



A Palliative Care Update: Introduction of NEW South Muskoka Community Palliative Care Referral Pathway & Clinical Pearls for Goals of Care Discussions

MAHC Grand Rounds

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Disclosure of Affiliations, Financial Support, and Mitigating Bias

I have no relationships with for-profit or not-for-profit organizations.



Learning Objectives

1. Comprehend the NEW Palliative Care Referral Pathway in South Muskoka.
2. Identify appropriate patients for the South Muskoka Palliative Care Program based on prognostic indicators for common conditions.
3. Carry out goals of care discussions with patients.

South Muskoka Community Palliative Care Referral Pathway

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- Sarah Hudson
 - Clinical Coach | Muskoka Almaguin
Ontario Health Team

Adults in Community Settings Model of Care

13 recommendations to make palliative care **more accessible** and **coordinated**.

1. **Early identification of individuals who would benefit from palliative care.**
2. **At any point in the patient's illness, there will always be a designated care coordinator.**
3. **24/7 access to an interprofessional palliative care team.**
4. A care plan based on the patient's wishes, values and beliefs.
5. Pain and symptom management.
6. **Emotional, psychological and spiritual care.**
7. **Practical and social supports.**
8. Timely planning for end-of-life care.
9. Support for family/caregivers of the patient.

Foundational
Elements

System
Gaps

**Prioritized
recommendations
for implementation**

With special considerations for:

10. Residents living in long-term care homes.
11. Culturally appropriate care for First Nation, Inuit, Métis or urban Indigenous patients.
12. French language services.
13. Individuals who are homeless or vulnerably housed.

OH's Palliative Care Priorities

Palliative Care priorities aligned to OH's top priorities.

