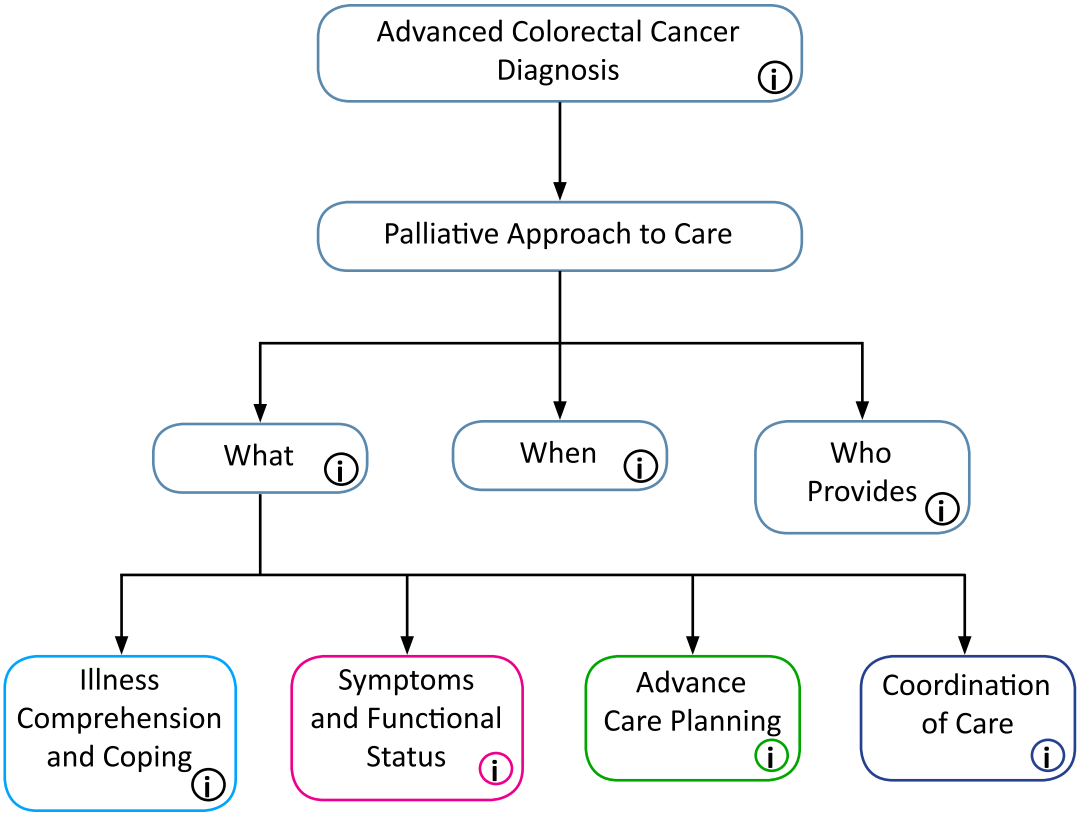
Integrating an Early Palliative Approach into Advanced Colorectal Cancer Care - Interactive Care Pathway

