CREDIT · VALLEY
Équipe de Santé Familiale · Family Health Team

CVFHT Enhanced Care / Palliative Care Model

AFHTO Conference
October 17, 2012

Presenters : Dr. K. Kent, MD
Gordon Canning, NP

Ontario

CREDIT VALLEY
Équipe de Santé Familiale • Family Health Team

Who are we?

Our Mission of Excellence:

High Standard Interprofessional Primary Care + Family Medicine Teaching

2 sites
11,000 patients
15 IHPs
10 Physicians
18 Admin staff
20 Family Practice Residents

Multiple CDM and Preventative Care Programs

Ontario

CREDIT · VALLEY
Équipe de Santé Familiale · Family Health Team

Goals of Session

1. To review outline of the CVFHT Enhanced Care / Palliative process to date
2. To describe the initial process of the initial PDSA cycle
3. To review two active cases in our program
4. To review what has worked well and challenges

Ontario

Palliative Care Context

- Demographics age over 65 yr (Statistics Canada, 2001)
  - CVFHT
    - 1, 130 patients over age 65
  - Mississauga Halton LHIN
    - 52, 150 (8.5%)
- Where to most people want to die?
  - 90% want to die at home, cabin, close to nature or on a beach!
  - 10 will reply in a hospital (Wilson, 2011)
- Currently approximately 30% die at home

Palliative Care Context

- Pilot Palliative Care Mentorship Program offered by CCO and Credit Valley Hospital Palliative Care group
  - Purpose to increase the capacity of primary care physicians and others related to end of life care
  - Provide further outreach into the community from our FHT
  - Build relationships with community partners related to palliative care

Initial Process

- Learning Essential Approaches to Palliative and End of Life Care (LEAP)
  - 2.5 day course Feb 1-3rd
  - Provided by Palliative care physician and 3 Palliative Care NP's
  - 11 modules over 2.5 days
  - Attended by CVFHT interprofessional team (Pharmacist, Social Work, Dietitian, Physicians, Nurse Practitioner, Family Practice Nurse) and community (Palliative Nurses, CCAC Case Manager)

Initial Process

- Met July 19, 2012 as a sub group
  - Patients identified from a single physician roster
    - Those over age 65
    - Surprise questions: "Would not be surprised if the individual passed away in the few months, weeks, day?"(Gold Standard Framework, 2011)
    - Initiate a PDSA cycle
  - Initial 15 patients were contacted by phone by a Nurse Practitioner
  - Initial intake interview/assessment by Nurse Practitioner scheduled if they consented

Foundation of Improvement Model

- **Plan / Do / Study / Act**
- Increase the knowledge of this group and identify changes needed to lead to a desired end state
- Identify undesirable results early
- High degree of group buy-in

Questions:

