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palliative care outcomes collaboration

PCOC for Irish Palliative Care Services

National Clinical Programme for Palliative Care

M. O'Reilly & F. Twomey
November 2023

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Origins of PCOC

- Initiated in 2005 in Australia; benchmarks since 2009
- Government funded
- 95% of Australian palliative care services submit data
- Clear evidence – improves palliative care patient outcomes

- Currow, DC, Allingham, S, Yates, P, Johnson, C, Clark, K, Eagar, K. (2015) Improving national hospice/palliative care service symptom outcomes systematically through point-of-care data collection, structured feedback and benchmarking.
- Eagar, K., Watters, P., Currow, D. C., Aoun, S. M., & Yates, P. (2010). The Australian Palliative Care Outcomes Collaboration (PCOC)--measuring the quality and outcomes of palliative care on a routine basis.
- Clapham, S., Daveson, B. A., Allingham, S. F., Morris, D., Blackburn, P., Johnson, C. E., & Eagar, K. (2021). Patient-reported outcome measurement of symptom distress is feasible in most clinical scenarios in palliative care: an observational study involving routinely collected data.

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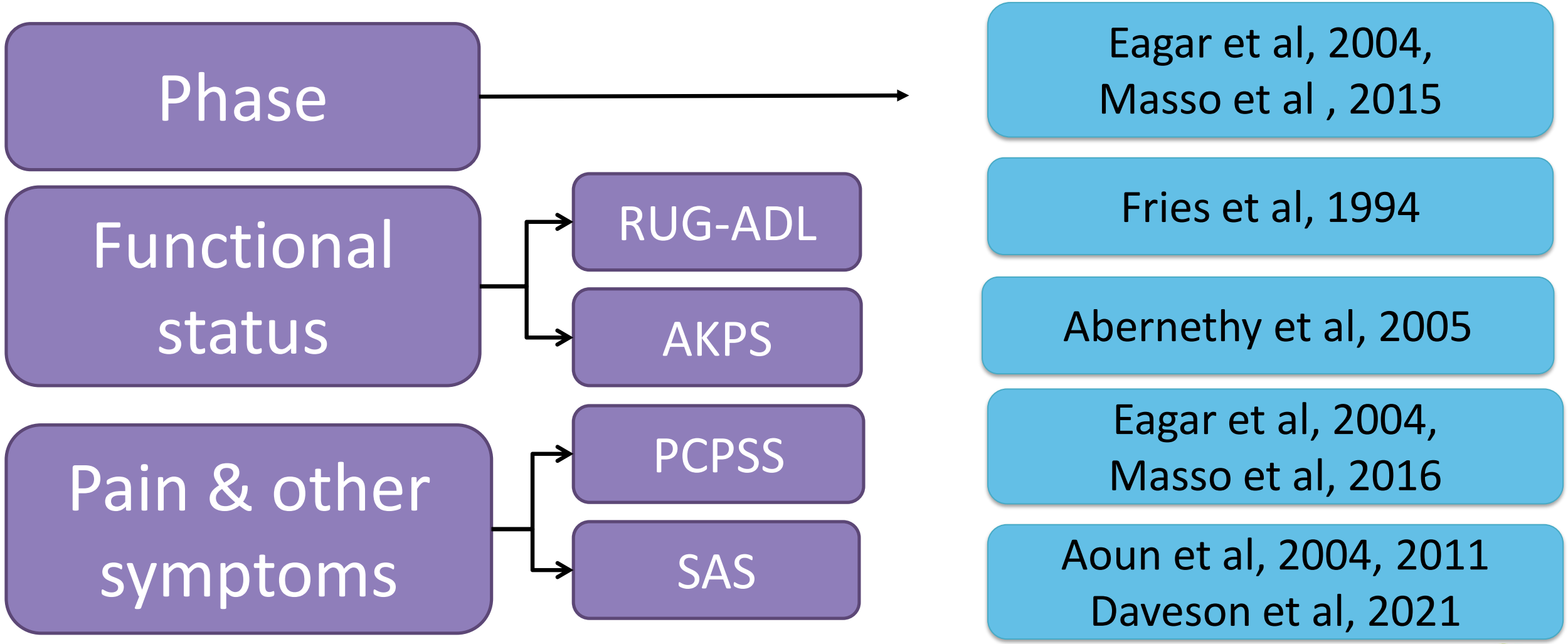
Five core clinical assessment tools



