Fondazione Guido Berlucchi
Organizzazione Non Lucrativa di Utilità Sociale (ONLUS)

FONDAZIONE FLORIANI
UNA RISPOSTA ALLA SOFFERENZA DEI MALATI INGUARIBILI

interRAI Palliative Care for assessment of patient's needs: Italian Teseo-Arianna Project

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Director of the Section for the implementation of the principles in Law 38 of 15 March 2010, containing rules to ensure the access to palliative care and pain therapy - Technical Committee for Health - Ministry of Health (DM 20 May 2015 Ministry of Health)

Agenda

1. Introduction
2. Identification
3. Assessment
4. Results
5. Conclusions

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ICO Institut Català d'Oncologia

WHO Collaborating Centre for Housing and Health

PUBLIC HEALTH'S FUTURE CHALLENGE

How to improve care of identified patients? (1/2)

	Actions	Recommendations
1	**Multidimensional assessment** of situation and start of integrated person-centered care	Explore all dimensions (physical symptoms, emotional, social, spiritual, …)with validated tools Start integrated care process Assess caregivers' needs
2	Explore values, performance and worries of **patients and families**	Gradually start Advance Care Planning
3	**Revise illness/condition** status	Revise status, prognostic, objectives, possible complications Recommendations for prevention and response to crisis. Bear in mind static (severity) and dynamic (evolution or progression)aspects
4	**Revise treatment**	Update objectives, therapeutic adjustment, de-prescribing if necessary, therapeutic conciliation among services
5	Identify and take care of main **caregiver**	Needs and demands: Assessment (caring capacity, adjustment, complicated grief risk), Education and support, Empowerment

How to improve care of identified patients? (2/2)

	Actions	Recommendations
6	**Involve team** and identify responsible	In: Evaluation, Therapeutic Plan, Roles Definition in follow-up and emergency care
7	Define, share and start **Comprehensive and Multidimensional Therapeutic Plan**	Respecting patients' preferences, managing all dimensions, using the square of care, involving teams
8	**Integrated Care**: Organize care provision with all services involved with particular focus on defining the role of the specific palliative care and emergency services	Start case management and preventive care, shared-decisions process, care pathways between services, organizing transitions, building consensus among services, involve patients in the proposals
9	Registry and **share** relevant clinical **information** with all services involved	Shared clinical charts, sessions
10	Assess, review and **monitor results**	Frequent reviews and updates, audit post-care, generate evidence

How to improve palliative care in health and social services? (1/2)

Measures to improve palliative care	
1	Design, establish and protocol a **formal proposal of improvement**
2	**Determine prevalence and identify persons** with palliative care needs with validated instruments
3	Establish protocols, registries and instruments based on evidence to **assess patients' needs** and respond to the most prevalent ones
4	T**rain the healthcare professionals** in palliative care
5	Identify main **caregivers** and offer them support and education, including grief care

How to improve palliative care in health and social services? (2/2)

Measures to improve palliative care	
6	I**ncrease team work**
7	In services with high prevalence, designate specific professionals (referents)with or advanced intermediate education and specific timeframes for palliative care
8	Increase offer and intensity of caring focused on improving identified patients' **quality of life**
9	**Integrated care:** to establish care pathways, intervention criteria for conventional and specific services, to define roles in conventional, continuous and urgent care, to coordinate and share information among settings
10	Take into account and respond to **ethical challenges** of timely identification: to promote benefits and reduce risks and guaranteeing the patients' rights

Objectives

- ✓ Foster the assess to PC by early identifying people with chronic diseases, both cancer and non cancer, with limited life expectancy
- ✓ To test, within the Local Network of PC, an organizational model based on multidimensional evaluation and on the integration between primary and specialized care, as expected by the intesa Stato Regioni del 25/7/2012

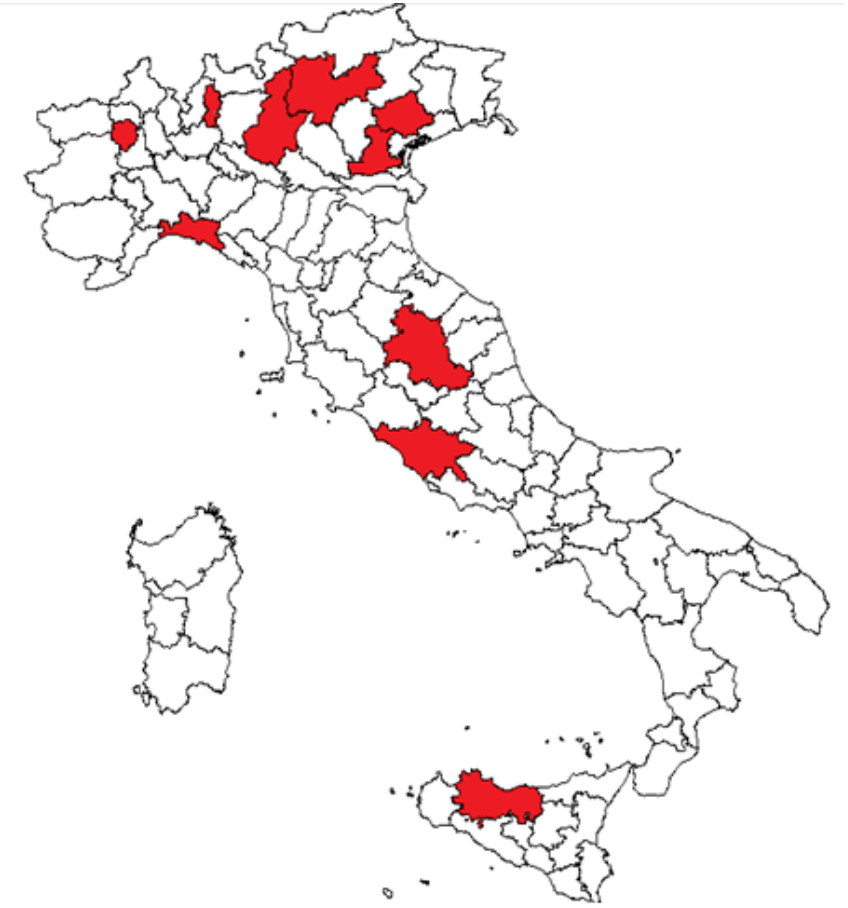
Methods

- ✓ The adoption of certified tools able to guarantee the **early identification (GSF)** and the **multidimensional assessment** of patients with needs of Palliative Care **(interRAI – PC)**
- ✓ The creation of a **structured and efficient system to communicate clinical care information** within all professionals (**Teseo-AriannaMG** e **Atlante**)
- ✓ The evaluation of interventions through the systematic collection and statistical analysis of structural, process and outcomes indicators

