Redefining Palliative Care

Palliative care and end-of-life care are terms often used interchangeably in the medical field. In cancer care, palliative care was historically provided at hospices for patients with a bleak prognosis in an effort to make their last days comfortable and pain-free. As a result, palliative care was defined as being end-of-life care, provided for patients who were not receiving any treatment to actively treat their disease. As new research and treatment for cancer emerges, the role of palliative care has evolved.

Today, palliative care plays an important role not only in end-of-life care, but throughout a patient’s trajectory. Recent studies show that palliative care offered to patients earlier on in their cancer journey can significantly improve quality of life during active treatment and can increase survival rates. Hospice care, or end-of-life care, is a type of palliative care but the two are not mutually exclusive. It’s more than providing comfort at the end of a person’s life. Palliative care, as defined by the Canadian Hospice/Palliative Care Association, “is aimed at relieving suffering and improving the quality of life for persons who are living with or dying from advanced illness or in bereavement.” Focusing on a broad range of physical and psychological impacts from cancer, it can include: pain and symptom management, caregiver support, psychological, cultural, emotional and spiritual support, for patients as well as family members.

“Many aspects of palliative care are applicable earlier in the course of a disease,” says Dr. Anita Singh, Regional Palliative Care Lead. “Palliative care can, and often should, be provided alongside a person’s treatment — whether that be at the beginning of a person’s journey or at the end.”

Introducing palliative care early in the disease perspective is also an important mandate of Cancer Care Ontario (CCO). CCO has established recommendations on the organization and delivery of palliative care services in Ontario through their Regional Models of Care for Palliative Care.

In the South West, the South West Regional Cancer Program and the LHIN, along with many community partners have begun to take a closer look at hospice and palliative care throughout the region. Five collaborative tables have been set up to review current state and key issues in palliative care including: broad access and timeliness, caregiver supports, service capacity and human resources care settings, improving integration and continuity of care across care settings, accountabilities and building public awareness.

The goal of these collaboratives is to establish effective hospice and palliative care services that are standardized, easily accessible, and that will support the communities throughout the region.

On May 1 the South West Regional Cancer Program hosted its first ever Surgical Oncology Quality Symposium. This one day symposium, hosted at the Lamplighter Inn in London, saw multidisciplinary care providers from across the cancer system come together to educate, innovate, and inspire.

Brachial of Dr. Stephen Pautler, Regional Surgical Oncology Lead, the day offered a platform for cancer surgeons and health care professionals to discuss current issues and future directions of surgical oncology, in an effort to share knowledge and build collaborative approaches to these issues. According to Dr. Pautler, “Surgical quality was a topic rarely discussed 20 years ago. Over the past couple decades, surgeons, hospital leaders, government, and the public have recognized the need to talk about the topic. The symposium was a step in the right direction.”

Presentations were delivered by various providers from hospitals across the South West region and beyond. Topics included: the impact of pathology on surgical oncology success, surgical specific outcomes in Ontario, current successes, and future direction. Among the presenters was Dr. Jonathan Irish, Provincial Head, Surgical Oncology Program, Cancer Care Ontario, who spoke on the topic of wait times as an important measure of quality. Presentations were padded with stimulating questions and group discussion.

Dr. Brent Hollebeck, Associate Chair for Research, Divisions of Oncology and Health Services Research, University of Michigan, provided the keynote address. Focusing on the importance of collaborative quality improvement, Dr. Hollebeck explained how state-wide surgical quality was created and changed in Michigan through the Michigan Urological Surgery Improvement Collaborate (MUSIC) and the Michigan Bariatric Surgery Collaborative (MBSC). “We don’t have the luxury of a coach (for technique or decision making) once we finish residency,” Dr. Hollebeck explained during his presentation, “hence, the beauty of a collaborative.”

The day was capped off with small group discussions related to key quality issues in cancer surgery including, standardizing Hepato-Pancreato Biliary (HPB) synoptic reporting.

All presentations from the day have been posted in the Partner’s Area of southwestcancer.ca under News/Bulletins.

Sharing Knowledge, Improving Quality
Creating Change Through Collaboration

In 2001, the Aboriginal Cancer Care Unit (ACCU) of Cancer Care Ontario (CCO) conducted a province wide analysis of cancer issues in the Aboriginal population. The purpose was to explore Aboriginal people’s attitudes and experiences with cancer services, in order to establish an evidence based rationale for the development of an Aboriginal Cancer Strategy (ACS).

There are more Aboriginal people living in Ontario than any other province in Canada. Due to these numbers and higher rates of exposure to harmful risks, cancer is expected to increase more for Aboriginal Ontarians than for the general population.