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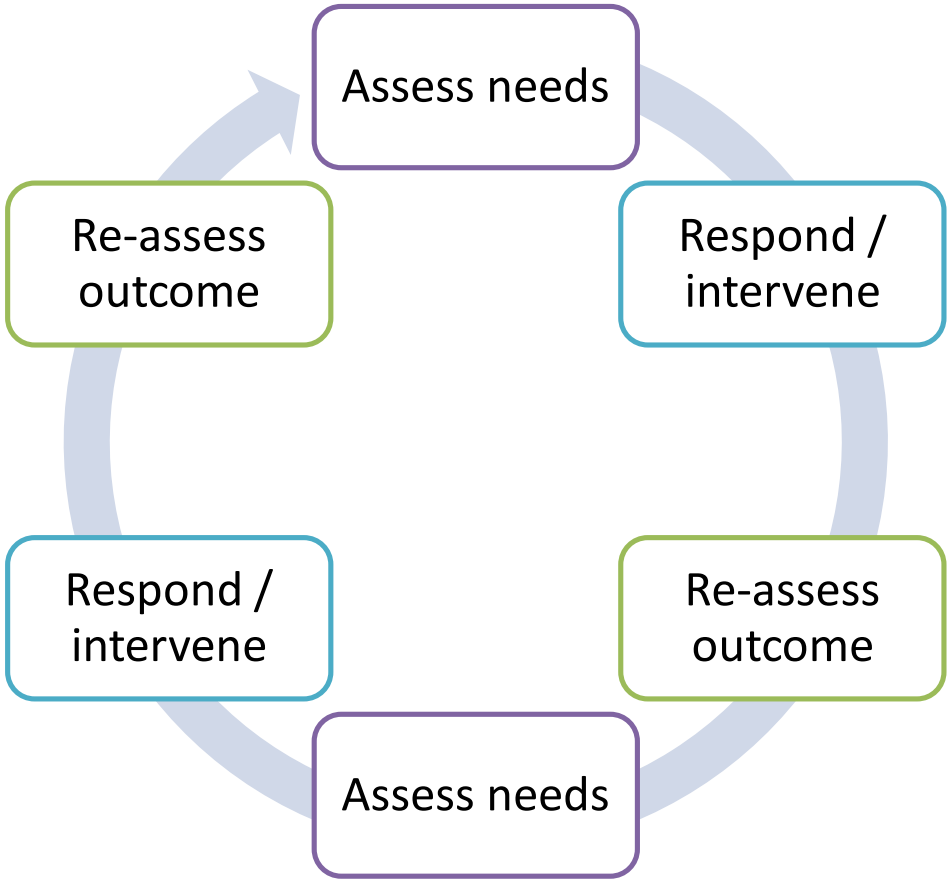
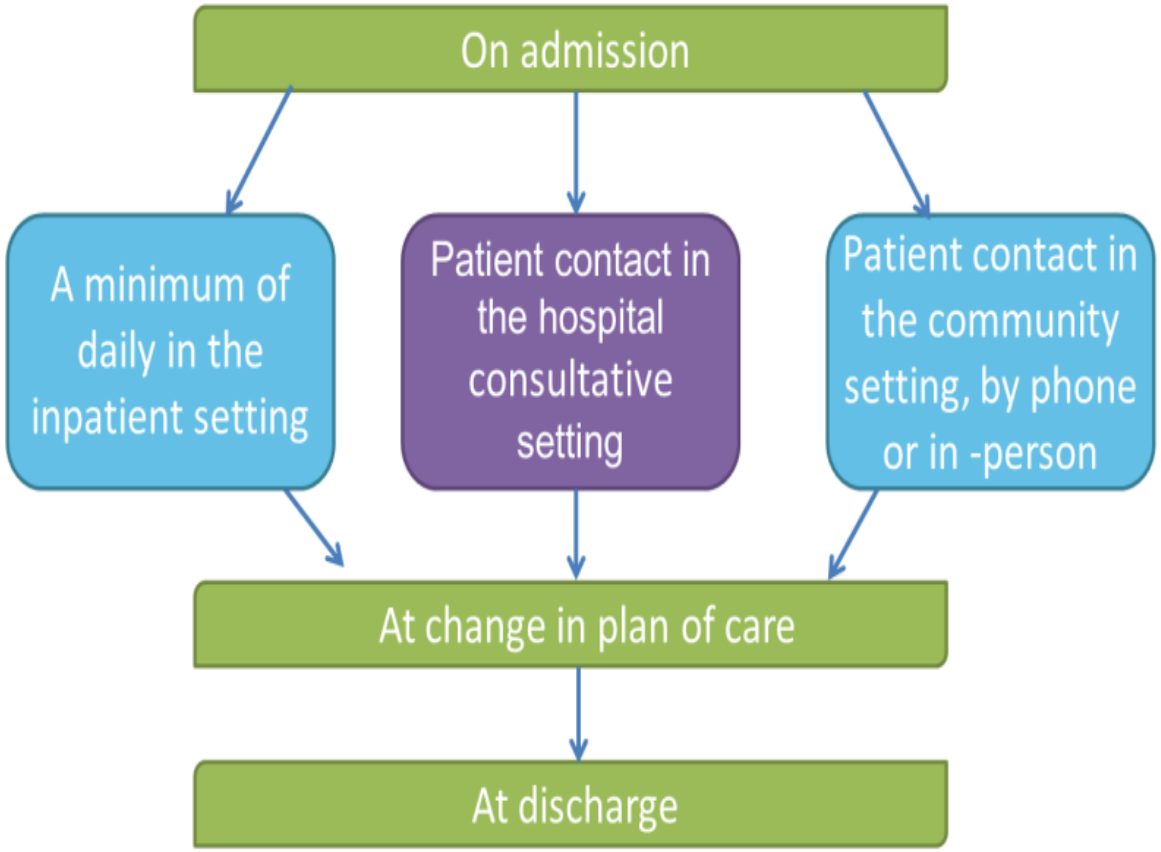
Assessment & **Response** Framework





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Examples of Impact on Care
Request for IPU admission

Milford Care Centre

Request for admission to the Specialist Palliative Care IPU

(Each section to be completed, please tick or circle appropriate options)

Date first presented:

Complete or affix addressograph label here

iCare No:_____ DOB:_____

Surname _____

First Names _____

Gender Male ☐ Female ☐

Known to Service Yes ☐ No ☐

Type of Referral

1: New (First IPU admission); 2: Request for re-admission;

Referred For

1: Symptom control; 2: EOLC; 3: Rehabilitation; 4: Respite; 5: Transfusion; 6: Other

Referred by:

1: H@H; 2: SPCDU; 3: MCC OPD; 4: GP; 5: SPCT UHL; 6: SPCT SJH; 7: SPCT Ennis;

8: SPCT Nenagh; 9: UL Hospitals – Medical Oncology; 10. UL Hospitals – Radiation Oncology;

11. UL Hospitals – Other Medical Team; 12. Other

Specify Other (12) above

The patient admission score is the sum of the following four components

1. Patient Phase of Illness			
Stable (Score = 0)	Unstable (Score = 4)	Deteriorating (Score = 2)	Terminal (Score = 4)

2. Problem Severity Score (0 = absent; 1 = mild; 2 = Moderate; 3 = severe)			
Pain Severity 0 1 2 3	Other symptoms 0 1 2 3	Psychological/Spiritual 0 1 2 3	Family/carer 0 1 2 3

3. Australia-modified Karnofsky Performance Status									
10	20	30	40	50	60	70	80	90	100
(Score = 4)			(Score = 2)			(Score = 0)			

4. Estimated Prognosis			
< 1 week (Score = 4)	< 4 weeks (Score = 2)	One to three months (Score = 1)	>Three months (Score = 0)

Category 1: Score ≥14; Category 2: Score 11 – 13; Category 3: Score 7 – 10; Category 4: Score ≤7

Referral Date	Admission Score Day 1 Date		Bed Offered on Day 1?	OUTCOME – Patient admitted, Episode start date		OUTCOME – Bed offered but patient not for admission
_____ (Referral date for this episode)	_____		Yes ☐ No ☐	Date (if not Day 1): _____ (Date of admission)		Date: _____
Date Ready for Care _____ (Date the patient is ready and available for care)	Score	Category	If no, why not? ___ (1-4)	Score	Category	Why the patient is not for admission? ____ (1-9)

IRELAND palliative care outcomes collaboration

Does inpatient hospice care improve patient outcomes effectively?