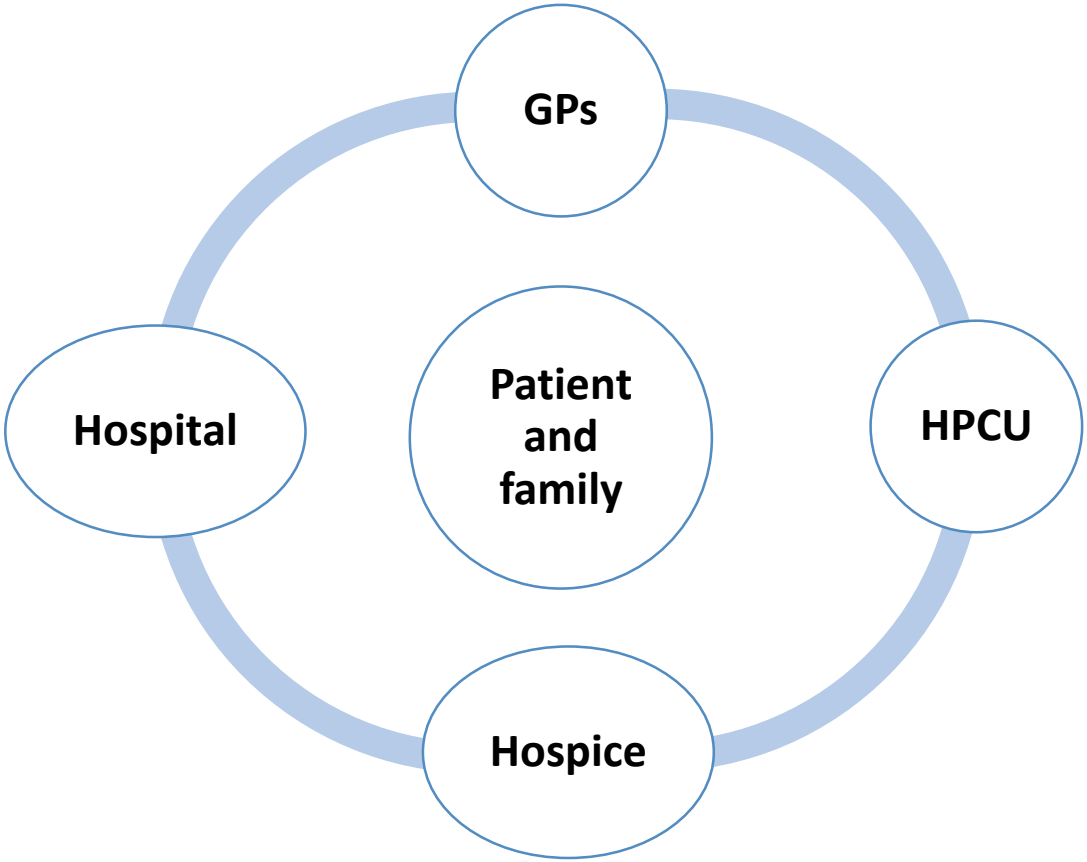
Methods – Multicenter observational longitudinal study

The study involved:

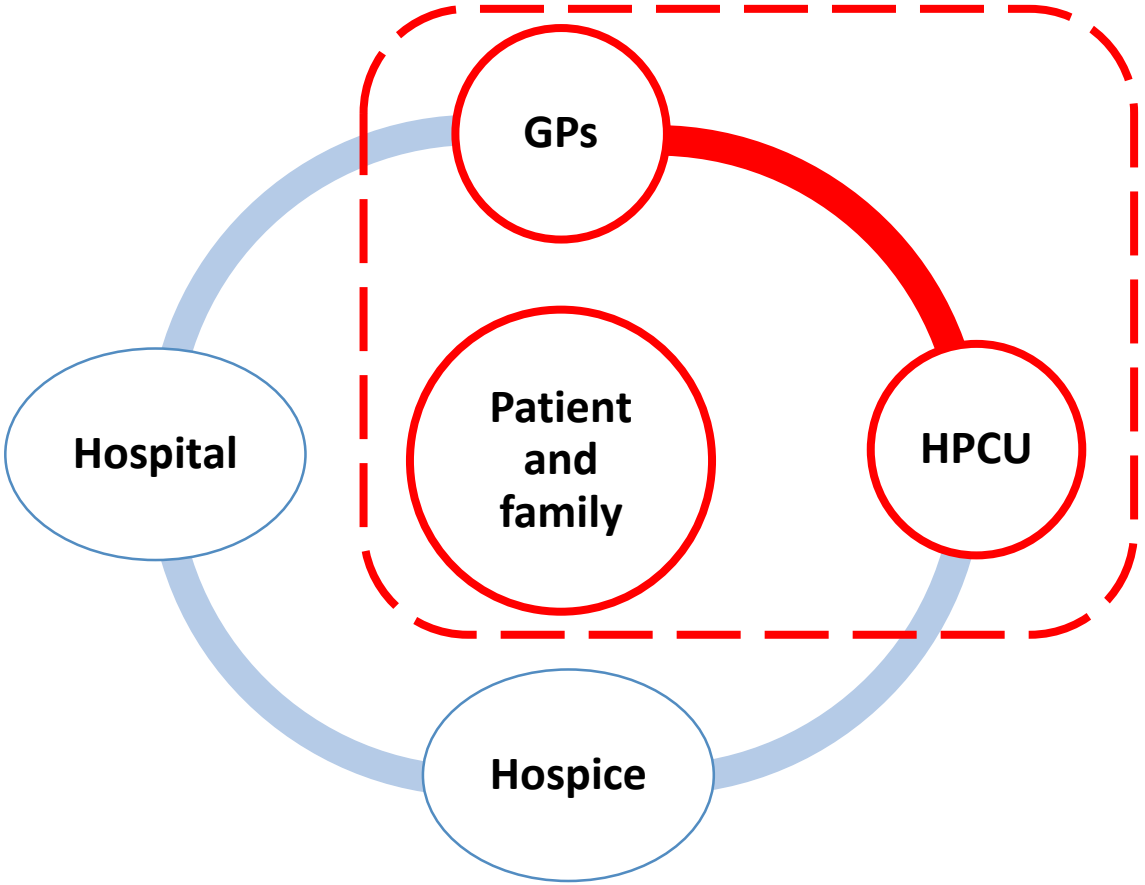
- ✓ **10 Home Palliative Care Units (HPCUs)**:
  - **Primary PC** (GPs + consult by PC physician and nurse)
  - **Specialized** (PC physician and nurse + GPs and other professionals)
- ✓ **94 GPs**