Advancing Patient-Centred Care Through Our Top Priorities



Primary Care



Emergency
Department



ALC/Community
Access



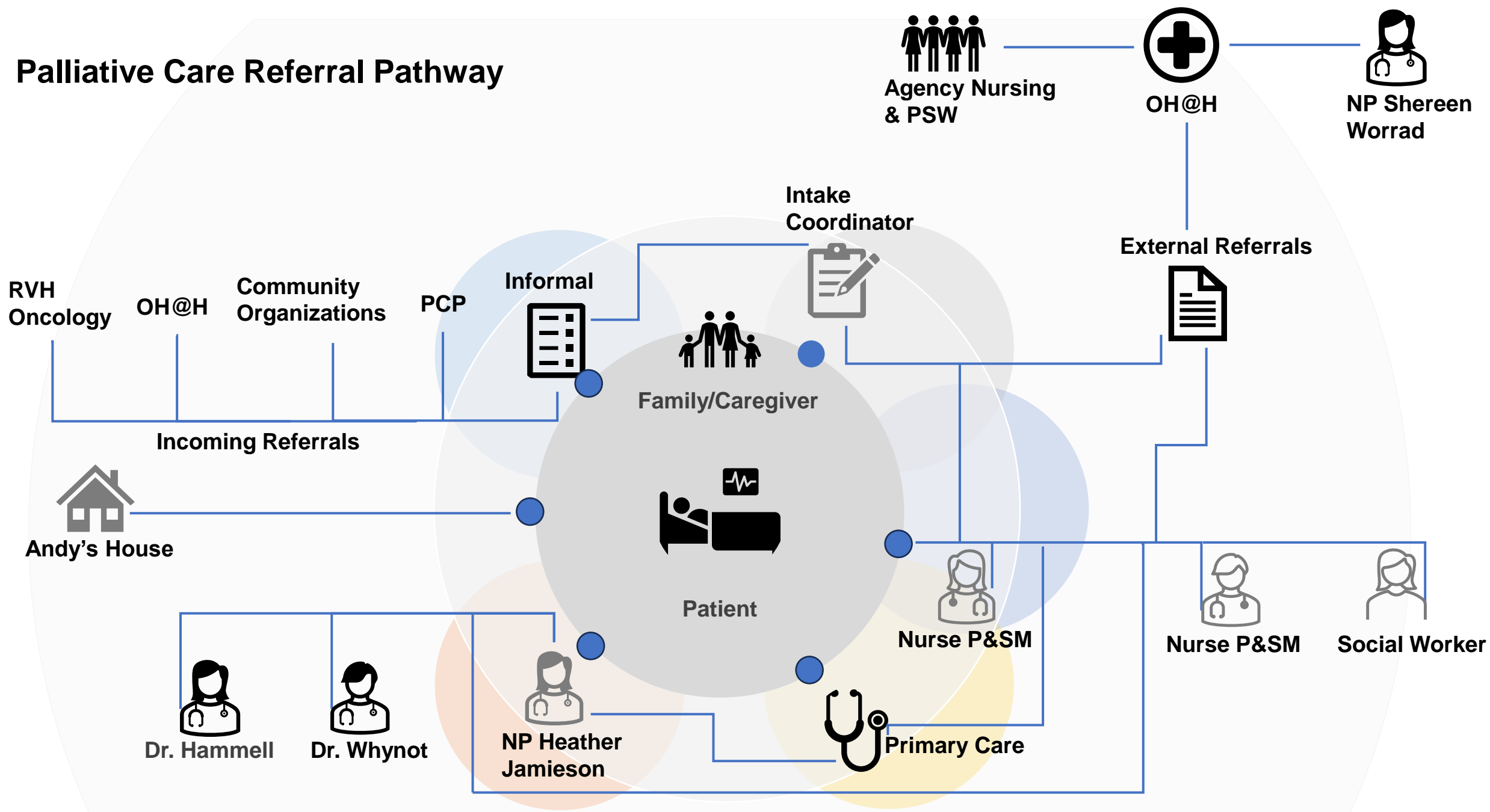
Surgery



Strong Ontario
Health

1. Patients and families receive end-of-life care in a location aligned with their preferences* and their care needs (care in right location). *Care preferences may evolve over the course of an illness trajectory.
2. Patients receiving palliative care will, as much as possible, be able to avoid unplanned emergency room visits/acute care admissions in the last month of their lives.
3. The family/caregivers of the patient with a life-limiting illness will be supported throughout the person's illness trajectory, at the end of life, and through death and bereavement.

Palliative Care Referral Pathway





Community Palliative Care Referral South Muskoka

Please complete this referral form and all accompanying documentation and submit by:

Fax: 705-646-1609, Email: intake@hospicemuskoka.com, or Phone: 705-204-2273

Referral Requests are checked daily, Monday to Friday 8:30am-4:30pm.

Patients will be contacted within 1-2 business days of referral.

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
HCN:		Gender:	
VC:		Preferred Language:	
Address:		Phone #:	
Current Location:		Alternate Contact Name, Relationship & Phone #:	
Estimated Hospital D/C Date:		Translation Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Living Arrangements:	<input type="checkbox"/> Alone <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Family <input type="checkbox"/> Other:		
Ontario Health at Home Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Current Home Supports:	<input type="checkbox"/> PSW <input type="checkbox"/> Nurse <input type="checkbox"/> NP <input type="checkbox"/> Other:		

REFERRAL INFORMATION			
Palliative Diagnosis:		Date of Diagnosis:	
Reason for Referral:			
Current Symptoms/Concerns:			
Additional Medical History:			
Prognosis:	<input type="checkbox"/> <12 Mos <input type="checkbox"/> <6 Mos <input type="checkbox"/> <3 Mos <input type="checkbox"/> <1 Mo <input type="checkbox"/> Unknown		
PPS:		Allergies:	
Does Patient Have Primary Care Provider:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Followed by:	
Would Primary Care Provider like palliative NP/MD to follow:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Care Provider Notified of Referral:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient Aware of Diagnosis, Prognosis & Referral to Care?:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Level of Urgency:	<input type="checkbox"/> Non-urgent <input type="checkbox"/> Urgent	Hospice Referral Requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Hospice:			
Additional Information Attached (medications, labs/imaging, consultations & recent clinical notes):			

REFERRING PROVIDER INFORMATION			
Provider Name:		Family Provider (MD/NP):	
Phone #:		Phone #:	
		Billing #:	
Fax #:		Fax #:	

INTAKE USE ONLY	
Provider to Complete Assessment:	
Date of Consult:	
Location:	

****OCEAN Referral Available under Hospice Muskoka-Andy's House-> Community Palliative Services**

How do you identify
patients appropriate for
the South Muskoka
Palliative Care Program?

