

ORAL ABSTRACT #1 and winner of the top oral presentation

Benefits and Barriers of Palliative Care to the Homeless by In-Shelter Programs: A Qualitative Study

In Toronto alone, the homeless are 29 times as likely to have hepatitis C, 4 times as likely to have cancer, 5 times as likely to have heart disease and 1 in 7 are in severe pain. Despite their poor health status, more than half do not have a family doctor, more than a third felt judged or treated with disrespect by their health care doctor and 1 in 5 had a negative experience with hospital security. The homeless population are dealing with severe co-morbidities and death at a younger age with poor access to healthcare services.

Implementation of an in-shelter hospice program in Ottawa showed a savings of \$1.39 million to the health care system by instituting an in-shelter palliative care program. They also found many homeless patients had sentiments that they would not want tertiary or palliative hospitalization but would prefer to die in the shelter system. As the benefit of in-shelter palliative care programs has already been demonstrated, this study aims to elucidate the barriers in implementing the programs, as well as indicate any enabling factors and methods to overcome these barriers. Using semi-structured interviews, 6-10 shelter staff will be interviewed from three distinct Toronto shelters. The interviews will last approximately 1 hour and focus on the experiences with death/dying, and perceived benefits and barriers to in-shelter palliative care. It is the hope of this study to establish methods for implementing in-shelter palliative care programs to improve the quality of life for the homeless.

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ORAL ABSTRACT #2

Use of a Palliative and End of Life care pathway in a Canadian Acute Care Setting: A Quality Improvement Project in the academic General Internal Medicine units at the University Health Network

Background: Patients at the end of life (EOL) often experience physical and psychosocial suffering which are often under-recognized in acute care settings. Internationally, Palliative & EOL care pathways have been found to improve multidisciplinary communication and care for patients nearing end-of-life. However, no such pathway exists in Canada. Drawing on current literature, our research team has developed a care pathway for use in acute care settings, with goals to facilitate early identification of

patients in their last year of life, promote early advance care planning, and build capacity for EOL care.

Objective: This project is a stakeholder analysis for the developed pathway and aims to gain an understanding of the thoughts of General Internal Medicine (GIM) team members on its integration in acute care units.

Methods: Semi-structured interviews were conducted with key GIM stakeholders in a Toronto academic hospital to explore their opinions on the pathway, and on its integration into GIM patient care processes. Interview transcripts were analyzed for emerging themes.

Results: Ten interviews and subsequent data analysis are currently underway, with anticipated completion by April 2015. Results will be reported in the proposed presentation.

Conclusions: This study is the first in Canada to allow for an understanding and integration of the elements important to an acute care specialty service in the development of a Palliative & EOL care pathway. More importantly, this project will serve to build capacity amongst multidisciplinary GIM health care providers to increase advance care planning discussions and improve palliative and EOL care for patients.

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ORAL ABSTRACT #3

Family Practice Provision of a Palliative Approach

Ninety percent of Ontarians will face progressive life-limiting illness; however, only one-third of Canadians will be able to receive palliative care from specialist palliative teams. Increasingly, there is an expectation that clinicians in primary care practices will provide the baseline palliative care for their patients. It has been our understanding that primary care clinicians may be uncomfortable with this concept due to their lack of confidence, knowledge, and training in the area of “palliative care”. However, this presentation will demonstrate that some primary care practices are providing “primary level palliative care”, but instead refer to this type of care as “comprehensive care”. From the perspectives of primary care practices’ reported activity involving this patient population, is “primary level palliative care” any different than “comprehensive care”? Through semi-structured interviews and focus groups with family doctors and primary care nurses we will reveal how primary care practices provide care to patients with advancing life-limiting illness. Our data suggests that certain activity within primary care practice is palliative care; however, it is not labelled as such.

We sought to capture this activity in order to renegotiate our understanding of care in the context of primary practice. In addition, this information will act as a useful tool enabling primary care practices to interpret their methods of caring for patients with advancing illness using a familiar language that is relevant to primary care practitioners. Lastly, could this data shed light on why it has been so challenging for palliative care specialists to “engage and integrate” palliative care into the primary care setting?

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ORAL ABSTRACT #4

Interdisciplinary Palliative Rehabilitation Program for patients living with advanced cancer

Background: Patients with active cancer face a considerable burden from the effects of both the disease and its treatment. Palliative Rehabilitation Program (PRP) is an interdisciplinary program designed to ameliorate disease effects and to improve patient’s functioning. The present study evaluated changes in functioning, symptoms, and well-being after the completion of an eight week interdisciplinary palliative rehabilitation program.

Methods: There were 308 patients referred to 8-week PRP; assessed by physician, nurse, dietician, physiotherapist, occupational therapist, social worker. Measures used were: Edmonton Symptom Assessment

Scale (ESAS), Patient Generated Subjective Global Assessment (PGSGA), Distress Thermometer with symptom checklist, MD Anderson Symptom Inventory (MDASI), 6 minute walk, Timed up and go, grip strength, forward reach test, General Self Efficacy scale, Berg balance scale and Multidimensional Fatigue Inventory (MFI).

