William Osler Health System

Going Beyond

Virtual Palliative Care: Right Patient, Right Time, Right Place, Right Care

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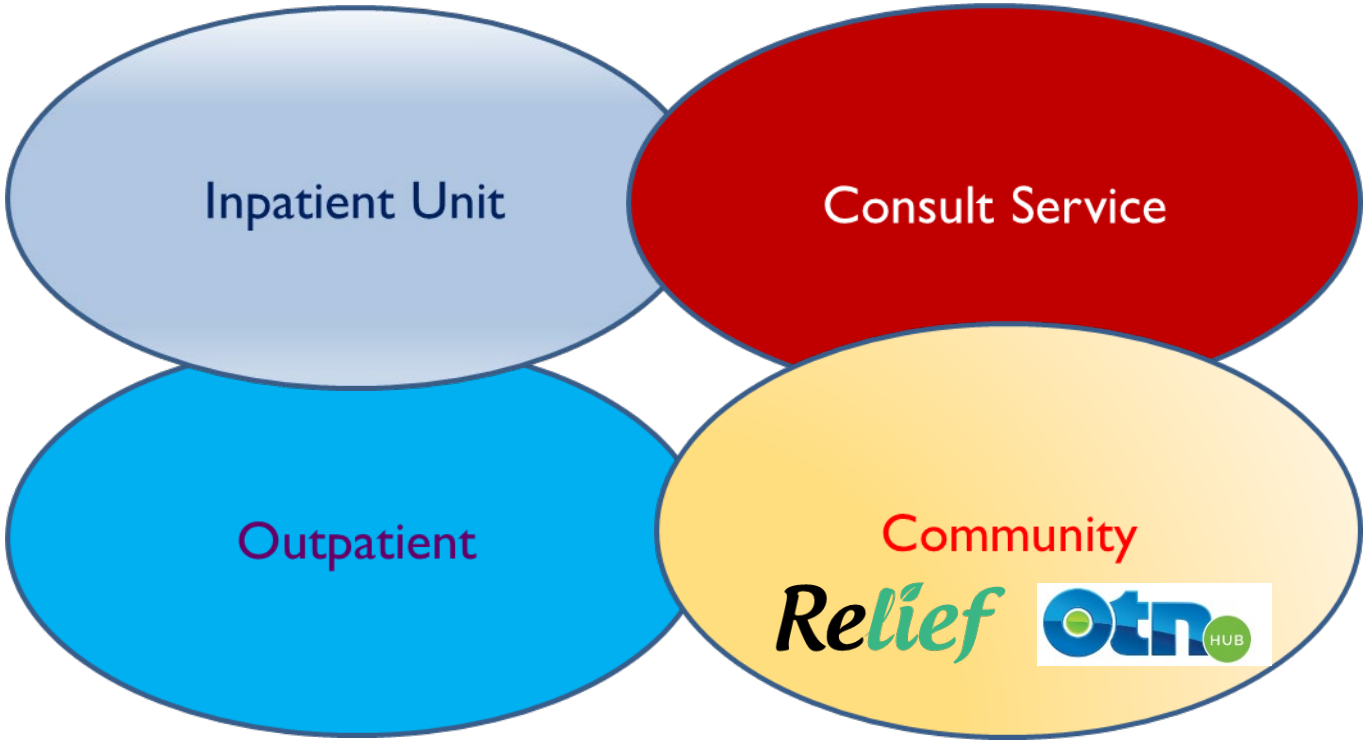
October 2nd, 2018

William Osler Health System

Disclosures

- Disclosures- I have no conflicts of interest in presenting today
- Biases- I have no biases in presenting today
- Compensation- I am not being compensated in any manner for presenting today

