CCO Integrated Care & INTEGRATE Case Study

JUNE 15, 2018
Agenda

1. Integrated Care
2. INTEGRATE project
3. Conclusions
4. Discussion
WHO Definition - Integrated Care

“Comprehensive delivery of services designed according to the needs of the population and the individual, and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care”
Goal:
Drive integrated care delivery by strengthening accountability across healthcare settings
Ontario Cancer and Renal Plans (2015-19)

Ontario Cancer Plan IV

Ontario Renal Plan II

GOAL
Integrate patient care throughout the kidney care journey
Integrated Care - grounded in improving patient care, focusing on transitions and coordination of treatment that is person-centred; collaborative and continuous
Perspectives of Integrated Care

Patient Perspective
“My care is planned with people who work together to understand me and my caregivers, co-ordinate and deliver services to achieve my best outcomes and experience.”

Provider Perspective
“My role and my colleagues roles are clearly defined and we effectively and efficiently communicate with one another about our shared patients.”

Health System Perspective
“There is a common service delivery model, and indicators shared between organizations to improve patient transitions, manage complex conditions and reduce adverse events.”

Cancer Care Ontario
IC video
INTEGRATE Project:

Case Study of Early Integration of Palliative Care
Benefits of Early Palliative Care

- Longer survival
- Better quality of life
- Improved symptom management
- Improved patient satisfaction
- Less aggressive care
- Lower cost of care

Early Palliative Care for Patients with Metastatic Non-Small Cell Lung Cancer (Temel, 2010)
“Would you be surprised if this patient were to die in the next year?”

- YES: Initiate Palliative Care Planning
- NO: Regular Care
INTEGRATE Project Background

3 year pilot
Jan‘14 – Jan’17

Model developed in partnership with:
- Patients/caregivers
- Primary & Oncology clinicians
- Allied health practitioners
- Community partners
- Administrative Leaders

CPAC & CCO

4 CCs
Cancer Centres

+ 4 PCs
Primary Care Practices

3 Regions in Ontario
INTEGRATE Goal and Objectives

Enable early identification & management of patients who would benefit from a palliative approach to care across settings

Adapt and Implement Provider Education

Implement & Evaluate Integrated Care Models
## Participating Sites (N=8)

<table>
<thead>
<tr>
<th>Region</th>
<th>Cancer (Disease Site)</th>
<th>Primary Care Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toronto Central North</td>
<td>Odette Cancer Centre (CNS: MCC &amp; Clinic) *Glioblastoma only</td>
<td>Sunnybrook Academic Family Health Team</td>
</tr>
<tr>
<td>Toronto Central South</td>
<td>Princess Margaret Hospital Cancer Centre (CNS: MCC &amp; Clinic)</td>
<td>Forest Hill Family Health Group</td>
</tr>
<tr>
<td>North Simcoe Muskoka</td>
<td>South Muskoka Regional Cancer Centre (GI: MCC, Lung: MCC)</td>
<td>Barrie and Community Family Health Team</td>
</tr>
<tr>
<td>Champlain</td>
<td>Ottawa Hospital Cancer Centre (Thoracic DAP, H&amp;N: Clinic)</td>
<td>Petawawa Centennial Family Health Team</td>
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</tbody>
</table>
Integrated Palliative Care Model

**Integrated Care Approach: Interprofessional Education**

**Step 1: IDENTIFY**

- **LEAP Provider Tool**
- **CCO Website**

**Step 2: ASSESS**

- **Primary Care + Oncology**
- **Palliative**
- **Community**

- **Assess Symptoms & Functional Status**

**Step 3: PLAN/MANAGE**

- **Discussion with Patient & Family**
  - Advance Care Planning and/or Goals of Care discussions

- **Symptom Management**

- **Triage & Referrals**

**Rounding on shared patients**

- **Primary care/ oncology**
- **CCAC coordinator/nurse**
- **Palliative clinic nurse**

**Linkages to Home and Community Care**

**Standardized Reporting from Oncology to Primary Care**

**“Would you be surprised if this patient died in the next year?”**

**INTEGRATED CARE APPROACH**

- **Interprofessional Education**
- **LEAP Provider Tool**
- **CCO Website**

**Cancer Care Ontario**
The "surprise question" for predicting death in seriously ill patients: a systematic review and meta-analysis.

_CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne_
PubMedID: 28385893


White et al. _BMC Medicine_ (2017) 15:139
DOI 10.1186/s12916-017-0907-4

How accurate is the ‘Surprise Question’ at identifying patients at the end of life? A systematic review and meta-analysis

Nicola White, Nuriye Kupeli, Victoria Vickerstaff and Patrick Stone
SQ within INTEGRATE

• Recent systematic review of the SQ – in studies reviewed (n=26), pooled accuracy for oncology - 79%; for renal 76% and 72% for other disease groups

• In INTEGRATE:
  • SQ was used as a trigger to identify patients
  • PPS and disease burden assessments used to trigger referral to home care
Results

“I could feel the a palpable difference in our clinic with this project”

Oncologist
Provider Education (N=216)

Significant changes in knowledge:

<table>
<thead>
<tr>
<th></th>
<th>Pre (%)</th>
<th>Post (%)</th>
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</thead>
<tbody>
<tr>
<td>Physicians (N= 87)</td>
<td>53</td>
<td>74</td>
</tr>
<tr>
<td>Nurses (N=123)</td>
<td>57</td>
<td>68</td>
</tr>
<tr>
<td>Social Workers (N=6)</td>
<td>20</td>
<td>42</td>
</tr>
</tbody>
</table>
## PCP Patients ID with the SQ (N=294)

<table>
<thead>
<tr>
<th>Primary Care Team</th>
<th>Start Date</th>
<th># of Dr’s</th>
<th>Total # Patients/Dr</th>
<th># of Patients ID (% of practice Target – 1%)</th>
<th># of Reported Patient Deaths (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunnybrook Academic Family Health Team</td>
<td>April 2015</td>
<td>10</td>
<td>9,603</td>
<td>55 (0.5%)</td>
<td>25 (45%)</td>
</tr>
<tr>
<td>Forest Hill Family Health Group</td>
<td>May 2015</td>
<td>3</td>
<td>4,666</td>
<td>9 (0.2%)</td>
<td>6 (67%)</td>
</tr>
<tr>
<td>Barrie and Community Family Health Team</td>
<td>June 2015</td>
<td>15</td>
<td>24,553</td>
<td>134 (0.5%)</td>
<td>47 (35%)</td>
</tr>
<tr>
<td>Petawawa Centennial Family Health Team</td>
<td>Nov. 2014</td>
<td>8</td>
<td>6,293</td>
<td>96 (1.5%)</td>
<td>24 (25%)</td>
</tr>
</tbody>
</table>
## Cancer Patients ID with the SQ (N=933)

<table>
<thead>
<tr>
<th>Cancer Centre</th>
<th>Disease Site</th>
<th>Start Date</th>
<th>Total number of cases reviewed</th>
<th># of Patients Identified (%)</th>
<th># of Reported Patient Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunnybrook Health Sciences Centre (SHSC)</td>
<td>CNS*</td>
<td>Feb 2015</td>
<td>MCC: 142</td>
<td>142 (100%)</td>
<td>60 (39%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinic: 12</td>
<td>12 (100%)</td>
<td></td>
</tr>
<tr>
<td>Princess Margaret Hospital (PMH)</td>
<td>CNS</td>
<td>Mar 2015</td>
<td>MCC*: 40</td>
<td>40 (100%)</td>
<td>33 (30%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinic: 205</td>
<td>69 (34%)</td>
<td></td>
</tr>
<tr>
<td>Royal Victoria Regional Health Centre (RVH)</td>
<td>Lung</td>
<td>Feb 2015</td>
<td>MCC: 351</td>
<td>68 (19%)</td>
<td>29 (43%)</td>
</tr>
<tr>
<td></td>
<td>GI</td>
<td>Feb 2015</td>
<td>MCC: 553</td>
<td>50 (9%)</td>
<td>22 (44%)</td>
</tr>
<tr>
<td>The Ottawa Hospital (TOH)</td>
<td>Lung</td>
<td>June 2015</td>
<td>DAP: 2119</td>
<td>509 (24%)</td>
<td>130 (26%)</td>
</tr>
<tr>
<td></td>
<td>H&amp;N</td>
<td>Sept 2015</td>
<td>Clinic: 180</td>
<td>43 (24%)</td>
<td>10 (23%)</td>
</tr>
</tbody>
</table>

