Réseau de cancérologie Rossy

Rossy Cancer Network

Toward early referral to palliative care and improved documentation of goals of care, levels of care and advanced care planning

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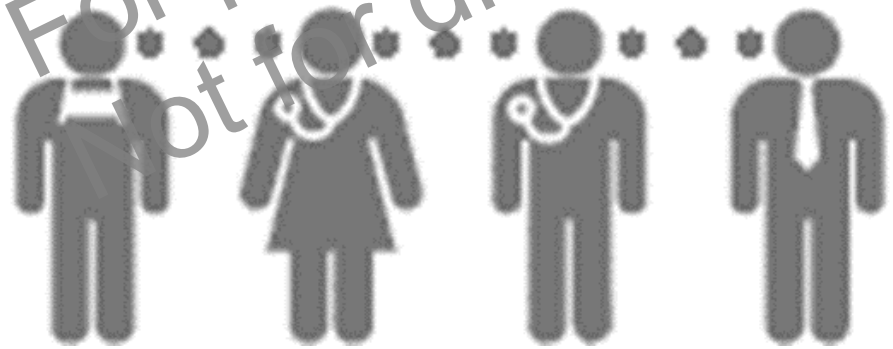
Outline

- Project goal and objectives
- Our approach
- Review of the baseline data
- Key process elements
- Tools for health care providers
- Evaluation parameters

Project goal

The goal of our project is to establish **early collaborative partnership** between Oncology and Palliative/Supportive Care to put in place a timely plan for patient decline.



Project objectives

- **Improve documentation of goals of care, and advance care planning (ACP)**
  - Goals of care discussed and documented in the patient medical record
  - Level of Care (LoC) form completed
  - Advanced care planning re: a substitute decision maker discussed and documented
- **Offer early referral to supportive/palliative care for symptom management** (within 60 days of diagnosis)
  - Currently there is a **level 1 evidence** of the benefits of early integration of palliative/supportive care for patients with advanced disease. Benefits include:
    - Better quality of life (QoL)
    - Reduction in avoidable hospitalizations and treatments
    - Better alignment between patient preferences and care delivered