Early Identification & Prognostic Indicator Guide¹

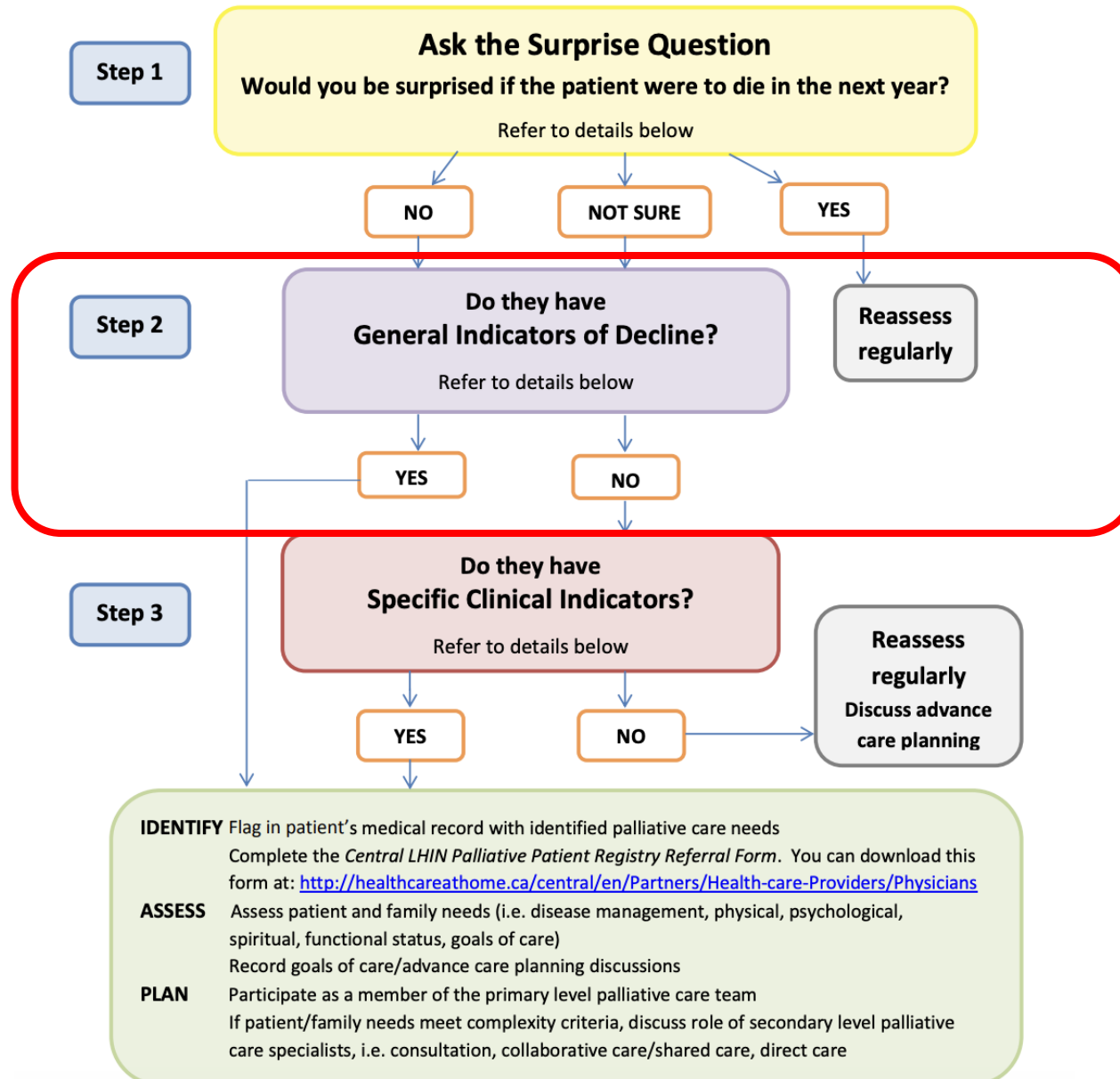
- Tool utilized by Ontario Health.
- Adapted from the Gold Standards Framework (GSF) Prognostic Indicator Guidance tool developed by the GSF Centre in the UK.
- Tool used in UK to support GPs, care homes, and hospital
- Goal is to identify patients in their last year of life who may benefit from palliative care
- Applicable across care settings
- Not disease specific

Three criteria that suggest patients are nearing the end of life¹

The Surprise Question: ‘Would you be surprised if this patient were to die in the next few months, weeks, days’?

General indicators of decline - deterioration, increasing need or choice for no further active care.

Specific clinical indicators related to certain conditions.



