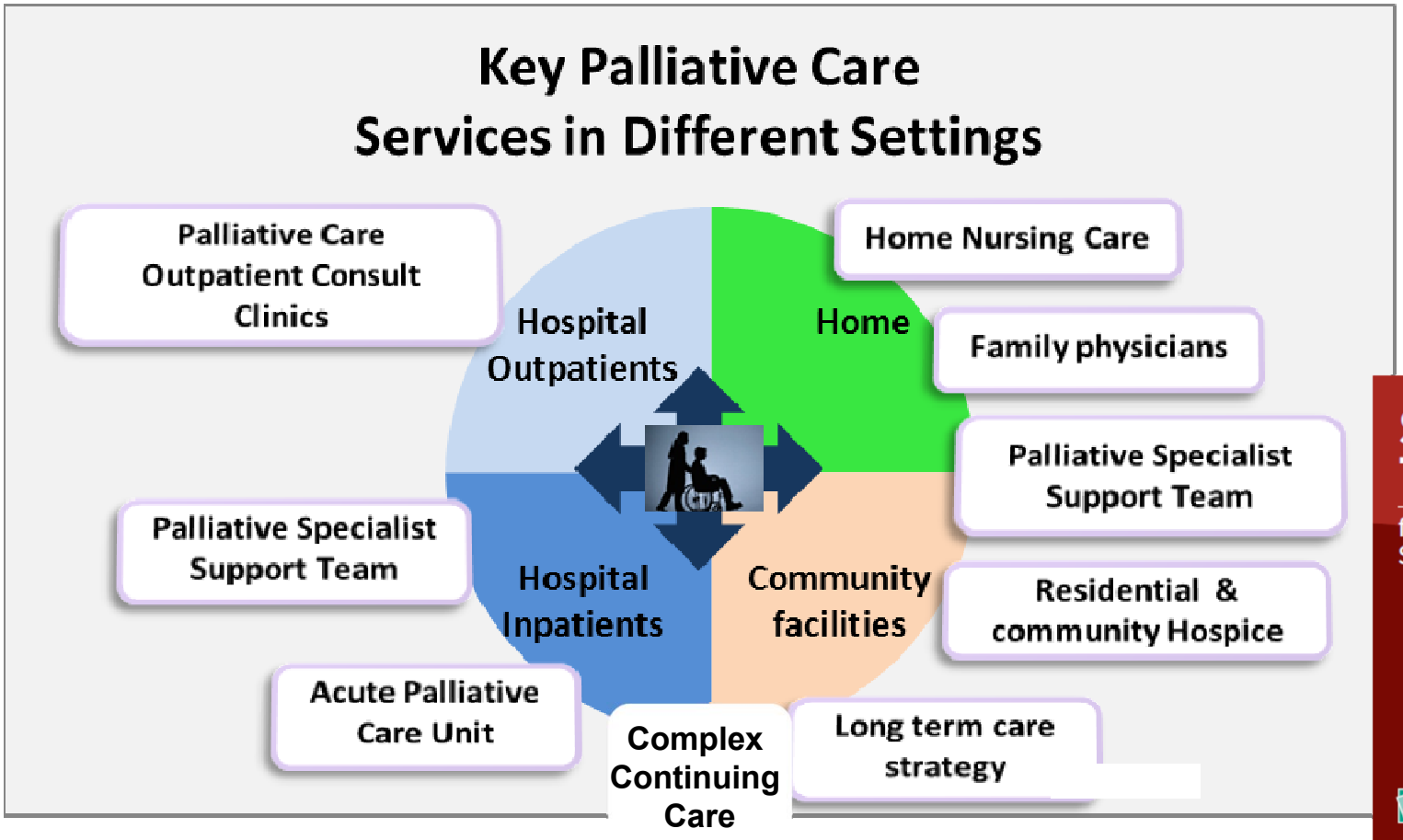


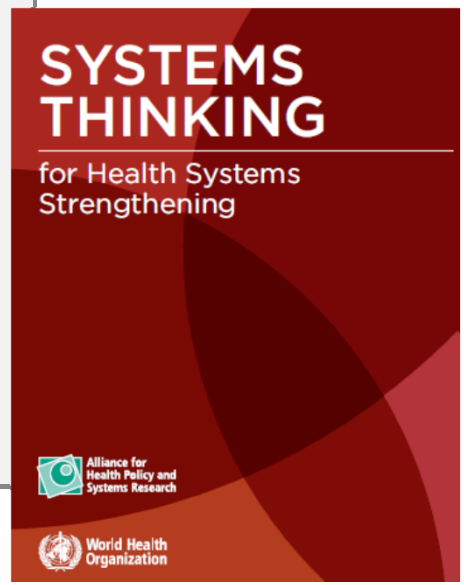
Specialist palliative care

Palliative Care approach

The Palliative Care Approach (generalist level)

Identify	• Identify patients early who may benefit from palliative care
Assess	• Their understanding of the illness & information needs • Symptoms • Psychosocial & spiritual needs • Quality of life • Values, wishes, preferences
Plan	• Advance care planning • Goals of care and care plans, • Treatment plans • Link to resources and other care providers • Prepare for emergencies
Manage	• Symptoms • Psychosocial & spiritual needs • Essential discussions • Refer for assistance as needed


Key Palliative Care
Services in Different Settings
Palliative Care
Outpatient Consult
Clinics
Hospital
Outpatients
Home
Home Nursing Care
Family physicians
Palliative Specialist
Support Team
Palliative Specialist
Support Team
Hospital
Inpatients
Community
facilities
Residential &
community Hospice
Acute Palliative
Care Unit
Complex
Continuing
Care
Long term care
strategy


SYSTEMS
THINKING
for Health Systems
Strengthening
Alliance for
Health Policy and
Systems Research
World Health
Organization

Enhancing family physician capacity to deliver quality palliative home care

An end-of-life, shared-care model

Denise Marshall MD FCFP Doris Howell PhD RN Kevin Brazil PhD Michelle Howard MSc PhD Alan Taniguchi MD FCFP

ABSTRACT

PROBLEM BEING ADDRESSED Family physicians face innumerable challenges to delivering quality palliative home care to meet the complex needs of end-of-life patients and their families.