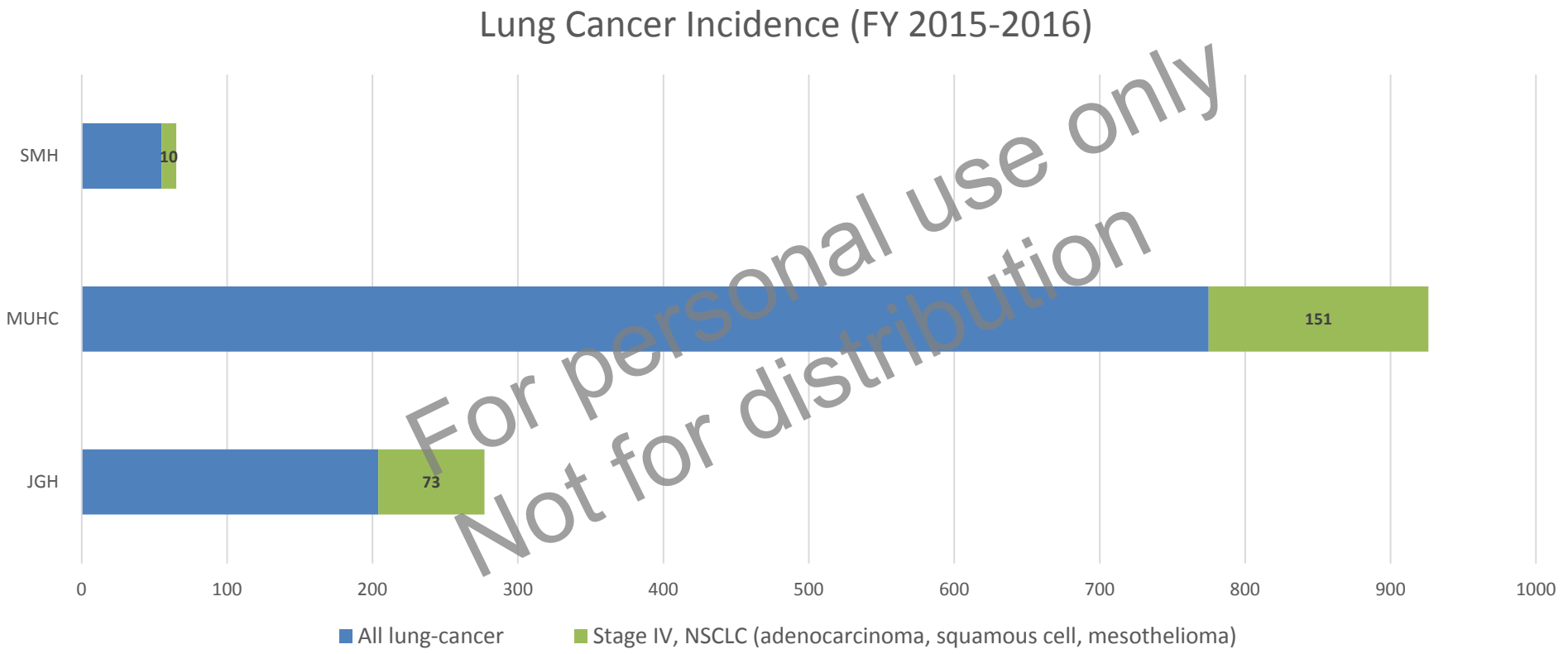
Rationale

- Many patients with metastatic cancer become ill and arrive to the hospital with no prior discussion about their goals of care (GoC)
- Several guidelines (e.g. ASCO, NCCC) now recommend that oncologists have a discussion about advance care planning early in the disease trajectory
- Several studies have identified approaches that were successful in increasing rate of ACP discussion and documentation. The key elements of these approaches include:
  - Identifying patients from health records
  - Providing electronic prompts to physicians
  - Educating staff
  - Regularly reporting results

Our approach

- Identify the eligible patient population (inclusion and exclusion criteria)
- Conduct chart reviews to obtain baseline rates
- Establish a working group at each RCN site
- Develop processes and tools to support the oncology health care providers
  - New “Goals of Care Form” approved by the Medical Records
  - Prompts and reminders to the oncology team
  - Education sessions
- Track the process adherence
- Evaluate the impact of the initiative

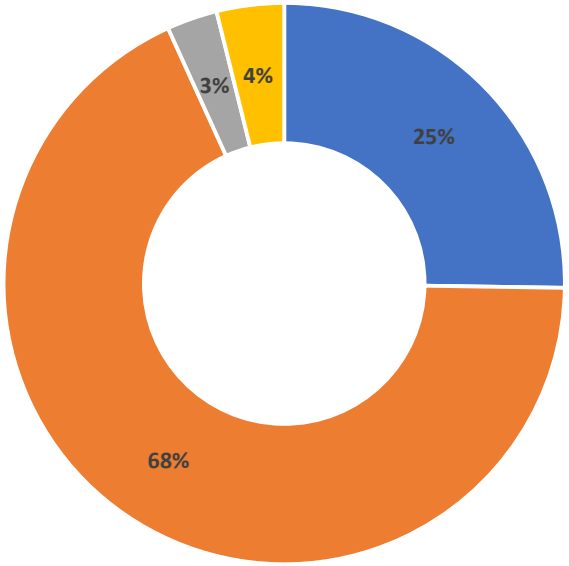
Patient population



Source: JGH, MUHC, SMHC Cancer Registries

Review of the baseline data: GoC documentation

GoC documentation by the medical profession (MUHC and SMHC; n=103)



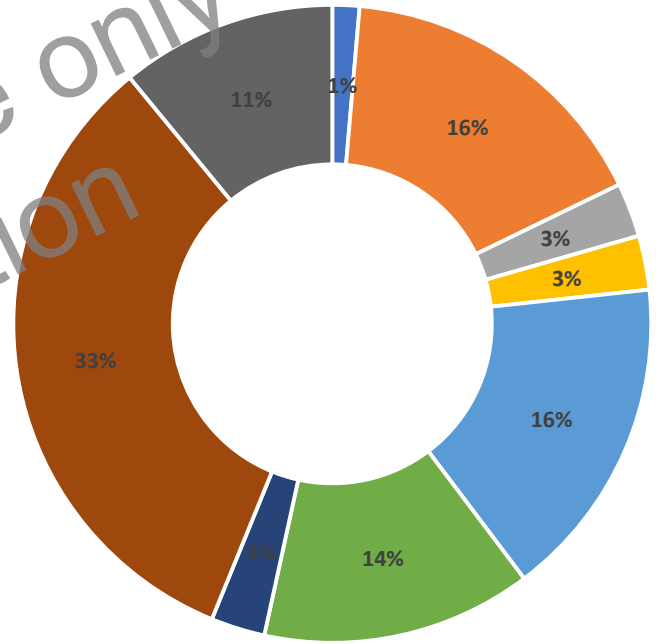
RCN Site	Number of patients	Goals of care documented	Goals of care documented within 60 days	% GoC documented within 60 days
MUHC	139	96	94	67.6%
SMHC	9	7	5	55.6%