General Indicators of Decline

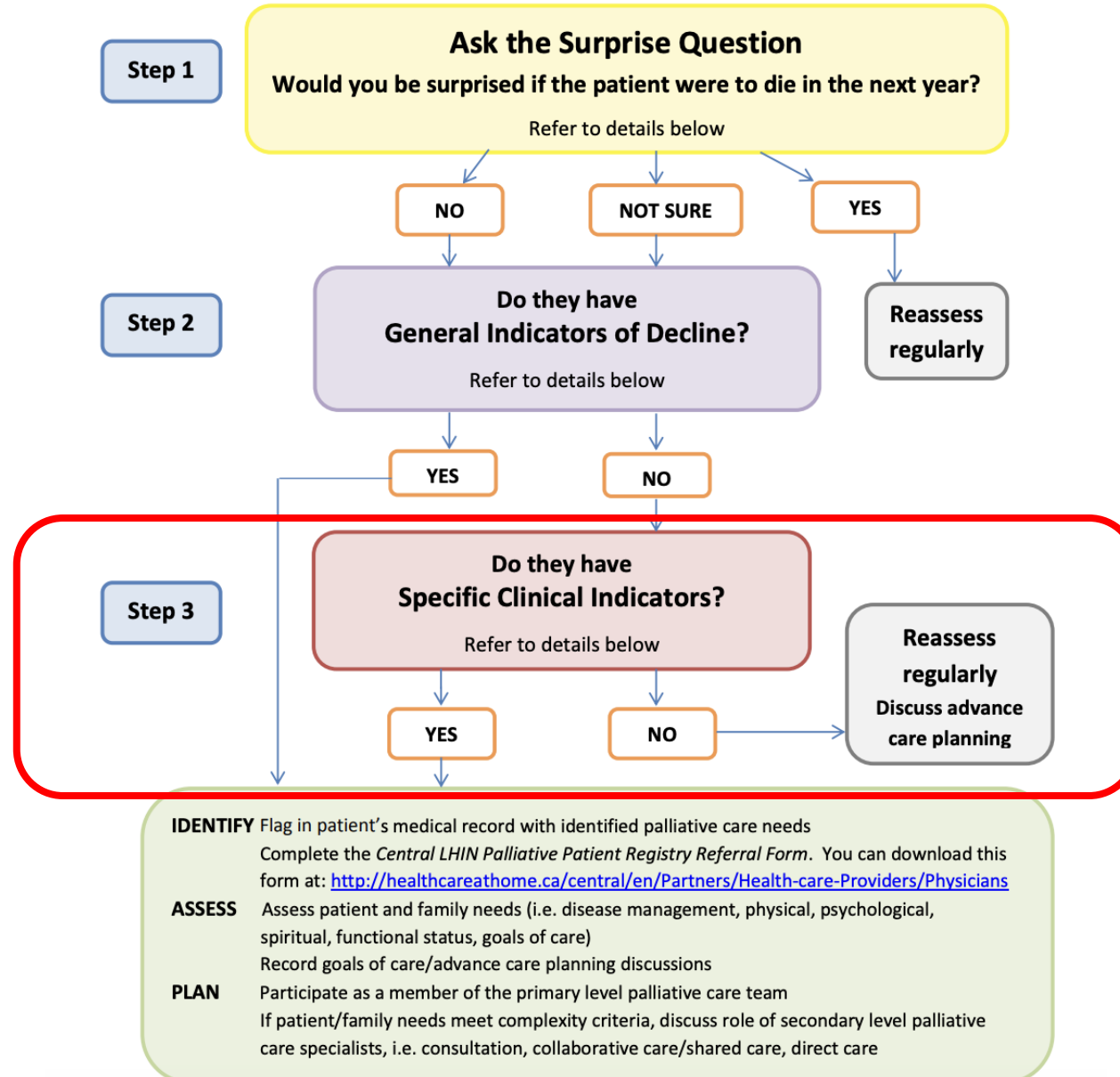
- Advancing disease → increasing symptom burden
- Decreasing response to treatments
- Patient chooses to not pursue disease modifying treatment
- General physical decline -> declining PPS (e.g. PPS < 60)
- Weight loss - >10% in past six months
- Repeated unplanned/crisis hospital admissions
- Sentinel event, e.g. serious fall, bereavement, retirement or medical grounds
- Serum albumin <25g/l

**Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity



Early Identification & Prognostic Indicator Guide

Guidance for clinicians to support earlier identification of patients nearing the end of life and who could benefit from a hospice palliative care approach

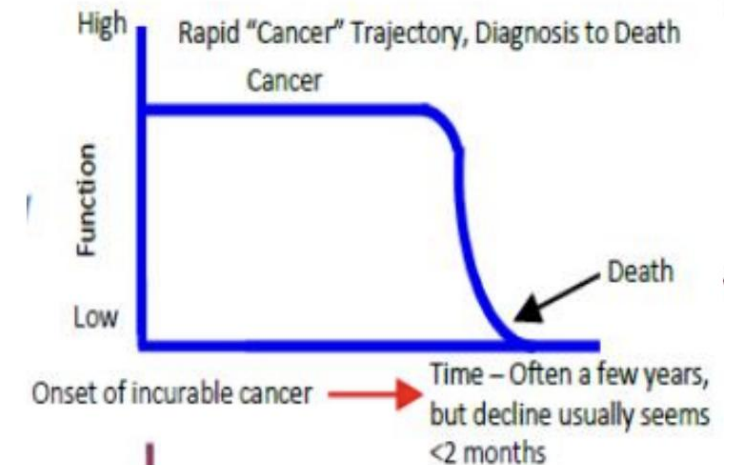


Specific Clinical Indicators¹

Cancer

- Rapid or predictable decline. Supported scales such as PPS or ECOG.
 - If patient is spending more than 50% of time in bed/lying down, prognosis is about 3 months or less
- Metastatic cancer

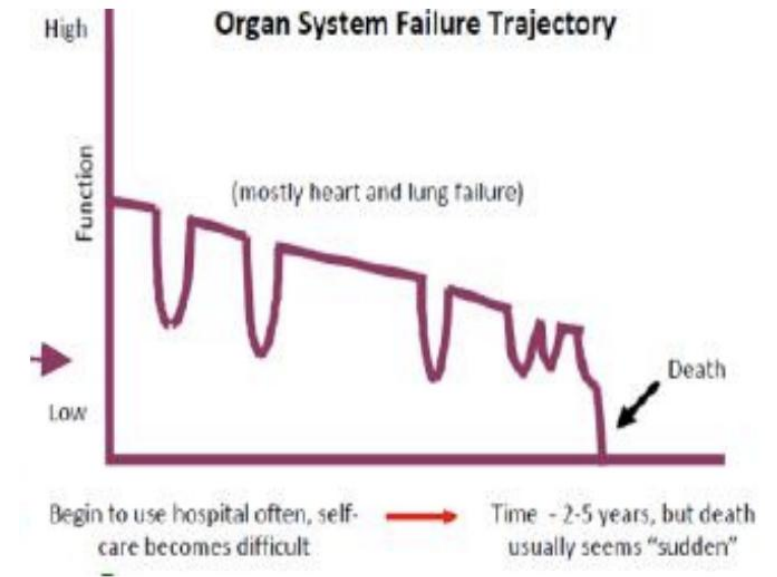
Varying Disease Trajectories²



Specific Clinical Indicators¹

Organ System Failure (erratic decline)

- Lung Disease (COPD)
- Heart Disease (CHF)
- Kidney Disease
- Liver Disease
- Neurological Diseases



Heart and Lung Disease¹

COPD (At least two of the indicators below):

- Severe Disease (e.g. FEV1 <30% predicted)
- Recurrent hospital admissions (≥ 3 in last 12 months due to COPD)
- Chronic oxygen use
- MRC grade 4 to 5 (dyspnea after 100m on the level or confined to house)
- Right heart failure
- > 6 weeks of systemic steroids for COPD in preceding 6 months

CHF:

- NYHA Stage 3 or 4 (shortness of breath at rest on minimal exertion)
- Repeated hospital admissions with heart failure symptoms
- Challenging physical or psychological symptoms despite optimal tolerated therapy

Kidney and Liver Disease¹

Renal Disease

- Stage 4 or 5 Chronic Kidney Disease
- Patients choosing the 'no dialysis' option or discontinuing dialysis
- Challenging physical symptoms or psychological symptoms despite optimal tolerated renal replacement therapy
- Symptomatic Renal Failure – nausea and vomiting, anorexia, pruritus, reduced functional status, intractable fluid overload