Results: One hundred and sixty three participants completed the PRP. Eighty males and 83 females; m age 62 years (32-90). Participants experienced significant improvements in: PGSGA nutrition ($p = 0.001$); ESAS tiredness ($p=0.001$), anxiety ($p<0.001$), appetite ($p=0.002$), wellbeing ($p<0.001$); Distress level ($p<0.001$), symptom checklist: practical problems ($p<0.001$), emotional problems ($p<0.001$), information concerns ($p<0.001$), physical problems ($p<0.001$); MDASI general activity ($p<0.001$), mood ($p<0.001$), work ($p<0.001$), relation ($p=0.001$), walking ($p<0.001$), enjoyment ($p<0.001$); MFI General ($p<0.001$); Berg Balance ($p<0.001$), reach forward ($p<0.001$), timed up and go ($p<0.001$) and Six minute walk test ($p=0.001$).

Conclusions: Participation in the PRP is beneficial to the patients as it improves nutrition, reduce symptom burden, reduce distress level, reduce interference by symptoms in daily life and improves physical, functional and overall well-being.

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ORAL ABSTRACT #5

An Outpatient Initiative to Improve Non Cancer Palliative Care Transitions

Non-cancer care has not traditionally been the focus of palliative care initiatives. Internationally, emphasis is being placed on providing care for this population, but few outpatient palliative resources are available to patients who are not yet at end of life. A clinic to provide palliative supports to non-cancer patients was initiated August 2013. This clinic provides multiple supports: 1) Patient and family education. 2) Early advanced care planning and goals of care transitions 3) Easing transitions from intensive specialist involvement with active care, to a symptom management focus 4) Assistance with care transitions (community to acute care, acute care to community, dying at home options) 5) Provision of psychosocial support and easy access to palliative expertise 6) Practitioner directed symposiums and workshops. To date, 97 patients have been seen. Thirty-two hepatic, 33 renal, 29 pulmonary, 29 cardiac, and 3 hematologic patients have been assessed and followed. Twenty nine patients have deceased, 58 have been hospitalized, and 11 had concurrent cancer. Sixteen transplant patients were seen. Three patients died before the initial consult was completed. At each clinic visit, ESAS-r scores were collected. These scores have indicated a high symptom burden, despite the average Palliative Performance Status of 70%. Most patients did not have Advanced Care Planning completed at the initial visit, and were not aware that Palliative Care applied to them. There continues to be heightened interest in integrating palliative concepts in multiple areas of patient care, and the clinic continues to gain exposure and grow in its success.

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POSTER ABSTRACTS

This first abstract by Dr. Rafael Sumalinog was the winner of the poster competition

End-of-life preparations and palliative care for the homeless: A systematic literature review

Background

Homelessness is a chronic issue in Canada, affecting 150,000 to 300,000 individuals annually. The homeless face higher prevalence of diseases, comorbidities, and mortality rates than the average population. They experience discrimination in health care, where most die in acute-care hospitals against their preferences.

Despite these, scarce research has been done on providing end-of-life (EOL) preparations and palliative care for the homeless.

Objective

To perform a systematic literature review evaluating end-of-life preparations and palliative care interventions for the homeless.

Methods

A search protocol was developed and executed in databases with peer-reviewed English and gray literature articles published from 1980 to 2014. Two independent reviewers screened titles and abstracts of articles based on a predetermined eligibility criteria, for further inclusion to full-text screening. Study characteristics will be tabulated in standard data extraction and quality assessment forms. Qualitative and quantitative findings will be analyzed statistically or based on appropriate descriptive categories.

Preliminary Results

Peer-reviewed databases resulted in 2226 articles. Gray literature databases yielded 105. Four articles were included for final analysis: two RCTs, retrospective cohort study, and qualitative study. These show differences in completion of advance directives, cost-effectiveness of shelter-based palliative care, and effectiveness of harm reduction services for the homeless at EOL. The findings and quality of these studies will be evaluated.

Conclusions

Few studies have been conducted to improve palliative care and end-of-life preparations for the homeless.

Specifically, research is lacking on the effects of interventions on quality of life, accessibility of palliative services, and early palliative care models.

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Clinical and psychological correlates of cognition in pain. The role of clinical hypnosis and self-hypnosis to relief pain, anxiety and pain-related symptoms in severe chronic illnesses: a group therapy study' at Verona University.

This research is a proposal to study the effectiveness of the use of hypnosis and self-hypnosis, to relief pain, anxiety and pain-related symptoms in severe chronic illnesses (cancer, disabilities and many more chronic diseases) in Palliative Care.

"Hypnosis is a procedure involving cognitive processes in which a subject is guided by a hypnotist to respond to suggestions for changes in sensations, perceptions, thoughts, feelings, and behaviors. Hypnosis can alter and eliminate the psychological experience of pain and also the brain's neurophysiologic processing of pain"

(APA Division 30).