Review of the baseline data: LoC & ACP documentation

RCN Site	Number of patients	LoC documented	LoC documented within 60 days	% LoC documented within 60 days
MUHC	139	67	36	25.9%
SMHC	9	6	1	11.1%

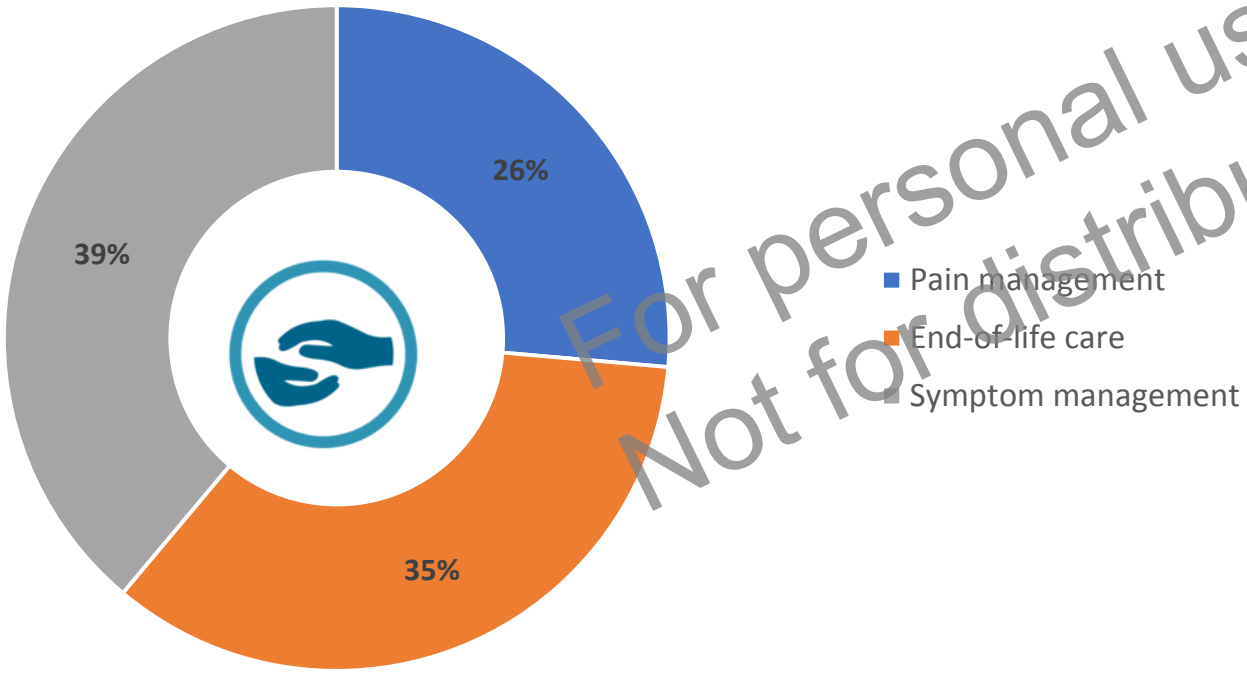
RCN Site	Number of patients	ACP discussion documented	ACP documented within 60 days	% ACP documented within 60 days
MUHC	139	3	1	0.7%
SMHC	9	0	0	0.0%

LoC documentation by medical profession (MUHC & SMHC; n=73)



Baseline referral patterns to Palliative Care (PC)

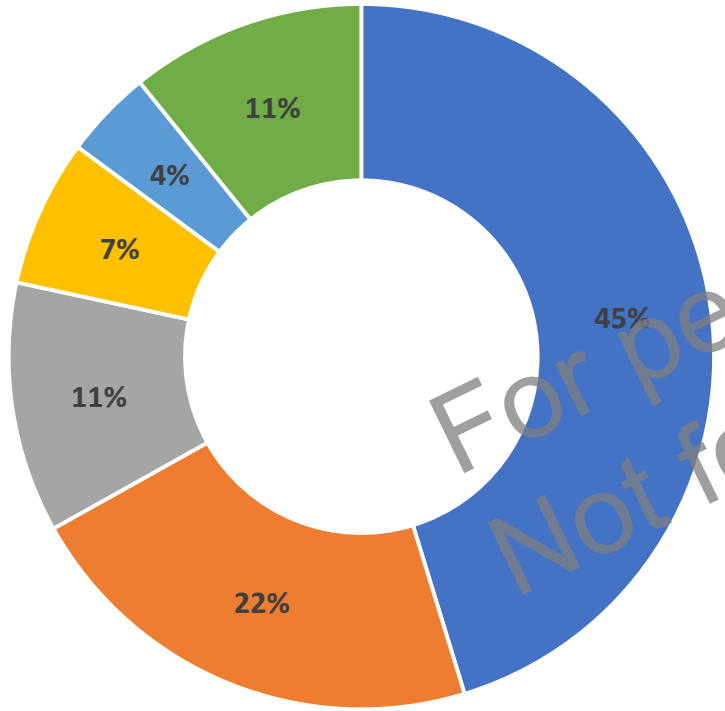
Primary reason for referral to palliative care
(MUHC &SMHC; n=72)



