Cancer Care Ontario
Action Cancer Ontario

Palliative Care Collaborative Care Plans
CCPs

Stable Stage

Ontario
Cancer Care Ontario
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Collaborative Care Plan - Stable Stage
Palliative Performance Score 100 - 70
ECOG or Patient ECOG/Patient Reported Functional Status (PRFS) Score 0 - 1

Background Information
Collaborative Care Planning is a process used by interdisciplinary teams to improve quality and efficiency of care for specific patient populations. Teams develop collaborative care plans to:

- Guide the care of patients
- Promote the critical review of care processes
- Promote quality patient care
- Promote interdisciplinary collaborative practice
- Promote patient satisfaction

What are the Collaborative Care Plans?
These Collaborative Care Plans (CCPs) build on the work of the Kingston Frontenac Leeds and Addington Palliative Care Integration Project[1] and align with the Canadian Hospice Palliative Care Association's (CHPCA) Model for Hospice Palliative Care[2]. These revised CCPs were developed by a provincial working group[3] that was tasked with developing a tool targeted at the generalist provider that would improve the quality of patient care by increasing consistency across providers and settings.

The CCPs uses the CHPCA Model as a framework. Each "Domain of Issue" from the Model (e.g., Disease Management) is listed on a separate page and is broken down by the Model's Essential and Basic Steps During a Therapeutic Encounter. The Palliative Performance Scale[4] (PPSv2)/ECOG/Patient ECOG (Patient Reported Functional Status) can be used to determine which plan is appropriate. A separate Care Plan is provided for each stage; Stable (PPS 100 - 70%/ECOG/PRFS 0-1), Transitional (PPS 60 - 40%/ECOG/PRFS 2-3), and End-of-Life (PPS 30 - 0%/ECOG/PRFS 4).The Edmonton Symptom Assessment System (ESAS)[5] is being used as a common symptom self screening tool for cancer patients in Ontario and therefore is referenced throughout the document.

Definition of Collaborative Care Plans
CCPs are interdisciplinary guides to practice designed to place the patient at the focal point of care, to promote continuity and coordination of care, and to promote communication amongst all disciplines. The CCPs define the activities, interventions and expected patient outcomes that should occur for patients requiring palliative services based on their functional performance as defined by Palliative Performance Scale[4] (PPSv2)/ECOG/Patient ECOG (Patient Reported Functional Status). The CCPs provide a guide to clinical practice but should never replace sound clinical judgment. Each patient is an individual and treatment should be modified according to the individual patient's needs and the particular circumstances.

Disclaimer
Care has been taken in the preparation of the information contained in this report. Nonetheless, any person seeking to apply or consult the report is expected to use independent clinical judgment in the context of individual clinical circumstances or seek out the supervision of a qualified clinician. Cancer Care Ontario makes no representation or guarantees of any kind whatsoever regarding the report content or use or application and disclaims any responsibility for its application or use in any way.

Acknowledgements
We would like to acknowledge the work of the Palliative Care Integration Project, Palliative Care Medicine, Queen's University who developed the original version of the CCPs. We would also like to acknowledge the provincial CCPs Working Group members who generously donated their time and expertise toward the development of this resource (refer to Table entitled CCPs Working Group for a complete list of the members).

How do levels of Palliative Performance Scale (PPSv2) version 2 *(developed by Victoria Hospice Society)/* ***Patient Reported Functional Status (PRFS) or Patient ECOG/ECOG compare?[1,2]***

	ECOG Level	Patient Reported Functional Status (PRFS) or Patient ECOG Level	PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
Stable Stage	0	0	100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
	1	1	90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
			80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
Transitional Stage	2	2	70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
			60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
	3	3	50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
			40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
End of Life Stage	4	4	30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
			20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
			10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
	5		0%	Death	-	-	-	-

*Home is defined as the person's usual residence (may include long term care facility)
Used with permission Victoria Hospice, 2006

COLLABORATIVE CARE PLAN FOR STABLE PATIENTS

[1] Ma et al. Interconversion of three measures of performance status: an empirical analysis. Eur J Cancer. 2010 Dec;46(18):3175-83
[2] Baracos et al. *Prognostic Factors in Patients With Advanced Cancer: Use of the Patient-Generated Subjective Global Assessment in Survival Prediction.* Journal of Clinical Oncology, October 1, 2010 vol. 28 no. 28 4376-4383.