The Four Pillars of Palliative Care at Osler



Background

- 11 Palliative Care Physicians
  - Outpatient Clinic: 10 half-day clinics per week
  - Outpatient Community/Home visiting: 3-5 full-days per week
- Volumes
  - Outpatient Clinic: ~120 appointments/month for ~100 unique patients
  - Outpatient Community/Home visiting: ~50 visits/month for ~40 unique patients
- Pressures
  - Urgent visits are triaged
  - Wait times for new consultations at times is greater than 10 business days
  - Wait times for follow-ups

Relief A Collaboration

Proof of concept pilot study in partnership with:

- Supportive Palliative Care Program, William Osler Health System
- uCarenet
- Centre for Aging and Health Brain Innovation (CABHI) + Spark Grant

Relief

Patients being treated with a palliative approach:

1. Require frequent symptom monitoring
2. May have delayed access to health care professionals to address their worsening symptomatology
3. Go to ER to obtain emergent therapy as a first desperate choice
4. May remain in ER for an indefinite period of time in a less than ideal crowded waiting or treatment room
5. Could have unnecessary and unwanted diagnostic tests and treatments

Our Goals

To accurately assess patients' symptoms in their home and provide timely intervention and treatment when required

Providing palliative care to the right patient, in the right place, at the right time

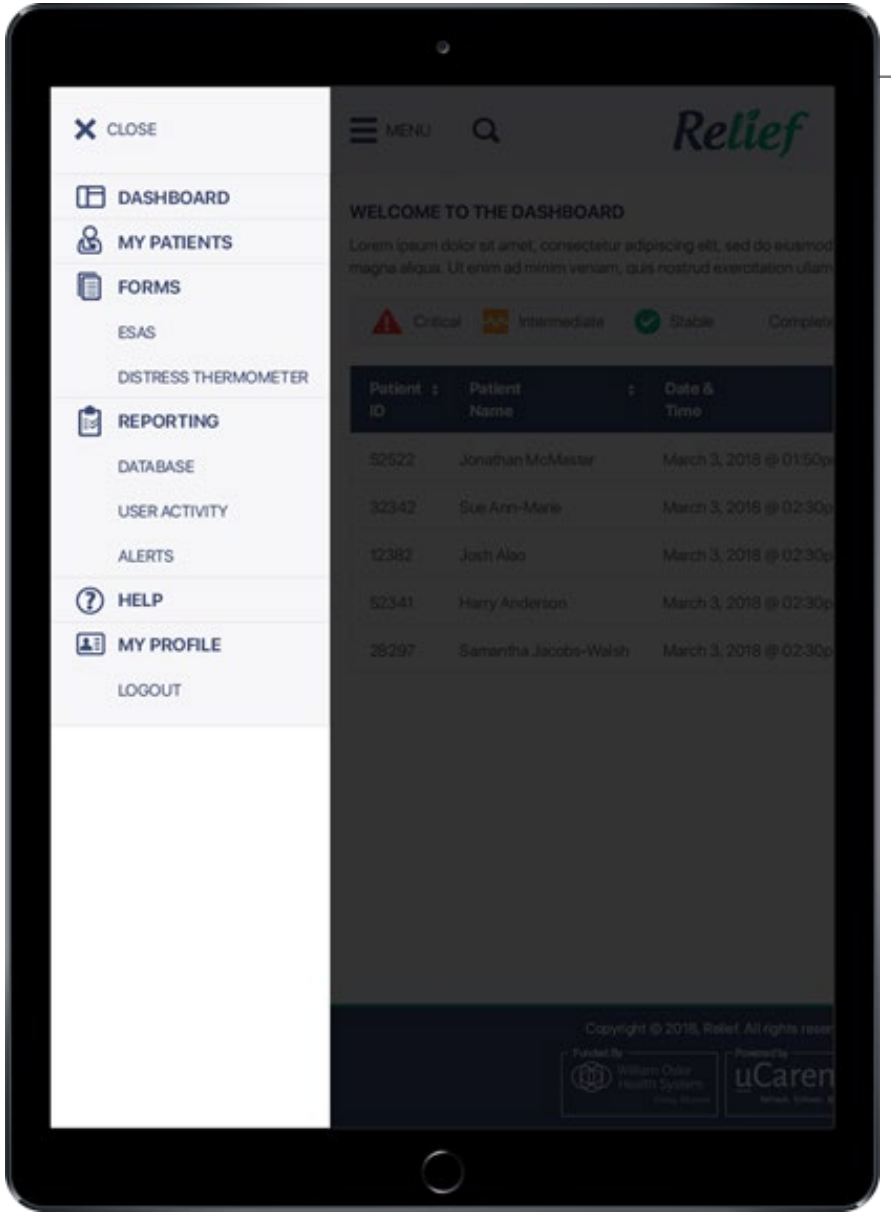
Keeping people in their home as independent as possible, as safe as possible, as comfortable as possible, for as long as possible