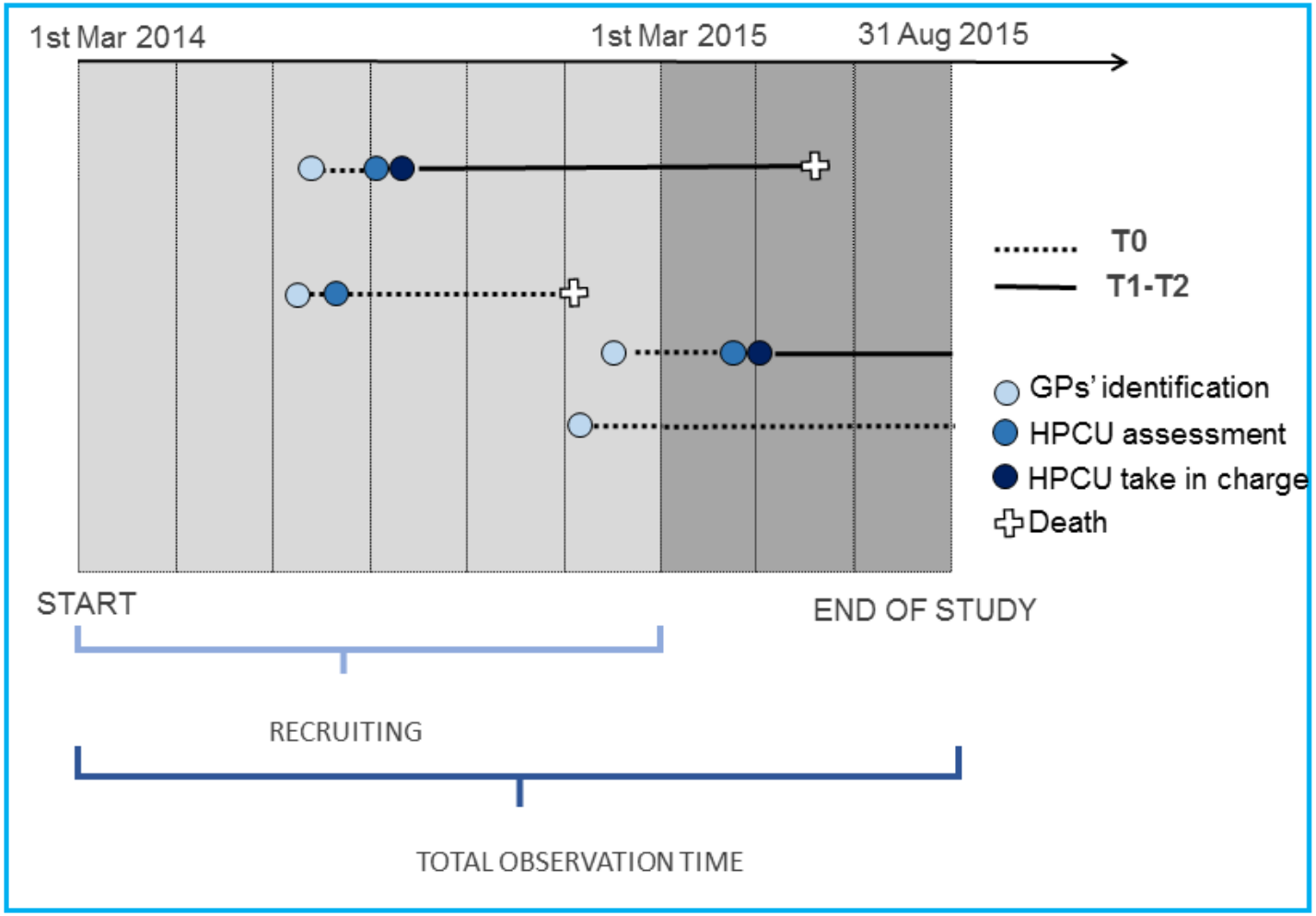
Local Network of Palliative Care



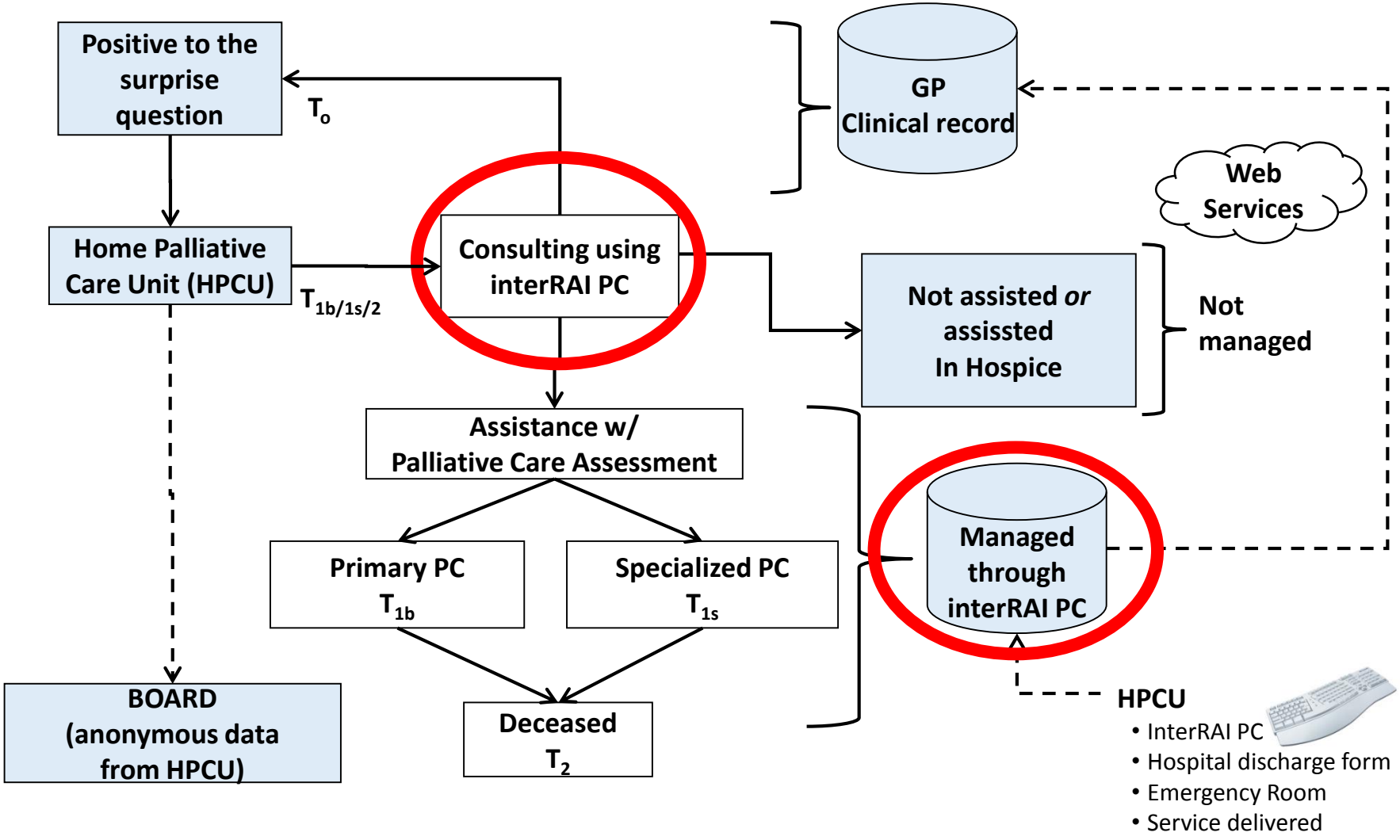
Teseo-Arianna's Focus



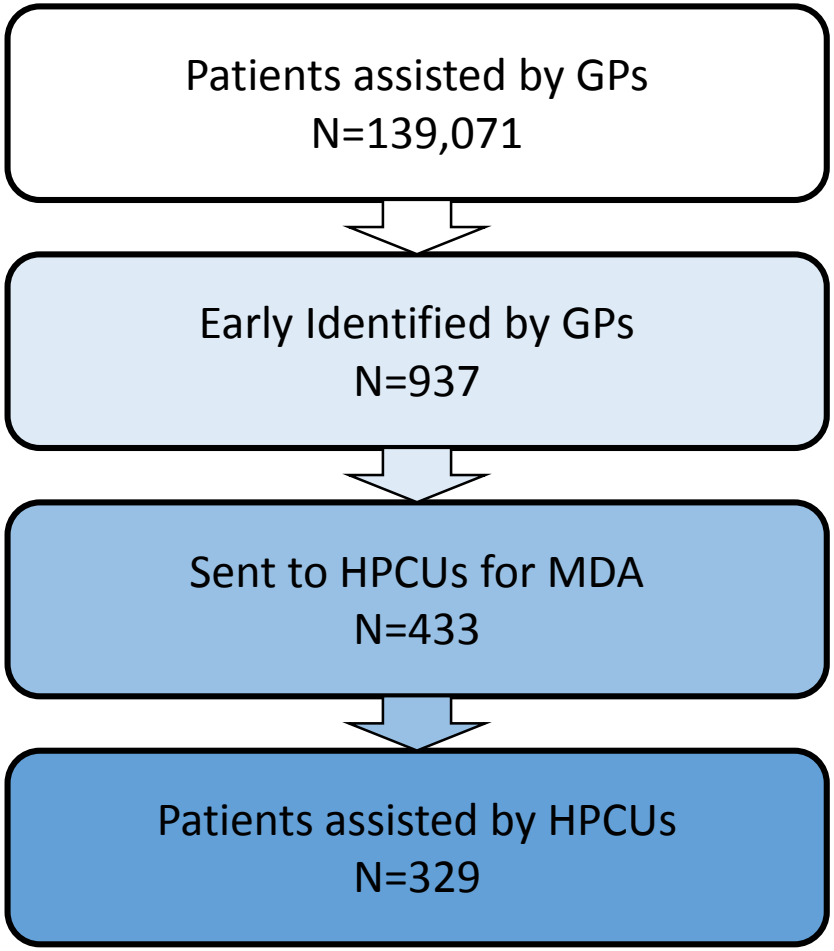
Methods – Study Design



Methods – ICT infrastructure and data exchange



Results – Flow Chart



the gold standards framework

Atlante

interRAI

interRAI Assessment System PC

interRAI Palliative Care (PC)