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Is Inpatient Hospice Care Clinically Effective? Using Phase of Illness to Evaluate Care Outcomes for Patients Admitted to a Specialist Palliative Care Unit in Ireland

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Mairéad Doherty, MB, MRCPI, MICGP,[1] Siobhain Coffey, RGN, Grad Dip (Pall Care), BSc, MSc,[1]
John Sheridan, RGN, RSCN, H Dip (Pall Care), BA,[1] and Sue Moran, RGN, Dip, BSc[1]

Abstract

Background: In health care, clinical effectiveness involves evaluating the degree to which clinical interventions achieve beneficial patient and caregiver outcomes.
Objective: To evaluate the clinical effectiveness of care in a specialist palliative care unit (SPCU) in Ireland, including an analysis of the temporal relationship among admission, Phase of Illness and patient and family distress.
Design/Measurements: A consecutive case series with prospectively collected admission data ($n=400$). Using a casemix tool (Phase of Illness), pain, other symptoms, psychological and family distress, and performance status were documented on admission and then daily by medical staff.
Results: Three hundred forty-two (85%) patients had complete data recorded on day 1. After admission, there were linear correlations between days since admission and progressive improvements in pain (Cramer's $V=0.131$, $p<0.001$), other symptoms ($V=0.206$, $p<0.001$), psychological distress ($V=0.101$, $p<0.001$), and family distress ($V=0.124$, $p<0.001$). Forty-three percent were in an unstable phase on admission. Nearly two thirds (60.7%) of these unstable patients converted to a stable phase within 48 hours of admission. Over the first 72 hours, 70.7% of unstable patients converted to a stable phase. There was also a significant correlation between phase stabilization and pain and symptom control ($p=0.007$). Stable phase over the first 4 days and first 14 days was associated with significantly higher performance status.
Conclusion: This study demonstrates the significant clinical effectiveness of SPCU admission across the different aspects of patient and family care.

Keywords: hospice care; inpatients; palliative care; prospective studies; symptoms; treatment outcomes

Background

CLINICAL EFFECTIVENESS is defined as the application of the best knowledge, derived from research, clinical experience, and patient preferences to achieve optimum processes and outcomes of care.[1] Many measures have been proposed to evaluate the efficiency and effectiveness of palliative care interventions; however, most have not been tested or evaluated prospectively or longitudinally.[2] Multiple metrics have been evaluated with the aim of demonstrating clinical effectiveness.[3–7] To demonstrate clinical effectiveness, we must monitor our effect on patient and caregiver outcomes and collect data in a manner that is minimally burdensome to patients, caregivers, and staff. In palliative care, five phases of patient illness have been identified: stable, unstable, deteriorating, terminal, and bereaved.[8] The Palliative Care Problem Severity Score (PCPSS) is a tool that quantifies case complexity for pain, other symptoms, psychological distress, and family/caregiver distress and scores each domain on a 0–3 basis.[9] As such, the overall score is out

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The blog of the European Association for Palliative Care

EAPC VZW

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One voice, one vision for palliative care

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Role of the palliative care physician in the motor neurone disease clinic

Irish specialist palliative care team awarded Best European Paper of 2020 at EAPC World Congress Online

Posted on November 8, 2021 by pallcare

HIGHLIGHT FROM THE 17th WORLD CONGRESS ONLINE OF THE EUROPEAN ASSOCIATION FOR PALLIATIVE CARE

Mike Lucey, *Consultant in Palliative Medicine at Milford Care Centre, Limerick, Ireland, tells us more about the winning paper he co-authored that was awarded 'Best European Paper published in 2020' by 'Journal of Palliative Medicine'. And there is FREE access to the full-text article until* ***12 December 2021***

PCOC Ireland Operations team, left to right: Feargal Twomey and Martina O Reilly (Milford Care Centre), Jacinta Kelly (Sligo Hospice), Brian Creedon (Waterford Regional Hospital), Michael Lucey and Siobhain Coffey (Milford Hospice)

It is a great honour to receive the award for the best European paper published in

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Do we utilise resources efficiently?

Research

The association between phase of illness and resource utilisation–a potential model for demonstrating clinical efficiency?

Michael Lucey, Martina O'Reilly, Siobhain Coffey, John Sheridan, Sue Moran, Feargal Twomey, Marian Conroy, Kathy Eager and David Currow

Abstract

Background: Healthcare efficiency involves demonstrating flexible inter-relationships between resource utilisation and patient need. In palliative care, five phases of patient illness have been identified: stable, unstable, deteriorating, terminal and bereaved. Evaluating the association between phase of illness and nursing activities could demonstrate clinical efficiency. **Aim:** The aim of this study was to evaluate the association between the phase of illness and the intensity of nursing care in a specialist palliative care unit. **Methods:** This was a prospective, observational cohort study of consecutive admissions (n=400) to a specialist palliative care unit. Patient phase of illness was documented on admission and daily thereafter. A nursing activity tool was developed, which scored daily nursing interventions (physical, psychological, family care and symptom control). This score was called the nursing total score (NTS) and reflected the intensity of nursing activities. Data were entered into SPSS and descriptive statistics weregenerated. **Results:** A total of 342 (85%) patients had full data recorded on admission. Stable, unstable, deteriorating and terminal phases were associated with progressively increasing median NTSs on days 1, 2, 3 and 4 (all p<0.01). Phase stabilisation from the unstable to the stable phase during this timeframe resulted in reductions in physical care (p=0.038), symptom management (p=0.007) and near-significant reductions in family support (p=0.06). **Conclusion:** A significant association was demonstrated between phase of illness and intensity of nursing activities, which were sensitive to phase changes, from unstable to stable. This demonstrates technically efficient resource utilisation and identifies a potential efficiency model for future evaluations of inpatient palliative care.

