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FACULTY OF MEDICINE

BC Cancer Agency
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Family Practice Oncology Network

FAMILY PRACTICE ONCOLOGY CME DAY

ADVANCED PANCREATIC CANCER WORKSHOP

CCOPE CANCER CARE OUTREACH PROGRAM ON EDUCATION

2016 SYLLABUS

ubccpd.ca

CANCER CARE OUTREACH PROGRAM ON EDUCATION (CCOPE)

ADVANCED PANCREATIC CANCER WORKSHOP

BC Cancer Agency Family Practice Oncology CME Day

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Faculty / Author Disclosure Statements

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Name	Affiliations, financial or otherwise, with a commercial organization that may have a direct or indirect connection to the content of this syllabus
Ms. Tanuja Barker	Nothing to disclose
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Syllabus Updated: May 2016

ADVANCED PANCREATIC CANCER WORKSHOP

Participant Syllabus

Table of Contents

OVERVIEW OF THE CANCER CARE OUTREACH PROGRAM ON EDUCATION (CCOPE)

WHAT IS CCOPE?

The Cancer Care Outreach Program on Education (CCOPE), provided by the UBC Division of Continuing Professional Development (UBC CPD) in partnership with the BCCA Screening Groups and Family Practice Oncology Network (FPON), is an important educational initiative to provide BC family physicians with a better understanding of their roles and best practices across the cancer care continuum. Content for this workshop has been adapted and condensed from the Advanced Cancers Care Workshop Syllabus.

HOW DO THE CCOPE WORKSHOPS WORK?

These interactive case-based workshops for family physicians and others working in family practice settings aim to offer support along the primary cancer care continuum. A facilitator who is well versed in providing advanced cancer care to patients leads each workshop, which are delivered to a small group of family physicians in an informal environment in order to allow for dialogue surrounding case management.

With the help of the Steering Committee and Advanced Cancers Care Working Group, a workshop designed to help participants familiarize themselves with best practices for the management of advanced cancers care was developed. This condensed syllabus contains one case addressing:

- Role of primary care physicians along the advanced pancreatic cancer care continuum and recognition of this relationship with other healthcare providers;
- Appropriate diagnostic and prognosis procedures;
- Main treatment options and their potential side-effects for pancreatic cancer; and
- Palliative approaches to care with consideration of prognosis and patient perspective

BC CANCER RESOURCES

The BC Cancer Agency (BCCA) offers several facilities and networks across the province to support cancer care. These include six regional centres (see the table below).

BC Cancer Agency Facilities	Location	Main Contact Number	Toll Free Number
Abbotsford Centre	32900 Marshall Rd, Abbotsford, BC V2S 0C2	604-851-4710	1-877-547-3777
Sindi Ahluwalia Hawkins Centre for the Southern Interior	399 Royal Avenue, Kelowna, BC V1Y 5L3	250-712-3900	1-888-563-7773
Fraser Valley Centre	13750 96th Avenue, Surrey, BC V3V1Z2	604-930-2098	1-800-523-2885
Vancouver Centre	600 West 10th Avenue, Vancouver, BC V5Z 4E6	604-877-6000	1-800-663-3333
Vancouver Island Centre	2410 Lee Avenue, Victoria, BC V8R 6V5	250-519-5500	1-800-670-3322
Centre for the North	1215 Lethbridge Street, Prince George, BC V2M 7E9	250-645-7300	1-855-775-7300

There are also 19 community-based Community Cancer Centres located across the province. For more information about these centres and other community services, please visit the BC Cancer Agency website at: http://www.bccancer.bc.ca/RS/default.htm

Family Practice Oncology Network (FPON)

The Family Practice Oncology Network (FPON) offers support to family physicians in British Columbia who provide cancer care, by offering access to various resources and tools. For example, they publish a bi-annual journal, are involved with the development of cancer care guidelines and offer CME opportunities, such as collaborating to deliver these series of workshops, and host monthly Oncology CME Webcasts.

The General Practitioners in Oncology (GPO) training program allows family physicians the opportunity to strengthen their oncology skills and build valuable contacts and confidence. In turn, the GPOs offer access to their knowledge base to family physicians within their communities. For a list of GPOs per community, please see the table on the following page.

For further information about the Family Practice Oncology Network, please visit their website at: http://www.bccancer.bc.ca/health-professionals/networks/family-practice-oncology-network or contact Jennifer Wolfe at (604)219-9579.

General Practitioners in Oncology by Community

Updated October 2015 **Source: BCCA (2015). GPOs by Community**

At present, 84 GPOs from 36 different communities have completed the GPO Training Program and are actively practising in BC and the Yukon. Five (*) are in the process of completing the program and 10 have been practising since before the program began in 2004. In total, there are 99 GPOs practising in BC at present.

Community	Name
Abbotsford	Dr. Al Chafe*
	Dr. Eric Gable
	Dr. Raziya Mia
	Dr. Sian Shuel
Campbell River	Dr. Anne Morrison
	Dr. Willem Prinsloo
	Dr. Jim Proctor
Comox	Dr. Tanya Austin
	Dr. Amitabh Bakshi
	Dr. Wai Ling Dan
Cranbrook	Dr. Shawna Dawe*
	Dr. Keith Lowden
Dawson Creek	Dr. Cornelia Popa*
	Dr. Servaas Verster
Duncan	Dr. Valorie Cunningham
Fort St. John	Dr. Mike Wright
	Dr. Becky Temple
Gibsons	Dr. Monica Marton
Golden	Dr. Trina Larsen Soles
Grand Forks	Dr. Jeanne Borstlap
	Dr. Geoffrey Coleshill
Hope	Dr. Ertha Nanton
Kamloops	Dr. Suzi Tevendale
	Dr. Johan Van Heerdan
Kelowna	Dr. Henry Docherty
	Dr. Carolyne McLelland
	Dr. Gerald Patridge
	Dr. Mary Wall
Kitimat	Dr. Sabina Kay
	Dr. Andries Van Schalkwyk*
	Dr. Marius Wahl
Ladysmith	Dr. Emanuel Fritsch
	Dr. Michael McGuire
Masset	Dr. Michele Leslie
Nainamo	Dr. Michael Dunne
	Dr. Elizabeth Kenward
	Dr. Randy Marback
Osoyoos	Dr. Karin Kilpatrick
Penticton	Dr. Donella Anderson
	Dr. Sandra Pansegrouw
	Dr. Wendy Ross
	Dr. Marianne Willis
Port Alberni	Dr. Wendy Johnsen
Powell River	Dr. Stephen Burns
Prince George	Dr. Meredith Hunter
	Dr. Sandra Lamb
	Dr. John Mah
	Dr. Linda Wilson
Prince Rupert	Dr. Luke Tse
Queen Charlotte City	Dr. Jamie Chrones
	Dr. Tracy Morton
	Dr. Caroline Shooner
Salmon Arm	Dr. James Levins
Sechelt	Dr. Robert Newman
Smithers	Dr. Elizabeth Bastian
	Dr. Daphne Hart
	Dr. Mary Knight
	Dr. Roderick Leighton*
Surrey	Dr. Karen Hossack
	Dr. Andrea Pollock
Terrace	Dr. Jaco Fourie
	Dr. Paul Warbeck*
Vancouver	Dr. Sherry Chan*
	Dr. Andrea Cheung
	Dr. Donald Cooper
	Dr. Rose-marie Coschizza
	Dr. Val Geddes
	Dr. Mary Georgilas
	Dr. Mike Mamacos
	Dr. Maryam Nazary
	Dr. Leah Norgrove
	Dr. Peter Pavlovich
	Dr. Judith Rodrigo
	Dr. Lori Saretsky
	Dr. Ismet Tejpar
	Dr. Angela Thermann
	Dr. Sherry Zheng
Vanderhoof	Dr. Suzanna Campbell
	Dr. Davy Dhillon
	Dr. Shannon Douglas
Vernon	Dr. Christine Blyth
	Dr. Chris Cunningham
	Dr. Allison Rankin
Victoria	Dr. Jody Anderson
	Dr. Stephen Ashwell
	Dr. Elisabeth Crisci*
	Dr. Taryl Felhaber
	Dr. Dean Kolodziejczyk
	Dr. Ryan Liebscher
	Dr. David Peterson*
	Dr. Dagmar Smatanova
	Dr. Margaret Smith
Whitehorse	Dr. Robin Jamieson
	Dr. Danusia Kanachowski
	Dr. Sally McDonald
	Dr. Lucille Stuart
Williams Lake/100 Mile House	Dr. Gord Hutchinson
	Dr. Emil LaBossière
**Nigeria	Dr. Kelechi Eguzo