RCN Site	Number of patients	Referral to palliative care	Referral to PC within 60 days	% referral to PC within 60 days
MUHC	139	67	38	27.3%
SMHC	9	5	3	33.3%

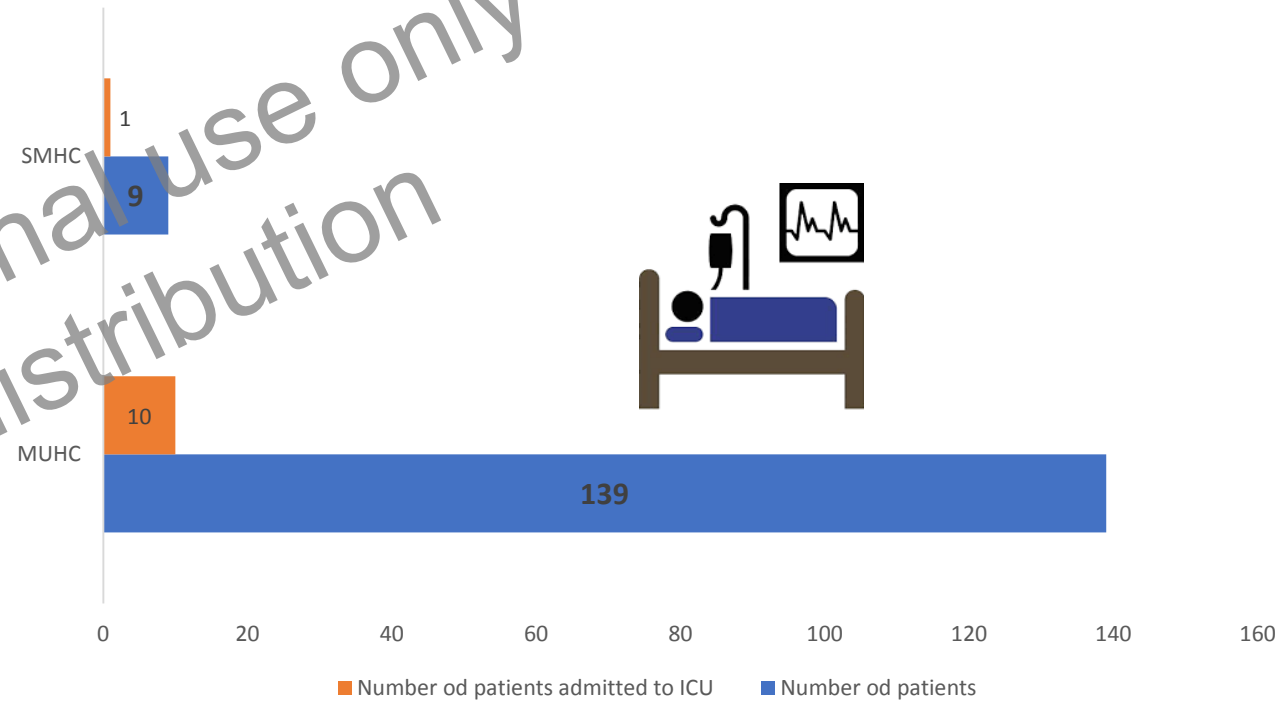
ER visits & ICU Admissions

Number of ER visits
(MUHC and SMHC; n=148)



none 1 visit 2 visits 3 visits 4 visits 5 and more visits

ICU Admissions
(MUHC & SMHC; n=148)



Key process elements

1

Within 60 days of diagnosis - discuss and document:

- ✓ **Goals of Care**
- ✓ **LOC (new INESSS form)**
- ✓ **Naming a substitute decision maker**

2

If step 1 is not done by the primary oncology team, then a patient should be referred to the palliative/ supportive care team

3

Patient followed- up in Oncology and w/t palliative/supportive care (if required, for symptom management)

Key elements remain the same across RCN, but **the process is tailored to the existing organizational structure and resources available** at each RCN site

St. Mary's Multidisciplinary Team Approach to Early Referral to PC and Documentation of GoC, LoC, ACP