1. What are we trying to accomplish?
2. What does improvement look like?
3. How can we change our measure?

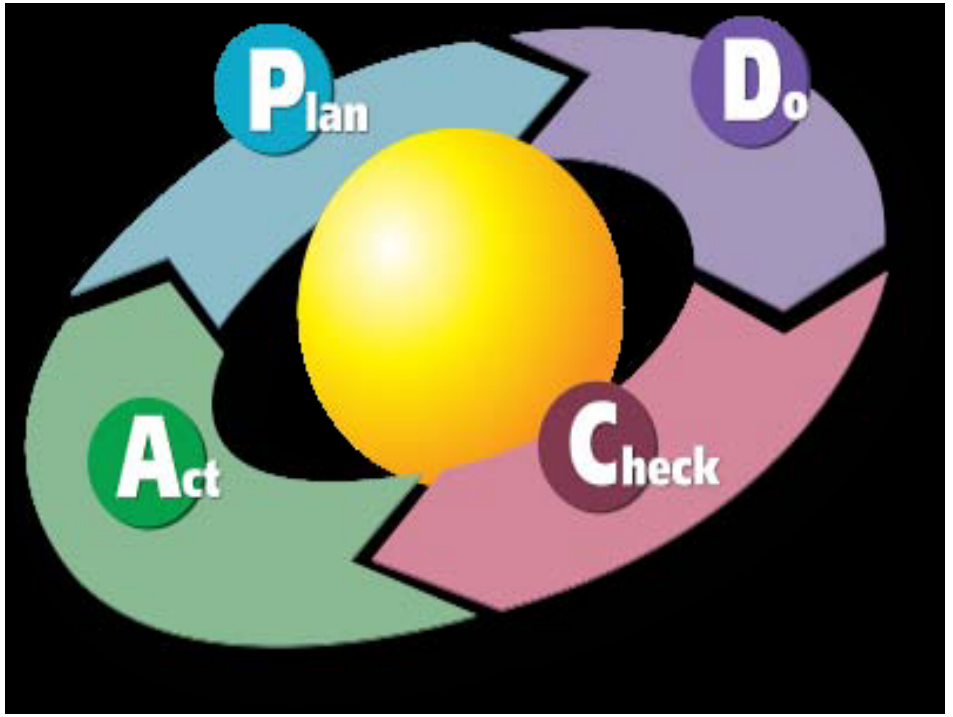


Image from Wikipedia, PDCA Cycle

Initial Intake

- Initial assessment with Nurse Practitioner
  - 60 min face to face meeting
    - Comprehensive geriatric health history, assessment
      - Cognitive screen MMSE / MoCA as needed
    - Seniors Assessment tool (BC Guidelines, 2008)
    - Medication review and reconciliation
    - TUG test
    - Height / Weight / BMI
    - ESAS assessment
    - PPS
    - CSHA clinical frailty score
  - Chart review; 60min to 120min
  - Physician communication with issues identified

Seniors Assessment Tools

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds

Rockwood et al, 2005

CREDIT · VALLEY
Équipe de Santé Familiale · Family Health Team

Seniors Assessment Tool

Guidelines & Protocols Advisory Committee

SENIORS ASSESSMENT TOOL

This Assessment Tool pertains to the Guideline:
Frailty in Older Adults – Early Identification and Management
www.BCGuidelines.ca

Ministry of Health Services

NAME OF SENIOR	PERSONAL HEALTH NUMBER	DATE
NAME OF PHARMACY		LOCATION

1. How has your health been since your last visit? ❑ better ❑ same ❑ worse: _____
2. Do you have concerns or problems with any of the following:

Medications	❑ No	❑ Yes: _____
Pain	❑ No	❑ Yes: _____
Falls	❑ No	❑ Yes: _____
Decreased energy	❑ No	❑ Yes: _____
Nutrition	❑ No	❑ Yes: _____
Memory	❑ No	❑ Yes: _____
Bladder/Bowels	❑ No	❑ Yes: _____
Hearing	❑ No	❑ Yes: _____
Vision	❑ No	❑ Yes: _____
Sleep	❑ No	❑ Yes: _____
Depression/Lonliness	❑ No	❑ Yes: _____
Looking after yourself	❑ No	❑ Yes: _____
Looking after your home	❑ No	❑ Yes: _____
Finances	❑ No	❑ Yes: _____
Transport	❑ No	❑ Yes: _____

3. Where do you live? ❑ own home ❑ with family ❑ facility
   ❑ other: _____
4. Do you live alone? ❑ No ❑ Yes
5. Do you have help in the home? ❑ No ❑ Yes:
6. Do you have a contact for emergencies? ❑ No ❑ Yes
   If yes, who could you call? ❑ family friend ❑ neighbour ❑ Lifeline
   ❑ other: _____
7. Have you signed a Power of Attorney? ❑ No ❑ Yes
8. Have you made a Will? ❑ No ❑ Yes
9. Do you want to discuss end-of-life plans? ❑ No ❑ Yes
10. Have you signed a "No CPR" form? ❑ No ❑ Yes
11. Would you consider Lifeline quick response? ❑ No ❑ Yes ❑ I have Lifeline (or similar service)

HLTH/BCMA 6011 (FEB 2008)

The Seniors Assessment Tool was developed as part of the Seniors-at-Risk Initiative (Trail, B.C.)

Ontario

Palliative Assessment Tools

- Palliative Performance Scale
  - Used to obtain a basis of the patients functional capacity and prognosis.
  - Developed for cancer patients where performance status / functional ability are the most important prognostic factors
    - Patients more than 50% of time in bed, prognosis is likely <3 months

Palliative Assessment Tools

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Victoria Hospice Society, 2001

Palliative Assessment Tools

- Edmonton Symptom Assessment System
  - 10 point likhert scale
    - Evaluate pain, tiredness, nausea, depression, anxiousness, drowsiness, appetite, feeling of well being, shortness of breath, other specific problems.
    - Validated for the use of assessing common symptoms in cancer patients

CREDIT · VALLEY
Équipe de Santé Familiale · Family Health Team

ESAS

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Image adapted from Capital Health Regional Palliative Care Program