WORKSHOP LEARNING OBJECTIVES

Upon completion of these workshop cases, participants will:
Employ effective techniques for disclosing an advanced cancer diagnosis and discussing the prognosis with patients and their families
Describe common treatment options and their expected side effects
Access available resources for palliative care

PRE-READINGS

PRE-READINGS

1. GPAC (Guidelines & Protocols Advisory Committee) (2010). Palliative Care for the Patient with Incurable Cancer or Advanced Disease. Retrieved from: http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative1.pdf

2. Journal of Pain and Symptom Management (2013). The Bow Tie Model of 21st Century Palliative Care. Retrieved from: http://www.researchgate.net/publication/259252026_The_Bow_Tie_Model_of_21st_Century_Palliative_Care

3. Lebel S et al. (2014) "Addressing fear of cancer recurrence among women with cancer: A feasibility and preliminary outcome study". Journal of Cancer Survivorship (Impact Factor: 3.29). 04/2014; 8(3). DOI: 10.1007/s11764-014-0357-3

PANCREATIC CANCER

PATIENT: MR. LARRY GOODMAN

LEARNING OBJECTIVES:

After completing the workshop case, participants will be able to:

- Employ effective techniques for disclosing an advanced cancer diagnosis and discussing the prognosis with patients and their families
- Describe common treatment options for pancreatic cancer and their expected side effects
- Access available resources for palliative care

Case Scenario:

Larry is a 42-year-old mechanic. His wife of 16 years (a teacher's assistant) has encouraged him to go for a check-up as he has been complaining about a loss of appetite, feeling tired and being stressed at work. He presents to your office. During your review, you find out that his parents are in their sixties and in good health. He has two children, a 14-year-old son and 9-year-old daughter and no relevant family history. He is a moderate drinker and a former smoker. He weighs 175 lbs.

1. What are the key areas that you need to check during this first visit?

Notes:

Case Progression:

The bloodwork results indicate elevated liver enzyme test results and lipase, elevated WBC and some degree of anemia (low Hb) and you discuss the results at his follow-up appointment.

Larry reduces his number of working hours to a part-time basis, but his energy levels and appetite do not improve and a few months later, he starts to develop signs of jaundice. His wife accompanies him on his next visit. She is very concerned about his discoloration, continued weight loss (he now weighs 165lbs) and rapid health decline. She is very anxious about the likely diagnosis. Someone at her work has mentioned that it could be “liver cancer” and she is very distressed and upset that she did not get her husband to seek medical advice earlier. She repeatedly asks herself aloud “why didn’t I send you sooner?” On the other hand, Larry is quiet and seems stoic, but he probably is very frightened.

2. What do you advise the couple?

Notes:

Case Progression:

You sent him to get further tests. The CT scan reveals a mass head of pancreas, hepatic and para-aortic lymphadenopathy causing dilation of the common bile duct.

3. What further tests should be ordered? (Note: in rural settings this may be done by a radiologist)

Notes:

Case Progression:

The biopsy indicates adenocarcinoma. A biliary stent is inserted and cancer marker (CA19-9) is repeated

4. How would you disclose the diagnoses to Larry?

Notes:

5. What are your next steps?

Notes:

6. How can you deal with accusations or feelings of guilt?

Notes:

Case Progression:

Larry sees his oncologist and you receive a copy of the oncologist letter outlining his treatment options. The letter confirms a likely poor prognosis of less than 12 months.

The options for treatment as outlined in the objectives are covered below.

A month later, Larry develops back pain in the low thoracic area. He comes in to see you about this and on examination, there is no spinal restriction of movement, or localized tenderness. However, there is slight epigastric abdominal tenderness and he’s noticeably in pain when he gets on and off the examination couch.

Age and PS	**Treatment**	**Side Effects**
Young, PS 0-1	FOLFIRINOX vs Gemcitabine/Abraxane (depends on oncologist)	FOLFIRINOX – fatigue, N/V, diarrhea/abdominal cramping, stomatitis, significant risk of febrile neutropenia, anemia, thrombocytopenia, cold-induced peripheral neuropathy (cannot touch/drink anything below room temperature immediately following chem for days to weeks after – gets longer with each cycle), photosensitivity (easier tan/burn), coronary vasospasm (~1% risk, higher if previous history of hear disease), QT prolongation (important if on extended courses of ondansetron, so use with caution) Gemcitabine/Abraxane – fatigue, N/V, peripheral neuropathy (not cold induced), alopecia, stomatitis, arthromyalgias, nail changes, risk of febrile neutropenia, thrombocytopenia, anemia, diarrhea, constipation, edema, rare risk of pneumonitis (~1%) Gemcitabine - fatigue, stomatitis, risk of febrile neutropenia, thrombocytopenia, anemia, diarrhea, edema, rare risk of pneumonitis (~1%)
Older, PS 0-1	Gemcitabine /abraxane	
Young, PS 2	Gemcitabine /Abraxane	
Older, PS 2	Gemcitabine	
Young, PS 2-3 (but not solid 3)	Gemcitabine	

*all chemotherapy drugs/protocols and patient information sheets can be found on the BCCA website www.bccancer.bc.ca

7. Larry wants to know what you can do to alleviate his back pain. What are your next steps?

Notes:

Case Progression:

The CT scan shows worsening of retroperitoneal disease and overall disease progression, despite the chemotherapy treatment. The oncologist indicates in her letter that she is concerned about Larry's declining health status and recommends that further chemotherapy would likely not be helpful. Larry comes to see you after his appointment with the oncologist and seeks your opinion about further treatment options.