Description of study design: we have selected a group of patients with severe chronic diseases, evolving in pain, anxiety and pain-related symptoms. We have organized a group therapy utilizing direct and indirect clinical hypnosis and self-hypnosis, by metaphors and relaxing musical videos, for reliving symptoms.

The hypnotherapy group is a group therapy, where the people context and group process is explicitly utilized with clinical hypnosis as a mechanism of change by developing the manifestations of conscious energy, exploring and examining interpersonal relationships within the group, to discover the benefits of pain and anxiety relief.

A follow -up after nine months was completed for:

1. VAS the visual analogical scale for the evaluation of the pain
 2. HAMA Hamilton anxiety scale, for the evaluation of anxiety and related symptoms.
- The preliminary data after 9 months of clinical hypnosis and self-hypnosis in severe chronic diseases, suggest that hypnosis is very effective in decreasing pain, anxiety and pain related-symptoms in severe chronic diseases.

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Successful relief of chronic severe localized neuropathic pain, associated with spinal cord trauma, as a result of Lidocaine patch 5%: a case report.

The main objective of the present work is to report and discuss data, in a case report of successful complete pain relief, in a localized severe neuropathic pain, using the Lidocaine 5% patch (L5% P).

Chronic neuropathic pain is very frequent after a spinal cord trauma, recent data showing that at least 80% of the patients experience pain at a serious level. In this patient, it results from a direct injury to the cord, 16 years ago. Patient is a male, 68 years old, in 1997 had a spine trauma and fracture at C5-C6, with tetra paresis. The spinal cord trauma, caused to the patient weakness and loss of feeling. The physical exam, including a neurological exam demonstrated: stabbing, penetrating, and constant pain, night and day, at the right hand, of high intensity (NRS Numeric Rating Scale = 9-10) predicted by a combination of pain interference, localized pain and depressed mood.

Neuropathic pain associated with spinal cord injury is caused by complex neural mechanisms and is often refractory to standard therapy. There are few reports of the use of the lidocaine 5% patch (L5%P) for neuropathic pain. The Lidocaine patch 5%, was an effective treatment for the severe neuropathic pain at the right hand, in this case of a man with an old spinal cord injury. NRS was 10 before the treatment and 1-2 after. This underutilized drug (L5% P), may be a very important therapy for chronic local neuropathic pain in incurable severe diseases.

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Doodles, Snippets, Mind Maps and Apps: Just-in-Time Online Learning Options for Palliative and End-of-Life Care

Technologies, including tablets and apps, are becoming ubiquitous in today's health care environments. In addition to accessing patient information at the point-of-care, they also

present exciting platforms and opportunities to support just-in-time learning. Pallium Canada produces peer-reviewed palliative and end-of life (EOL) care courseware and learning materials. These resources include a suite of products for mobile devices and desktop computers to support distributed learning and clinical decision-making at the point-of care.

The E-Learning tools that are demonstrated include: “Pallium Doodles,” “Pallium Snippets,” “Pallium Courselets,” Mind Maps and the Resource App. Doodles are short 1 to 3 minute videos that combine voiceover narration with animated sketching to shape attitudes and correct misconceptions surrounding palliative care. Snippets are short online modules (2 to 5 minute) designed to educate professionals on a specific subject. Courselets are 20 to 30 minute modules designed to achieve several learning objectives and an in-depth understanding on a subject. Mind Maps are quick-reference resources that guide stakeholders to learn more about products and initiatives. The Resource App consists of national, provincial and local resources and includes clinical tips, decision and communication aids, directories and tools.

This poster also provides an overview of the Pallium Portal (Learning Management System (LMS)) that supports Pallium Canada’s E-Learning tools by organizing and tracking learner activity. The Pallium Portal is the central hub for professional development and provides access to participant applications, facilitator registration, and online courseware. It is accessible on all devices, all screen sizes, and is mobile-friendly.

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Methadone for Analgesia: On-Line Training Tool to support Physicians

In collaboration with the Canadian Society of Palliative Care Physicians (CSPCP) and leading methadone experts, and using the latest research and clinical best practices, Canadian Virtual Hospice has created an interactive online training tool. The Tool provides core competencies in methadone prescribing in palliative care, and will lead to standardized evidence-based care. Methadone prescribing by palliative care and pain and symptom management teams is limited by the paucity of family doctors able to provide ongoing prescriptions for methadone for analgesia in patients discharged to care in the community, either because of being stable or for end of life care. The on-line learning model allows for flexibility, increased access to training and should increase the number of physicians applying for an exemption license to prescribe Methadone.

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Creating a free, mobile palliative app with a big EMPACT!

Mobile devices including smartphones are being used with increasing frequency in the practice of medicine.

The ability to access relevant, clinical information quickly and easily in the office or at the bedside is of great benefit to health care providers from all disciplines. Though there has been an explosion in the number of mobile medical applications, there are currently very

few to support palliative care.

EMPACT (Edmonton Mobile Palliative App & Clinical Tool) is being developed to support the Edmonton Zone Palliative Care Program. It was created using a free web-based app builder without coding or the need for specialized computer skills or experience. The app complements the program's webpage providing mobile access to: palliative care assessment tools, tips & clinical practice guidelines, virtual hospice tour and weblinks to additional clinical and education resources.