Effective Date: January, 2019

Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4



Advanced Colorectal Cancer Diagnosis ⓘ

Palliative Approach to Care

What ⓘ

When ⓘ

Who Provides ⓘ

Illness Comprehension and Coping ⓘ

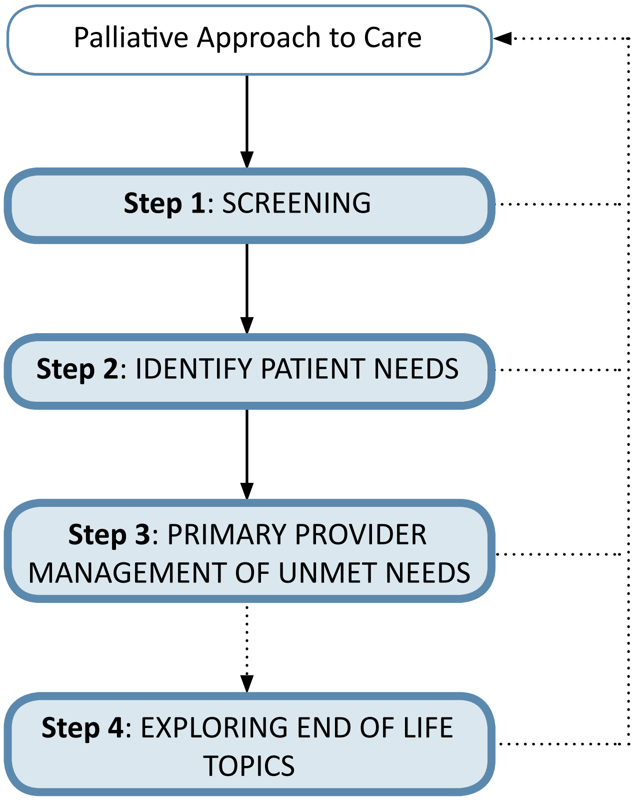
Symptoms and Functional Status ⓘ

Advance Care Planning ⓘ

Coordination of Care ⓘ

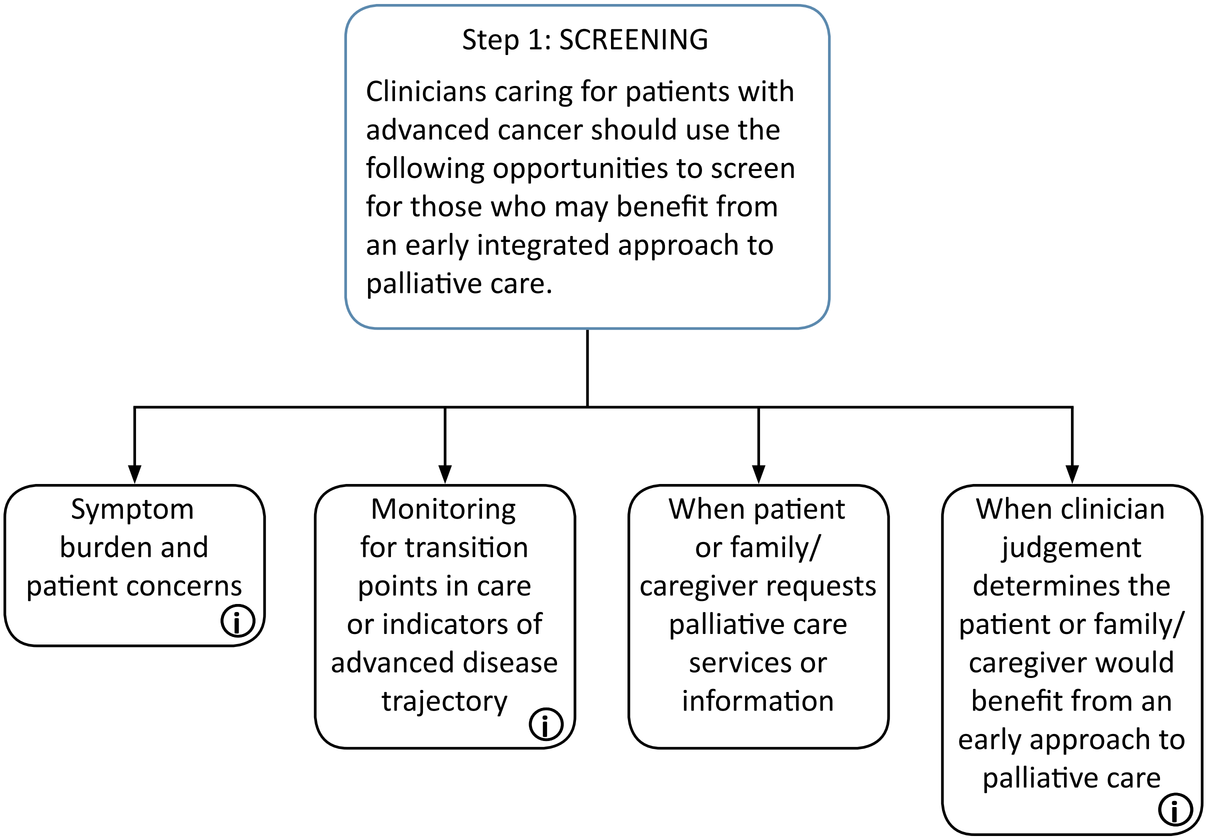
Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4



Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4



Step 1: SCREENING

Clinicians caring for patients with advanced cancer should use the following opportunities to screen for those who may benefit from an early integrated approach to palliative care.

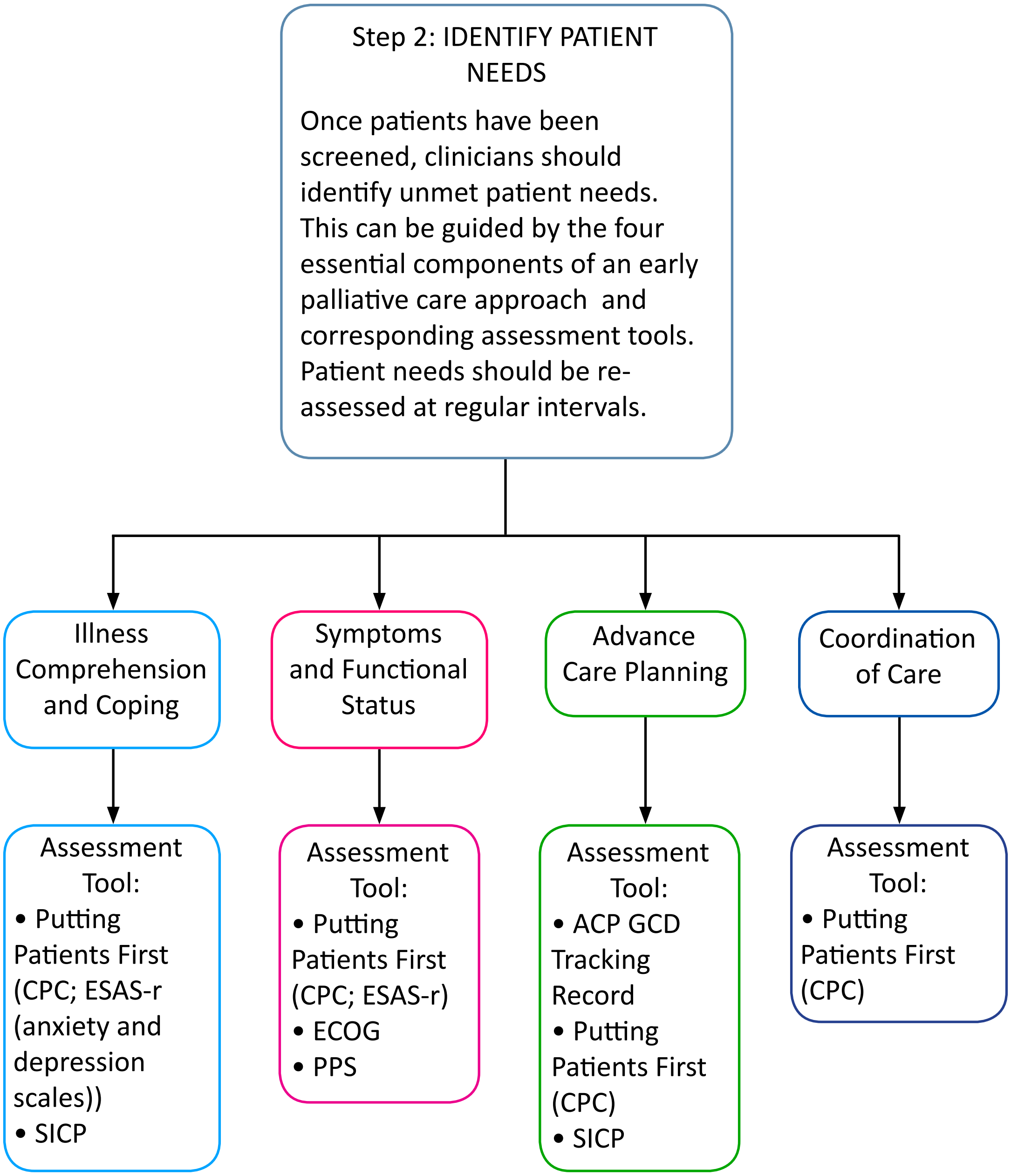
- Symptom burden and patient concerns ⓘ
- Monitoring for transition points in care or indicators of advanced disease trajectory ⓘ
- When patient or family/caregiver requests palliative care services or information
- When clinician judgement determines the patient or family/caregiver would benefit from an early approach to palliative care ⓘ