8. **What guidance would you offer Larry in making decisions and choices at this stage?**

Notes:

Case Progression:

Later that month Larry returns to your office and complains about worsening pain.

9. **Would Larry benefit from block treatment?**

Notes:

Case Progression:

Larry is offered a brief admission for celiac plexus block. This is usually done as a day case, but he is feeling very weak and is in bed most of the time, so he is admitted.

The procedure goes smoothly and his pain is relieved considerably. Larry and family are encouraged. His opioids are reduced somewhat during the stay. His Palliative Performance Status (PPS) is now 40% and he is discharged. At this point, if his end of life plan has not yet been discussed, it MUST be covered now. If he wishes to die at home, the paperwork for Anticipated Death At Home can be completed.

Ten days later you are called to see him at home. He has been vomiting for two days and has a distended abdomen. You observe that he has increased bowel sounds. He has not passed gas or stool for 3 or 4 days. He is clinically obstructed. After discussion about the likely diagnosis, he chooses to pursue any possibility of treatment and is transferred to hospital. Surgical assessment indicates that there is no prospect for a good surgical outcome.

10. Larry wants to know what can be done to make him more comfortable. What do you advise him?

Notes:

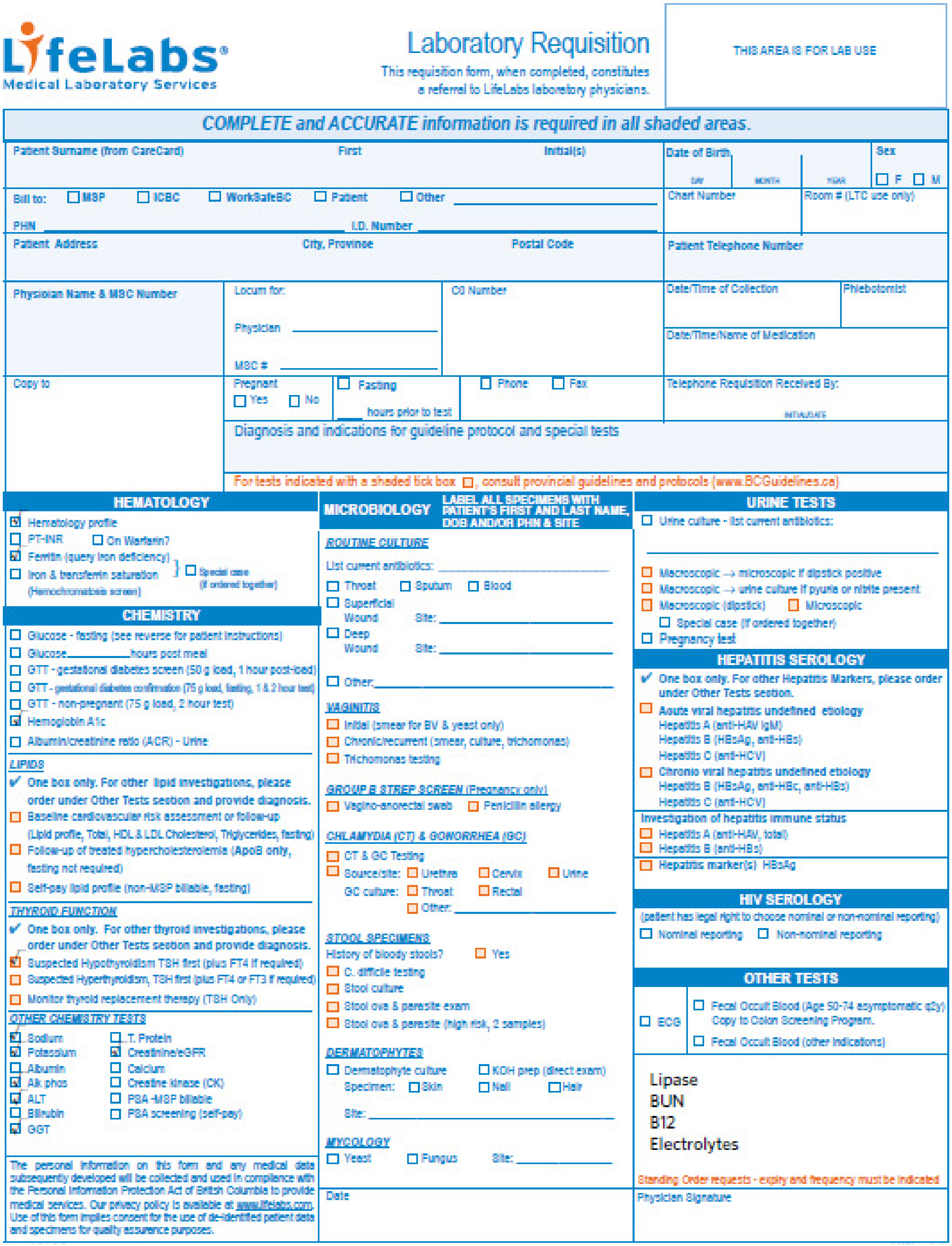
Case Progression:

He is discharged from the hospital, but later that month Larry becomes too weak for his wife to continue his management, even with maximum home support and home care nursing. The children are showing signs of great distress. He agrees to and is transferred to a hospice. Larry dies in hospice several weeks later.

Notes:

SUPPLEMENTARY RESOURCES

Supplementary Resource 1: Pre-filled Lab Requisition Form *Note that blank form can be downloaded from: http://www.lifelabs.com/healthcare-providers/Pages/Requistions-and-Forms.aspx?Province=BC



LifeLabs®
Medical Laboratory Services

Laboratory Requisition

This requisition form, when completed, constitutes a referral to LifeLabs laboratory physicians.

THIS AREA IS FOR LAB USE

COMPLETE and ACCURATE information is required in all shaded areas.