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Investigating end stage liver disease in a geriatric palliative care setting.

Objective: To investigate the demographics and clinical course of patients with end stage liver disease (ESLD) admitted to a geriatric palliative care unit (PCU) as compared to patients with cancer and other non-cancer diagnoses.

Design: Retrospective chart review.

Setting: Palliative care unit, Baycrest Hospital, Toronto, Ontario.

Participants: Patients admitted to the PCU between September 1, 2011 – April 10, 2014 (N=691).

Main outcome measures: Age, sex, length of stay (LOS), diagnosis, Palliative Performance Scale score (PPS) on admission.

Results: Five-hundred and fourteen (74%) patients had a cancer diagnosis and 177 (26%) patients had a noncancer diagnosis. Twenty-six patients had ESLD. ESLD made up the third largest percentage (15%) of noncancer diagnoses. Compared to patients with cancer, ESLD patients did not differ significantly ($p>0.05$) with respect to age, PPS on admission, or length of stay. As compared to patients with other non-cancer diagnoses, patients with ESLD were significantly younger ($p<0.001$) and had a higher PPS on admission ($p<0.001$).

Conclusion: With respect to age and PPS on admission, ESLD patients were more similar to patients with cancer than patients with other end stage chronic diseases. Despite perceived challenges with prognostication in ESLD, LOS did not differ significantly between ESLD patients and patients with cancer or other non-cancer diagnoses. PPS on admission was significantly higher than other non-cancer patients with no difference in LOS. This indicates that patients with ESLD may deteriorate at more rapid rate than patients with other noncancer diagnoses. As such, timely palliative care access is greatly important for these patients.

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A qualitative exploration of the effects of an early palliative care intervention on patient-caregiver pairs

Introduction

Early palliative care (EPC) has been shown to improve patient quality of life and satisfaction with care, while caregivers report improved satisfaction with care. The potential impact on patient-caregiver dyads has not been extensively explored.

Objectives

To explore the impact of an EPC intervention on patient-caregiver dyads, in terms of their relationships, communication about the end-of-life, and preparation for the future.

Methods

Patients and family caregivers were recruited as part of a cluster-randomised controlled trial of an early palliative care intervention from 24 medical oncology clinics at the Princess Margaret Cancer Centre, Toronto, Canada, from December 2006-February 2011. Both groups completed quantitative measures monthly for 4 months, and were invited to participate in one-on-one qualitative interviews at study-end. Qualitative analyses were conducted using a grounded theory approach.

Results

Thirteen patient-caregiver dyads completed interviews (26 participants: 10 intervention, 16 control).

Intervention pairs showed remarkable congruency in the content of their interviews, and in particular were more likely to report positive changes in shared priorities and strengthened relationships. They also described improved communication about the future, characterized by dual awareness, or an ability to balance hope with realism. Control group pairs were more likely to report divergent priorities and were more avoidant of end-of life discussions.

Conclusions

EPC for patients with advanced cancer and their caregivers may help to strengthen relationships through a discussion of priorities, improved communication, and preparation for the future. Larger studies are needed to confirm these findings.

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LEAP Renewal

The Pallium Canada Learning Essential Approaches to Palliative and End-of-Life Care (LEAP) course was introduced in 2002 as an interprofessional clinical introduction to palliative care; targeting physicians, nurses and pharmacists. Since then, hundreds of workshops have been delivered in Canada and studies have shown significant improvement in knowledge and attitudes for those working with palliative patients and their families post training.

Pallium Canada has recently undergone a LEAP Renewal process to update the LEAP Core to reflect new evidence. Pallium Canada, in collaboration with stakeholders, has and continues to develop tailored thematic modules that will support palliative care specialties. New courseware is currently in development to address specific thematics and encompass different settings based on unique health care professionals palliative care educational needs.

Thematics include:

- LEAP Mini
- LEAP LTC and Nursing Homes
- LEAP Surgery

- LEAP Mini Oncology
- LEAP Aboriginal
- LEAP Emergency Department
- LEAP Paramedic
- LEAP Hospital
- LEAP Non-Cancer
- LEAP Hospice
- LEAP Undergraduate
- LEAP Pediatrics

The updated LEAP Core courseware has been developed with a continued focus on interprofessionalism and a standardized approach to enhancing palliative care in Canada. This poster demonstrates the LEAP Renewal process, including the development and updating of learning objectives based on professional competencies. The poster also demonstrates the stakeholder engagement process involved in the LEAP Renewal process and the development plan for the listed thematic.

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Physicians' Attitudes on Systematic Symptom Assessment and Management: Toward 'Best Practice'

Background: Cancer patients experience a high symptom burden throughout the illness trajectory. Evidence suggests that the use of systematic symptom assessment instruments - such as the Edmonton Symptom

Assessment System (ESAS) - might lead to better patient outcomes.