Liver Disease (Advanced cirrhosis with one or more complications in past year):

- Diuretic resistant ascites, hepatic encephalopathy, hepatorenal syndrome,
- Recurrent variceal bleeds
- Liver transplant contraindicated
- Child-Pugh Class C

Neurological Diseases¹

Examples include Motor Neuron Diseases, Parkinson's Disease, and Multiple Sclerosis

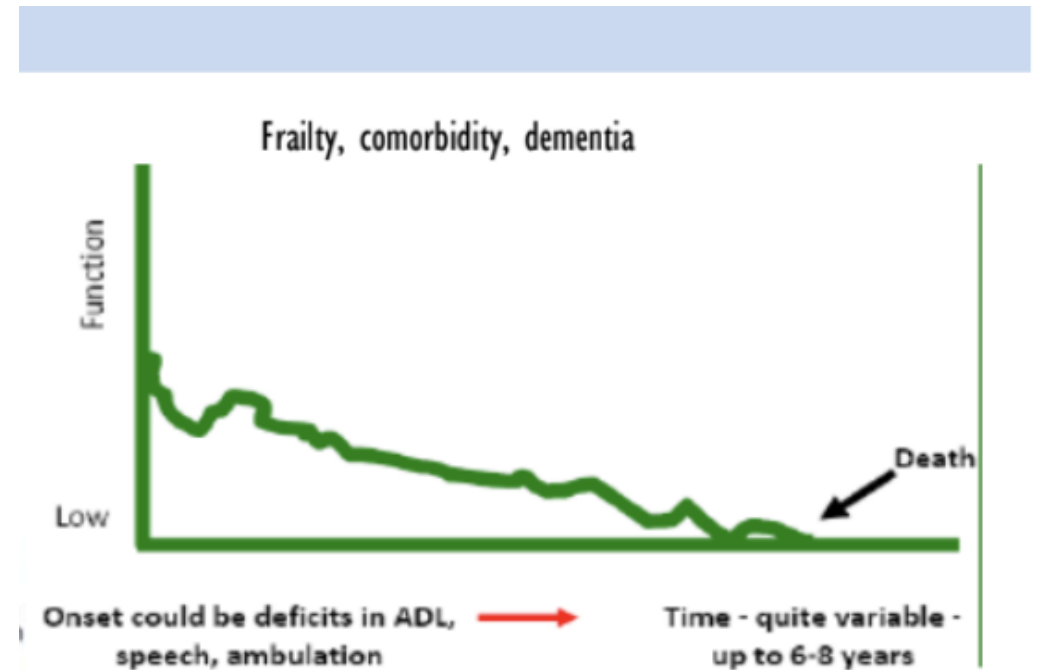
General features:

- Progressive physical and/or cognitive decline despite optimal therapy
- Complex symptoms that are difficult to manage
- Dysphagia leading to recurrent aspiration pneumonia, sepsis, breathlessness or respiratory failure
- Increased difficulty in communication due to dysarthria or aphasia

Specific Clinical Indicators¹

Frailty/Dementia - gradual decline

- Frailty
- Dementia
- Stroke



Frailty, Dementia, or Stroke¹

Frailty

(Multiple co-morbidities with significant impairment in day to day living) and:

- Deteriorating functional status
- Combination of at least three of the following symptoms: weakness, slow walking speed, significant weight loss, exhaustion, low physical activity, depression

Dementia

- Loss of ADLs
- No consistently meaningful verbal communication
- Plus any of the following:
 - Weight loss, urinary tract Infection, severe pressures sores (stage 3 or 4),
 - recurrent fever, reduced oral intake, aspiration pneumonia