<table>
<tr><th>DOMAINS OF ISSUES</th><th colspan="2">THE PROCESS OF PROVIDING CARE IN THE STABLE STAGE:
ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER</th></tr>
<tr><td rowspan="6">DISEASE MANAGEMENT

• Primary diagnosis, prognosis, evidence

• Secondary diagnoses (e.g., dementia, psychiatric diagnosis, substance use, trauma)

• Co-morbidities (e.g., delirium, seizures, organ failure)

• Adverse events (e.g., side effects, toxicity)

• Allergies</td><td>STEP 1 : ASSESSMENT</td><td>STEP 4: CARE PLANNING</td></tr>
<tr><td>Assess:
• Person and family’s understanding of disease, possible/ expected co-morbidities and prognosis
• Relevance of current disease management protocols e.g. ongoing investigations, medications, treatments, clinic visits, plan of treatment
• Monitor functional status scores on admission, per visit, quarterly (in LTC), and with any change in condition</td><td>• Develop a plan of treatment related to disease management that takes into account the person’s values and goals
• Mutually determined goals of care provide a foundation for all care planning</td></tr>
<tr><td>STEP 2: INFORMATION SHARING</td><td>STEP 5: CARE DELIVERY</td></tr>
<tr><td>• Determine need for translation
• Confirm confidentiality limits
• Address any deficits in understanding of disease, co-morbidities and prognosis</td><td>• Determine the professional care team member who will lead, coordinate and facilitate the functions and activities of the team
• Identify the most responsible physician
• Provide family and informal caregivers with the orientation, ongoing education, training and support required to ensure confidence and competence in provision of care
• If relocation of care delivery occurs, facilitate communication of the plan of care to the appropriate health care professional in the new setting through transfer of forms, or telephone consultation</td></tr>
<tr><td>STEP 3: DECISION-MAKING</td><td>STEP 6: CONFIRMATION</td></tr>
<tr><td>• Determine who the person wants to include in the decision making process (substitute decision maker if the person is incapable)</td><td>• Determine the person/family/team’s understanding of:
  • the prognosis
  • expected course of the illness
• Determine the person/family/team’s satisfaction with the current plan of treatment as it relates to management of the disease and co-morbidities</td></tr>
</table>

COLLABORATIVE CARE PLAN FOR STABLE PATIENTS

DOMAINS OF ISSUES

PHYSICAL

- Pain & Other Symptoms (other symptoms include, but are not limited to):
  - Cardio-respiratory: breathlessness, cough, edema, hiccups, apnea, agonal breathing patterns, effusions (pleural, peritoneal)
  - Gastrointestinal: nausea, vomiting, constipation, obstipation, bowel obstruction, diarrhea, bloating, dysphagia, dyspepsia
  - Oral conditions: dry mouth, mucositis
  - Skin conditions: dry skin, nodules, pruritus, rashes
  - General: agitation, anorexia, cachexia, fatigue, weakness, bleeding, drowsiness, fever/chills, incontinence, insomnia, lymphoedema, myoclonus, odor, prolapse, sweats, syncope, vertigo
- Level of consciousness & cognition
- Motor Function (e.g. mobility, swallowing)
- Sensory Function (hearing, vision)
- Physiologic Function
- (e.g. breathing, circulation, sexual)
- Fluids, nutrition
- Wounds
- Habits (e.g. alcohol, smoking)

THE PROCESS OF PROVIDING CARE IN THE STABLE STAGE: ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER

STEP 1 : ASSESSMENT

- Assess the person and family's knowledge and understanding of the ESAS score and their ability to use ESAS independently
- Monitor the ESAS scores on admission, per visit, quarterly (in LTC), or with any change in condition to identify any physical issues of concern
- Conduct a comprehensive physical assessment to identify any issues related to any of the body systems
- Any identified issue will require further in depth assessment
- Utilize validated assessment tools (e.g., comprehensive pain assessment)

STEP 2: INFORMATION SHARING

- Determine the person and family's desire for information at each visit
- Share information related to issues identified in a timely manner and in a language and manner understandable and acceptable to the person and family
- Openly discuss any requests related to management of physical symptoms (e.g., nutrition, hydration, dyspnea)

STEP 3: DECISION-MAKING

- Assess the person's decision making capacity whenever a decision related to treatment is being made
- Encourage person and family to consider their options and current goals and prioritize the importance of each of the identified issues
- Obtain informed consent for treatments based on options offered