Diagnosis, prognosis & treatment discussion

ONCOLOGIST

Explains the diagnosis & prognosis
Fills out the level of care form
Refers the patient to Palliative Care

Patient understanding of the GOC

PIVOT NURSE

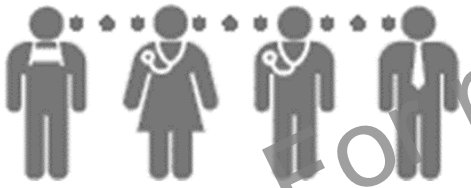
Confirms patient understanding of his/her diagnosis
Discusses patient's values, priorities and expectations

Advanced Care Planning

SOCIAL WORKER

Discusses advanced care planning (Will, Power of Attorney, Mandate, Advanced Medical Directive)

If the process is not completed, reminders are given at the weekly tumor board meetings



First Appointment
Part A "Goals of Care" form

Follow-up Appointment
"Levels of Care (LOC)" form

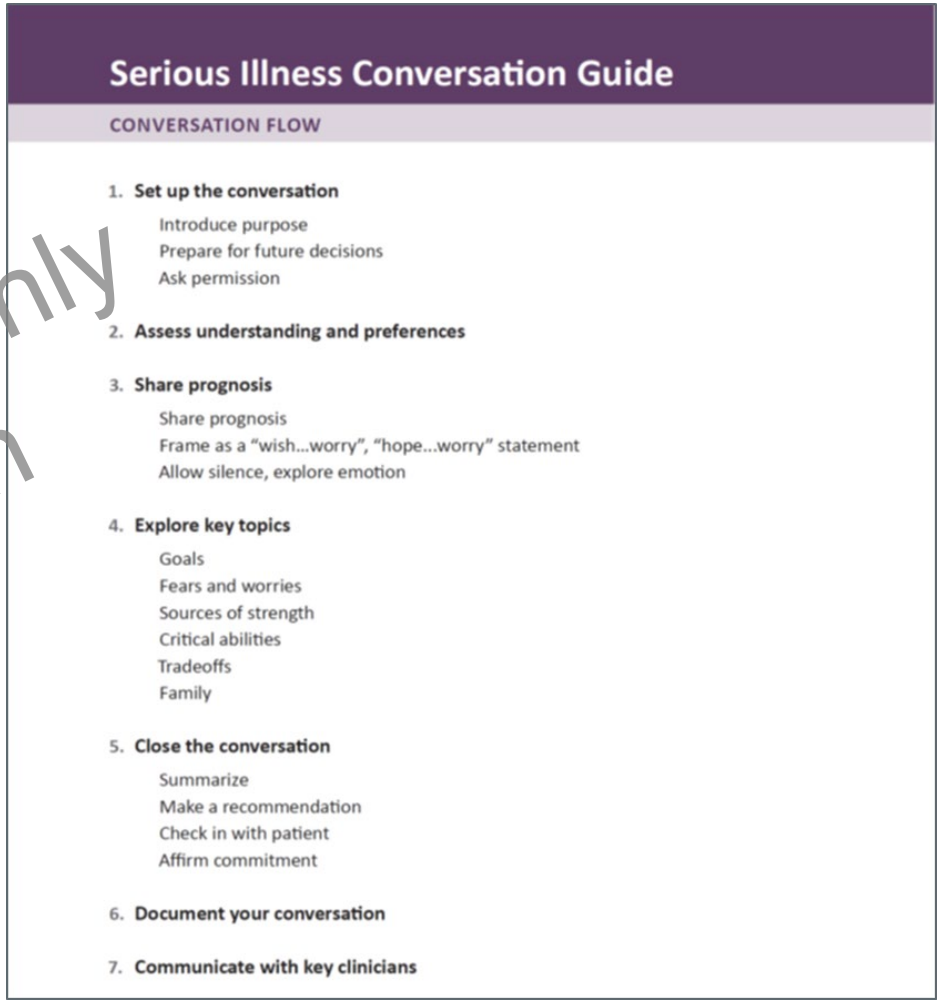
Appointment with a pivot nurse
Part B "Goals of Care" form

Appointment with a social worker
Part C "Goals of Care" form

Tools for Health Care Providers to facilitate better and earlier conversation about GoC, LoC and ACP

Serious Illness Conversation Guide

- Serious Illness Conversation Guide developed by the team of palliative care specialists at Dana Faber
- The guide offers a structured way of discussing values, goals and priorities of patients with advanced disease
- Topics include:
  - Setting up the conversation
  - Assessing patient understanding and preferences
  - Sharing prognosis
  - Exploring key topics
  - Closing the conversation
  - Documenting the conversation
  - Communicating with key clinicians