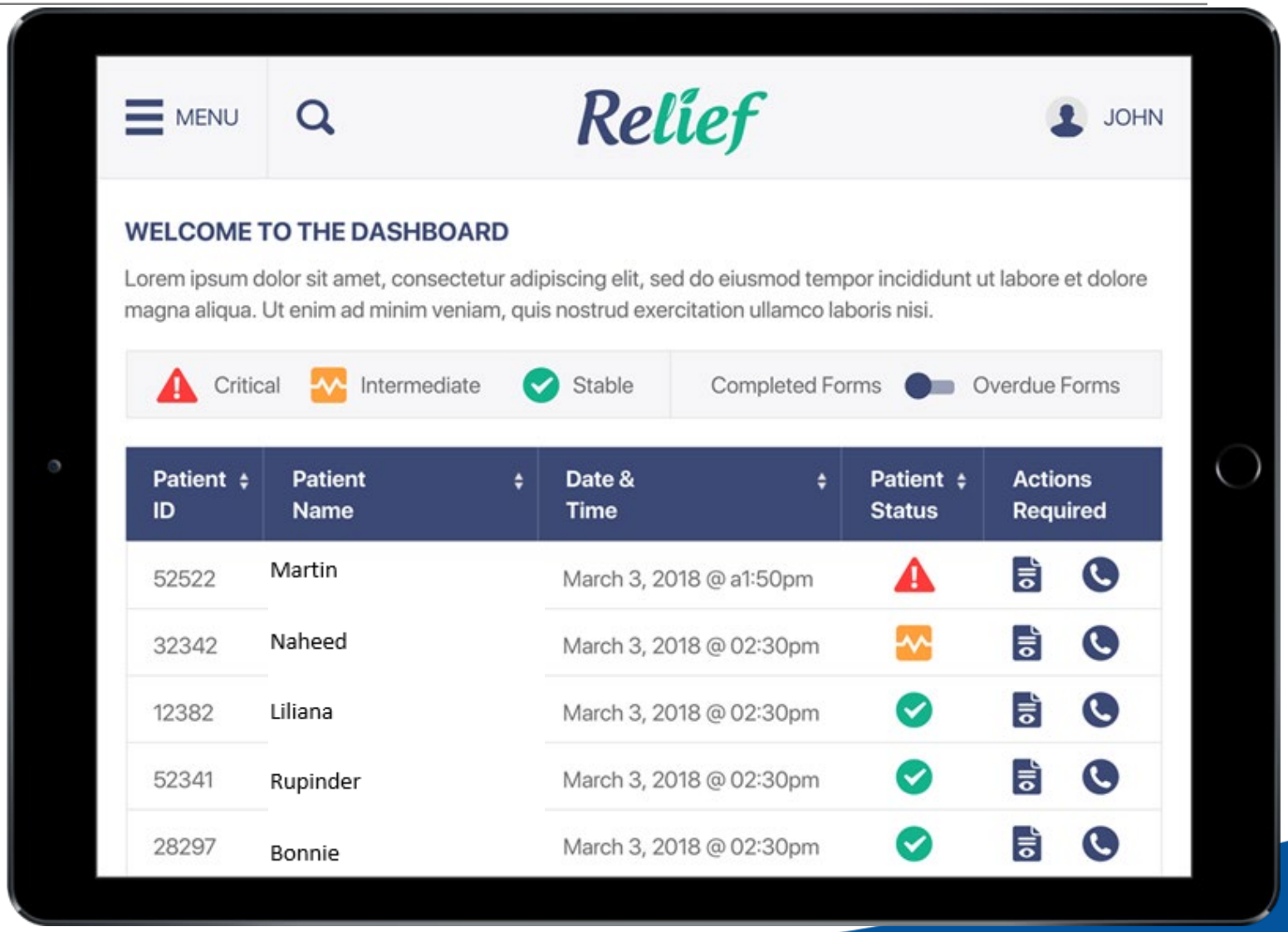
Relief Solution

Easy to use mobile (browser based) e-health app for patients to regularly self-report key clinical indicators to their palliative physician/clinical team:

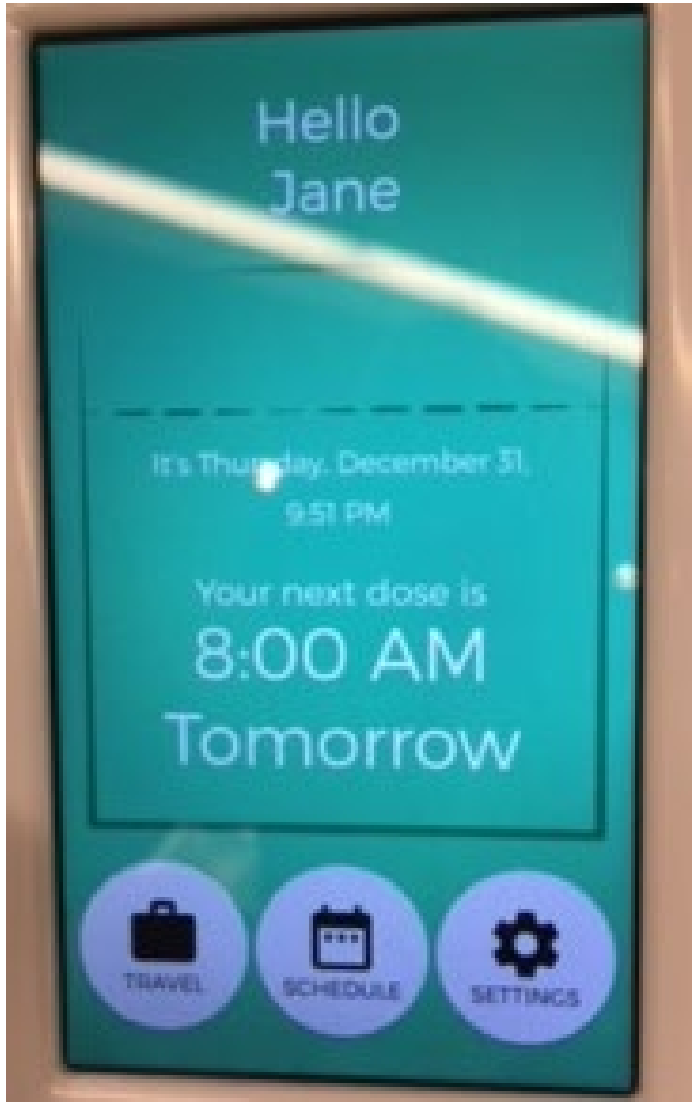
- Real-time data collection (ESAS, DT, and BPI) of patient self-reported symptoms with daily monitoring of patient status and triaging of patients' needs
- Alerts clinicians of changes to patients' symptom status (**green** **yellow** **red**)
- Enables clinicians to respond proactively to the patient's deteriorating condition, thus reducing patient/family distress and preventing ER visits and hospitalization
- On-demand reporting to clinicians on current status of symptoms & historical data