STEP 4: CARE PLANNING

- Consider consult and/or referral to Palliative Care Team or Clinic for difficult/complex symptom management issues
- Initiate other interdisciplinary referrals
- Customize a plan of treatment that is flexible and aims to:
  - address the identified symptoms
  - respect the person's choices
  - respect the person's culture, values, beliefs, personality and preferences
  - support the desire for control, independence, intimacy and sense of dignity for as long as possible
  - proactively address emergent issues (e.g., who to call, what to do, escalating symptoms)
  - anticipates potential complications

STEP 5: CARE DELIVERY

- Facilitate caregivers' awareness of the resources and supplies necessary to deliver physical care based on current and anticipated needs (e.g., contact information list)
- Teach and evaluate the caregivers' understanding, knowledge and skill necessary to execute the plan of treatment (e.g., medication administration)

STEP 6: CONFIRMATION

- Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of physical issues

COLLABORATIVE CARE PLAN FOR STABLE PATIENTS		
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE STABLE STAGE: ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	
PSYCHOLOGICAL • Personality strengths, behaviour, motivation • Depression, anxiety • Emotions (e.g., anger, distress, hopelessness, loneliness) • Fears (e.g., abandonment, burden, death) • Control, dignity, independence • Conflict, guilt, stress, coping responses • Self-image, self-esteem	**STEP 1 : ASSESSMENT**	**STEP 4: CARE PLANNING**

	• Monitor ESAS scores per visit, quarterly (in LTC), on admission, or with any change in condition to identify any psychological issues of concern (e.g., depression, anxiety and well-being)
	• If required a comprehensive assessment should be done by a health care professional
	• Utilize validated assessment tools (e.g., comprehensive depression assessment tools)
	• Identify:
	  • strengths & vulnerabilities
	  • emotional and behavioural responses
	  • methods of coping
	  • realistic and unrealistic expectations
	  • previous losses
	  • level of tolerance for inconsistency and changes in the plan of treatment
	  • conflicted relationships
	• Explore person and family's fears, as appropriate
		• Customize a plan of care that is flexible and aims to:
		  • address the identified psychological issues (e.g., fears, anger, anxiety, depression, etc.)
		  • respect the person's choices
		  • respect the person's culture, values, beliefs, personality, and preferences
		  • support the desire for control, independence, intimacy and sense of dignity
		• With the permission of the person/family, refer to other team members/community resources as appropriate
		• Consider referral to Social Work/Mental Health/Spiritual/ Pastoral Care Consultant, Hospice and other volunteers

	STEP 2: INFORMATION SHARING	**STEP 5: CARE DELIVERY**
	• Respect the confidentiality limits as defined by the person • Share information in a timely manner and in a setting where privacy can be ensured	• Promote a setting of care that is safe, comforting and provides ample opportunity for privacy and intimacy • Be sensitive to changes that may cause anxiety for the person and family
	STEP 3: DECISION-MAKING	**STEP 6: CONFIRMATION**
	• Recommend individualized complementary therapeutic interventions aimed at relieving suffering and enhancing quality of life and that are not associated with undue risk or burden (e.g., music therapy, massage, guided imagery) • Voluntary consent is required for any treatment options offered	• Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of psychological issues

COLLABORATIVE CARE PLAN FOR STABLE PATIENTS		
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE STABLE STAGE: ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	

SOCIAL
• Cultural values, beliefs, practices
• Relationships, roles with family, friends, community
• Isolation, abandonment, reconciliation
• Safety, comforting environment
• Privacy, intimacy
• Routines, rituals, recreation, vocation
• Financial resources, expenses
• Legal (e.g., powers of attorney for business, for business, advanced directives, last will/ testament, beneficiaries)
• Family caregiver protection
• Guardianship, custody Issues
	STEP 1 : ASSESSMENT
	• Assess changes in roles and the impact within family unit
	• Identify issues related to;
	  ○ conflicted relationships
	  ○ mental health
	  ○ socio economic status
	• Identify the need for assistance with financial, legal affairs and issues related to future incapacity
	• Identify person and family's current and potential support system
	• Consider an in-depth assessment by a Social Worker
		STEP 4: CARE PLANNING
		• Encourage activities that will strengthen family bonds
		• Consider referral to Social Work, Legal/Financial Consultant, Hospice and other volunteer programs, First Nations and other cultural groups