OBJECTIVE OF PROGRAM To implement a model of shared care to enhance family physicians' ability to deliver quality palliative home care, particularly in a community-based setting.

PROGRAM DESCRIPTION Family physicians in 3 group practices (N=21) in Ontario's Niagara West region collaborated with an interprofessional palliative care team (including a palliative care advanced practice nurse, a palliative medicine physician, a bereavement counselor, a psychosocial-spiritual advisor, and a case manager) in a shared-care partnership to provide comprehensive palliative home care. Key features of the program included systematic and timely identification of end-of-life patients, needs assessments, symptom and psychosocial support interventions, regular communication between team members, and coordinated care guided by outcome-based assessment in the home. In addition, educational initiatives were provided to enhance family physicians' knowledge and skills.

CONCLUSION Because of the program, participants reported improved communication, effective interprofessional collaboration, and the capacity to deliver palliative home care, 24 hours a day, 7 days a week, to end-of-life patients in the community.

RÉSUMÉ

PROBLÈME À L'ÉTUDE Le médecin de famille rencontre d'innombrables défis lorsqu'il veut prodiguer des soins palliatifs de qualité à domicile pour répondre aux besoins complexes des patients en fin de vie et à ceux de leur famille.

Marshal D, et al. Can Fam Physician 2008;54

Models of Practice:
A Conceptual Framework for specialist palliative care teams


BEST WAY
EASY WAY

How many Palliative Care Beds are needed?

