The Bow Tie Model in Action: Referral Triggers

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Disclosures

• I have co-authored a book for patients and their families living with serious illness
• Designed to be used from time of diagnosis, to operationalize the Bow Tie Model (available on Amazon)
• No other relevant conflicts
Some day, we will all die, Snoopy!

True, but on all the other days, we will not.
New Paradigm

• Prognostication (diagnosis of dying) progressively more and more difficult
• Delays in response to immune therapies can approximate to life expectancy
• Dying on treatment
• High expectations from patients/families

• Widespread misperception of having to choose between either disease-targeting or palliative care in treatment focus
• Palliative care discussion at times of transition can be threatening
BC Cancer Early Palliative Care Integration Study

• GI cancer patients on first visit to Medical Oncology
• All stages, all GI cancers, irrespective of prognosis
• Randomized to intervention or control arm
• Control was usual care, including Pain & Symptom Management/Palliative Care referral (low barrier)
• Symptom assessment and Canadian Problem Checklist at first 4 visits
• Intervention arm offered referral to PSMPC team member, right then and there if possible, if any symptom 4+/10
• Short-term and long-term outcomes still being collected and analyzed
BC Cancer Early Palliative Care Integration Study: lessons so far

• Cancer stage does not correlate with level of distress or number of problems
• Many patients are overwhelmed on their first visit and incapable of completing detailed assessments
• Many patients do not want a PSMPC referral initially, because too many appointments already, and very focused on chemo
• May be hard to show differences between arms when standard care is already good
• Willing oncology collaborators in studies tend to be already “believers”
Barriers to Early Integration: supply and demand-sides

• Up-front investment required - competition for funds with exciting new advances in oncology
• Palliative care is human-intensive: needs operating funds, not capital grants
• You can’t do it on the cheap: single disciplines do not achieve the same benefits as multidisciplinary teams, and prescribers required
• Have to start early to get the maximal benefits (~4 months minimum)
• But perception is still that palliative care is synonymous with EOL care, even amongst many palliative care providers
• Association with death delays access to care
Overcoming Barriers

• Re-labelling (or de-labelling) care
• Palliative Care and Hospice no longer synonymous
• Ensure all the components of palliative care are delivered without requirement to have accepted mortality
  • Prevention, assessment and management of symptoms
  • Serious illness conversations and advance care planning
  • Communication and coordination of care
• Without colluding with patients and families to avoid planning for dying
• Need a dual reality: hope for the best, plan for the rest.....
Canadian Virtual Hospice has video of me demonstrating on a whiteboard
Cancer Diagnosis
Cancer Diagnosis

Cure

Control

Cancer Diagnosis
Cancer Diagnosis

Cure

Control

Survivorship

Palliative Care

Bereavement

Cancer Diagnosis
The Bowtie Model of 21\textsuperscript{st} Century Palliative Care

Disease Management

Cure
Supportive Care
Control
Rehabilitation
Hospice

Palliative Care

Survivorship
Bereavement

\textit{P. Hawley JPSM 2014}
The Bowtie Model of 21\textsuperscript{st} Century Palliative Care

Disease Management

- Cure
- Control
- Supportive Care
- Hospice

Rehabilitation

Survivorship

Palliative Care

Bereavement

P. Hawley JPSM 2014
This is where you are now.....
This is where you are now.....

Disease Management

Cure

Control

Symptom Management and Supportive Care

Rehabilitation

Hospice

Palliative Care
This is where you are now.....
“We can never be 100% certain what will happen”
Ideal “Bow Tie Model” Palliative Care Service

• Services available introduced early
• Services 'dip' in and out when need arises
• Open door accessibility, preferably 24/7
• Co-location with oncologists for patient-centred care provision
• Clear role definitions
• Multidisciplinary team functioning, with team meetings and excellent communication
• Close links with community hospice (or palliative care) services and rehabilitation services
Triggers for Referral?

• Self-referral only works if patients are well-informed and insightful
• Disease-associated automatic triggers may miss distress early in course of disease
• Oncologist discretion referrals depends on
  • patient’s willingness to disclose distress
  • oncologist’s sensitivity to identifying palliative care needs
  • oncologists’ confidence and competence in palliative care
  • time
  • process complexity
• Waiting for distress expression to trigger a referral could restrict opportunities for anticipation/prevention
Triggers for Referral

- As flexible as possible
- Link referral to complexity of need
- Referrers’ capacity will vary
- Threshold for specialist support will vary
- Education of referrers is a key responsibility for specialists

- Linda Watson has done excellent work on this in Calgary
- “Green, yellow, red” model makes a lot of sense and most centres are considering or already using similar graded response systems
Triggers for Referral

• Regular distress screening with alerts generated and addressed by appropriate person/service
• Stepped levels of support
• Needs skilled triage and good quality referrals
• Recognition of need for flexibility to accommodate referrer heterogeneity
• “Just in time” education of referrer critical to long-term sustainability of services
Questions