	STEP 2: INFORMATION SHARING • Inform the person and/or family of the resources available in the community to address social issues • Share information about advance care planning	**STEP 5: CARE DELIVERY** • Be respectful of person's culture, values, beliefs, personality and preferences
	STEP 3: DECISION-MAKING • Encourage person and family to consider their options and current goals and prioritize the importance of each of the identified issues (e.g., financial, relationship, legal)	**STEP 6: CONFIRMATION** • Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of social issues

COLLABORATIVE CARE PLAN FOR STABLE PATIENTS		
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE STABLE STAGE** **ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	
SPIRITUAL • Meaning, value • Existential, transcendental • Values, beliefs, practices, affiliations • Spiritual advisors, rites, rituals • Symbols, Icons	**STEP 1 : ASSESSMENT**	**STEP 4: CARE PLANNING**

	• Monitor ESAS scores on admission, per visit, quarterly (in LTC), or with any change in condition to identify spiritual issues (e.g., anxiety, depression, well being, fatigue, pain)
	• Utilize comprehensive spiritual assessment tools
	• Explore with person and family:
	  • their meaning of life, death and preparedness for illness process
	  • their relationships
	  • the concept of anticipatory grieving
	  • their hopes and fears
	  • beliefs and practices that have sustained them in the past
	• Consider an in-depth assessment by a Spiritual Advisor
		• Customize a plan of treatment that is flexible and aims to:
		  • Respect the person's and family's culture, values, beliefs, personality and preferences
		  • incorporate the icons, symbols, rites and rituals that have particular meaning to the person
		  • make the environment conducive to reflection, compassion, tenderness, transcendence, love, the sacred
		  • acknowledge hope
		  • reframe goals into short term tasks that can be accomplished
		• Consider referral to Pastoral/Spiritual Advisor or other team member

	STEP 2: INFORMATION SHARING	**STEP 5: CARE DELIVERY**
	• Facilitate timely and uninterrupted interactions • Allow the person to express fears and suffering without hesitation or shame • Discuss goals	• Team members employ the appropriate communication skills that are key to sensitive discussions • Avoid quick fix responses and religious clichés • Listen; meaning comes from within the person and is best discovered by the person telling his or her story and the caregiver listening
	STEP 3: DECISION-MAKING	**STEP 6: CONFIRMATION**
	• Offer options to both person and family members in support of spiritual healing (e.g., journaling of thoughts and feelings, meditation, music) • Determine what rituals and devotional practices would have meaning in the circumstances and obtain consent to incorporate them into the plan of treatment	• Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of spiritual issues

<table>
<tr><th colspan="3">COLLABORATIVE CARE PLAN FOR STABLE PATIENTS</th></tr>
<tr><th>DOMAINS OF ISSUES</th><th colspan="2">THE PROCESS OF PROVIDING CARE IN THE STABLE STAGE
ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER</th></tr>
<tr><td rowspan="6">PRACTICAL

• Activities of daily living (e.g., personal care, household activities)

• Dependents, pets

• Telephone access, transportation</td><td>STEP 1 : ASSESSMENT</td><td>STEP 4: CARE PLANNING</td></tr>
<tr><td>• Assess practical needs:
  • Functional assessments (e.g., activities of daily living)
  • Children’s needs
  • Caregiver’s needs</td><td>• Develop a plan of treatment that incorporates interventions to maintain independent functioning for as long as possible
• Facilitate timely access to equipment
• Facilitate appropriate referrals (e.g., physiotherapy, occupational therapy)</td></tr>
<tr><td>STEP 2: INFORMATION SHARING</td><td>STEP 5: CARE DELIVERY</td></tr>
<tr><td>• Facilitate family members’ awareness of available local community resources</td><td>• Minimize changes in care plan
• Promote a consistent, consensual and coordinated care plan</td></tr>
<tr><td>STEP 3: DECISION-MAKING</td><td>STEP 6: CONFIRMATION</td></tr>
<tr><td>• Determine what services/resources the person/family are prepared to accept</td><td>• Determine the person/family/team’s satisfaction with the plan of treatment as it relates to the management of practical issues</td></tr>
</table>