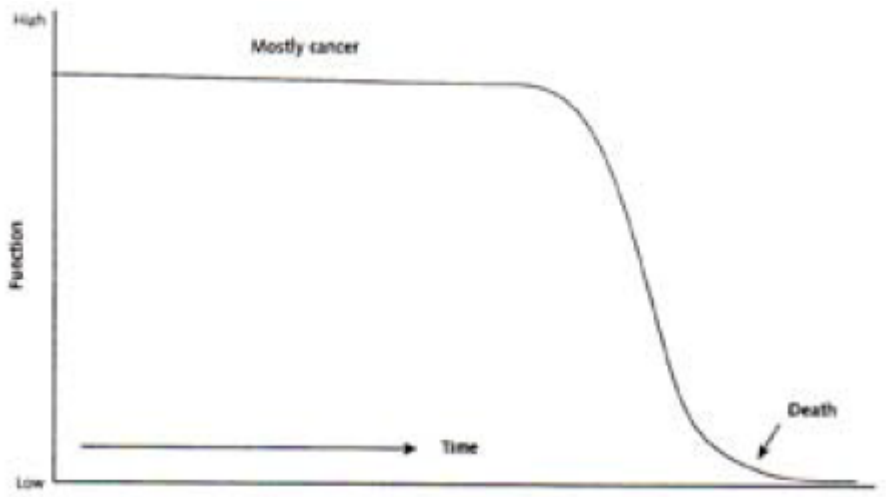
Ontario

Palliative Tools

Cancer

- Metastatic
- Single most predictive factor is performance status (PPS) and functional ability
- >50% time in bed, prognosis is estimated to be 3 months or less

Rapid Cancer Trajectory, Diagnosis to Death



Onset of incurable cancer ⇨ Time – Often a few years but decline seems < 2/12

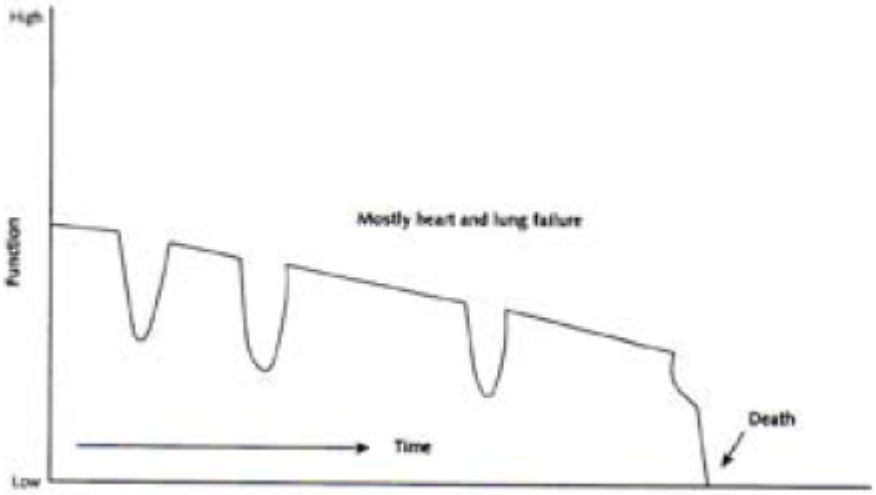
Gold Standard, September 2011

Palliative Tools

Organ Failure – Erratic Decline

- COPD
  - Assessed Severe; FEV1 <30% predicted
  - Recurrent hospital admissions (>3 in 1 year)
  - MRC 4/5
  - Increasing steroids >6/52 past 1 year
- Heart Disease (2 of the following)
  - CHF NYHA Stage 3 or 4 (SOB at rest or min exertion)
  - +ve surprise question
  - Repeat hospitalization d/t HF
  - Con't difficult physical or psych symptoms despite optimal therapy

Organ System Failure Trajectory



Begin to use hospital often, decline in self-care ⇨ Time 2-5yrs, death usually seems "sudden"

Gold Standard, September 2011

Palliative Tools

Frailty

- Multiple co morbidities with significant impairment in ADL and:
  - Weakness
  - Slow Walking speed
  - Significant weight loss
  - Low physical activity
  - Depression