Key Points

World Health Organization

Early identification

1.IDENTIFICATION

the gold standards framework®

World Health Organization

Impeccable assessment

2.ASSESSMENT

interRAI™
interRAI Assessment System PC
interRAI Palliative Care (PC)

3.PLAN

Results - Early identification

Tool based on **GSF** («GSF Prognostic Indicator Guidance»):

- **Surprise Question**: *"Would you be surprised if this patient were to die in the next 12 months?"*
- General indicators of decline-deterioration
- Specific clinical indicators related to certain conditions

	Total	> 75 years
Identified T0	937	732
% on Assisted Patients	0.67%	3.67%

Positive Predictive Value (PPV) *of the tool =*
Dead before 1 year / All identified
517 / 937 = 55.2%

Incidence	0.67%
Prevalence	ca. 1-1.5%

Gòmez-Batiste X. et al. «Prevalence and characteristics of patients with advanced chronic conditions in need of palliative care in the general population: a cross-sectional study." Palliative Medicine 2014; 28(4): 302–311

Results - Main characteristics of Patients (N = 937)

Variable	Coding	Results
Age in years, median	Years	82.4 (IQR= 12.9)
Sex, n (%)	F	515 (55.0%)
	M	422 (45.0%)
Cancer	Yes	556 (59.3%)
	No	381 (40.7%)
Deceased	Yes	517 (55.2%)
	No	420 (44.8%)

Multidimensional Assessment in Palliative Care

1ª Generation

Evaluation of only one problematic area
E.g.: ADL , IADL, MMSE, etc..

2 ª Generation

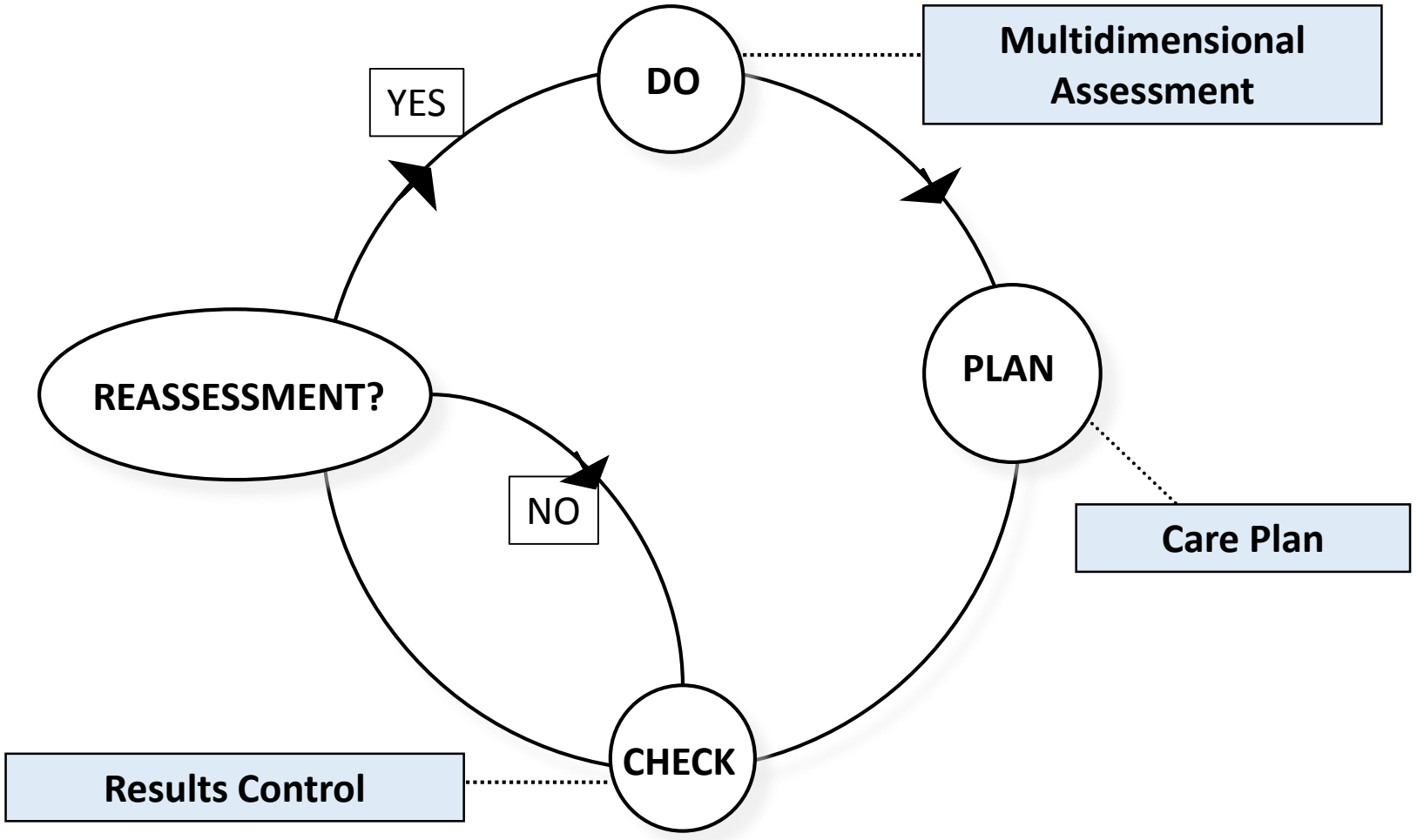
They have all-comprehensive value (>350 items)
They are specific for settings of care
They include symptoms evaluation, scales and treatments

