Waterloo Wellington
Integrated Hospice
Palliative Care

MAID and the Waterloo-Wellington Response

March 23, 2017

Objectives

1. **An Overview of the MAID Regional Working Group and Framework**
2. Sub-Region Updates about Local Progress to Support Access to MAID
3. WW MAID Case Reviews – Lesson Learned
4. Discussion/Q&A

Provincial Landscape

- Total number of cases completed in Ontario as of: January 31, 2017: **244**
- **241** physician-administered cases
- **3** patient administered cases
- **155** Cancer-Related, **25** ALS, **24** Other Neurological, **25** CV/Resp, **10** Other
- **138** in hospital, **106** in home settings
- Female: **130**, Male: **114**
- Average Age: **73** (range 35 -101)
- Total number of Referrals to Ministry as of March 17: **360**
- **WW number of Referrals to Ministry as of March 17: 35**

Key Messages from the Regional MAID Working Group

MAID and palliative care are distinct processes that may be accessed by patients concurrently.

Access to MAID is distinct from access to palliative care. Existing system resources / structures may be used to support referrals/access to MAID.

Experiences in Waterloo Wellington reveal that the patients who have pursued MAID, have not chosen palliative care OR MAID – they typically choose both.

Currently, some HPC providers are receiving MAID requests. In the absence of a defined process, Health Care Providers in all sectors are struggling to respond and support these requests. This is distressing and distracting these providers from delivering HPC. These providers describe feeling “unsupported” and “alone”.

Key Messages from the Regional MAID Working Group (Continued)

WW IHPC Regional Program is a key player in the development WW Regional MAID Framework to ensure that:

In all settings, the first next step after a request for hastened death is received is a comprehensive evaluation of the palliative care services that the patient has received to date.

High quality palliative care is provided to the patient and caregiver/family throughout the MAID/EOL experience (especially in anticipation of potential complex grief, loss and psychosocial issues - HPC providers are experts in addressing these issues).

Draft WW MAID Referral Framework – March 20, 2017

#1 Patient Request to Clinician

Clinician discusses /explores the request with the patient and provides information on all available treatment and care options. If patient chooses to proceed with MAID, the clinician either:

1.Provides the patient with an overview of the MAID process & conducts an eligibility assessment for MAID

OR

2. If the clinician chooses not to participate in the provision of MAID due to religious or conscientious objections, the clinician will inform the patient that they re unable to provide MAID and will refer the patient to the respective sub Region MAID Resource Group

Regional MAID Advisory Committee

Regional MAID Community of Practice

- Guelph Sub Region Resource Group
- Rural Wellington Sub Region Resource Group
- Cambridge/ ND Sub Region Resource Group
- Kitchener Waterloo Sub Region Resource Group

#2 Central Access Point - WWCCAC

Referrals may come from patients or care providers in acute care, post acute care, hospice, community, primary care, LTC etc. WWCCAC will support navigation of the referral to the persons Primary Care Provider OR Sub Region MAID Resource Group

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   Rural Wellington, Guelph, Cambridge, KW

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Rural Wellington

Executive Director Mount Forest Family Health Team, Suzanne Trivers
March 21, 2017

"We are a bit delayed in getting things in place in Rural Wellington, Emmi. We have agreed in principle that we need to work with the hospital and align our procedures since, especially in the north, we have limited uptake for participation.

The FHT leads are scheduled to meet in the next few weeks to discuss multiple issues including MAID. I will be using the information received through AFHTO to create a draft procedure that will dovetail with the hospital procedures. I will then need to have a conversation with our partnering agencies to determine how we want to proceed with our primary care providers and the communication piece.

I'm sorry that we are moving fairly slowly here. It's really important that we proceed carefully given the significant impact this could have on the trust of patients with their primary care providers in our very connected rural communities."

Guelph Family Health Team

Guelph MAID

Palliative Spring Education Evening

March 23, 2017

Jennifer Mackie, BA, RRT, MBA

Guelph MAID Project Manager

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Process and Tools for Guelph MAID Resource Group

- 2016 Survey of Guelph PCPs

Survey Results	Yes	No
Comfortable discussing with own patients	85%	15%
Would you contemplate being a referral source to others in the community?	44%	56%
Would contemplate providing MAID to own patients	60%	40%
Would contemplate providing MAID to referred patients	24%	76%

- Identified Lead PCP willing to support the procedure and peers to develop MAID skills
- Selected documents / tools for awareness and processes for patient MAID inquiries

Process and Tools for Guelph MAID Resource Group continued

- Tools include:
  - System flow map (Centre for Effective Practice)
  - Local flow maps: WW Region, Guelph
  - Roles of PCPs and include:
    - Information
    - Referral
    - Navigation / Event Management
    - Assessor/Opinion
    - Provider