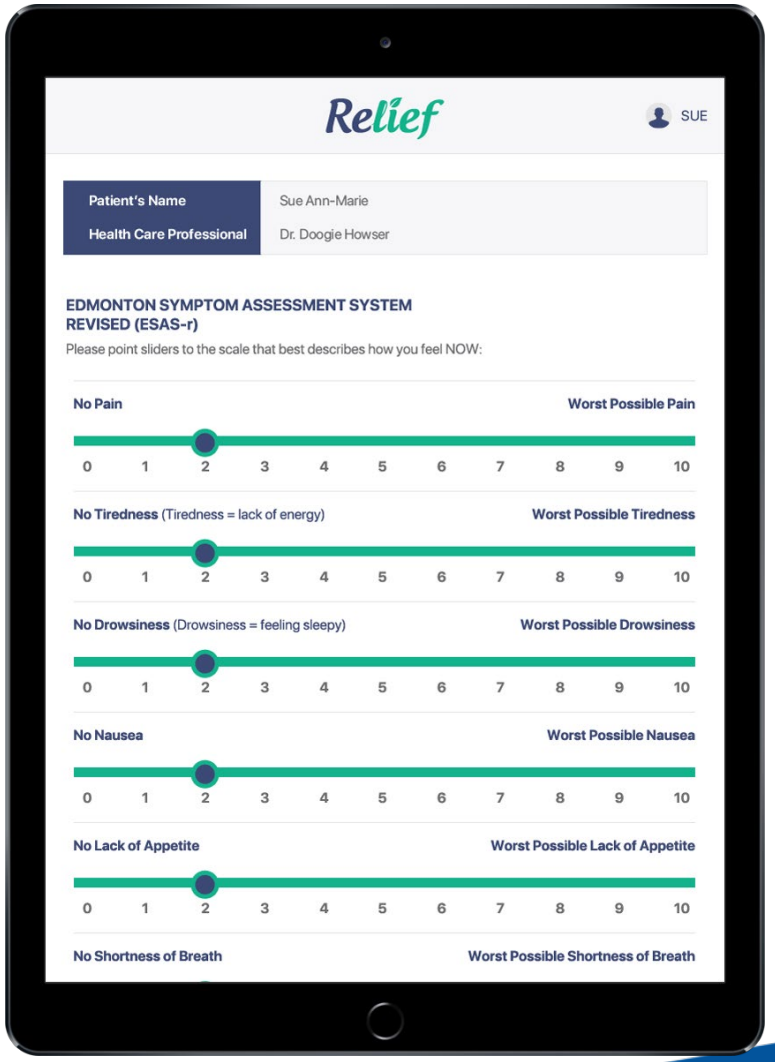
Clinician View





Patient View





Data and Outcome Measures:

Number of participants:

- active in the pilot by study at end date
- who called for symptom support
- who called for technical support
- received telephone intervention
- who required a home visit
- requiring telephone intervention without an alert triggered
- who presented to ER
- who required a hospital admission
- who were able to experience death in their home

- Number of alerts triggered
- Number of incidents of non-compliance to complete the self-report symptom tools
- Number and reason participants dropped out of the study

Metrics reportable to date

Number of participants in the study to date 17/20 recruited:

- Number and reason participants dropped out of study- 4 deaths, 1 withdrew
- Who called for symptom support- 3 calls with 2 unique participants
- Who called for technical support- 3, 1 unique patient and 1 nurse
- Who received telephone intervention- 37 follow up interventions
- Number of alerts triggered- 80 (July 30th – September 20th)

Metrics reportable to date continued

- Required a clinic visit- 2 for pain and other symptoms
- Required a home visit- 1 by visiting nurse
- Required telephone intervention without an alert triggered- 7
- Presented to ER- 1 for PCA pump support, not symptom
- Required a hospital admission- 4 direct admissions from home
- Were able to experience death in their home- 2
- Withdrew from the study- 1

Testimonials

Participants:

- “I am most impressed with your group. The attention and treatment is excellent, your team is very responsive, getting me in to have my lungs drained was excellent, I feel that we have made progress. I hope we are able to make more progress.”
- “Thank you so much. My pain went from a 9.5/10 yesterday to a 3-4/10 today. This is liveable.”
- “I am so thankful that you are here for me and my daughter.”