Cancer Care Ontario is working in close collaboration with Ontario’s Aboriginal leaders to create the third edition of the Aboriginal Cancer Strategy (ACSIII). The Strategy builds upon the success of the first two documents, and sets out to develop plans and solutions to continually improve our contributions to the cancer system, "to improve our attitudes and experiences with cancer services, in order to establish an evidence based rationale for the development of an Aboriginal Cancer Strategy (ACS)."

As Aboriginal Navigator, Chantel liaises with and advocates for the needs of First Nation, Inuit & Metis patients with cancer and their families within the cancer program and with other groups involved in cancer care. She also works to improve access to cancer services, while addressing cultural and spiritual needs.

PROFILE: Aboriginal Patient Navigator
Chantel Antone: Chantel is from the Oneida Nation of the Thames, located approximately 20 k.ms southwest of London, and has worked for First Nations (FN) for 18 years. Her work has been primarily for the Chiefs of Ontario, a political body which oversees the 133 First Nations in Ontario, and has assisted in an advocacy role to address First Nations issues in relation to social services. Previously, Chantel worked for the Ene St. Clair Regional Cancer Program on an under/never screened research project that targeted FN(First Nations, Inuit & Metis) people.

Chantel has two young children, and is passionate about hockey. “Having children helped me to realize the importance of healthy living not just for myself but for my family. I want to find ways to promote healthy living for our First Nations People and communities.” Chantel’s health journey led her to the field of nursing. Chantel is a registered practical nurse and is currently enrolled part-time in the RN BScN program.

As Aboriginal Navigator, Chantel liaises with and advocates for the needs of First Nation, Inuit & Metis patients with cancer and their families within the cancer program and with other groups involved in cancer care. She also works to improve access to cancer services, while addressing cultural and spiritual needs.

As identified in this year’s results, some areas where further improvements are needed include reducing the number of unplanned visits to the hospital following chemotherapy and radiation therapy, and standardizing care through guideline-recommended chemotherapy for non-small cell lung cancer patients following surgery. The 2014 CSQI results also show that only 62 per cent of those who participated in the annual patient satisfaction survey for symptom management indicated that their healthcare team talked to them about their Edmonton Symptom Assessment System (ESAS) scores. Focusing on improvements in these areas not only impacts the type of care received, but also improves the overall experience for our patients.

In the South West, we are doing exceptionally well with regards to breast screening participation. We have the second highest breast screening participation (OBSP + non-OBSP) rate in the province. Of all women screened in the SW LHIN, 83% received their mammogram through OBSP. There are also areas where improvements are required – breast screening (follow up of abnormal results), PET/CT utilization and wait times, and FDOT participation.

“We are committed to working with hospitals and health care providers across the region to develop plans and solutions to continually improve our contributions to the cancer system,” said Neil Johnson, Regional Vice President.

To better educate healthcare professionals on cultural sensitivity when working with First Nations, Inuit and Metis (FNIM) patients, CCO is developing a series of E-modules. The modules are CME-accredited and will be available to providers across the province later this summer.

An Aboriginal Palliative Care Resource Toolkit is also being developed that contains a series of pamphlets on palliative care along with a reference binder of materials. These materials were created in collaboration with FNIM communities and are intended to provide:

- a working definition of palliative care to share with FNIM communities;
- information to support decision-making and planning for those with advanced cancer;
- information to help primary caregivers in caring for their loved ones with advanced cancer; and
- personal stories and other resources to help FNIM communities develop capacity in palliative care.

Resources will be shared when available.

Alcohol Consumption Linked to New Cancer Cases
As many as 3,000 new cancer cases each year in Ontario can be attributed to alcohol consumption, according to a report released by Cancer Care Ontario.

The findings of the report demonstrate that a substantial number of cancers diagnosed in Ontario could be prevented by reducing alcohol consumption in the population, but that more awareness is needed. The report also shows that in the South West region, approximately 11% of people report drinking in excess of alcohol consumption recommendations for cancer prevention.

“We have raised awareness of the harm caused by drinking and driving, says Dr. Jan Owen, Regional Primary Care Lead for the South West Regional Cancer Program. “Now it is time to raise awareness of the strong link between alcohol and cancer.”

Drinking has been shown to contribute to several cancers including:

- oral
- larynx
- colorectal
- breast

Understanding of the effects of alcohol consumption on cancer risk has been found to be low, with only one third of Canadians aware of the link between drinking and cancer. “Many Ontarians are aware of the link between tobacco use and cancer, but there is much less awareness of the increased risk for cancer that comes with drinking alcohol,” says Dr. Linda Rabeneck, Vice President of Prevention and Cancer Control for Cancer Care Ontario. “That’s why this report is not only helpful for our partners in the public health system, but also for Ontarians who are consuming alcohol.”

According to recommendations from the Canadian Cancer Society, if alcoholic drinks are consumed, the number of drinks should be limited to less than one drink a day for women and less than two drinks a day for men.