Methods: This presentation will highlight the results of an exploratory mixed methods study conducted at the

Province of Ontario's 14 Regional Cancer Centres. As part of a larger program, an electronic 21-item questionnaire concerning provider attitudes toward systematic symptom assessment and management was sent to all 960 physicians (general practitioners in oncology, medical oncologists, radiation oncologists, surgical oncologists and palliative care physicians) in Spring of 2014. Systematic content analysis, descriptive statistics and Kendal Tau b or c tests were utilized for data analyses.

Results: Participants will learn about the responses received and their variation by Regional Cancer Centre and discipline. The majority of respondents (66%) agreed that the regular use of standardized symptom assessment instruments should be considered 'best practice', with a range from 59% (surgical oncologists) to 97% (palliative care physicians).

Conclusions: Despite high regard toward usefulness and recognition as 'best practice', a gap toward the utilization of standardized symptom assessment instruments in daily practice/inclusion into the care plan does exist. Participants will have a chance to reflect on their own attitudes toward systematic symptom assessment and management and think about applicability to various settings and disease sites. Future research will need to explore the reasons for disconnect and focus on potential avenues to overcome these to further enhance person-centered care.

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Palliative Education and Care for the Homeless (PEACH) – Improving the lives of the homeless in Toronto through early palliative care

Little is known regarding the palliative needs of the homeless and vulnerably-housed in Canada, many of whom have higher comorbidity rates and 2.3-4 times more deaths than the average population. Their access to appropriate palliative services is hampered by multiple factors, such as the lack of continuous housing, social support, and various mental health issues. This is worsened by the discrimination that they experience in the healthcare system—resulting in their deaths at acute care settings despite their wish to be otherwise. The Palliative Education and Care for the Homeless/Vulnerably Housed (PEACH) program, under the Inner

City Health Associates (ICHA) in Toronto, aims to alleviate these gaps by providing early, holistic palliative care for these populations. Whereas traditional palliation is delivered at the end-stages of serious illness, this outpatient approach coordinates with patients early in their disease and provides palliative services along with standard medical care. This has been shown to improve the quality of life, symptom control, satisfaction, and prognostic understanding for patients, while reducing overall healthcare costs.

PEACH accompanies its patients geographically and provides services appropriate to their disease trajectory.

It adopts an interdisciplinary approach within the primary care framework and connects patients to community services, such as shelter accommodation and hospice support.

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Can a Standardized Pediatric Palliative Care Referral Criteria Tool Identify Children Most at Risk for Dying?

Aims: Retrospective review of patients admitted to a tertiary care pediatric hospital over one year to determine if children meeting criteria for referral to palliative care were at increased risk of dying in the study period or the subsequent five years.

Patients and Methods: After ethics approval, patients admitted April 1, 2006 to March 31, 2007 were identified; diagnoses during admission were reviewed. All deaths from start date until 5 years after end were obtained.

Admitted children with acute and resolving medical conditions were excluded from further study unless they died in the interval. Charts were reviewed electronically; paper charts where more information was needed.

Criteria for referral were based on guidelines from the Center to Advance Palliative Care (CAPC).

Results: 5996 hospital admissions represented 4898 individual children. There were 4033 children excluded due to lack of a life-limiting condition. Five (0.1%) of these excluded children died of unrelated illnesses. 865 remaining children were categorized by primary

diagnosis; cardiovascular, malignancy, neonatal, neurologic or other. Among these 865 children, 179 (20.7%) met criteria for referral to palliative care, and 88 (49.2%) of this group have died. Of the other 686 children who were categorized but did not meet criteria for referral 15 (2.2%) have died either during the study period or subsequently. Conclusions: The CAPC guidelines are good predictors of children who are most at risk from dying. Institutions and individual programs should advocate for these children to have access to high quality palliative care.

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Deaths in Acute Care at Eastern Health: a chart review

All patients who died in acute care in Eastern Health for the year 2010 were retrospectively reviewed. This included over 1200 patients. Data was analyzed to determine a number of factors, including demographics, location of death, treatments and DNR status. Specifically we looked at how many of these patients had active treatment until death and what services were involved in care. Comparisons were made to the patients who were referred to the palliative care service during the same time period. It was noted that 60% of the deaths in acute care were respiratory or cardiac while those referred to palliative care were 98% cancer.

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Organizational Predictors of the Quantity of Undergraduate Medical Education in Palliative End of Life Care at Canadian Medical Schools

Undergraduate medical education in Palliative End-of-Life Care (PEOLC) has been identified as a priority.

National curriculum standards such as the EFPPEC competencies exist; however, some students graduate with the perception they have little to no exposure, indicating that national implementation of PEOLC curriculum is inconsistent. The objectives of this study were to describe the type and content of undergraduate PEOLC curriculum in Canadian medical schools, and to examine through interviews, how organizational and environmental factors have impacted both implementation and sustainability of curricula.