- **For every 100 000 inhabitants**
  - **10 Palliative care beds**
    - **1/3 acute palliative care beds**
    - **2/3 hospice type beds**

- Gómez-Batiste X, Porta-Sales J, Pascual A, Nabal M, Espinosa J, et al. Catalonia WHO Palliative Care Demonstration Project at 15 Years (2005). J Pain Symptom Manage 2007;33:584-590
- Xavier Gomez-Batiste, Josep Porta, Albert Tuca, Jan Stjensward. Organización de Servicios y programas de Cuidados Paliativos. Arán Edicones SL. Madrid, Spain. 2005:54-79
- Gómez-Batiste X et al. Diseno, implementazion y evaluacion de programas publicos de cuidados paliativos. Medicina Clinica 2010;135(4):179-185

Staff mixes and ratios (in FTEs per 10 beds) of PCUs

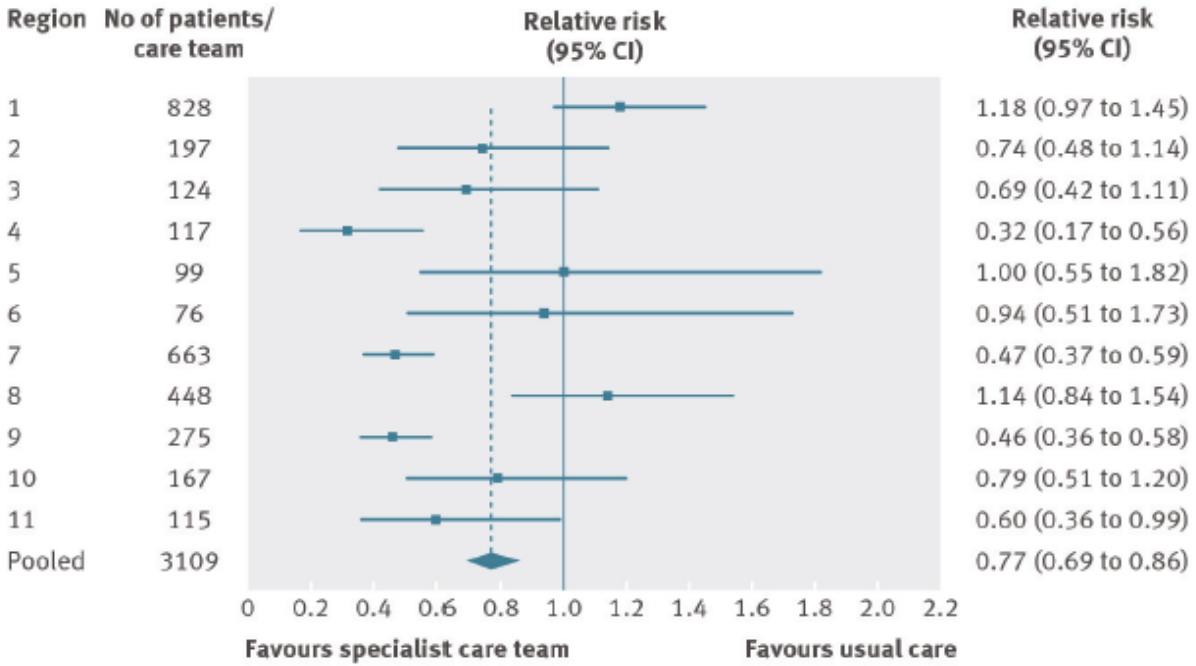
	Bruyère PCU	Edmonton PCU	Calgary PCU	Hospice Ottawa
# of beds	31	20	20 (27)	10
Nursing (RNs/RPNs)				
Days	**2.3** (1.3/1)	**3.5** (2/1.5) + 1 HCA	**3.4** (2.6/0.8)	**3** (2/1)
Eve	**1.9** (1/1)	**2.5** (1.5/1) + 1 HCA	**3.4** (2.6/0.8)	**3** (2/1)
nights	**1.3**	**2.5** (1.5 +1 HCA)	**2.5** (2/0.5)	**3** (1/2)
Social worker	0.26	0.5	0.5	Part time
Spiritual care	0.13	0.5	0.25	Part time
Pharmacy	0.32	0.4	0.3	Part time
Psychology	0	0.3	Access to	-
PT/OT	0.13/0	0.4	0.5 /0.25	Not needed
Dietician	0	0.2	0.25	Not needed
MDs	1	1	1.5	Different MRPs
Clerk	Part time	Full time day	Full time day	Volunteers day