Serious Illness Conversation Guide

CONVERSATION FLOW

1. **Set up the conversation**
   - Introduce purpose
   - Prepare for future decisions
   - Ask permission
2. **Assess understanding and preferences**
3. **Share prognosis**
   - Share prognosis
   - Frame as a "wish...worry", "hope...worry" statement
   - Allow silence, explore emotion
4. **Explore key topics**
   - Goals
   - Fears and worries
   - Sources of strength
   - Critical abilities
   - Tradeoffs
   - Family
5. **Close the conversation**
   - Summarize
   - Make a recommendation
   - Check in with patient
   - Affirm commitment
6. **Document your conversation**
7. **Communicate with key clinicians**

(https://www.talkaboutwhatmatters.org/documents/Providers/PSJH-Serious-Illness-Conversation-Guide.pdf)

Care at the End of Life for Advanced Cancer Patients: When to stop cancer treatment

Choosing Wisely Canada

When you have cancer and you have tried many treatments without success, it can be very hard to know when to stop treatment. Sometimes, even with the best care, cancer continues to spread. It is hard to accept, but the best thing for you at that point may be to stop the cancer treatment. Instead, you could focus on getting care to keep you comfortable and out of pain.

This fact sheet explains how to know when it is time to stop treatment and focus on end-of-life care. You can use this information to talk with your health care provider about your options and choose the best care for you.

Cancer responds best to treatment the first time.

When you treat a tumour for the first time, there is hope that the treatment will destroy the cancer cells and keep them from returning. If your tumour keeps growing, even with treatment, there is a lower chance that more treatment will help.

This is especially true for solid tumour cancers, like breast, colon, and lung cancer, and sarcoma. Health care providers know a lot about how these cancers grow or shrink over time and how they respond to treatment. They have found that treatment after treatment often offers little or no benefit.

How do you know when to stop treatment?

It can be hard for the patient, caregivers and the health care provider to talk about stopping treatment for the cancer and focus on end-of-life care. Your health care provider may bring it up, but sometimes you may need to start the discussion. Your health care provider should give you clear answers to any questions you ask.

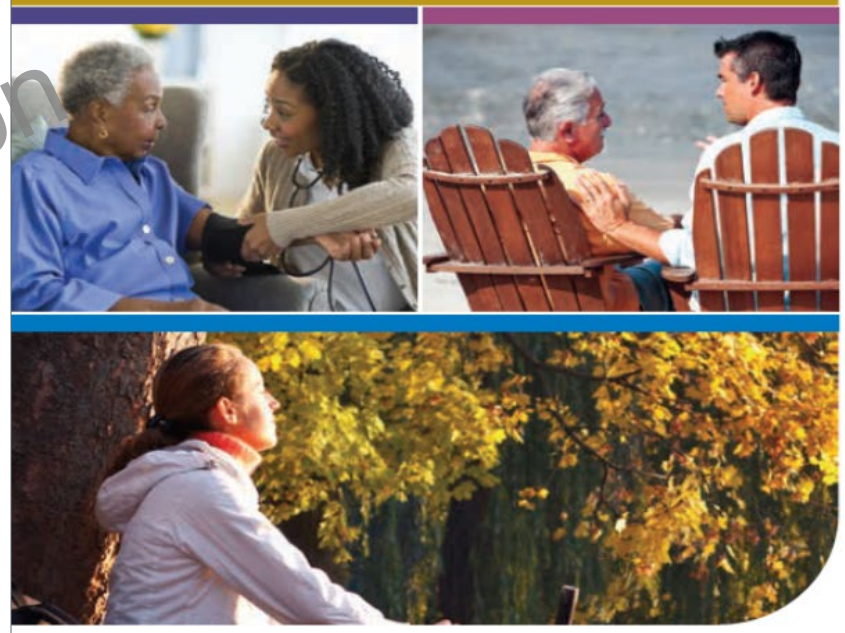
You need to understand how advanced your cancer is. Ask your health care provider about the stage of your cancer and how much it has spread. Ask about

Canadian reviews of this pamphlet included the Canadian Association of Medical Oncologists, Canadian Association of Radiation Oncology, Canadian Society for Surgical Oncology, and Canadian Partnership Against Cancer.

Patient Education Material

Canadian Cancer Society

Advanced Cancer



1 888 939-3333 | cancer.ca

Santé et Services sociaux Québec

DT9262

LEVELS OF CARE AND CARDIOPULMONARY RESUSCITATION

The goals of care below are indicative and are intended to orient medically appropriate care.