Methods:

Using a modified Dillman approach, an online survey was sent to an identified PEOLC undergraduate education lead at each Canadian medical school. Survey data were used to classify schools into high, medium and low tiers based on number of hours of palliative care education. One school from each tier was chosen to participate in semi-structured telephone interviews (n=3). Interviews were transcribed verbatim and interpreted using constant comparative analysis. Themes were examined within and between the interviewed

schools in order to identify socio-institutional barriers and facilitators to implementing PEOLC curriculum.

Results:

Fourteen medical schools (82%) responded to the survey. Data are currently being analyzed and findings will be presented.

Discussion & Conclusion:

Interviews revealed perceptions of the curriculum and its integration into the schools' overall programs, key events that have influenced its status, and barriers/facilitators to implementation and sustainability. This study articulates a set of factors that influence existing educational offerings in PEOLC, and helps to identify strategies to enhance future successes in national PEOLC education.

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Physician's prescription patterns of opioids as Breakthrough pain analgesia in patients with cancer pain

In Canada, few guidelines have been produced for the management of breakthrough cancer pain and we have not found documentation on how it is managed by physicians. We explored using a self-administrated survey, targeting physicians with experience in palliative care, the patterns of opioids' breakthrough analgesia (BTA) prescriptions for the specific control of breakthrough pain in patients with cancer pain.

Method: The survey was distributed to practicing physicians, members of the Canadian Society of Palliative

Care Physicians, through the mailing list of the Society.

Results: Most of our 243 respondents are family physicians (56%), followed by palliative care physicians

(20%). Almost all of them (96%) usually prescribe opioids as BTA and 93% prescribe the same type of opioid as the around the clock one. Few use methadone for chronic cancer pain (34%) or as BTA (43%) when methadone is used as around the clock opioid. Fentanyl is prescribed as BTA in 25% of patients using fentanyl patches and in 22% when other types of opioids are used around the clock. The preferred interval for opioids' prescription as BTA is every 2 hours.

Discussion: In this sample, the use of opioids as BTA is consistent with guidelines except for prescription's intervals, and Methadone seems to remain an opioid used mainly by specialists.

This study provides a better understanding of the current trends of prescribing opioids for management of breakthrough pain in cancer patients and may help non palliative care specialist physicians in the proper use of opioids as breakthrough analgesia.

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Palliative Home Care Response Team Workload & Outcomes Project

Objectives: The Calgary Zone Palliative Home Care Response Team had a reduction from 2 evening RNs to 1 in June 2013. In the year following, it was found that RNs were often

unable to respond to calls and/or make required home visits. The purpose of this project is to determine an appropriate staffing model for safety, quality and sustainability of after-hours palliative care in Calgary with performance indicators for continuous monitoring. Methods: Phase I includes consultation with other palliative programs, literature review, collection of workload data, chart audit, and staff and family surveys. Phase II will evaluate the models using SWOT and cost analyses with the intention of implementing a new model for 2016.

Results: Phase I data found the number of weekly contacts to be 49.2 ± 15.5 (SD), for 6.1 ± 3.3 (SD) unique patients per day, with mean face-to-face time of 118.6 ± 76.5 (SD) minutes, and telephone support time of 39.2 ± 23.5 (SD) minutes. Of the 30 audits conducted, 83% of calls were resolved with telephone support while 13% required a home visit. The number of hourly incoming calls ranged from 0 to 15. Results to date justified the return of the 2nd RN on the evening shift.

Conclusions: The data collected so far depicts the unpredictability of the after-hours palliative care workload.

The next steps are to obtain more information for Phase I (including surveys), identify potential staffing models, and to use workload and outcomes data in addition to SWOT and cost analyses (Phase II) to determine the new model.

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Advanced Cancer Patients' Perspectives on a Video Decision Support Aid used to Enhance Goals of Care Discussions

Background: Advance Care Planning/Goals of Care discussions can positively impact the quality of end-of-life care but few studies have evaluated Goals of Care video decision support aids in the setting of advanced cancer.

Aim: To explore perspectives of patients with advanced cancer on the use of a video decision support aid developed to enhance awareness of different Goals of Care (GOC) and to examine how the video influences participants' knowledge and perceptions about GOC.

Methods: A pre-post design using a qualitative approach was used. Before and after watching the video, semi-structured interviews were conducted with 14 participants from an Outpatient Radiation Oncology Bone Metastases Clinic. Extended Elaboration Likelihood Model was the conceptual framework used to guide data analysis.

Results: Participants found the video scenarios made the GOC framework more personally relevant. They were able to relate their experiences to the video. After watching the video, nine participants identified their current approach to care as either medical care or comfort care. Participants found the timing and professional clinic environment appropriate for watching the video. Several participants expressed their intention to initiate discussions with their health care providers and to formalize their GOC plans.

Significance and practical application: A purpose-specific video was a useful tool to engage patients in GOC in an outpatient oncology clinic. Ability to relate past and present experiences to the scenarios shown in the video influenced effectiveness of the video. Video made the GOC framework "real" and helped participants articulate personalized questions for their health care providers.

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A National Strategy To Improve Access To Palliative Care in Saudi Arabia

Interdisciplinary medical education lacks standardized curricula for teaching palliative care in Saudi Arabia.