COLLABORATIVE CARE PLAN FOR STABLE PATIENTS		
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE STABLE STAGE: ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	
END OF LIFE CARE/ DEATH MANAGEMENT • Life closure (e.g., completing business, closing relationships, saying goodbye) • Gift giving (e.g., things, money, organs, thoughts) • Legacy creation • Preparation for expected death • Anticipation & management of physiological changes in the last hours of life • Rites, rituals • Pronouncement, certification • Perideath care of family, handling of the body • Funerals, memorial services, celebrations	**STEP 1 : ASSESSMENT** • Assess level of burden and stress being experienced by the caregivers • Assess and review resuscitation status • Explore what the person and family know and what they don't know (e.g., prognosis, dying process)	**STEP 4: CARE PLANNING** • Facilitate the implementation of a plan of treatment that addresses the physical, psychological, cultural and spiritual needs of the person, family and informal caregivers • Develop a plan with the family regarding access to 24/7 telephone support • Confirm the completion of the Do not Resuscitate Confirmation Form (DNRC form) in Ontario for person who has chosen no CPR • Discuss the (in)appropriateness of calling 911
	STEP 2: INFORMATION SHARING • Explore and discuss questions that the person and family may have	**STEP 5: CARE DELIVERY** • Promote a calm, peaceful and comfortable environment for the person and family regardless of the setting • Encourage and support life review, when appropriate
	STEP 3: DECISION-MAKING • Identify goals and expectations of care	**STEP 6: CONFIRMATION** • Determine the family/team's satisfaction with the plan of treatment as it relates to the management of end-of-life care/death issues

COLLABORATIVE CARE PLAN FOR STABLE PATIENTS		
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE STABLE STAGE: ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	
LOSS, GRIEF • Loss • Grief (e.g., acute, chronic, anticipatory) • Bereavement planning • Mourning	**STEP 1 : ASSESSMENT** • Identify previous losses • Identify person and family members' previous and current coping (e.g., alcohol use and substance use) • Assess for evidence of suicidal ideation • Identify person and family members who are at risk for complicated grief (e.g., multiple unresolved losses, death of a child) • Utilize comprehensive assessment tools	**STEP 4: CARE PLANNING** • Incorporate cultural and spiritual rites and rituals that have meaning for the family into the plan of treatment (e.g., gift giving, legacy creation, memory boxes, hand casts) • Refer to appropriate Health Care Providers for advanced interventions (e.g., suicidal ideation) • Consider referral to Spiritual Advisor, Pastoral Care, Grief Counselor, Hospice and other Volunteer programs
	STEP 2: INFORMATION SHARING • Encourage the person and/or family to express feelings and emotions • Share information about the grieving process and anticipatory grief • Provide examples of rituals that can facilitate healthy grieving • Provide age appropriate information about grief responses.	**STEP 5: CARE DELIVERY** • Provide age specific resources for those who are grieving
	STEP 3: DECISION-MAKING • The person and family determine the support desired unless there is evidence of suicidal ideation.	**STEP 6: CONFIRMATION** • Determine the person/family/teams' satisfaction with the plan of treatment as it relates to the management of loss and grief issues

References

1. Kingston Frontenac, Addington and Leeds Palliative Care Integration Project, Collaborative Care Plans, Palliative Care Medicine Queen's University March 2006
2. Ferris FD, Balfour HM, Bowen K, Farley J, Hardwick M, Lamontagne C, Lundy M, Syme A, West P. A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice. Ottawa, ON: Canadian Hospice and Palliative Care Association, 2002 http://www.chpca.net/
3. Refer to Table below for list of Working Group Members
4. Victoria Hospice, 2003 Palliative Performance Scale (PPSv2)
5. Alberta Health Services (previously Capital Health) Regional Palliative Care Program. Edmonton Symptom Assessment System (ESAS)

Regional Educational Programs

CAPCE - **C**omprehensive **A**dvanced **H**ospice **P**alliative **C**are **E**ducation **P**rogram for **N**urses **-** The program focuses on developing a Hospice Palliative Care Resource Nurse within the health care provider organization in which they work – long-term care homes, hospices, hospitals, Community Care Access Centres` and community nursing agencies.

LEAP- **L**earning **E**ssential **A**pproaches to **P**alliative and **E**nd-of-Life Care - The 2.5 day LEAP course offers an opportunity for active learning about current best-practice in caring for patients with life-threatening and life-limiting illness, with a special focus on family practice and community settings.

CCPs Working Group Members

Stephanie Buchanan Clinical Practice Leader Bayshore Home Health	Kathy Coulson Advanced Practice Nurse, Palliative Care Kingston General Hospital
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