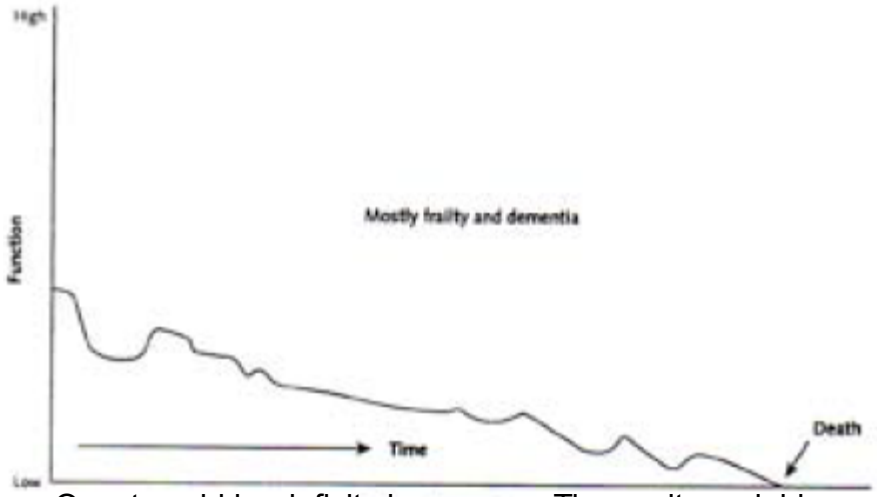
Dementia

  - Unable to walk without assistance
  - Urinary and fecal incontinence
  - No meaningful conversation
  - Total dependence for ADL

Plus any of the following:

  - Weight loss / reduced oral intake
  - UTI / Aspiration Pneumonia / Pressure sores – stage 3 or 4
  - Recurrent fever

Prolonged frailty or Dementia Trajectory



Onset could be deficits in ADL, Speech or mobility ⇒ Time quite variable – up to 6-8 years