Patient Surname (from CareCard) First Initial(s)

Date of Birth DAY MONTH YEAR

Sex ☐ F ☐ M

Bill to: ☐ MSP ☐ ICBC ☐ WorkSafeBC ☐ Patient ☐ Other

Chart Number

Room # (LTC use only)

PHN

I.D. Number

Patient Address City, Province Postal Code

Patient Telephone Number

Physician Name & MSC Number

Locum for:

Physician

MSC #

CC Number

Date/Time of Collection

Phlebotomist

Date/Time/Name of Medication

Copy to

Pregnant ☐ Yes ☐ No

☐ Fasting

hours prior to test

☐ Phone ☐ Fax

Telephone Requisition Received By:

INITIALS/DATE

Diagnosis and indications for guideline protocol and special tests

For tests indicated with a shaded tick box ☐, consult provincial guidelines and protocols (www.BCGuidelines.ca)

HEMATOLOGY

☑ Hematology profile
☐ PT-INR ☐ On Warfarin?
☑ Ferritin (query iron deficiency)
☐ Iron & transferrin saturation (Hemochromatosis screen)
☐ Special case (if ordered together)

CHEMISTRY

☐ Glucose - fasting (see reverse for patient instructions)
☐ Glucose________hours post meal
☐ GTT - gestational diabetes screen (50 g load, 1 hour post-load)
☐ GTT - gestational diabetes confirmation (75 g load, fasting, 1 & 2 hour test)
☐ GTT - non-pregnant (75 g load, 2 hour test)
☑ Hemoglobin A1c
☐ Albumin/creatinine ratio (ACR) - Urine

LIPIDS

✓ One box only. For other lipid investigations, please order under Other Tests section and provide diagnosis.
☐ Baseline cardiovascular risk assessment or follow-up (Lipid profile, Total, HDL & LDL Cholesterol, Triglycerides, fasting)
☐ Follow-up of treated hypercholesterolemia (ApoB only, fasting not required)
☐ Self-pay lipid profile (non-MSP billable, fasting)

THYROID FUNCTION

✓ One box only. For other thyroid investigations, please order under Other Tests section and provide diagnosis.
☑ Suspected Hypothyroidism TSH first (plus FT4 if required)
☐ Suspected Hyperthyroidism, TSH first (plus FT4 or FT3 if required)
☐ Monitor thyroid replacement therapy (TSH Only)

OTHER CHEMISTRY TESTS

☑ Sodium
☑ Potassium
☐ Albumin
☑ Alk phos
☑ ALT
☐ Bilirubin
☑ GGT
☐ T. Protein
☑ Creatinine/eGFR
☐ Calcium
☐ Creatine kinase (CK)
☐ PSA -MSP billable
☐ PSA screening (self-pay)

The personal information on this form and any medical data subsequently developed will be collected and used in compliance with the Personal Information Protection Act of British Columbia to provide medical services. Our privacy policy is available at www.lifelabs.com. Use of this form implies consent for the use of de-identified patient data and specimens for quality assurance purposes.

MICROBIOLOGY

LABEL ALL SPECIMENS WITH PATIENT'S FIRST AND LAST NAME, DOB AND/OR PHN & SITE

ROUTINE CULTURE

List current antibiotics:
☐ Throat ☐ Sputum ☐ Blood
☐ Superficial Wound Site:
☐ Deep Wound Site:
☐ Other:

VAGINITIS

☐ Initial (smear for BV & yeast only)
☐ Chronic/recurrent (smear, culture, trichomonas)
☐ Trichomonas testing

GROUP B STREP SCREEN (Pregnancy only)

☐ Vagino-anorectal swab ☐ Penicillin allergy

CHLAMYDIA (CT) & GONORRHEA (GC)

☐ CT & GC Testing
☐ Source/site: ☐ Urethra ☐ Cervix ☐ Urine
GC culture: ☐ Throat ☐ Rectal
☐ Other:

STOOL SPECIMENS

History of bloody stools? ☐ Yes
☐ C. difficile testing
☐ Stool culture
☐ Stool ova & parasite exam
☐ Stool ova & parasite (high risk, 2 samples)

DERMATOPHYTES

☐ Dermatophyte culture ☐ KOH prep (direct exam)
Specimen: ☐ Skin ☐ Nail ☐ Hair
Site:

MYCOLOGY

☐ Yeast ☐ Fungus Site:

Date

URINE TESTS

☐ Urine culture - list current antibiotics:
☐ Macroscopic → microscopic if dipstick positive
☐ Macroscopic → urine culture if pyuria or nitrite present
☐ Macroscopic (dipstick) ☐ Microscopic
☐ Special case (if ordered together)
☐ Pregnancy test

HEPATITIS SEROLOGY

✓ One box only. For other Hepatitis Markers, please order under Other Tests section.
☐ Acute viral hepatitis undefined etiology
Hepatitis A (anti-HAV IgM)
Hepatitis B (HBsAg, anti-HBs)
Hepatitis C (anti-HCV)
☐ Chronic viral hepatitis undefined etiology
Hepatitis B (HBsAg, anti-HBc, anti-HBs)
Hepatitis C (anti-HCV)

Investigation of hepatitis immune status
☐ Hepatitis A (anti-HAV, total)
☐ Hepatitis B (anti-HBs)
☐ Hepatitis marker(s) HBsAg

HIV SEROLOGY

(patient has legal right to choose nominal or non-nominal reporting)
☐ Nominal reporting ☐ Non-nominal reporting

OTHER TESTS

☐ ECG
☐ Fecal Occult Blood (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program.
☐ Fecal Occult Blood (other indications)