Institution name

Last name of user
First name
File number
Date of birth Year Month Day
Sex ☐ M ☐ F
Health insurance number

Revise using a new form following any change in health status or at the request of the user or his/her representative.

Capacity to discuss levels of care

☐ Competent ☐ Incompetent: ☐ Homologated mandate ☐ Public/private curator; Name: _____
☐ Minor under 14 years old Name of tutor, relationship with user: _____

Previous advance wishes: ☐ None available ☐ Prior level of care form ☐ Advance medical directive ☐ Living will or other

Levels of care: check and provide details in the box below *(Explanatory notes on the reverse side)*

☐ Goal A: Prolong life with all necessary care
☐ Goal B: Prolong life with some limitations to care
☐ Goal C: Ensure comfort as a priority over prolonging life
☐ Goal D: Ensure comfort without prolonging life

Give details on specific interventions in the box below, as needed.

e.g., hemodialysis, blood transfusion, nutritional support (enteral or parenteral), preventive care, etc.

Cardiopulmonary resuscitation (CPR): check and provide details in the box below *(Explanatory notes on the reverse side)*

Cardiac (circulatory) arrest

☐ Attempt CPR
☐ Do NOT attempt CPR

Check if NOT desired, to guide prehospital care for goals B and C *(see reverse side)*

☐ NO emergency intubation (goals B and C only)

Explanatory notes on the discussion and instructio

Discussed with: ☐ User ☐ Representative
Contact information

Record the names of the participants as well as the words used during the discussion and all information that helps clarify the user's wishes.

Name of physician | Signature | Date (year, month, day)
Contact information

If a copy of this form is given to the user or his/her representative, it is signed by him/her so that paramedic ambulance technicians can follow the instructions on the form.

Name of user or representative | Signature | Date (year, month, day)

AH-744A DT9262 (2016-01) LEVELS OF CARE AND CARDIOPULMONARY RESUSCITATION ☐ User's file ☐ Physician's copy

Explanatory notes

- **This form is not a substitute for consent to treatment, which must always be obtained *(except in certain emergency situations)*.**
- **This form must be signed by a physician.**

Description of levels of care

The discussion about levels of care is carried out with the user or, in the case of incapacity, with his/her representative, in the spirit of shared decision-making about medically appropriate care. The explanations and examples provided in the following descriptions do not assume capacity on the part of the user, nor do they necessarily reflect his/her usual care setting.

Goal A
Prolong life with all necessary care

- Care includes all interventions that are medically appropriate and transfer[1] if the intervention is not available in the current setting.
- All invasive interventions can be considered, including, for example, intubation and intensive care.

▶ **In the prehospital setting**, unless otherwise advised by the user or his/her representative, all protocols apply; intubation, assisted ventilation[2] and assisted respiration[2] are included when appropriate.

Goal B
Prolong life with some limitations to care

- Care incorporates interventions with the aim of prolonging life, which offer the possibility of correcting deterioration in health status while preserving quality of life.
- Interventions may lead to discomfort that is judged to be acceptable by the user or his/her representative acting in the sole interests of the user, given the circumstances and the expected outcomes.
- Certain interventions are excluded since they are judged to be disproportionate[4] or unacceptable[4] by the user or his/her representative acting in the sole interests of the user, given the potential for recovery and undesired consequences *(e.g., short-term or long-term intubation, major surgery, transfer)*.

▶ **In the prehospital setting**, unless otherwise advised by the user or his/her representative, all protocols apply; assisted ventilation[2] and assisted respiration[2] are included; intubation is included unless indicated as not desired on the form (checked in the prehospital care box).

Goal C

- [illegible] management of symptoms.
- as needed in order to correct certain reversible health problems, is/her representative acting in the sole interests of the user *(e.g., oral or*
- idered only if care available locally is insufficient to ensure comfort [illegible] *for respiratory distress at home)*.

▶ **In the prehospital setting**, unless otherwise advised by the user or his/her representative, all protocols apply; assisted respiration[2] is included; intubation and assisted ventilation[2] are included unless indicated as not desired on the form (checked in the prehospital care box).

Goal D
Ensure comfort without prolonging life

- Care is exclusively aimed at maintaining comfort through the management of symptoms *(e.g., pain, trouble breathing, constipation, anxiety)*.
- Interventions do not aim to prolong life; illness is left to its natural course.
- A treatment that is usually given with curative intent may be used, but only because it represents the best option to relieve discomfort *(e.g., oral antibiotics for a lower urinary tract or C. difficile infection)*.
- Transfer to an appropriate care setting is considered only if care available locally is insufficient to ensure comfort *(e.g., for a hip fracture with significant discomfort or for respiratory distress at home)*.