Patients who screen positive for one or more of these screening methods meet criteria for use of an early integrated palliative approach to care.

Patients who screen negative should be rescreened regularly.

Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4



Step 2: IDENTIFY PATIENT NEEDS

Once patients have been screened, clinicians should identify unmet patient needs. This can be guided by the four essential components of an early palliative care approach and corresponding assessment tools. Patient needs should be re-assessed at regular intervals.

Illness Comprehension and Coping

Assessment Tool:
- Putting Patients First (CPC; ESAS-r (anxiety and depression scales))
- SICP

Symptoms and Functional Status

Assessment Tool:
- Putting Patients First (CPC; ESAS-r)
- ECOG
- PPS

Advance Care Planning

Assessment Tool:
- ACP GCD Tracking Record
- Putting Patients First (CPC)
- SICP

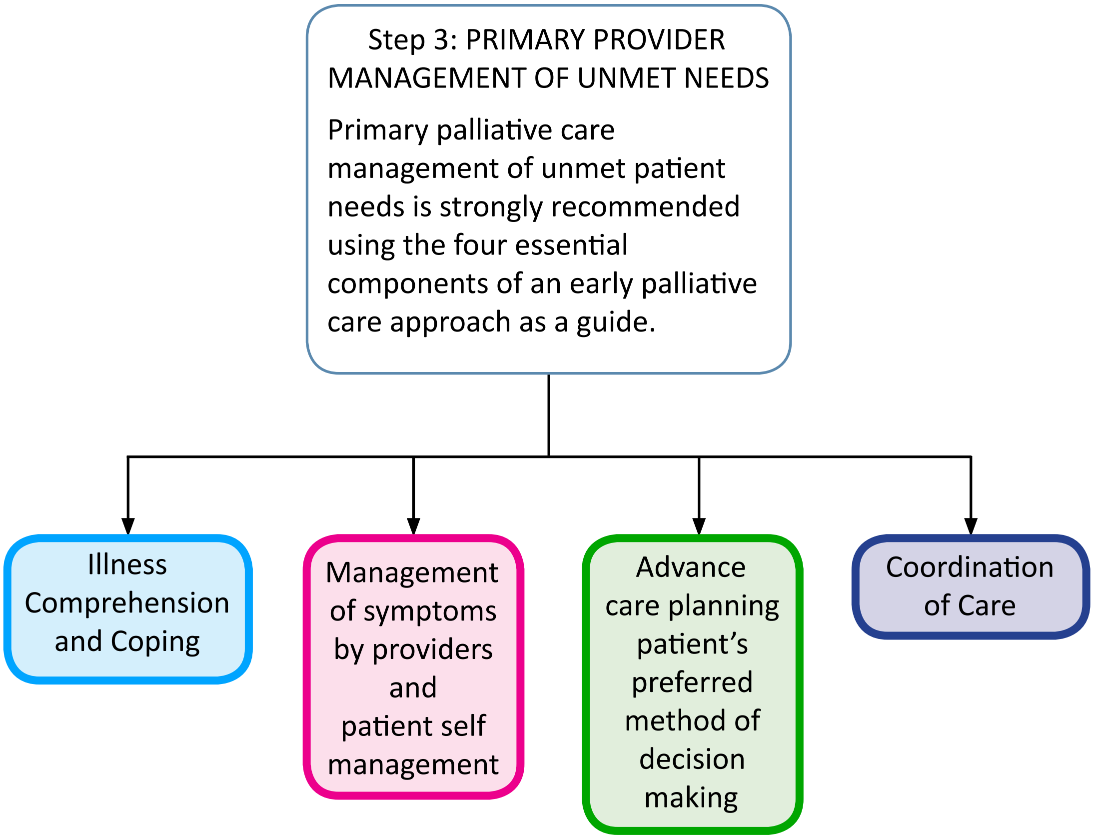
Coordination of Care

Assessment Tool:
- Putting Patients First (CPC)

PPF= Putting Patients First, CPC= Canadian Problem Checklist, ESAS-r= Edmonton Symptom Assessment System- Revised, SICP= Serious Illness Care Program, ECOG= Eastern Cooperative Oncology Group, PPS= Palliative Performance Scale, ACP/GCD Tracking Record= Advance Care Planning/Goals of Care Designation

Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4



Step 3: PRIMARY PROVIDER MANAGEMENT OF UNMET NEEDS

Primary palliative care management of unmet patient needs is strongly recommended using the four essential components of an early palliative care approach as a guide.

- Illness Comprehension and Coping
- Management of symptoms by providers and patient self management
- Advance care planning patient's preferred method of decision making
- Coordination of Care

Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4

Step 3: Illness Comprehension and Coping