Key words: hospice care · clinical efficiency · inpatients · treatment outcome · palliative care

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Clinical efficiency measures how healthcare resources are being used to get the best value for money (Williams, 1988). For a healthcare system to be truly efficient, it must demonstrate three key aspects of clinical efficiency: technical efficieny, productive efficiency and allocative efficiency (Palmer and Torgerson, 1999).

Technical efficiency

Technical efficiency is where there is a clear physical relationship between the resource (capital or labour) and the health outcome. In a healthcare context, this could be that an increase in activity of healthcare staff, or an increased use of a resource such as a particular medication, produced a beneficial outcome for a patient. It ties an activity to an outcome.

Productive efficiency

Productive efficiency is where there is either the maximisation of a health outcome for a given cost, or the minimisation of a cost for a given health outcome. This is the classic management paradigm of getting the maximum beneficial effect for the minimum investment.

Allocative efficiency

Thereafter, once technical and productive efficiencies have been demonstrated, allocative efficiency is achieved by the health system by ensuring resources are allocated, so as

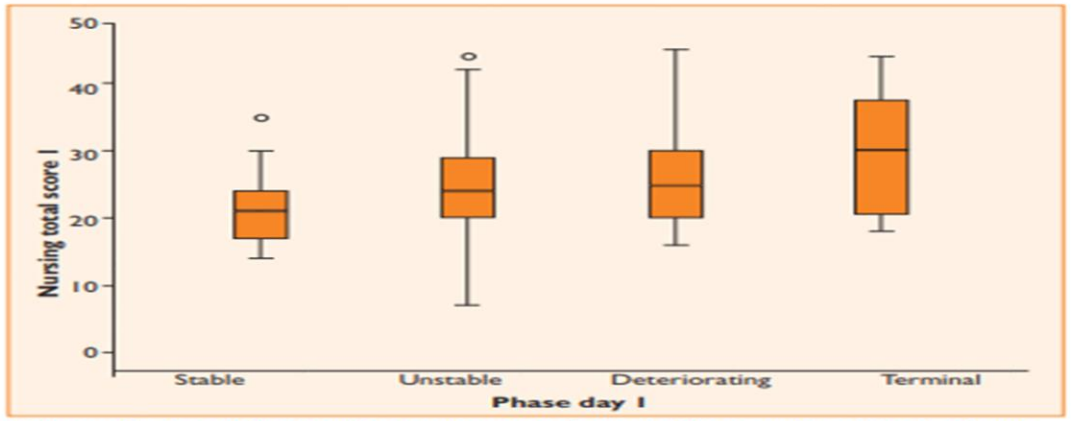

Figure 4. Association between nursing activity and patient phase

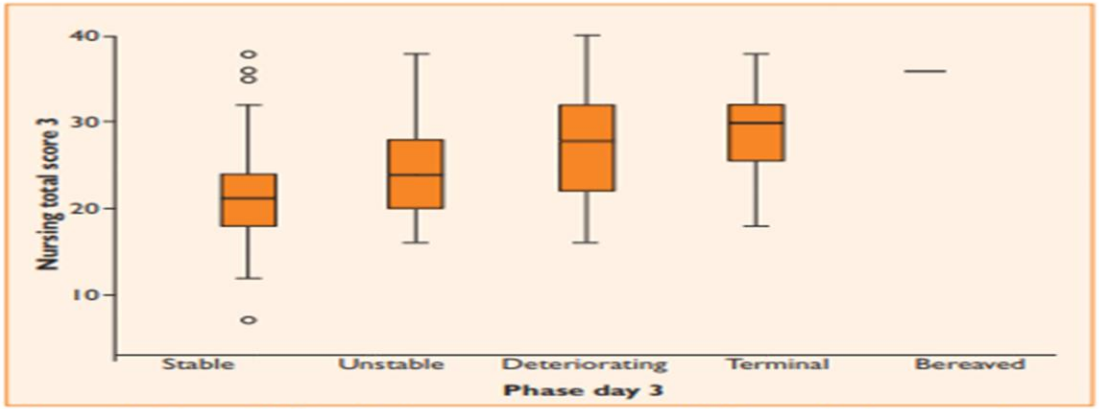

Figure 5. Association between nursing activity and phase on day 3

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Triage for Community Specialist Palliative Care

Triage team meeting x3 per week

Decisions based on:

- Palliative Care Phase
  - Urgency
- Functional status
  - OPD/Ambulatory MDT Clinic/ SPC Day Unit/Community
- PCPSS/SAS
  - Severity/ complexity of symptoms
  - Needs medical review?
  - Needs IPU admission?

Short report

Using a validated case mix tool for use in the telephone-assisted triage of patients in a specialist palliative care community setting: a consecutive case series

Emer Hough, Michael Lucey, Martina O'Reilly, Hannah Featherstone, Feargal Twomey, Siobhan Coffey

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Accepted 15 February 2023

ABSTRACT

Objectives Allocating resources in palliative care is challenging due to the nature of life-limiting illness coupled with the propensity for significant physical symptoms and psychological distress. At present, there is no established system for triaging referrals and prioritising resource allocation.

This study aimed to evaluate the feasibility of using a case mix assessment tool for telephone-assisted triaging of referrals to a specialist palliative care service. This assessed a patient's phase of illness, Problem Severity Score (PSS) for complexity of symptom burden and psychological distress, and functional status.

Methods Using a prospective consecutive case series approach, 450 referrals to community palliative care over a 6-month period were assessed. Scores for phase of illness, PSS and functional status were assessed at triage, as was the triage category of urgency of response.

Results Analysis demonstrated that phase of illness corresponds with triage category, with terminal or unstable phase patients significantly associated with urgent (category 1) referrals and highest priority for review. Decreased functional status and high PSS were useful predictors for increased urgency of referral

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Optimising triage of referrals to community palliative care can facilitate timely intervention and improve symptom control. However, there is no established triage system to implement this.