*Surprise Question only asked for patients with Glioblastoma
ACP, Communication and Referrals after ID

- ACP discussion: 78% (n = 1021)
- PC report transmitted: 73% (n = 480)
- CCAC services: 73% (n = 584)
Provider Evaluation (N=119)

- LEAP helped develop a **common language and approach** for clinical collaboration
- **Significant positive change** in provider comfort and confidence in delivering palliative care
- **Model was most successful** when embedded into existing clinical work flows; partnerships pre-existed and senior leaders were accountable

- Achieving **provider buy-in** and confidence
- Determining **patient readiness**, both clinically and emotionally
- Still room to **improve communication and coordination** between providers/sites, clarify roles and responsibilities
Patient/Caregiver Evaluation (N=19)

- **Positive experiences of care** (relationships with providers and service accessibility)
- Providers **initiated ACP** discussion and did so **at the right time**
- Providers **supported caregivers** in preparing for the death of their loved ones and they felt involved in decision-making about the care to the extent they wanted

- **Different levels of patient ‘readiness’** to have ACP and GoC conversations
- **Difficulty pinpointing the palliative aspects of care; more focused on cancer care experience as a whole and on completion of daily tasks**
- **Confusion regarding different providers**, their roles and who to contact when
INTEGRATE Value Assessment

• Partnership with ICES (Sunnybrook)

• 1187 patients enrolled in INTEGRATE; matched cohort analysis looking at service utilization

• Index date defined as 1 day after the date of enrollment into project
ED visits, ICU days and access to home care visits (N=1185)

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<tr>
<th></th>
<th>Intervention Group</th>
<th>Control Group</th>
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<tbody>
<tr>
<td>ED visits</td>
<td>3.1</td>
<td>2.3</td>
</tr>
<tr>
<td>ICU days</td>
<td>0.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Home care visits</td>
<td>67</td>
<td>33</td>
</tr>
</tbody>
</table>
% Physician Home Visit 1 year Prior and 1 year After (N=1187)
Increased Access to Palliative Radiation (N=364)

- Intervention group: 43%
- Control Group: 23%
Opioid dispensed 1 year before index date and during follow-up (N=629)
Value Assessment Results

For patients ID with SQ:

• Higher rate of patients receiving home care
• Increase in physician home visits in the follow-up period
• Higher rate of patients receiving palliative radiation
Sustainability

“This is a new way of doing things, not a new thing to do”

Paula Doering
Regional Vice President, Champlain LHIN
INTEGRATE Sustainability – NHS Model

- ≥ 55 suggests that QI initiative can be sustained
- 35-55 look for ways to improve sustainability
# NHS Sustainability - Learnings

<table>
<thead>
<tr>
<th><strong>Tool</strong></th>
<th><strong>Process</strong></th>
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| • Well received by the sites  
• Multidimensional and easy to use  
• Predicts the likelihood of sustainability  
• Identifies strengths and areas of improvement  
• Monitors progress over time | • Plan from project onset and measure at least twice, beginning and end  
• Involve project resources from different hierarchic levels to have a fulsome discussion  
• Clearly define clinical and administrative leadership  
• Keep the focus on collective performance, rather than on specific individuals |
Conclusions
INTEGRATE Conclusions

1. LEAP and Integrated Models improved provider awareness, comfort, and confidence
2. Piloted settings are excellent forums for early ID of patients and can be sustained
3. Increased access to palliative care services
4. Patient and caregivers emphasized personalized care and need for role clarity with homecare
5. More work need to improve integration of care across settings with homecare partners