Testimonials

Health Care Providers:

- “Looks great to me, just tested it out. Looking forward to enrolling patients.”
- “The app is amazingly easy to use as a clinical nurse.”
- “The app is easy to navigate and read the reports.”

The WOHS: BCH Ontario Telemedicine Network-Palliative Care Pilot Program

A close partnership was initiated with the OTN team which allows for a smooth appointment booking of the right patients requiring OTN visits

Timeline & Criteria

- Pilot timeline

  From August 3 - 21, 2018; 6 full-day OTN-PC clinics completed

- Recruitment criteria includes patients:

  Currently enrolled in BCH Outpatient Clinic and/or Home Care Palliative Program

  Experiencing urgent pain/symptom issues

  Not seen in appropriate amount of time for follow-up due to current wait-times

  Physically situated remotely (>30 minute drive) from BCH

- Exclusion criteria

  No new consultations

  No access to appropriate telemedicine medium

  NB: Lack of WiFi access was not an exclusion criteria!

Enrolment & Diagnoses

Total number of patients recruited (in 13 business days):

- 30 patients
- Diagnoses
- Cancer: 16/30 = 53%
- Dementia: 6/30 = 20%
- Congestive Heart Failure: 3/31 = 10%
- Chronic Obstructive Pulmonary Disease: 1/31 = 3%
- Other: 4/31 = 14%

Screening, Booking & Outcomes (13 days)

- Number of total patients screened: 61
  - Successfully booked OTN appointments: 37
  - Rejected OTN appointments: 24
  - Successfully completed appointments: 36
  - Unsuccessful appointments: 1

- Number of patients booked for second OTN visit: 35
  - Plus 1 in-person community visit (e.g. home visit)

System Level Measures

This initiative addresses system level measures know as the Ontario Palliative Care Network “big dot indicators”, which include:

1. The % of patients dying in hospital vs home

2. The % of patients receiving home care visits in the final 90 days of life

3. The % of patients having one or more ER visits

Benefits of Relief and OTN HUB

- Early identification of symptoms, timely management, treatment initiated before symptoms escalate results in fewer ER visits.
- Triaging allows nursing resources to be prioritized appropriately for urgent physical/psychosocial symptomatic care in the home.
- The right patients receive timely/appropriate care by Palliative Physicians right in their home, whilst those needing more comprehensive assessment are seen in clinic or admitted directly to APCU.
- There is clear benefit to the patient not having to come to hospital in those cases where the triage indicates it was not necessary.

Future directions

- Now that proof of concept has been established the results will be presented to CW LHIN senior management for adoption and ongoing support.
- This would allow for sustainability of this two pronged innovation.
- Utilizing RELIEF and OTN hand in hand, allows for a more proactive approach vs reactive approach, identifying the right patients who benefit from earlier intervention.
- Ongoing training and education of health care providers, patients and families is essential for continued growth and improvement of the innovation.

Future directions continued

- We believe the innovation of the RELIEF app partnered with OTN is applicable for other sectors including long-term care homes and hospices and can be adapted for “Health Links”.

- The innovation benefits all involved with its use, including home care coordinators, independent nursing agencies, and families.

- Spread and scale will be determined by the LHIN within the next year.

References

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- Thank you

- Questions and Answers

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OUR VISION

PATIENT-INSPIRED HEALTH CARE WITHOUT BOUNDARIES

OUR MISSION

INNOVATIVE HEALTH CARE DELIVERED WITH COMPASSION

OUR VALUES

RESPECT, EXCELLENCE, ACCOUNTABILITY, DIVERSITY, INNOVATION

William Osler Health System