WHAT THIS STUDY ADDS

⇒ A case mix assessment tool assessing phase of illness, Problem Severity Score and functional status can be used systematically to triage the urgency of referrals to community palliative care. Telephone triage of urgency of referral using this system corresponds to urgency of referral on in person review.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The case mix assessment tool can be considered for use in telephone triage of urgency of referrals.

of a corresponding predefined category of urgency to the referral'.[2]

Enhancing triage systems can facilitate early palliative home care intervention,

Multidisciplinary Ambulatory Palliative Care Clinic (MAP) Clinic

- Milford Care Centre – Central hub
  - IPU/OPD/Specialist Day Unit/Community base
- Regional bases (community):
  - Ennis
  - Newcastle West
  - Thurles & Nenagh

Community MDT care can be delayed due to workload.

- MDT Ambulatory Palliative Care Clinic (MAP Clinic).
  - Expedite access to comprehensive care & planning
  - Need for ≥2 MDT assessments
  - Triage:
    - Phase: Stable/Deteriorating
    - AKPS >50
    - RUG-ADL <12
  - Willing and able to attend

Australia-modified Karnofsky Performance Status

Complete Definition

Clinician rated assessment of performance relating to work, activity and self-care over a 24hr period

100. Normal, no complaints or evidence of disease
90. Able to carry on normal activity, minor signs or symptoms of disease
80. Normal activity with effort, some signs or symptoms of disease
70. Care for self, unable to carry on normal activity or to do active work
60. Occasional assistance but is able to care for most needs
50. Requires considerable assistance and frequent medical care
40. In bed more that 50% of the time
30. Almost completely bedfast
20. Totally bedfast & requiring nursing care by professionals and/or family
10. Comatose or barely rousable

Resource Utilisation Group – Activities of Daily Living

Abbreviated Definition

Clinician rated assessment of dependency over 24hr period

For Bed Mobility, Toileting & Transfers

1. Independent or supervision only
3. Limited physical assistance
4. Other than two person physical assist
5. Two or more person physical assist

For Eating

1. Independent or supervision only
2. Limited assistance
3. Extensive assistance / total dependence / tube fed

Complete RUG-ADL definitions available on the PCOC website www.pcoc.org.au

MAP Clinic

- 57 patients evaluated
- Saved 9,021 km & 152 hours of staff travel time
  - €6,700 saved on staff wages for travel time
  - €7,217 saved on associated transport costs

- Preliminary patient/MDT evaluation:
  - 100% of patients found the clinic beneficial
  - 100% of MDT saw clear benefits to the patient & family
  - Helps streamline patient follow-up
    - No need for visits at home for 70%
    - Saves staff time and resources

Patient feedback

Question: Has being asked to score the distress different problems caused you made you feel more involved in your care?

Oh yes, notice has been taken of my reaction as to what is happening and to the care I receive.

It does, it's the first place I've been asked anything, nobody listened to me before and I tried to tell them before coming here

It does. It would have to.

Oh definitely, I feel more of a partnership but then again, I find the place very patient orientated. If you are not quite sure it gives you a chance to be specific on your symptoms

I am more involved in my care; my life has changed dramatically. Nothing has worked, radiotherapy or chemotherapy until now. I feel very involved.

I would always feel more involved, yes

No I do not

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Outcome Measures

Benchmarks

There are 20 benchmarks:

1 benchmark on **timeliness of care**

1 benchmark on **responsiveness to urgent needs**

6 benchmarks on **pain management***

9 benchmarks on **symptom management***

3 benchmarks on **family/carer problems***

* some measures are case-mix adjusted

After Review of Reports

Case reviews

Audits

QI projects

- PDSA cycles
- Managers
- PCOC Champions
- Staff

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Reports you Receive

Outcome Dashboard

***one per setting**

Outcomes Report

Patient outcomes in palliative care

Supplementary data

***one per setting**

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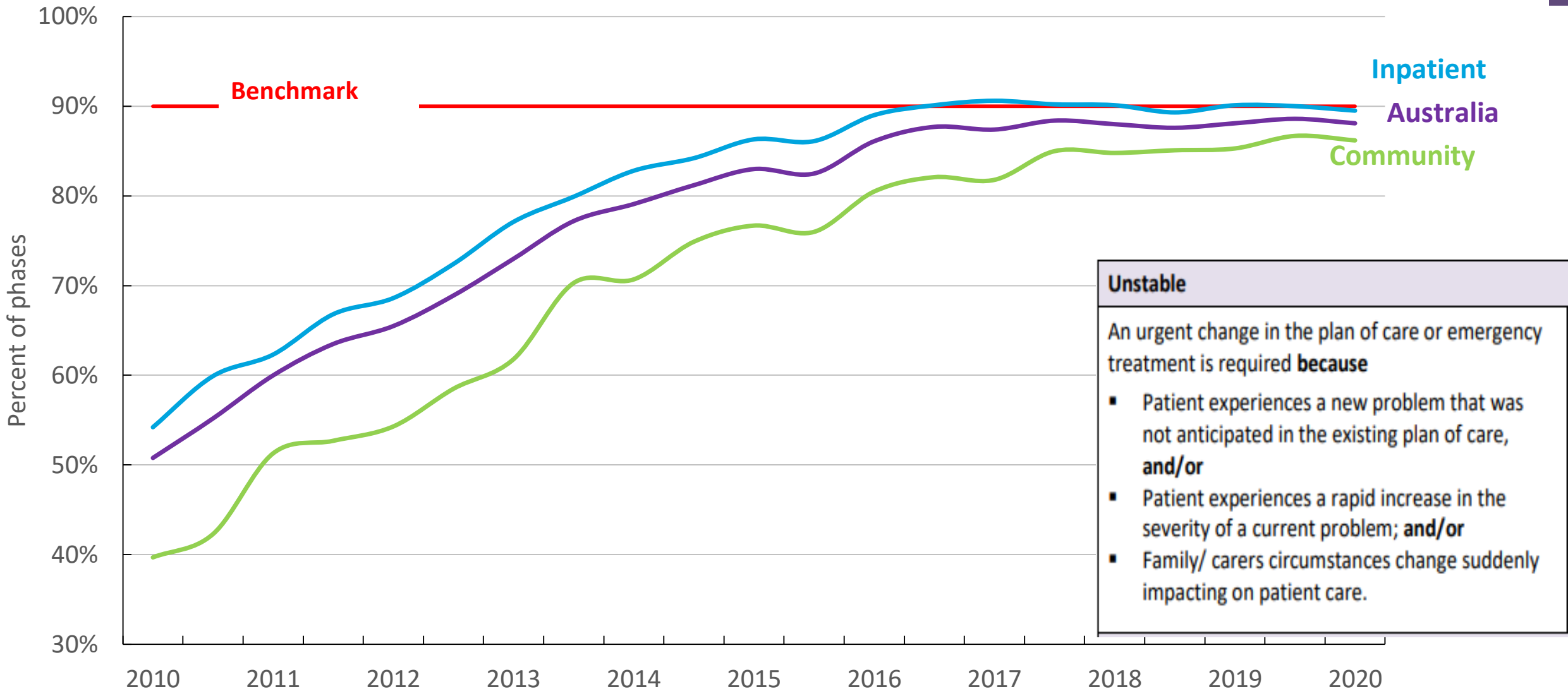
90% Unstable phase ≤ 3 days