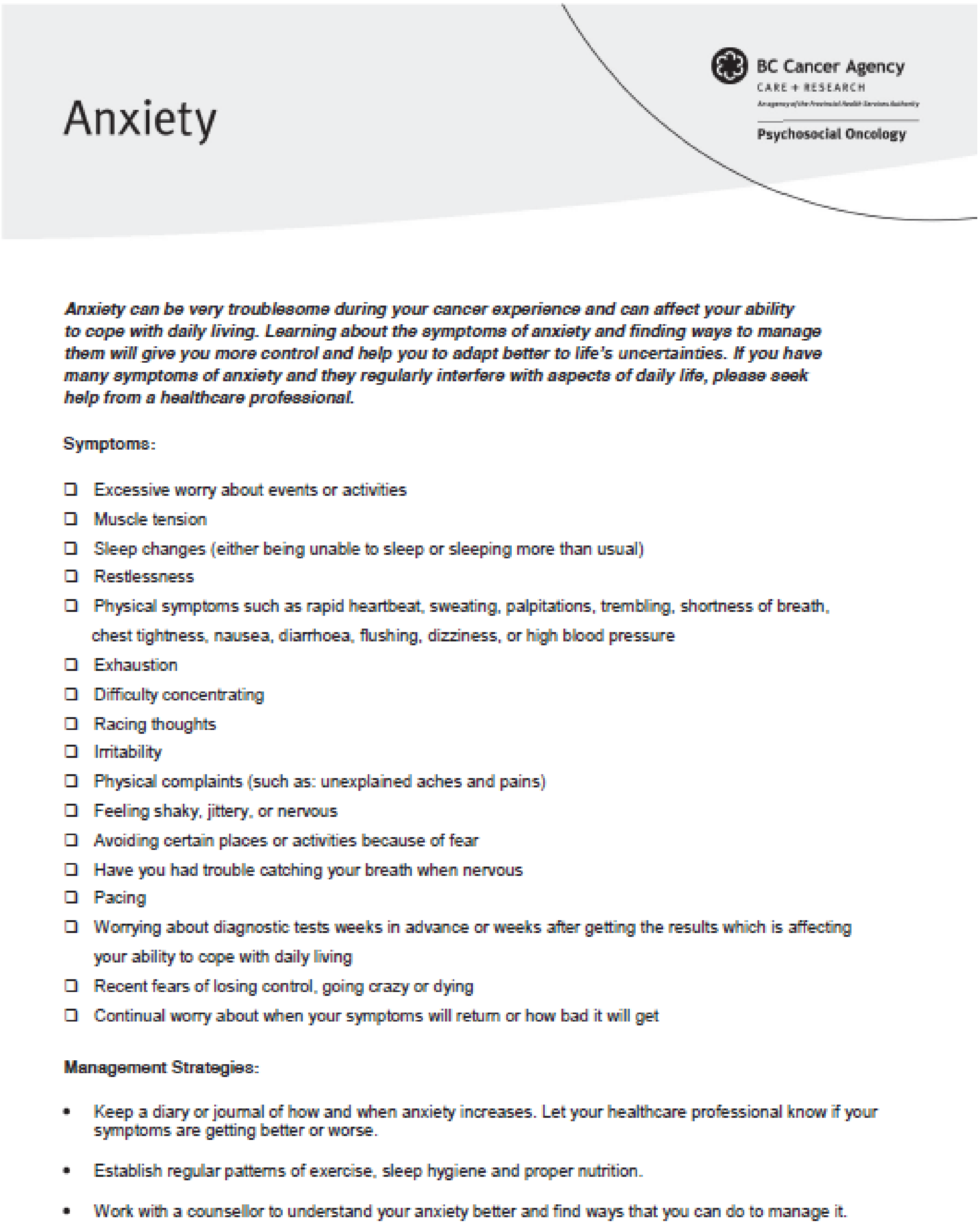
Lipase
BUN
B12
Electrolytes

Standing Order requests - expiry and frequency must be indicated

Physician Signature

Supplementary Resource 2: Coping with Anxiety Fact Sheet

http://www.bccancer.bc.ca/NR/rdonlyres/9E1A20D0-F427-4B88-B774-72C8EEA48CF2/65164/Anxiety2.pdf



Anxiety

Anxiety can be very troublesome during your cancer experience and can affect your ability to cope with daily living. Learning about the symptoms of anxiety and finding ways to manage them will give you more control and help you to adapt better to life's uncertainties. If you have many symptoms of anxiety and they regularly interfere with aspects of daily life, please seek help from a healthcare professional.

Symptoms:

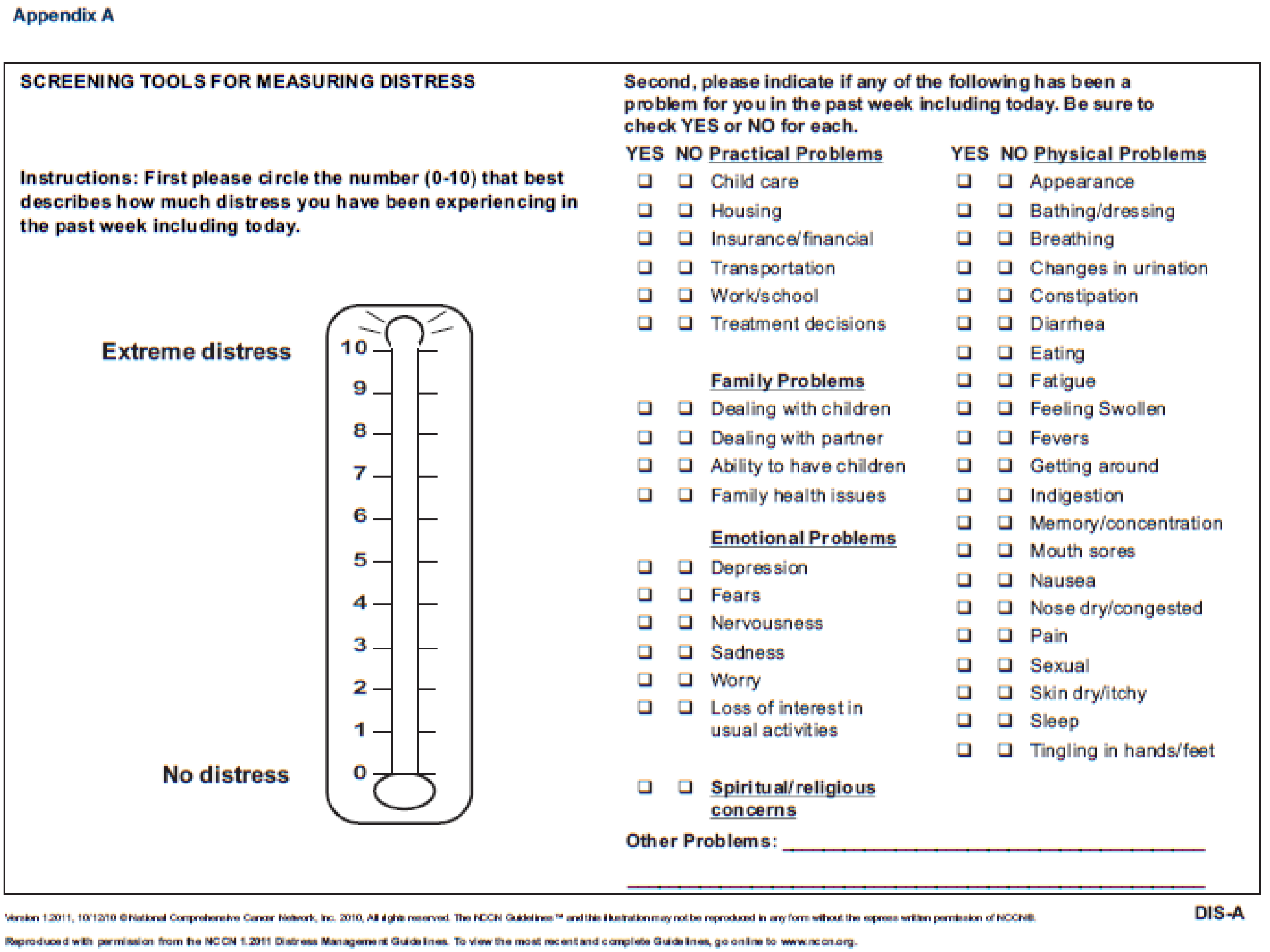
- ☐ Excessive worry about events or activities
- ☐ Muscle tension
- ☐ Sleep changes (either being unable to sleep or sleeping more than usual)
- ☐ Restlessness
- ☐ Physical symptoms such as rapid heartbeat, sweating, palpitations, trembling, shortness of breath, chest tightness, nausea, diarrhoea, flushing, dizziness, or high blood pressure
- ☐ Exhaustion
- ☐ Difficulty concentrating
- ☐ Racing thoughts
- ☐ Irritability
- ☐ Physical complaints (such as: unexplained aches and pains)
- ☐ Feeling shaky, jittery, or nervous
- ☐ Avoiding certain places or activities because of fear
- ☐ Have you had trouble catching your breath when nervous
- ☐ Pacing
- ☐ Worrying about diagnostic tests weeks in advance or weeks after getting the results which is affecting your ability to cope with daily living
- ☐ Recent fears of losing control, going crazy or dying
- ☐ Continual worry about when your symptoms will return or how bad it will get