Objectives:

To describe the development, implementation and initial evaluation of an educational program in palliative care for health professional in Saudi Arabia.

Method:

A continuing medical education (CME) program called Palliative Care for Health Care Professional (PallCare) was developed that consisting of 12-14 hours teaching to be delivered in 2 day. The extensive education program discussed; introduction and general concepts of Palliative medicine, common problems in palliative medicine to cover end stage chronic illnesses, palliative care (PC) services in adults and children, total pain, cultural & psychological, and spiritual aspect of pain; forming effective PC team and professional development in palliative medicine.

Result:

The PallCare program was implemented in 2011 and has trained 381 of Health Care Professional in MOH, Saudi Arabia as of May 2013. Initial assessment of the program shows significant improvement of knowledge with pre-test examination scores of 47% improving to 88% on post -tests. Initial assessments also shows more participants changing their attitudes to favour involving the patients in management plans, interprofessional care, communication skills training, comfort with diagnosis and management of complex PC patients, provide appropriate and compassionate care for patients and families when death is imminent, practice audits and quality control.

Conclusion:

The initial evaluations show that the PallCare program facilitates Health Care Professionals' knowledge acquisition and provides PC skills that can be applied in practice. Our results should prompt others to create similar CME programs based on their health care needs to improve palliative care delivery.

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Palliative Needs of an Inner City Population in the Setting of a Community-Based Model of Palliative Care Delivery

People from inner city neighborhoods have higher mortality rates and die at younger ages compared to the general population. Based on these findings, it has been suggested that there may be need for increases in palliative care intervention for this unique population. The Edmonton Zone Palliative Care Program is a community-based model of palliative care services that strives to provide access for individuals at home and regional health care institutions. Theoretically all individuals who present for medical care should be able to

receive palliative services. A retrospective cohort study was conducted at the Boyle McCauley Community Health Centre – a primary care clinic that services three of Edmonton’s inner city neighborhoods. A convenience sample of 50 consecutive deceased patients was analyzed to determine and classify the etiology of death using the classification system of theoretical trajectories of decline. Secondary outcomes included demographic information, location of care and death, and palliative care referrals. The etiologies of death were: organ failure 42% (21/50) where 71% (15/50) was cirrhosis, sudden death 28% (14/50), cancer 26% (13/50), advanced dementia 2% (1/50), and unknown 2% (1/50). Mean age of death was 56 years old and 70% (35/50) were male. 54% (27/50) died in hospital. 62% (31/50) had history of alcohol abuse. 20% (10/50) received palliative care consultations. These findings demonstrate that this marginalized population is dying at a relatively young age from primarily preventable causes, reflecting need for change and improvement to current practices at the levels of prevention, acute and chronic management, and palliative care.

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Developing and improving the measurement properties of The Fast Cognitive Evaluation in people with cancer.

Introduction: It has been well established that cognitive deficits are prevalent in many end-stage of several diseases. The Montreal Cognitive Assessment and the Mini-Mental State Examination have been validated to assess the cognitive impairment in a geriatric population, but they have been found insufficiently sensitive for mild cognitive failure in cancer patients. The Fast Cognitive Evaluation (FaCE) is being developed in this population.

Purpose: To improve cancer patient's treatment and care, we aimed to improve the assessment of cognitive failure by developing a new adapted cognitive assessment test. The most adequate questions assessing each item have been identified to use a minimum amount of questions.

Method: 139 patients (median age: 64 years, 47% male) at different stage of various cancers from Centre de recherche clinique et évaluative en oncologie in Quebec, were included. The FaCE assesses with 38 questions, 6 cognitive aspects such as memory, visuospatial and executive functions for less than 10 minutes.

Results: the preliminary results show that the items for which the lowest proportion of patient answered right was assessing the attention (1.4%), whereas the highest (91.4%) was assessing orientation. The median score was 27 (minimum: 10, maximum: 36).

Conclusion: This study will allow the development of a quick and easy cognitive test that could be used in all oncology departments worldwide. Future research comparing cognitive disorders in this population could use it to improve treatment and knowledge of this specific aspect.

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A CASE OF PARANEOPLASTIC NEUROPSYCHIATRIC SYNDROME PRESENTING AS
TERMINAL DELIRIUM

Background: Terminal delirium in cancer patients is associated with bad outcomes but reversible causes need to be ruled out.

Case Presentation: A 59 years-old patient presented with behavioral and cognitive changes over 2 weeks. She was non-verbal and combative, requiring an “involuntary admission” form. Infectious and metabolic investigations and initial brain imaging were unremarkable. She was diagnosed with localized small cell lung cancer and a neurologic paraneoplastic syndrome.

Case Management: After discussing the possibility of clinical improvement with chemotherapy, the family agreed on proceeding with treatment. When the delirium worsened after the first cycle, comfort care was recommended. However, the family chose to continue with treatment. A “certificate of incompetence to make treatment decisions”, pharmacologic and physical restraints were needed.