Process and Tools for Guelph MAID Resource Group continued

- Documents housed in EMR
  - Handouts for patient or MD/NP for awareness
  - Custom forms to initiate/support the process
    - Assessment/opinion – MOH forms; will move to Mt Sinai forms which are more person-centric
  - Process maps
    - Centre for Effective Practice
    - WW LHIN Region including contact info
    - Guelph contact / process
  - Vol. 25 (4), February 2017 PBSG: MAID *Responding to Patients* by www.fmpe.org is excellent

Challenges / Opportunities

- Early providers under the MOH process experienced challenges supporting MAID beyond Guelph
- Some MDs only willing to support the procedure for their own patients
- Many MDs willing to provide information and referral – and note that it is time consuming
- Those providing MAID are getting ‘over used’ so need to orient all 5 MDs in Guelph willing to support the procedure: experiential orientation session planned in April with rotating roster process to follow
- Site/location for patients where MAID at their ‘home’ is not available: working with Guelph General to establish a process for scheduling a day procedure involving a private room

Key Learnings

- Required a lead role to develop a plan for the local community
- Engagement with MDs/NPs is critical : for information, and participation as assessor/provider; and to gather experiences for shared learning
- MDs with MAID experience not willing to support procedure for out of town patients
- The day of the MAID procedure is an “event” and requires ‘event management’ support; looking at how admin or other staff can support the provider PCP
- Over time, increased awareness and of how to support MAID inquiries and procedures is expected to engage more MDs/NPs in the Guelph Resource Group over time.

In Closing

- We are on a big learning curve and are benefiting by the collaborative efforts across many organizations and regions.

Thank you for your attention!

Cambridge

- Dr. Kanuk Rhee

Kitchener Waterloo

- Dr. Eric Thomas

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CASE # 1: Cancer Patient in Acute Care Setting

63 yr old man metastatic NSCL cancer involving bone, liver, lungs.

Patient seen by oncologist diagnosis and possible treatment options discussed. Patient identified as having ++pain with poor control therefore, admitted to inpatient ward at hospital for PSM.

In hospital referral made to palliative/pain and symptom management team. Hints to MRP (ward GPO) that feels strongly about MAID and may not be interested in treatment options as discussed with oncologist previously.

Eligible for service. Completed in acute care setting

CASE # 2: Cancer Patient in Community

61 year old woman diagnosed in fall, 2016 with hepatobiliary cancer.

On first meeting with oncologist, requests MAID referral.

Referral made to HPC outreach team in community. HPC physician makes referral through MOH clinician referral line.

2 independent assessments completed.

Eligible for service. Completed in home setting.

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CASE # 3: Non-Cancer Patient in Community

76 year old man diagnosed with ALS in January 2017 after 2 years of progressive symptoms.

Seen by ALS clinic in London – treatment options reviewed. Referral made to HPC community outreach team.

After first meeting with community provider, asked “so how do we get on with this”. Requests MAID referral.

MRP family physician first experience with MAID request, agreeing to provide eligibility assessment and provision of intervention

CASE # 4: Non-Cancer Patient in Community

72 year old woman with end stage COPD, deteriorating function with multiple complications in her home.

Followed by HPC community outreach team. Requests MAID referral. Referral made to MOH clinician referral line.

1 eligibility assessment completed – meets eligibility criteria with existential suffering related to loss of independence and dependence on others – she does not want to die in her home setting.

She cannot bring herself to speak with her frail spouse about her wish – she believes he will be crushed by feelings of abandonment, loss. Withdrawal of request.

CASE # 5: Cancer Patient in Community

62 year old man with metastatic prostate cancer to bone (2008 diagnosed) with 2016 catastrophic SCC to T spine. Paralysis with remote chance of walking.

Followed by HPC community outreach – physician refers through MOH clinician referral line.

Last imaging 9 months ago – no evidence of other metastases.

Does not meet criterion of “natural death has become reasonably foreseeable, taking into account all of their other medical circumstances”.

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CASE # 7: Resident in Long Term Care Home

87 year old man living in nursing home x 6 months – multiple comorbidities but “well” and enjoys quality of life.

Recognizes that because of multiple comorbidities including a progressive neuro-degenerative illness and cognitive changes, he may not have cognitive capacity to request MAID in months to come – requests assessment from Nursing home physician.

MRP refers through Clinician referral line – 2 independent assessors acknowledge eligibility.

Nursing home develops policy to support death in his home.

CASE # 8: Resident in Retirement Home

96 year old “well woman” with progressive symptoms, investigated for probable GI malignancy. Not a candidate for systemic therapy, and doesn’t want it.

Requests MAID through RH physician, who supports her request and but is uncertain how to proceed.

Through community informal process, a 2nd eligibility assessor is identified who agrees to support MRP through process.

Resident meets eligibility criteria.

RH senior administration create policy to support resident to die in her home.

Ontario Palliative Care Network

Waterloo Wellington Integrated Hospice Palliative Care

Join our Stakeholder Distribution List to Receive Updates/Stay in Touch

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Hope is the only thing stronger than fear……