3 ª Generation

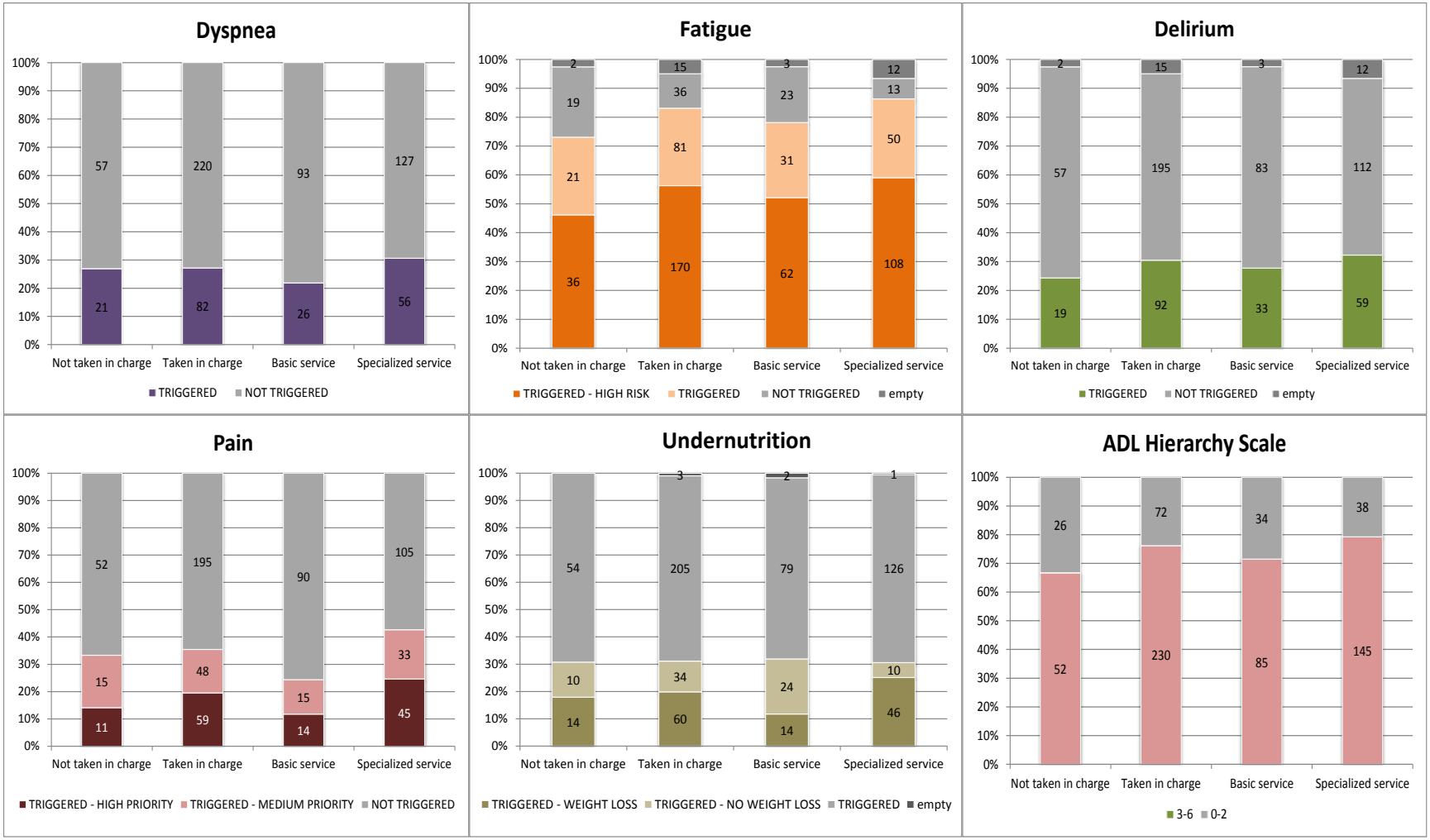
They are the actual evolution: E.g. Inter RAI
Modularity: 70% of common items, 30% «specific» settings
They foster the continuity of information management
They support the care planning
They stimulate the development of ICT

R. Bernabei et al. "Second and Third Generation Assessment Instruments: The Birth of Standardization in Geriatric Care" . Journal of Gerontology 2008 Vol. 63°, N° 3 308-313

Multidimensional Assessment and «dynamic» governance of care pathway



InteRAI - Palliative Care

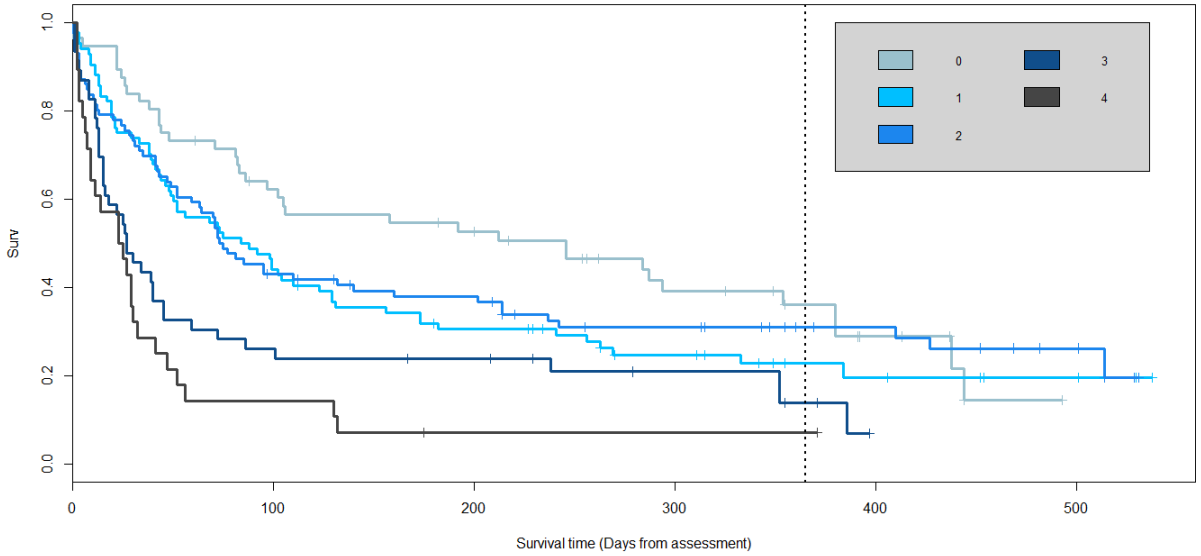


CHESS

CHESS measures the clinical complexity and instability of the health status such as: vomiting, dehydration, leftover food, weight loss, shortness of breath, edema, the final stage of the disease, the decline cognition and ADL.