Staff mix and ratios in Ontario PCUs

	RN/RPN/PSW**	Pharm	SW	Chaplain	PT	OT
PCUs in acute hospitals (n)	**9**	**0.36 [0.1-1.0]**	**0.44** [0-1.6]	**0.26** [0.1-0.7]	**0.28** [0.1-1.0]	**0-0.2**
Day: mean [range]	**2.9** [2.5-3.3]					
Eve: mean [range]	**2.39** [1.7-3.3]					
Night: mean [range]	**1.86** [1.3-2.6]					
PCUs in CCC (n)	**6***	**0.16 [0-0.3]**	**0.26** [0-0.7]	**0.18** [0.14-0.25]	**0.21** [0.1-0.5]	**0.25** [0-0.5]
Day: mean [range]:	**2.46** [2-3]					
Eve: mean [range]	**2** [1.6-2.9]					
Night: mean [range] (with 1 outlier removed):	**1.14** [0.6-1.5]					

Some facing significant funding cuts

Impact of community based palliative care teams……
Seow H et al. BMJ 2014



Relative risk of an emergency department visit in the last two weeks of life (exposed vs unexposed patients)

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group

Background: Hospital palliative care consultation teams have been shown to improve care for adults with serious illness. This study examined the effect of palliative care teams on hospital costs.

Methods: We analyzed administrative data from 8 hospitals with established palliative care programs for the years 2002 through 2004. Patients receiving palliative care were matched by propensity score to patients receiving usual care. Generalized linear models were estimated for costs per admission and per hospital day.

Results: Of the 2966 palliative care patients who were discharged alive, 2630 palliative care patients (89%) were matched to 18 427 usual care patients, and of the 2388 palliative care patients who died, 2278 (95%) were matched to 2124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of $1696 in direct costs per admission ($P=.004$) and $279 in direct costs per day ($P<.001$) including significant reductions in laboratory and intensive care unit costs compared with usual care patients. The palliative care patients who died had an adjusted net savings of $4908 in direct costs per admission ($P=.003$) and $374 in direct costs per day ($P<.001$) including significant reductions in pharmacy, laboratory, and intensive care unit costs compared with usual care patients. Two confirmatory analyses were performed. Including mean costs per day before palliative care and before a comparable reference day for usual care patients in the propensity score models resulted in similar results. Estimating costs for palliative care patients assuming that they did not receive palliative care resulted in projected costs that were not significantly different from usual care costs.

Conclusion: Hospital palliative care consultation teams are associated with significant hospital cost savings.

Arch Intern Med. 2008;168(16):1783-1790

PALLIATIVE MEDICINE

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Environmental & Occupational Health (SCI) 34 out of 162

Changes in quality of life following admission to palliative care units

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Palliative Care Program, Vancouver Hospital and Health Sciences Centre

Abstract

The primary goal of palliative care is to improve the quality of life (QOL) of people with a terminal illness. Previous studies of the impact of hospice/palliative care have documented improvement in physical and psychological symptoms, but not in overall QOL, due in part to the difficulties of measuring QOL. The McGill Quality of Life Questionnaire (MQOL) was developed to assess QOL in persons with advanced illness.

MQOL scores were determined on admission and 7–8 days later for sequential eligible and willing patients admitted to five palliative care units. These 88 patients represented 8% of those admitted to the units during the study period. Following the final MQOL completion, patients were interviewed and asked to describe the nature of the changes in QOL they had experienced since admission.

Significant improvements were found in the MQOL total score and subscale scores reflecting physical, psychological and existential well-being. In the interviews patients indicated that they had experienced changes in physical, emotional and interpersonal status, in spiritual outlook, and in their preparation for death. They also described the impact of the palliative care unit environment.