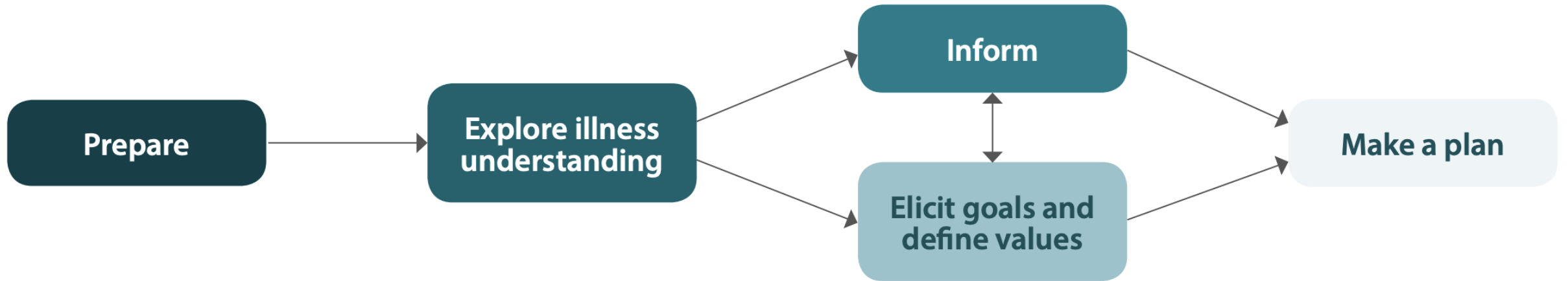
Stroke

- Persistent decreased or minimal conscious state or dense paralysis
- Medical complications
- Lack of improvement within 3 months of onset
- Cognitive impairment / post-stroke dementia



How to Approach A Goals of Care Discussion

Approach to Goals of Care Discussion⁴



Prepare for the conversation⁴

- Review the chart
- Acknowledge your own feelings and bias
- Remember fundamentals of good communication
 - Open-ended/clarifying questions
 - Summarizing comments and validation
 - Allow for silence for processing of information and emotions
 - Be prepared for emotions
- If possible, schedule meeting in advance to ensure a private and comfortable space with family/friends/SDM/POA in attendance, if applicable.

Explore the Illness Understanding⁴

- What is your understanding of your current illness or disease?
 - Knowledge is important but patient feelings are key to guide the discussion
- Ask about symptoms and quality of life
- Assess interest in knowing more about prognosis

Inform⁴

- Provide information based on patient needs (based on illness understanding)
 - Do they need help with better understanding their illness
 - Do they need support with processing information
 - Do they need support to talk to their family?

Back to basic with communication:

- Speak slowly, allow breaks
- No medical jargon
- Check for understanding (e.g. ask them to repeat back what you said)
- Provide time for processing

Responding to Emotions⁴

- Allow emotions to come up and acknowledge them
 - Wait until emotions settle to continue
- Silence....
- Respond openly and honestly
 - Do not offer empty reassurance
- “I wish” statements
- Third person statements and normalize uncertainty

Elicit values and define goals⁴

- What do they perceived as quality of life and what they consider important moving forward
 - E.g. attendance at big event
- What is the patient worried about and what resources do they need?
 - Relationship dynamics, degree of dependence, place of residence
- Code status (e.g., cardiac compressions, intubation, prolonged ventilation, etc.) may naturally come up at this point.

Plan and Document⁴

- Relate treatment plan back to goals and value
 - Note palliative care can still be involved when patient is receiving treatments
- Record patient wishes (e.g. views on further tests, interventions, or treatments)
- Document SDM or POA and encourage patient to discuss wishes/goals of care with this person.
- Summarize and end with supporting words

Revisit the conversation⁴

- Goals of care are ALWAYS CHANGING, especially if health status is changing
- Update plan accordingly
- Add supports and resources as appropriate

What to do if things do not go well⁴

- Explain why you are having the conversation
- Clarify your understanding of patient values and goals
- Reassess understanding and provide more information if required
- Try again...
- Consult others

References

1. Thomas, K., & Stobbart-Rowlands, M. (2011). Gold Standards Framework Annual Meeting. improving end of life care using Gold Standards Framework. *BMJ Supportive & Palliative Care*, 1(1). <https://doi.org/10.1136/bmjspcare-2011-000053.4>
2. Ontario Health at Home. (n.d.). *Early Identification & Prognostic Indicator Guide*. Better Palliative Care in Central LHIN. Early Identification & Prognostic Indicator Guide. <https://ontariohealthathome.ca/wp-content/uploads/2022/09/cen-palliative-early-id-prognostic-indicator-guide.pdf>
3. Lunney, J. R. (2003). Patterns of functional decline at the end of life. *JAMA*, 289(18), 2387. <https://doi.org/10.1001/jama.289.18.2387>
4. Ontario Palliative Care Network. (n.d.). *Approaches to goals of care discussions resource for healthcare providers*. Canadian Virtual Hospice. https://www.virtualhospice.ca/Assets/ApproachesToGoalsOfCare_20190719170307.pdf