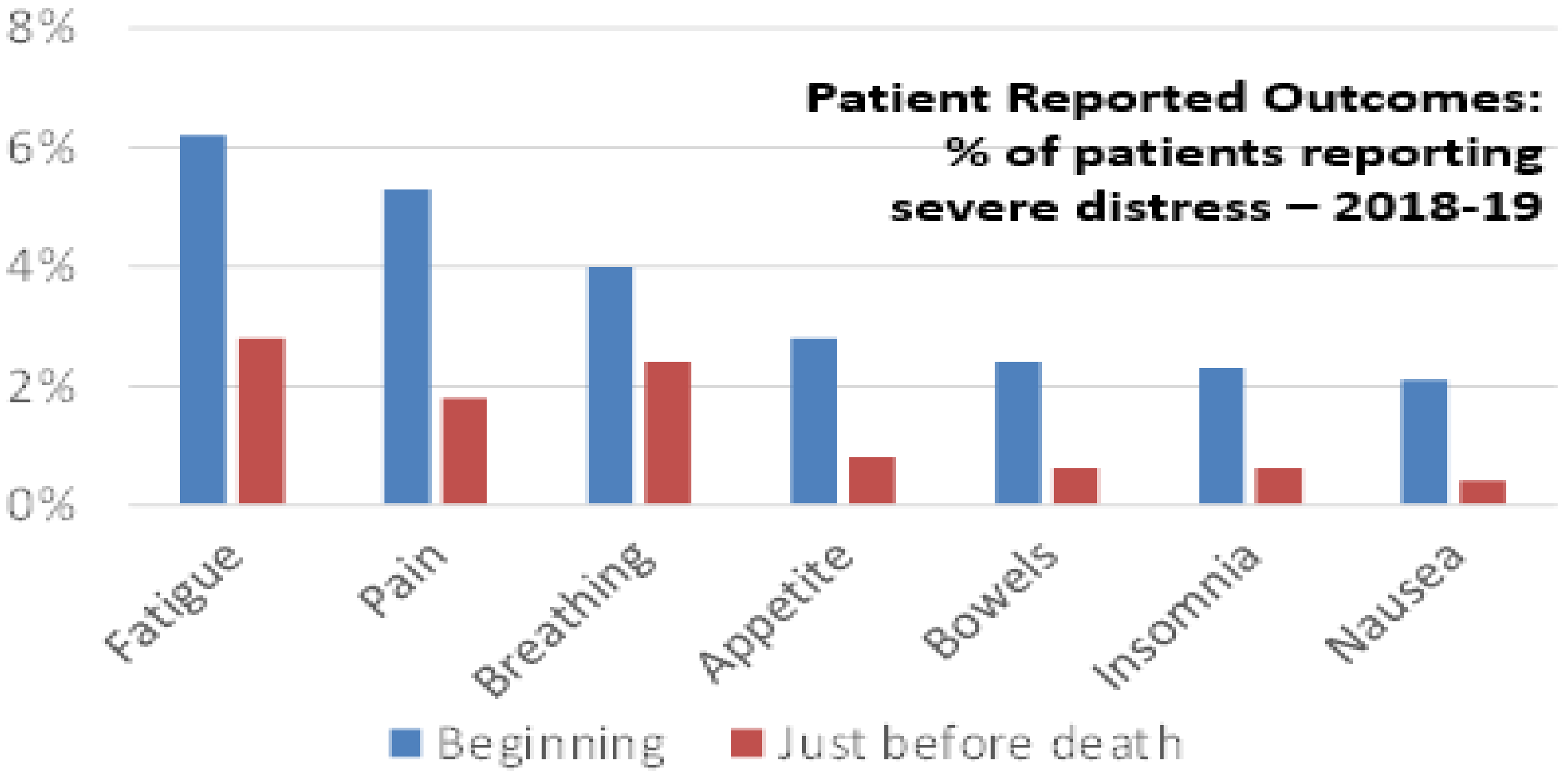


Unstable

An urgent change in the plan of care or emergency treatment is required **because**