Evidence has shown that addressing a patient’s understanding of their illness, how they are coping and how those close to them are coping, is associated with improved patient outcomes. In addition to consulting secondary palliative care providers, below are some other methods that can be used to support patients and family/caregivers.

	Method	**Description**
Specialist provided	Spiritual care	Existential and faith based supports
	Art therapy, music therapy	Facilitated creative art therapies
	Psychosocial counselling	Including: psychotherapy, Cognitive Behavioral Therapy, family therapy, individual and group therapy, CALM (Managing Cancer and Living Meaningfully)
Provided by family physicians, oncologists and nurses (with training)	Vital talk	Strategies and clinician resources for responding to difficult conversations
	SICP	Program of resources, education workshop and systems change processes to increase meaningful conversations between people living with serious illness and their clinicians about their values and priorities
	Dignity conserving therapy (including life review)	Question guides and approaches e.g. asking “what do I need to know about you as a person to give you the best care possible”

Patient preference, available time and clinician skills may be factors in the extent to which exploring patient illness understanding and coping occurs during clinical encounter, and clinician judgment is required about whether and when to refer for additional formal coping supports. This guideline encourages primary providers to explore and identify techniques to use in their practice.

Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4

Step 3: Management of symptoms by providers and patient self management

Providers

Management of symptoms is a cornerstone of palliative care. Symptom management tips sheets are available at www.ahs.ca/guru under Palliative & Supportive Care:

- Anxiety
- Constipation
- Decreased appetite and cachexia
- Delirium
- Depression
- Diarrhea
- Dyspnea
- Fatigue
- Malignant bowel obstruction
- Nausea and Vomiting
- Oral care
- Sleep disturbance
- Pain
- Tenesmus (a feeling, sometimes painful, of constantly needing to pass stool despite an empty rectum)