Higher scores indicate higher levels of clinical **complexity**.

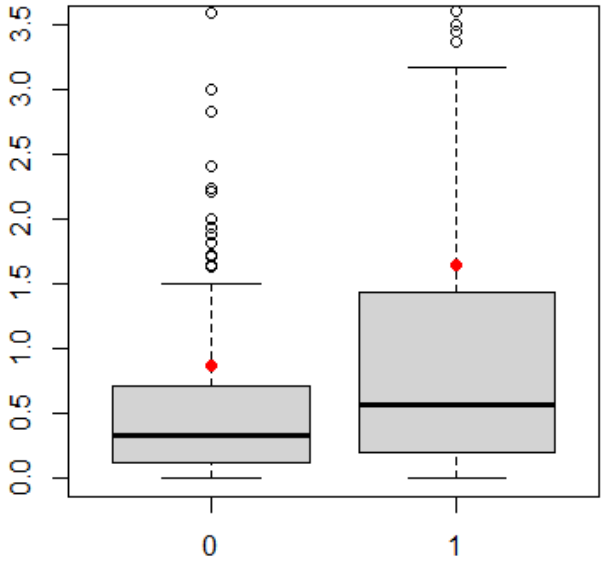
Survival Analysis stratified by CHESS index



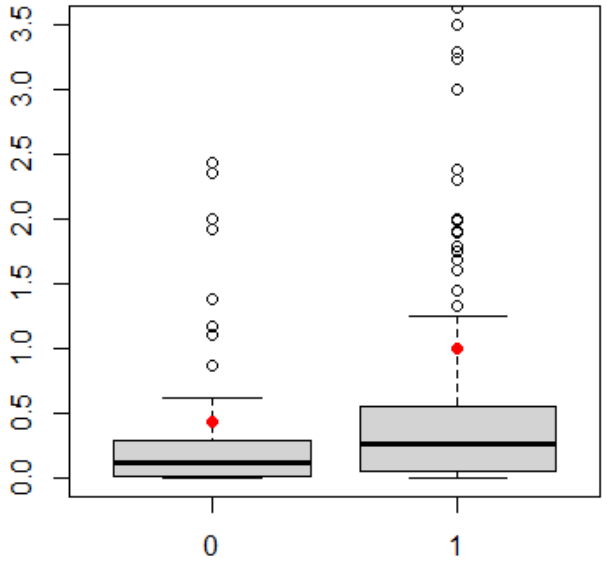
COX MODEL: Factors associated with mortality				
		HR	lower .95	upper .95
SEX	M	1.360	1.0377	1.781
ONC	onc	2.943	2.1864	3.961
PHP.	CHESS.1	1.462	0.9730	2.197
PHP.	CHESS.2	1.335	0.8847	2.015
PHP.	CHESS.3	2.836	1.7894	4.494
PHP.	CHESS.4	3.319	1.9804	5.563

Relation CHESS and professionals' accesses

Relation between NURSE accesses and CHESS



Relation between MED accesses and CHESS

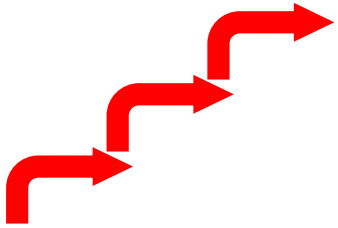


Group 0: CHESS 0,1
Group 1: CHESS 2,3,4

Kruskal-Wallis test (H0: same median):