This is the first study to demonstrate that hospice/palliative care can improve existential well-being in addition to psychological and physical symptoms. It provides evidence in the patients' own words that improvements in QOL go beyond symptom control following admission to a palliative care unit. However, the study results are generalizable only to those few patients admitted who are well enough to complete a questionnaire 1 week after admission.

Impact of Acute PCU

- 11 bed unit, specialized interprofessional staff
- Direct costs reduced by 56% overall after transfer to PCU

Smith T, et al. A high-volume specialist Palliative Care Unit and team may reduce in-hospital end of life care costs. J Pall Med 2004;6(5):699-705

Complete

Pallium Canada LEAP CORE
2-days, Community

Pallium Canada LEAP MINI
1-day intro, Community

Pallium Canada LEAP LTC
2-days, Long-Term Care

Pallium Canada LEAP ONCO
1-day, Cancer

Pallium Canada LEAP PARAMEDIC
1-day, Hybrid: Online & F2F

Pallium Canada LEAP UNDERGRAD
Basket of products

Pallium Canada LEAP RENAL
1-day

LEAP modules cover:

- Definitions and the approach
- Taking Ownership and early palliative care
- Palliative and end-of-life decision making
- Ethical Frameworks
- Hydration and Nutrition
- Transitions
- Withholding and withdrawing treatments
- Essential Conversations
- Advance Care Planning
- Pain management and other symptoms
- Essentials of psychosocial and spiritual care
- Last Days and Hours
- Palliative Sedation
- Grief and Bereavement
- Useful Tools and Resources
- Organizational Change
- Self-care

In Development

Pallium Canada LEAP CARERS
1-day, Compassionate Community

Pallium Canada LEAP SURGERY
1-day

Pallium Canada LEAP HOSPITAL
1-day

Pallium Canada LEAP ED
1-day, Emergency Department

Pallium Canada LEAP ESSENTIAL CONVERSATIONS
3-hour workshop

Pallium Canada LEAP ONLINE
Short, online modules

Pallium Canada LEAP INNER CITY
2-day

Planned

Pallium Canada LEAP LIVER
1/2 day to 1-day

Pallium Canada LEAP HEART
1/2 day to 1-day

Pallium Canada LEAP LUNG
1/2 day to 1-day

Pallium Canada LEAP CCC
1-day, Complex Continuing Care

Pallium Canada

A LEAP Palliative Care Course is delivered across Canada every 1.5 days

Pallium Canada

Lessons Learned: Scale up and spread model

529 Facilitators

Physicians, nurses, pharmacists, social workers, paramedics, etc.

March 2017

- Standardized courseware
- Train-the-trainer model
- Courses organized locally
- Partnerships
- Central registration

Pallium Canada

LEAP LTC

2-days, Long-Term Care

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LEAP RENAL

Learning Essential Approaches to Palliative Care

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LEAP PARAMEDIC

1-day, Hybrid: Online & F2F

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Palliative Care in New-Brunswick

Over the last 30 years, governance evolved and so did palliative care. A number of palliative care initiatives were developed by hospitals, including the NB Extra-Mural Program and nursing homes

Residential Hospice – 10-beds ea., 2010, 2016,
- community integrated approach, 2018

Medicare - Enhanced EMP home-visit rates 2015/16

Advanced Health Care Directive Act - 2016

Palliative Care in New Brunswick: A person-centred care and Integrated services framework has been released - 2018.

An advisory committee was formed:

- Develop an action plan
- Recommend strategies for the implementation and evaluation
- Advise on a standardized and coordinated approach to palliative care in the province