Case Outcome: After 2 cycles of chemotherapy, she could participate in the decision process and was discharged home. She completed radical chemo-radiotherapy and has remained free of disease progression for 18 months.

Conclusions: Patients with neurologic paraneoplastic syndromes may not be able to consent to treatment. It is paramount that a multidisciplinary team evaluates the benefits and risk of aggressive strategies and family members know the wishes of the patient to be able to make decisions in their behalf.

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Evaluation of a Standardized Electronic End-of-Life Order Set Targeted at Improving the Quality of End-of-Life Care within Hospital Inpatients

Background:

For clinicians who do not routinely care for imminently dying patients, symptoms can be difficult to address effectively. To improve the care of the hospitalized dying patient, we implemented a comprehensive electronic end-of-life order set to facilitate the provision of evidence and expert-based palliative care measures. With this order set, we aim to improve the availability of appropriate orders and associated care practices at end of life.

Methods:

This is a before-after study design. All adult inpatients in Calgary, Alberta with a goals-of-care designation

(GCD) consistent with “imminently dying” were included. Primary outcomes (availability of opioid and neuroleptic orders) were compared before and after the introduction of the order set.

Results:

2,221 patients were included. Following implementation of the order set, the availability of neuroleptic agents increased from 32.1% to 42.3% ($p < 0.0001$) and opioids increased from 92.6% to 95.1% ($p = 0.0165$) at 24 hours after C2 GCD order. Adjusting for other variables, the order set implementation predicted availability of neuroleptic (OR = 1.56 (95% CI: 1.26-1.93) and opioid (OR = 1.46 (1.01-2.11) orders.

Conclusion:

An end-of-life electronic order set increases the availability of opioid and neuroleptic orders for hospital inpatients who are imminently dying.

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Development and Validation of the Frailty-In-Cirrhosis (FIC) Prognostic Tool

Background: Cirrhosis of the liver is a progressive, highly symptomatic chronic disease that has very little option for cure and leads to a cycle of repeated hospitalizations and death. We lack screening tools to proactively identify patients at high risk of unplanned hospital admissions/death. Traditional tools (e.g. MELD) are limited by their focus on liver dysfunction and relative lack of modifiability.

Specific Aims: In a multicenter prospective cohort of 800 outpatients with cirrhosis (N=400 Edmonton derivation set, N=400 Calgary validation set) we aim to:

1. Determine the prevalence of frailty and domains of frailty using global performance scales (e.g. clinical frailty scale, palliative performance scale) and objective testing of individual frailty domains (e.g. depression, cognitive impairment, physical frailty)
2. Derive and externally validate a parsimonious FIC (frailty in cirrhosis) prognostic model that incorporates markers of frailty to predict unplanned hospitalization and death in outpatients with cirrhosis.
3. Determine and externally validate a clinically relevant FIC threshold that dividing low & high-risk patients
4. Describe the short-term cost and health quality of life impacts associated with a high FIC score

Study Significance: Frailty is not routinely evaluated in cirrhosis. This study aims to highlight the prevalence and prognostic relevance of frailty in cirrhosis and provide clinicians with the FIC tool to identify patients at high risk for unplanned hospital admission or death. This data will provide strong support for the early integration of palliative care strategies and empower clinicians and patients to develop holistic care plans that expand beyond a “disease-specific” model of care.

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Patient reported health related quality of life is a robust predictor of unplanned hospitalization and death in outpatients with cirrhosis

Background: Cirrhosis of the liver is a progressive, highly symptomatic chronic disease that has very little option for cure.

Aims: In a prospective cohort of outpatients with cirrhosis we aimed to evaluate the i) health related quality of life (HRQoL) as measured by the EuroQol (EQ5D), EQ-VAS and Chronic Liver Disease Questionnaire (CLDQ) and ii) the independent prognostic implications of a poor HRQoL to predict a combined outcome of unplanned hospitalization or death within 6 months.

Methods: Multivariate logistic regression was utilized. All models included 6 traditional prognostic factors:

MELD score, age, serum albumin, serum sodium, presence of ascites and hospitalization within the last 3 months, in addition to 1 HRQoL measure.

Results: Of 200 patients, mean age: 57 yrs; males: 65%, mean MELD score: 12.5. Mean EQ-VAS 62. At least moderate problems were reported across EQ-5D domains - pain (71%), usual activities (61%), mobility (58%), anxiety/depression (44%) and self-care (17%). In a multivariate model where the EQ-VAS was added to the panel of traditional prognostic markers, the EQ-VAS remained statistically significant (adjusted odds ratio 0.98(95% CI: 0.96 to 0.99), $p=0.009$). In a model including the CLDQ total score, this again was a robust independent predictor with an aOR of 0.63(95% CI: 0.47 to 0.86), $p=0.003$. Study Significance: This study highlights the high symptom burden in patients with cirrhosis. HRQoL as measured by general or disease specific scores is an independent predictor of unplanned hospitalization or death within 6 months and represents a potentially modifiable screening tool to identify patients in need of multidisciplinary palliative intervention strategies.

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