Management Strategies:

- Keep a diary or journal of how and when anxiety increases. Let your healthcare professional know if your symptoms are getting better or worse.
- Establish regular patterns of exercise, sleep hygiene and proper nutrition.
- Work with a counsellor to understand your anxiety better and find ways that you can do to manage it.

Supplementary Resource 3: Screening for Measuring Distress Tool

http://www.bcguidelines.ca/pdf/palliative3_appendix_a.pdf



Appendix A

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress

10
9
8
7
6
5
4
3
2
1
0

No distress

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES NO Practical Problems

☐ ☐ Child care
☐ ☐ Housing
☐ ☐ Insurance/financial
☐ ☐ Transportation
☐ ☐ Work/school
☐ ☐ Treatment decisions

Family Problems

☐ ☐ Dealing with children
☐ ☐ Dealing with partner
☐ ☐ Ability to have children
☐ ☐ Family health issues

Emotional Problems

☐ ☐ Depression
☐ ☐ Fears
☐ ☐ Nervousness
☐ ☐ Sadness
☐ ☐ Worry
☐ ☐ Loss of interest in usual activities

☐ ☐ **Spiritual/religious concerns**

YES NO Physical Problems

☐ ☐ Appearance
☐ ☐ Bathing/dressing
☐ ☐ Breathing
☐ ☐ Changes in urination
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Eating
☐ ☐ Fatigue
☐ ☐ Feeling Swollen
☐ ☐ Fevers
☐ ☐ Getting around
☐ ☐ Indigestion
☐ ☐ Memory/concentration
☐ ☐ Mouth sores
☐ ☐ Nausea
☐ ☐ Nose dry/congested
☐ ☐ Pain
☐ ☐ Sexual
☐ ☐ Skin dry/itchy
☐ ☐ Sleep
☐ ☐ Tingling in hands/feet

Other Problems: ______________________________

____

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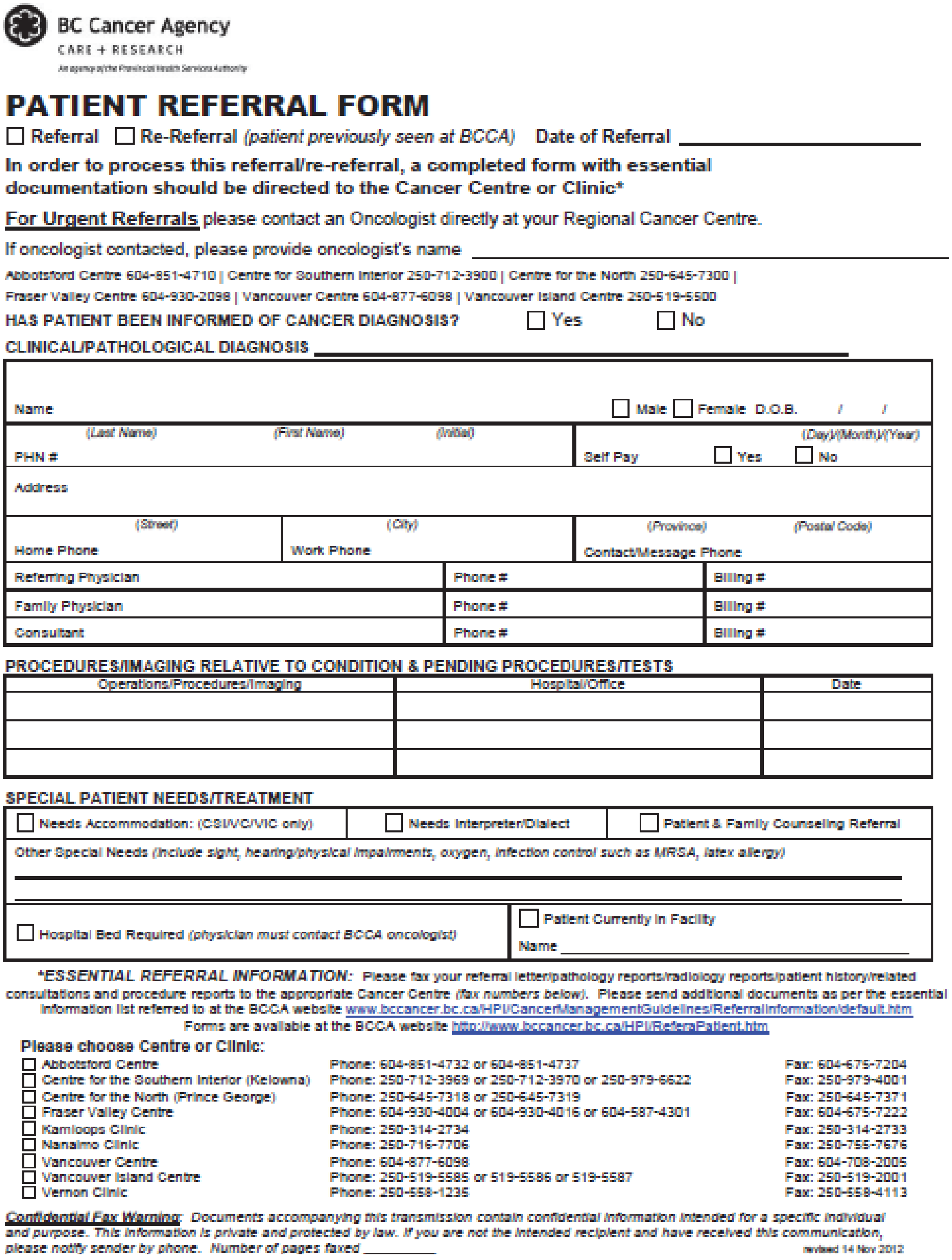
DIS-A

Reproduced with permission from the NCCN 1.2011 Distress Management Guidelines. To view the most recent and complete Guidelines, go online to www.nccn.org.