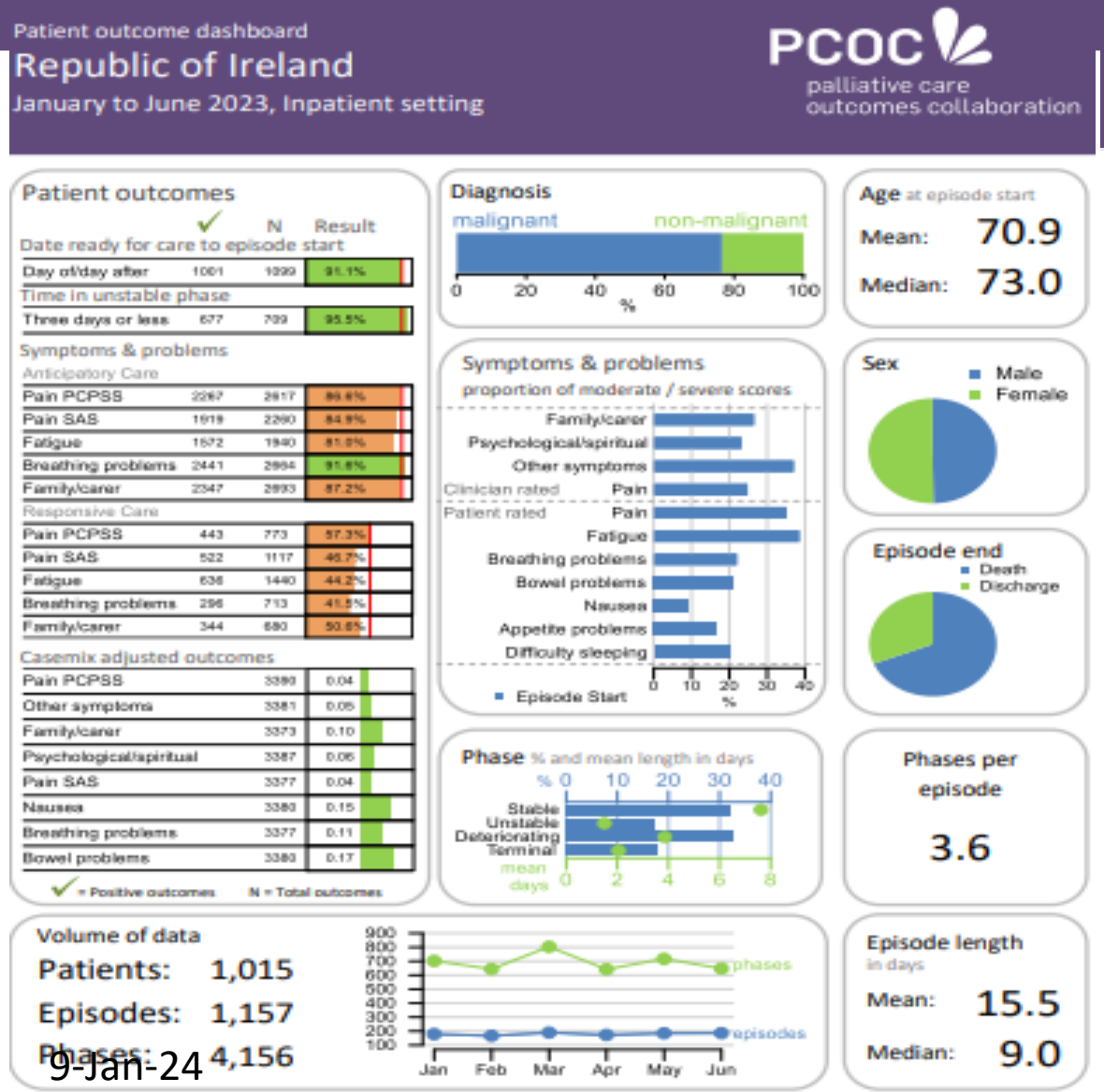
- Patient experiences a new problem that was not anticipated in the existing plan of care, **and/or**
- Patient experiences a rapid increase in the severity of a current problem; **and/or**
- Family/ carers circumstances change suddenly impacting on patient care.

