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

Dr. Manuel Borod
November 16, 2018
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

Lung Cancer Incidence (FY 2015-2016)

Source: JGH, MUHC, SMHC Cancer Registries
GoC documentation by the medical profession (MUHC and SMHC; n=103)

<table>
<thead>
<tr>
<th>RCN Site</th>
<th>Number of patients</th>
<th>Goals of care documented</th>
<th>Goals of care documented within 60 days</th>
<th>% GoC documented within 60 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>MUHC</td>
<td>139</td>
<td>96</td>
<td>94</td>
<td>67.6%</td>
</tr>
<tr>
<td>SMHC</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>55.6%</td>
</tr>
</tbody>
</table>
Review of the baseline data: LoC & ACP documentation

<table>
<thead>
<tr>
<th>RCN Site</th>
<th>Number of patients</th>
<th>LoC documented</th>
<th>LoC documented within 60 days</th>
<th>% LoC documented within 60 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>MUHC</td>
<td>139</td>
<td>67</td>
<td>36</td>
<td>25.9%</td>
</tr>
<tr>
<td>SMHC</td>
<td>9</td>
<td>6</td>
<td>1</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RCN Site</th>
<th>Number of patients</th>
<th>ACP discussion documented</th>
<th>ACP documented within 60 days</th>
<th>% ACP documented within 60 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>MUHC</td>
<td>139</td>
<td>3</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>SMHC</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

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)

- Pain management: 39%
- End-of-life care: 35%
- Symptom management: 26%

<table>
<thead>
<tr>
<th>RCN Site</th>
<th>Number of patients</th>
<th>Referral to palliative care</th>
<th>Referral to PC within 60% referral to PC within 60 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>MUHC</td>
<td>139</td>
<td>67</td>
<td>38</td>
</tr>
<tr>
<td>SMHC</td>
<td>9</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>
ER visits & ICU Admissions

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

- None: 11%
- 1 visit: 45%
- 2 visits: 22%
- 3 visits: 7%
- 4 visits: 11%
- 5 and more visits: 4%

ICU Admissions (MUHC & SMHC; n=148)

- MUHC: 139
- SMHC: 9

For personal use only
Not for distribution
Key process elements

Within 60 days of diagnosis - discuss and document:
- Goals of Care
- LOC (new INESSS form)
- Naming a substitute decision maker

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

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

**ONCOLOGIST**
- Diagnosis, prognosis & treatment discussion
- Explains the diagnosis & prognosis
- Fills out the level of care form
- Refers the patient to Palliative Care

**PIVOT NURSE**
- Patient understanding of the GOC
- Confirms patient understanding of his/her diagnosis
- Discusses patient’s values, priorities and expectations

**SOCIAL WORKER**
- Advanced Care Planning
- 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

For personal use only
Not for distribution
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

(https://www.talkaboutwhatmatters.org/documents/Providers/PSJH-Serious-Illness-Conversation-Guide.pdf )
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.
New INESSS Levels of Care Form
Goals of Care Form*
(short version)

*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 at 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

Project Team:
Dr. Manuel Borod, Dr. Hitesh Bhanabhai, Gligorka Raskovic, Rebecca Fox, Genevieve Redstone, Nathalie M. Aubin, Doneal Thomas, Myriam Fernandez

JGH, MUHC, SMHC Working Groups:
Dr. Jason Agulnik, Dr. Marcia Gillman, Dr. Scott Owen, Dr. Nicole Ezer, Dr. Joan Zidulka, Jeff Margenpan, Laura Delany, Rajesh Sharma

RCN Supportive Care Program Lead: Dr. Adrian Langleben
Thank you!