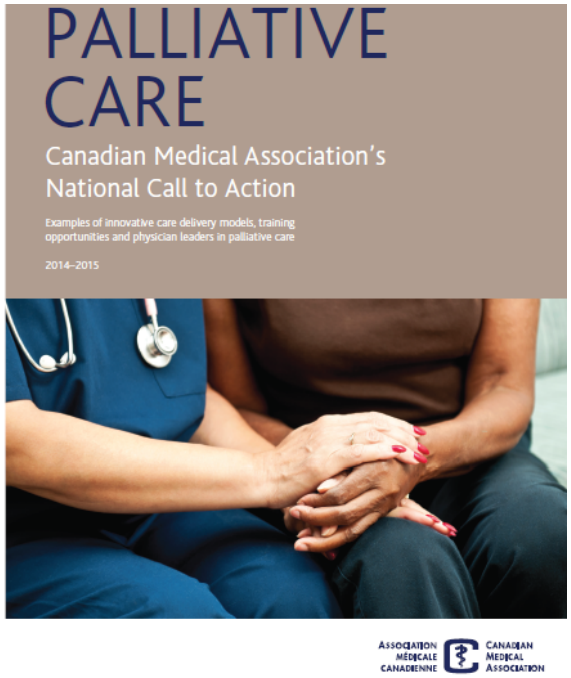
Palliative Care Resources in New Brunswick

- 75 palliative care beds (30 beds in 5 PC units and 45 beds on medical units)
- 2 hospice facilities with 10 beds + a 6 bed facility announced in 2018 (2017-2018…251 admissions and 245 deaths)
- Nursing homes in 2018
  - 4734 beds
  - Offer end-of-life care for their residents
  - This capacity is not accounted for in the palliative care bed count

The Extra-Mural Program since 1980

- Offers coordinated care provided by an interdisciplinary team
- Services provided throughout the province 24-7 in homes, special care homes and community residences
- 1,572 EMP patients received palliative care
  - 96% received RN visit
  - 46% received occupational therapy
  - 40% received respiratory therapy
  - 35% received the visit of a social worker
  - 33% received the visit of a clinical nutritionist, physiotherapist and speech language pathologist

THE TOP TEN SIGNS THAT PALLIATIVE CARE IS FULLY INTEGRATED IN A HEALTH CARE SYSTEM



1. Palliative care approach is activated early.
2. The "Surprise Question" is used in daily practice.
3. Goals of care and advance care planning (ACP) discussions are routine.
4. A strong primary-level palliative care base.
5. Specialist-level interprofessional palliative care consultation and support teams in hospitals and the community with home care nursing resources.