Patient reported outcomes

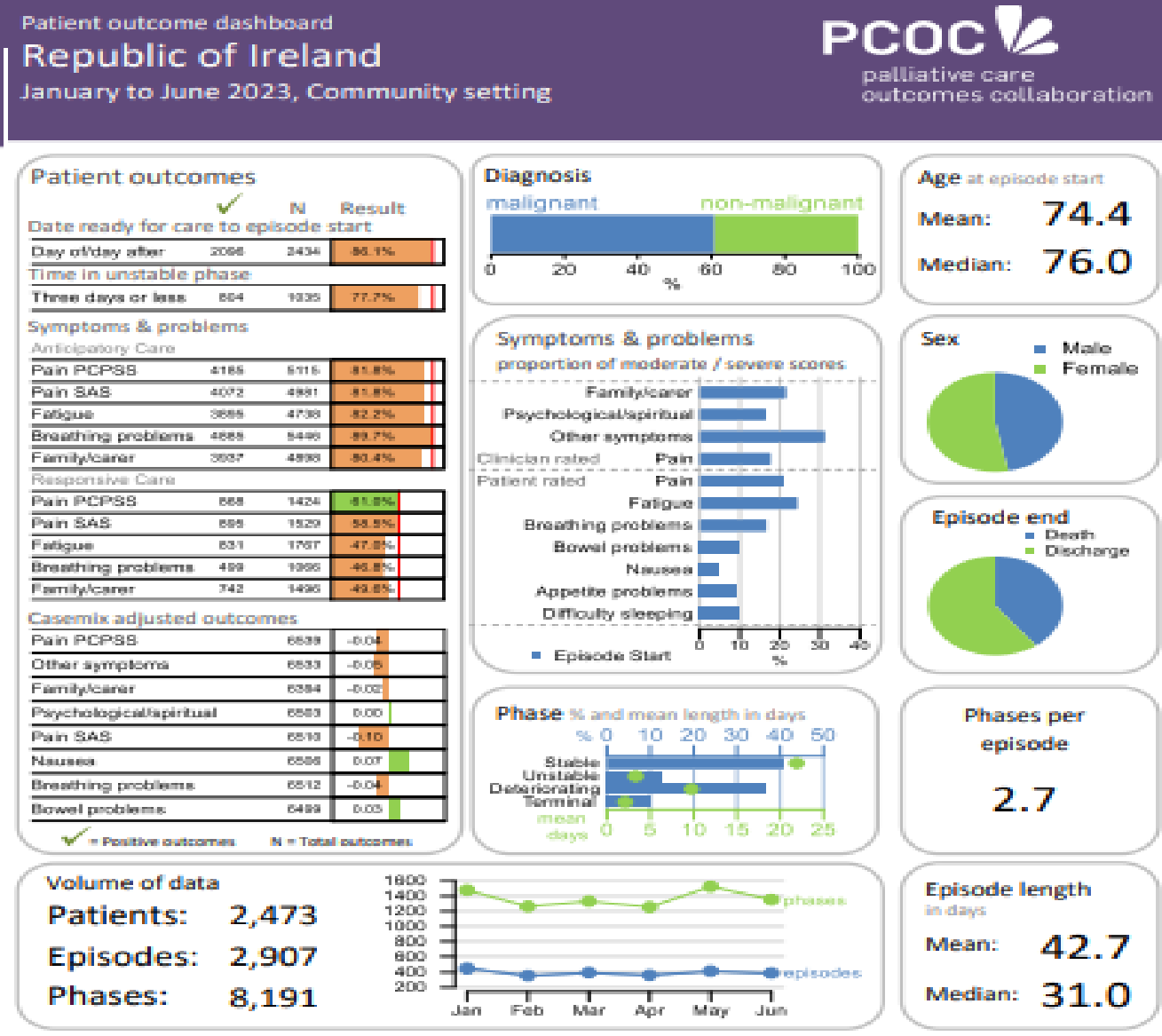


Outcome dashboard report – January to June 2023

Irish Inpatient Services 11 outcomes



Irish Community Based Services 4 outcomes



In conclusion

PCOC can help highlight and influence:

- Urgency of care
- Identify appropriate setting of care
- Resource allocation
- Evaluate and inform new initiatives
- Enhanced models of service delivery

Can aid in securing resources:

- Business case development
- Demonstrating outcomes and benefits of care

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Thank you for your time

Any questions?

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SPC Inpatient Service

Irish Jan – June 2023 11 outcomes met

Patient outcomes

	✓	N	Result
Date ready for care to episode start			
Day of/day after	1001	1099	91.1%
Time in unstable phase			
Three days or less	677	709	95.5%
Symptoms & problems			
Anticipatory Care			
Pain PCPSS	2267	2617	86.6%
Pain SAS	1919	2260	84.9%
Fatigue	1572	1940	81.0%
Breathing problems	2441	2664	91.6%
Family/carer	2347	2693	87.2%
Responsive Care			
Pain PCPSS	443	773	57.3%
Pain SAS	522	1117	46.7%
Fatigue	636	1440	44.2%
Breathing problems	296	713	41.5%
Family/carer	344	680	50.6%
Casemix adjusted outcomes			
Pain PCPSS		3390	0.04
Other symptoms		3381	0.05
Family/carer		3373	0.10
Psychological/spiritual		3387	0.06
Pain SAS		3377	0.04
Nausea		3380	0.15
Breathing problems		3377	0.11
Bowel problems		3380	0.17

✓ = Positive outcomes N = Total outcomes

Australian Jan to June 2023 16 outcomes met

Patient outcomes

	✓	N	Result
Date ready for care to episode start			
Day of/day after	21539	22162	97.2%
Time in unstable phase			
Three days or less	5865	6537	89.7%
Symptoms & problems			
Anticipatory Care			
Pain PCPSS	24000	26423	90.8%
Pain SAS	20572	22714	90.6%
Fatigue	21802	23413	93.1%
Breathing problems	24588	25685	95.7%
Family/carer	23182	24940	93.0%
Responsive Care			
Pain PCPSS	4090	6218	65.8%
Pain SAS	3752	6127	61.2%
Fatigue	3058	5308	57.8%
Breathing problems	1799	3084	58.3%
Family/carer	2255	3877	58.2%
Casemix adjusted outcomes			
Pain PCPSS		32641	0.09
Other symptoms		31987	0.25
Family/carer		28817	0.21
Psychological/spiritual		32307	0.21
Pain SAS		28841	0.29
Nausea		28730	0.19
Breathing problems		28769	0.30
Bowel problems		28672	0.30

✓ = Positive outcomes N = Total outcomes

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SPC Community Services

Irish Jan – June 2023 4 outcomes met

Patient outcomes

	✓	N	Result
Date ready for care to episode start			
Day of/day after	2096	2434	86.1%
Time in unstable phase			
Three days or less	804	1035	77.7%
Symptoms & problems			
Anticipatory Care			
Pain PCPSS	4185	5115	81.8%
Pain SAS	4072	4981	81.8%
Fatigue	3895	4738	82.2%
Breathing problems	4885	5446	89.7%
Family/carer	3937	4898	80.4%
Responsive Care			
Pain PCPSS	868	1424	61.0%
Pain SAS	895	1529	58.5%
Fatigue	831	1767	47.0%
Breathing problems	499	1066	46.8%
Family/carer	742	1496	49.6%
Casemix adjusted outcomes			
Pain PCPSS		8539	-0.04
Other symptoms		8533	-0.05
Family/carer		6394	-0.02
Psychological/spiritual		6503	0.00
Pain SAS		8510	-0.10
Nausea		6506	0.07
Breathing problems		6512	-0.04
Bowel problems		6499	0.03

✓ = Positive outcomes N = Total outcomes

Australian Jan – June 2023 6 outcomes met

Patient outcomes

	✓	N	Result
Date ready for care to episode start			
Day of/day after	16550	18919	87.5%
Time in unstable phase			
Three days or less	3840	4990	77.0%
Symptoms & problems			
Anticipatory Care			
Pain PCPSS	24653	28758	85.7%
Pain SAS	24455	28478	85.9%
Fatigue	20313	24432	83.1%
Breathing problems	27131	29051	93.4%
Family/carer	21401	25654	83.4%
Responsive Care			
Pain PCPSS	3478	5898	59.0%
Pain SAS	3475	6110	56.9%
Fatigue	4090	8625	47.4%
Breathing problems	1782	3635	49.0%
Family/carer	3071	6226	49.3%
Casemix adjusted outcomes			
Pain PCPSS		34656	-0.05
Other symptoms		33770	0.03
Family/carer		31880	0.02
Psychological/spiritual		33831	0.04
Pain SAS		34588	-0.06
Nausea		32889	-0.01
Breathing problems		32686	0.09
Bowel problems		32343	0.04

✓ = Positive outcomes N = Total outcomes

PCOC palliative care outcomes collaboration