CREDIT VALLEY
Équipe de Santé Familiale • Family Health Team

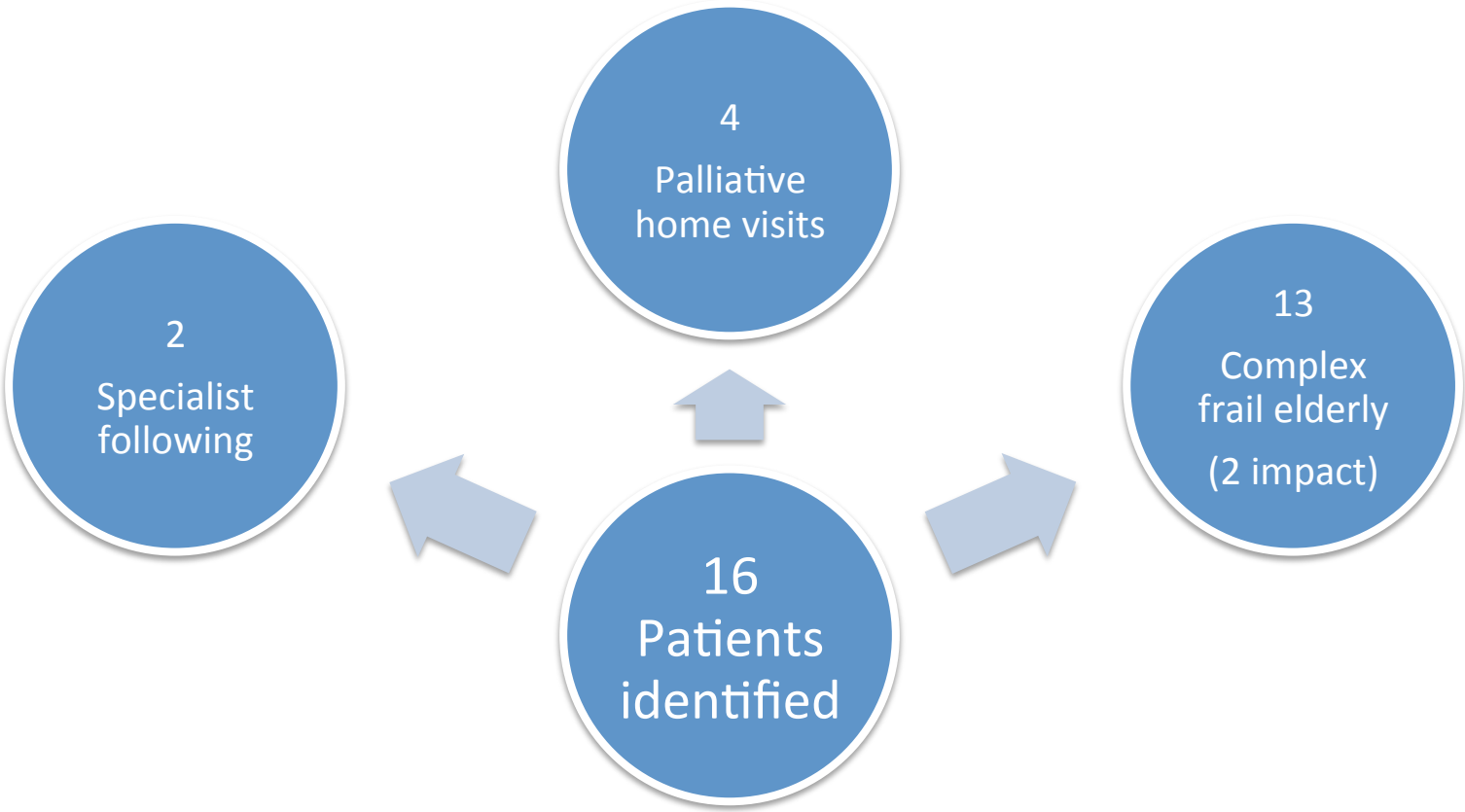
Current program status

Patients contacted	Patients declined	Attended session with NP	Requiring home visits	Seen Directly by MD	Total Number of Patients in first PDSA
15	3	12	4	2	14

- Reasons for decline; advanced terminal cancer/ALS, under the care of specialist and change of primary provider
- Two patients have been identified as sudden declines in level of function / care need and were seen directly by physician
- All patients who have met with NP hade indicated they are happy with the additional layer of care and wish to continue with both NP and MD.
- IHP team visits to be determined????

CREDIT VALLEY
Équipe de Santé Familiale • Family Health Team

Current Patient Map



Ontario

Case 1

- 67 yr female
- Dx: End Stage COPD
  - FEV1
  - Hospitalized from Dec 26, 2011 to April 2, 2012
  - AECOPD and NSTEMI
  - 50% ventimask continuous
  - MRC graded 5/5 (Too breathless to leave the house, or breathless when undressing)
  - Prednisone 15mg daily x >6weeks, unable to wean below this dose.

Case 1

PMH:

- Hypothyroid, COPD, CVA with Left anopsia, NSTEMI 2011 with ICU admission for HF, AFR, total knee arthroplasty
- Current PPS: 30-50%
- ESAS: Only concern is breathlessness 6/10

Palliative Care Issues

- Declining mobility, assist with ADL from home care
- Increasing sob at rest
- Anxiety
- Medical stability with combined respiratory and cardiac disease
- Advancing care needs

Case 2

- 88yr female
- Dx: Advanced PSP / Dementia
- PMH: DM-2, Chronic torticollis, Osteoarthritis, abdominal hernia repair, Chronic Sacral Ulcer (Stage 4), Severe Dysphagia
- Recurrent hospitalizations for UTI, Aspiration and Dehydration x 6 in 2012
- Bed bound, assist for all ADL
- Weight loss 45kg at present
- Severe pressure sores (Stage 4)

Case 2

- Urinary and fecal incontinence
- No Constant meaningful conversation
- PPS 10%
- ESAS: Unable to communicate

Palliative issues

- Hydration
- Pain control
- Terminal secretions
- Advanced Care Planning / communication
- Caregiver distress

Reflection

- The initial intake of patients were presented back to the team.
  - To date have not engaged the IHP's
  - Meeting set to further discuss IHP process
  - Integration / transition with other CVFHT programs
    - Lung heath
    - Impact
    - Diabetes
  - Next steps

CREDIT VALLEY
Équipe de Santé Familiale • Family Health Team

References

Capital Health. (2001). *Guidelines for using the Edmonton Symptom Assessment System. Retrieved Oct 1, 2012 from web site, http://www.npcrc.org/usr_doc/adhoc/painsymptom/esas.pdf*

Institute for Healthcare Improvement. (n.d.). *Improvement Methods: How to Improve. Retrieved Oct 1, 2012, from IHI.org: http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/*

Rockwood et al. (2005). A Global Clinical Frailty Scale of Fitness in Elderly People. Retrieved Aug 20th, 2012 from http://geriatricresearch.medicine.dal.ca/pdf/Clinical%20Faily%20Scale.pdf

The Gold Standard Framework. (2011). The GSF Prognostic Indicator Guidance retrieved September 26th, 2012 from http://www.goldstandardsframework.org.uk/Resources/Gold%20Standards%20Framework/General/Prognostic20Indication%20Guidance%20October%202011.pdf .

Wikipedia (2012). PDCA image retrieved October 1st, 2012 retrieved from http://en.wikipedia.org/wiki/PDCA

Ontario

CREDIT · VALLEY
Équipe de Santé Familiale · Family Health Team

References

Wilson, Donna. (2011). Quote from the CBC/News Health. Retrieved Oct 1, 2012 from http://www.cbc.ca/news/health/story/2011/05/04/f-milestogo-choosing-where-to-die.html

Ontario