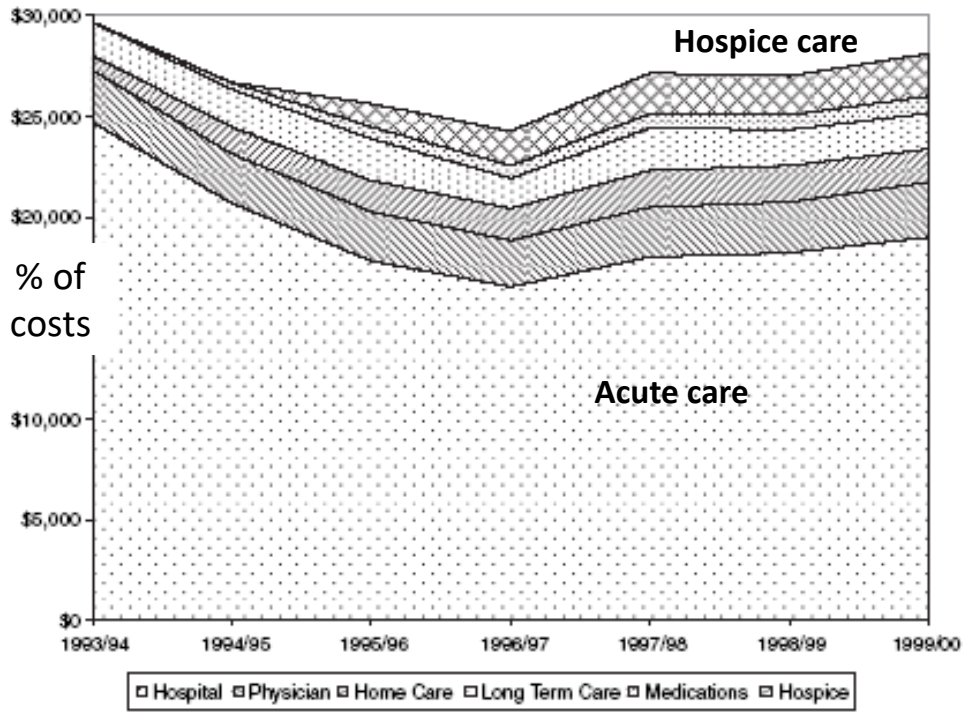
J Pereira 2015

THE TOP TEN SIGNS THAT PALLIATIVE CARE IS FULLY INTEGRATED IN A HEALTH CARE SYSTEM

6. Adequate numbers of acute palliative care unit and hospice beds.
7. Palliative care strategies in long term care (LTC) and nursing homes.
8. Specialist palliative care teams are adequately staffed.
9. Palliative care education: undergraduate, postgraduate and continuing professional development.
10. The right performance indicators and funding formulae.

J Pereira 2015

Fassbender K et al. Utilization and costs of the introduction of system-wide palliative care in Alberta, 1993 to 2000. Palliative Medicine. 2005:19-513-520



Results

- Total cost reduced
- Acute care costs reduced from 83% to 63% of costs
- In-hospital days reduced from 39 to 27 days
- Improved care for patients

Impact of a regional program: Catalonia

Reduction in ER admissions
Reduced acute-care hospital admissions
Reduced hospital stays

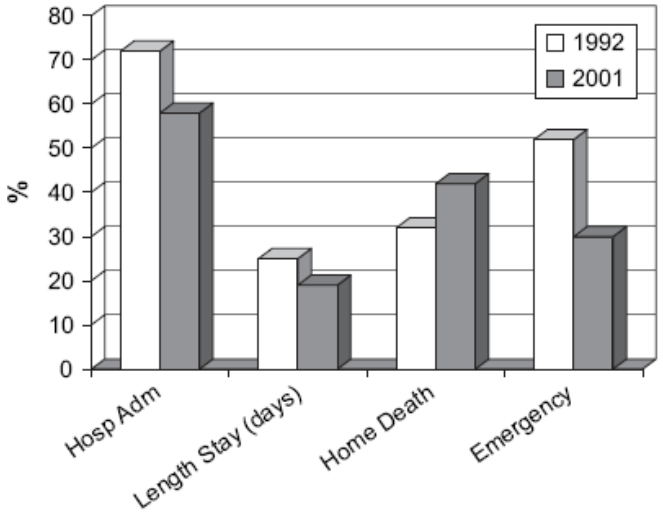


Fig. 2. Comparison of consumption of resources: 1992–2001. Hosp. Adm. = percentage of hospital

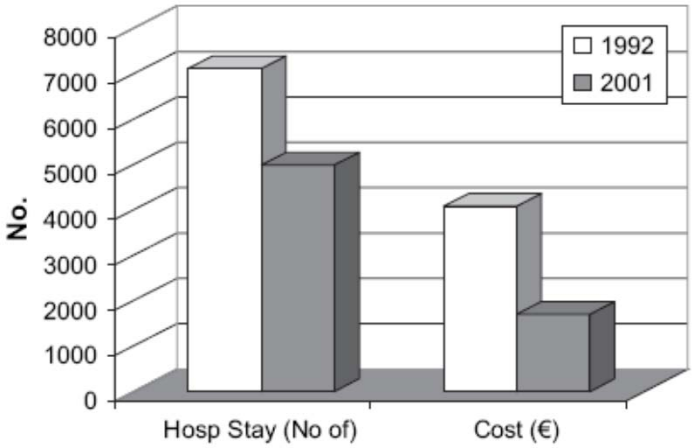


Fig. 3. Comparison of number of hospitalizations and cost: 1992–2001. Hosp. Stay = number of hospi-

Gomez-Batiste X, et al. Resource Consumption and Costs of Palliative Care Services in Spain: A Multicenter Prospective Study. J Pain Symptom Manage 2006;31:522--532.

Conclusion

- Palliative care starts early and can occur alongside treatments to control the disease
- It is everyone's business
- There are tools and resources to help and support you
- You make a difference in the lives of patients and families
- It brings joy