p-value = 0.004618

p-value = 0.0002862

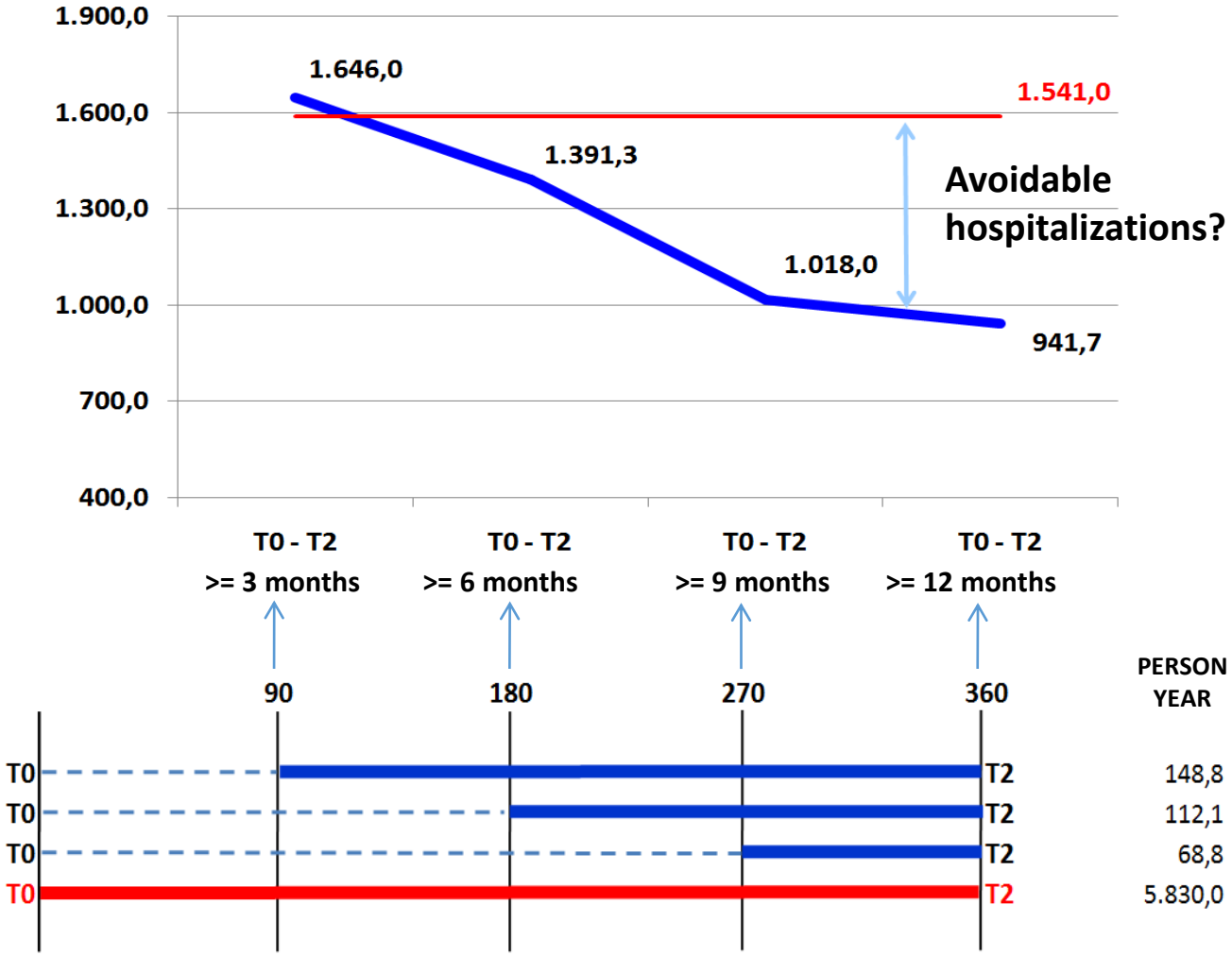


Results

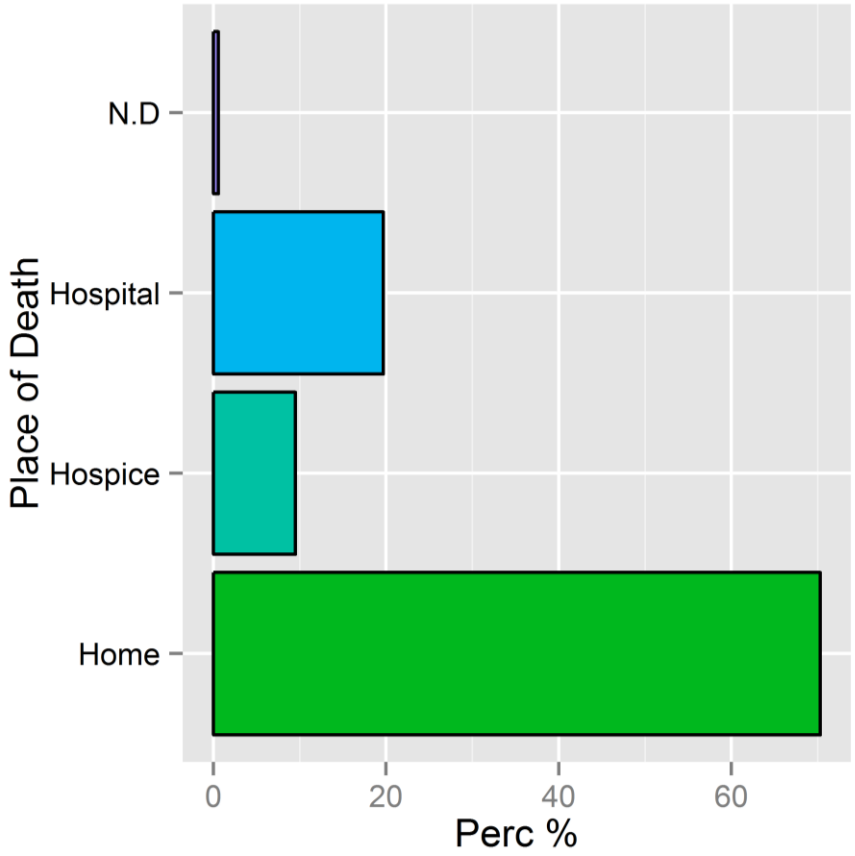
HOSPITALIZATION RATE

PLACE OF DEATH

Hospitalization rate for 1.000 - T_0-T_2 path



Place of Death



Place of Death	N	%
N/A	3	0.6
Hospital	102	19.7
Hospice	49	9.5
Home	364	70.3

Wheatley VJ, Baker JI. "Please, I want to go home": ethical issues raised when considering choice of place of care in palliative care. Postgrad Med J. 2007 Oct;83(984):643-8. Review.

Conclusions / 1

Why is it necessary an integrated care path?

- The needs have changed (patients with advanced and chronic conditions)
- It is necessary to reorganize the network of services, designing new models
- It is essential to adopt appropriateness criteria (evidence of effectiveness, fairness, proportionality, ethics, sustainability

Which are the core features?

- Early identifications
- Multidimensional assessment
- Care planning
- Multidisciplinary
- Training of professionals

Conclusions / 2

What is needed to achieve it?

- Shared protocols between primary and specialized care
- Primary Palliative Care (patients and families in touch with PC)
- Organizational and welfare standards (PC network, Primary PC, Specialized PC)
- Dedicated information systems ICT

How to measure the results?

- Process indicators: care planning in relation to assessed needs, intensity and duration of primary care, intensity, complexity and duration of PC
- Outcome indicators: symptoms control, use of hospital admissions, place of death