Supplementary Resource 4: BC Cancer Agency Patient Referral Form

http://www.bccancer.bc.ca/NR/rdonlyres/C4EBF6A4-8845-4945-984D-B8D5E5FD107B/64841/PatientReferralFormJune2013.pdf



BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

PATIENT REFERRAL FORM

☐ Referral ☐ Re-Referral *(patient previously seen at BCCA)* Date of Referral ____________

In order to process this referral/re-referral, a completed form with essential documentation should be directed to the Cancer Centre or Clinic*

For Urgent Referrals please contact an Oncologist directly at your Regional Cancer Centre.

If oncologist contacted, please provide oncologist's name ____________

Abbotsford Centre 604-851-4710 | Centre for Southern Interior 250-712-3900 | Centre for the North 250-645-7300 |
Fraser Valley Centre 604-930-2098 | Vancouver Centre 604-877-6098 | Vancouver Island Centre 250-519-5500

HAS PATIENT BEEN INFORMED OF CANCER DIAGNOSIS? ☐ Yes ☐ No

CLINICAL/PATHOLOGICAL DIAGNOSIS ____________

Name *(Last Name)* *(First Name)* *(Initial)*		☐ Male ☐ Female D.O.B. / / *(Day)/(Month)/(Year)*
PHN #		Self Pay ☐ Yes ☐ No
Address *(Street)*	*(City)*	*(Province)* *(Postal Code)*
Home Phone	Work Phone	Contact/Message Phone
Referring Physician	Phone #	Billing #
Family Physician	Phone #	Billing #
Consultant	Phone #	Billing #

PROCEDURES/IMAGING RELATIVE TO CONDITION & PENDING PROCEDURES/TESTS

Operations/Procedures/Imaging	Hospital/Office	Date

SPECIAL PATIENT NEEDS/TREATMENT

☐ Needs Accommodation: (CSI/VC/VIC only)	☐ Needs Interpreter/Dialect	☐ Patient & Family Counseling Referral
Other Special Needs *(include sight, hearing/physical impairments, oxygen, infection control such as MRSA, latex allergy)*		
☐ Hospital Bed Required *(physician must contact BCCA oncologist)*	☐ Patient Currently in Facility Name ____________	

**ESSENTIAL REFERRAL INFORMATION:* Please fax your referral letter/pathology reports/radiology reports/patient history/related consultations and procedure reports to the appropriate Cancer Centre *(fax numbers below)*. Please send additional documents as per the essential information list referred to at the BCCA website www.bccancer.bc.ca/HPI/CancerManagementGuidelines/ReferralInformation/default.htm
Forms are available at the BCCA website http://www.bccancer.bc.ca/HPI/ReferaPatient.htm

Please choose Centre or Clinic:

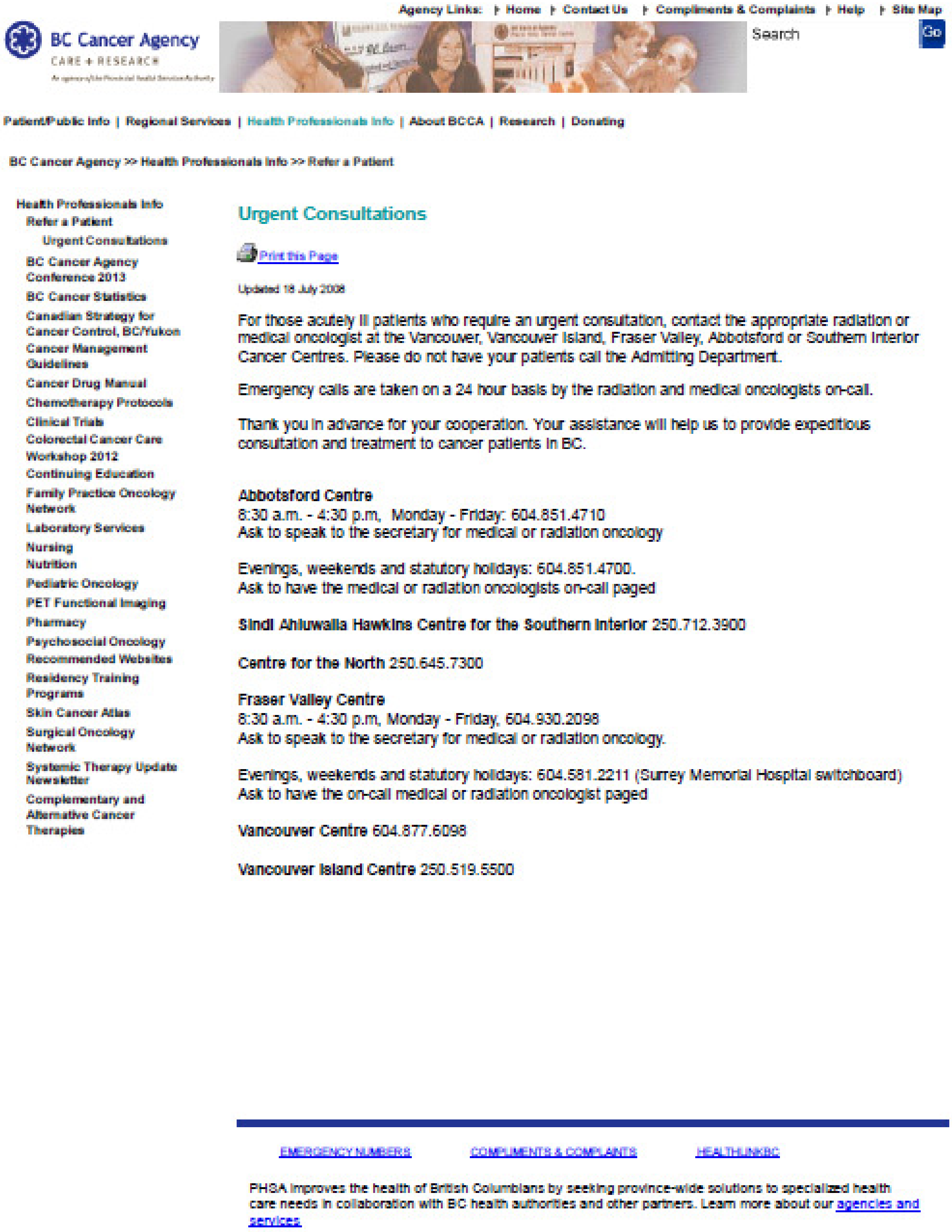
☐ Abbotsford Centre	Phone: 604-851-4732 or 604-851-4737	Fax: 604-675-7204
☐ Centre for the Southern Interior (Kelowna)	Phone: 250-712-3969 or 250-712-3970 or 250-979-6622	Fax: 250-979-4001
☐ Centre for the North (Prince George)	Phone: 250-645-7318 or 250-645-7319	Fax: 250-645-7371
☐ Fraser Valley Centre	Phone: 604-930-4004 or 604-930-4016 or 604-587-4301	Fax: 604-675-7222
☐ Kamloops Clinic	Phone: 250-314-2734	Fax: 250-314-2733
☐ Nanaimo Clinic	Phone: 250-716-7706	Fax: 250-755-7676
☐ Vancouver Centre	Phone: 604-877-6098	Fax: 604-708-2005
☐ Vancouver Island Centre	Phone: 250-519-5585 or 519-5586 or 519-5587	Fax: 250-519-2001
☐ Vernon Clinic	Phone: 250-558-1235	Fax: 250-558-4113