Patient

Patient self-management strategies can enhance symptom management, ability to cope and quality of life. Providers should encourage use of the following resources:

- Telephone triage or nurse navigator available at each Alberta Cancer Centre
- Healthlink (811) for health questions, or Inform Alberta (211) for questions about services available within the community
- Patients on Palliative Home Care can call for support 24/7
- CancerControl Alberta Patient Education Resources

Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4

Step 3: Advance care planning patient's preferred method of decision making

Encourage patients to have conversations about ACP throughout cancer treatment. Clinicians, within their scope of practice, can be instrumental in:

- Encouraging reflection on and expression of personal values, beliefs and preferences related to personal goals, health care and their preferred method of decision making (e.g. shared decision making, supported decision making with family/caregiver, self-determined, physician-directed)
- Sharing prognostic information, tailored to the patient's readiness and preferences around illness understanding.
- Supporting the patient in selecting an appropriate ADM.
- Encouraging the patient to communicate with their ADM, family/caregivers, other health care team members about their values, beliefs and preferences and who they have selected as ADM.
- Encouraging the patient to create a Personal Directive.
- Documenting ACP conversations on the ACP GCD Tracking Record.

Resources:

- Patient and health care provider resources are available at www.conversationsmatter.ca
- Serious Illness Care Program (SICP)

Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4

Step 3: Coordination of Care

Advanced cancer resources

- Calgary (Calgary Local Tips):
Calgary currently has tips that include information on caregiver support and community based resources and these provincially funded programs:
  - AADL- Alberta Aids to Daily Living
  - Financial benefits
  - Palliative Coverage Program (aka "Palliative Blue Cross")
  - Palliative Oxygen

- Edmonton (www.palliative.org):
Edmonton currently has tips on accessing palliative care resources and management of symptoms.

Referral Based Services for Advanced Cancer Care

- Referral Based Services for Advanced Cancer Care

- Alberta Referral Directory (ARD)

- Patient friendly palliative care descriptions are available in "Living Your Best During Systemic Therapy"

Communication and Documentation

Standardized communication increases consistency, minimizes duplication and improves teamwork while promoting patient safety. All providers should send updates to other providers when there are changes in the patient's condition, needs, or status. Important elements include patient's cancer illness understanding, prognosis, and details of ACP and GCD (Green Sleeve).

Communication tools include: Transition letters (Shared Care; No Further Systemic Therapy); Green Sleeve.

Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information

Definitions
Overview
Step 1
Step 2
Step 3
Step 4

Step 4: EXPLORING END OF LIFE TOPICS

Clinicians are recommended to support patients who are exploring end of life topics.

End of Life Planning

- Review ACP discussions and patient preferences for care at end of life (e.g. switch to focus on comfort care near end of life.
- Revisit caregiver supports.
- Ensure patient is on Palliative Coverage Program.
- Develop a plan for expected death in the community if patient would like to remain at home:
  - AHS Guideline on Expected death in the home

Estate and Funeral Planning

- Remind patient & their families to begin this planning early on, including wills and financial enduring power of attorney. Connect to appropriate resources (e.g. social work) as needed.

Hospice Access

- Hospice care is a specialized service available in certain locations that provides 24/7 facility based care to those approaching end of life and whose needs cannot be met at home.
- There are highly specific criteria for referral to hospice and access is often determined by secondary palliative care clinicians. Refer to “Service Description” or talk to your local palliative care clinician about whether hospice may be appropriate.

Medical Assistance in Dying

- AHS has developed the Medical Assistance in Dying Policy to guide medical assistance in dying services. A physician FAQ sheet is available.

Grief and Bereavement

- Ask patients about their emotional supports.
- Let patients and caregivers know that grief and bereavement resources are available both before and after death.
- Most services are accessed by self-referral and clinicians can help by providing the access information. Refer to “Service Description” document.

Please refer to the Advanced Colorectal Cancer Care Clinical Practice Guideline for additional information