▶ **In the prehospital setting**, unless otherwise advised by the user or his/her representative, the following protocols apply: oxygenation, salbutamol, nitroglycerin (chest pain) and glucagon. For respiratory distress in a conscious user, assisted respiration[2] (CPAP) can be used unless refused. Intubation and assisted ventilation[2] are excluded. Manoeuvres to clear an obstructed airway in a living user can be carried out.

Cardiopulmonary resuscitation (CPR)

CPR is part of the same discussion as levels of care. The decision is specified in a distinct manner to allow rapid decisions in the case of cardiorespiratory arrest. A CPR decision is only applicable in the case of a cardiac arrest with arrest in circulation. In the case that a CPR attempt is desired, measures available on site will be deployed while awaiting the arrival of emergency medical services, according to the situation.

New INESSS Levels of Care Form

Part A: Goals of Care Discussion

Discussion participants:

☐Patient
☐Family member(s)
☐Substitute decision maker (SDM)
☐Treating physician
☐Others_____

Discussion content:

Was the medical condition thoroughly explained to the patient? ☐Yes ☐No ☐To some degree

What is the patient's understanding of their medical condition?
☐Poor ☐Fair ☐Good ☐Very good ☐Excellent

Were the patient's values, priorities and expectations discussed? ☐Yes ☐No
If yes, please provide specifics

Were the goals of care (cure vs palliation) discussed with the patient? ☐Yes ☐No
If no, please state the reason

Part B: Level of Intervention Form/ Level of Care Form

Was the level of care (LOC) form completed? ☐Yes ☐No
If no, please state the reason

Part C: Advanced Care Planning Discussion

Does the patient have a legally binding document that designates a substitute decision maker?
☐Yes ☐No
If yes, please indicate the appropriate document type: ☐Will ☐Power of Attorney (POA)
☐Mandate ☐Living Will/RAMQ Advanced Medical Directives
Please indicate the name of the SDM:

Part D: Palliative Care Consult or Referral

Does the patient need to be seen by a palliative care specialist for symptom assessment and/or symptom management? ☐Yes ☐No

Name of health care professional	Signature	Date (yyyy/mm/dd)

Goals of Care Form* (short version)

Section A: Discussion sur les objectifs des soins

Participants à la discussion :

☐Patient
☐Membre(s) de la famille
☐Mandataire spécial (MS)
☐Médecin traitant
☐Autres_____

Contenu de la discussion :

Est-ce que la condition médicale a été expliquée au patient ? ☐Oui ☐Non ☐ à un certain degrée

Quelle est la compréhension du patient de son état de santé ?
☐Mauvais ☐Raisonnable ☐Bonne ☐Très bonne ☐Excellente

Est-ce que les valeurs, les priorités et les attentes du patient ont été discutées ? ☐Oui ☐Non
Si oui, s.v.p. spécifiez

Est-ce que les objectifs des soins (traitement vs palliatif) ont été discutés avec le patient ?
☐Oui ☐Non Si non, s.v.p. spécifiez la raison

Section B: Formulaire de niveau d'intervention / Formulaire de niveau de soins

Est-ce-que le formulaire sur le niveau de soins a été rempli ?
☐Oui ☐Non Si non, s.v.p. spécifiez la raison

Section C: Discussion sur la planification des soins avancés

Est-ce-que le patient a un contrat ayant force obligatoire qui désigne un mandataire spécial ?
☐Oui ☐Non

Si oui, veuillez indiquer le type de document approprié : ☐Testament ☐Procuration
☐Mandat ☐Testament de vie/Directives médicales avancées (RAMQ)

Veuillez indiquer le nom du mandataire spécial :

Section D: Consultation ou orientation vers les soins palliatif

Est-ce-que le patient doit être examiné par un spécialiste en soins palliatifs pour l'évaluation et / ou la gestion des symptômes ? ☐Oui ☐Non

Nom du professionnel de la santé	Signature	Date (aaaa/mm/jj)

*This version of the GoC form is in use at MUHC and JGH. SMHC uses a longer version of the form to facilitate the multidisciplinary approach to early referral to PC and early documentation.

Project evaluation (summer/fall 2019)

- Process indicators:
  - % patients with chart documentation re: goals of care; advance directive; LOC; (within 60 days)
  - % pts. having a least one visit w/t a supportive/ palliative care team (within 60 days)
  - % HCPs taking part in education sessions
- Outcome indicators:
  - % ICU admissions and % ER visits
  - % pts. on multiple of lines of systemic therapy (2nd, 3rd line)
  - % pts. on systemic therapy (last 30 days);

Acknowledgements

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Thank you!