Ontario’s Palliative Care Integration Project

Cancer Services in Ontario Conference
Ontario Hospital Association

Susan King, Provincial Improvement Coordinator, PPCIP, CCO

Erin Hughes, Director, Innovation and Special Projects, CCO

May 15, 2007
1.0 Project Overview
Several problems had been identified with the system:

- Lack of service integration and fragmentation of the palliative care system
- Inconsistent pain and symptom management practices
- Minimal use of standard assessment tools
- Challenges accessing palliative care services
Provincial Palliative Care Integration Project

- Based on a successful and proven palliative care integration initiative from the South East LHIN region
- Implementation in all 14 regions starting Sept 06
- Funded by MOHLTC and CCO
- The project consists of:
  - Quality improvement framework
  - Multidisciplinary education
  - Cross sectoral collaboration
  - Common, evidence-based tools
  - Formal evaluation
- Will result in a system with integrated care across care sites and improved patient related outcomes
<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are we trying to accomplish?</td>
</tr>
<tr>
<td>How will we know a change is an improvement?</td>
</tr>
<tr>
<td>What change can we make that will result in improvement?</td>
</tr>
</tbody>
</table>

**CYCLES for Testing and Implementing Change**

- **Plan**
- **Do**
- **Study**
- **Act**

Common Tools

Symptom Screening and Assessment:
  • *Edmonton Symptom Assessment System (ESAS)*
  • *Electronic Assessment*

Symptom Control:
  • *Symptom Management Guidelines (SMGs)*

Coordinated Palliative Support:
  • *Palliative Performance Scale (PPS)*
  • *Collaborative Care Plans (CCPs)*
Project Aims

• Target population
  – all lung cancer and palliative care patients in Regional Cancer Centre clinics, and
  – all palliative cancer patients in the home setting.

• Specific improvement aims developed
A Hierarchy of Improvement Aims

To improve care for palliative patients

1. 90% target population screened for symptom severity (ESAS)
2. 90% target symptoms are controlled. (SMGs)
3. 90% functional status is assessed (PPS) and coordinated support provided (CCPs).

WHY?

HOW?
A Hierarchy of Improvement Aims

2. 90% target symptoms (pain, dyspnea, depression) are controlled.

- Severity of index symptoms is reduced (72 hrs)
- Patients are satisfied with level of control.
- Referrals made for depression if 5 or above (72 hrs)

WHY?

HOW?
## Impact of Aims on the System

<table>
<thead>
<tr>
<th>Cancer System Goals</th>
<th>Improve Measurement</th>
<th>Increase Use of Evidence</th>
<th>Effective Use of Resources</th>
<th>Improve Access</th>
<th>Improve Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom Screening and Assessment</td>
<td>✅</td>
<td>✅</td>
<td></td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>Symptom control</td>
<td>✅</td>
<td></td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>Coordinated Palliative support</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>System outcomes*</td>
<td></td>
<td>✅</td>
<td></td>
<td></td>
<td>✅</td>
</tr>
</tbody>
</table>

* As currently published on the CSQI web site: fewer deaths in acute care, fewer emergency room visits, more home care and more physician visits to home.
2.0
Current Status
Organizing for Improvement

- Centralized project management
- Regional Improvement Coordinators
  - Coordinate and support the project within the region
  - Funded by the project
- 13 Regional Steering Committees
  - Regional project guidance and direction
- CCO Regional Vice Presidents
  - Provide leadership and report on progress
  - Link to Regional Steering Committees
- Regional Improvement Teams
  - “Work teams” that focus on process improvements required to achieve the targets
Snapshot of Accomplishments

• All Regional Cancer Centres and CCACs are participating
• All Regional Steering Committees have been created
• Over 40 Regional Improvement Teams exist across the province
• Provincial Collaborative May 17th with all regions
• Regions are using a web based tool to send data to CCO to identify progress toward the improvement aims
• Five hospital sites and four CCACs are using a web based tool where patients can enter their own symptom scores (“ISAAC”)
Interactive Symptom Assessment and Collection (ISAAC)

- Patients are able to complete an electronic ESAS prior to each clinic visit at a touch screen kiosk.
- Patients are also able to enter their scores from home via the internet.
- ESAS report displayed as a histogram including scores entered at both the clinic and home.
- Clinicians within the patient’s circle of care are able to access ESAS and PPS scores from the ISAAC website to assist in the monitoring of their patient’s symptoms and functional status over time.
ISAAC Kiosk
Please select the number that best describes the symptom pain

0 1 2 3 4 5 6 7 8 9 10

No pain Worst possible pain

Go Back Continue
Project Evaluation & Measurement

- Incorporates qualitative and quantitative methods to evaluate process, structure and outcomes
- Examining the impact of the quality improvement methodology
- As well, measuring the change in the quality of symptom management and palliative cancer care
Early Data Show Encouraging Results

Patients screened at least once with an ESAS and assessed with PPS – By Month (example of one centre’s experience)

<table>
<thead>
<tr>
<th></th>
<th>Nov 06</th>
<th>Dec 06</th>
<th>Jan 07</th>
<th>Feb 07</th>
<th>Mar 07</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESAS</td>
<td>12</td>
<td>15</td>
<td>227</td>
<td>495</td>
<td>571</td>
</tr>
<tr>
<td>PPS</td>
<td>4</td>
<td>11</td>
<td>154</td>
<td>422</td>
<td>442</td>
</tr>
</tbody>
</table>

*Data as of April 24, 2007*
Early results cont.

- 14 cancer centres submitting data
- 3 CCACs submitting data
- Clinical Aims Audits – 8 regions started
  - chart audits to assess clinical response to high symptom scores and use of collaborative care plans
  - Example of one centre’s experience

<table>
<thead>
<tr>
<th># audits for high pain score</th>
<th>% receiving further assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan - 9</td>
<td>55%</td>
</tr>
<tr>
<td>Feb - 9</td>
<td>67%</td>
</tr>
<tr>
<td>Mar - 15</td>
<td>88%</td>
</tr>
</tbody>
</table>
PDSA Cycle Example

**Plan**
- PPS score on hospital referrals to CCAC
- Improved communication of patients needs
- Implement at one hospital to trial referral form
- In last week of the first month of roll out count % of referrals with PPS score

**Do**
- Education to PMH clinic staff of (1) benefits of the PPS, (2) how to perform the PPS and (3) new process for placing PPS score on CCAC referrals

**Act**
- Determine impact of this cycle and look at how to improve outcome

**Study**
- In last week of the first month of roll out count % of referrals with PPS score
3.0 Moving Forward
Regional:

- Quality Improvement model has fostered stakeholder engagement, participation and ownership of the project
- Improved communication across sectors fosters collaboration and identification of opportunities to improve integration of palliative services
- Promotes professional development
- Has provided an opportunity for the discussion of what palliative care is, creating impetus for change
Overall project:

- Sustainability of successes needs to be considered early in the project
  - Tied to performance of leaders
- Cross provincial and local data critical to understanding progress and promoting collaboration
  - Resources required to collect data
Next Steps

• Cancer Centres and CCACs to achieve improvement aims by end of March 2008

• Additional goals for 2007/08:
  – Include new patient populations beyond lung cancer and palliative care.
  – Expand full functionality of “ISAAC” tools to other regions (patients entering their own data)
  – Explore ways to include other acute care hospitals in the project, including electronic data capture