***Confidential Fax Warning**: Documents accompanying this transmission contain confidential information intended for a specific individual and purpose. This information is private and protected by law. If you are not the intended recipient and have received this communication, please notify sender by phone. Number of pages faxed ________*

revised 14 Nov 2012

Supplementary Resource 5: Relevant Cancer Centres Contact Information

http://www.bccancer.bc.ca/HPI/refer/urgent.htm



Urgent Consultations

Updated 18 July 2008

For those acutely ill patients who require an urgent consultation, contact the appropriate radiation or medical oncologist at the Vancouver, Vancouver Island, Fraser Valley, Abbotsford or Southern Interior Cancer Centres. Please do not have your patients call the Admitting Department.

Emergency calls are taken on a 24 hour basis by the radiation and medical oncologists on-call.

Thank you in advance for your cooperation. Your assistance will help us to provide expeditious consultation and treatment to cancer patients in BC.

Abbotsford Centre
8:30 a.m. - 4:30 p.m, Monday - Friday: 604.851.4710
Ask to speak to the secretary for medical or radiation oncology

Evenings, weekends and statutory holidays: 604.851.4700.
Ask to have the medical or radiation oncologists on-call paged

Sindi Ahluwalia Hawkins Centre for the Southern Interior 250.712.3900

Centre for the North 250.645.7300

Fraser Valley Centre
8:30 a.m. - 4:30 p.m, Monday - Friday, 604.930.2098
Ask to speak to the secretary for medical or radiation oncology.

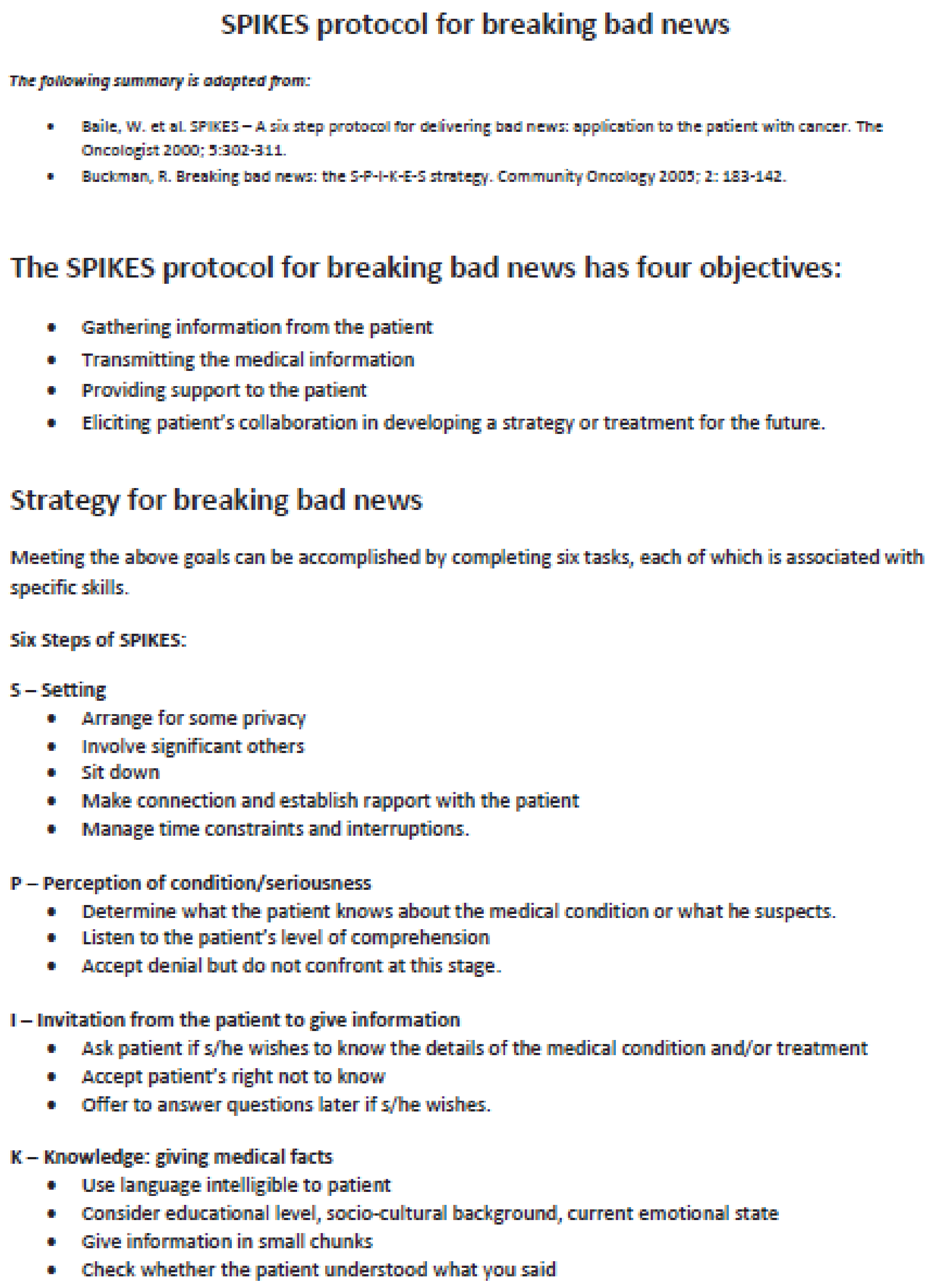
Evenings, weekends and statutory holidays: 604.581.2211 (Surrey Memorial Hospital switchboard)
Ask to have the on-call medical or radiation oncologist paged

Vancouver Centre 604.877.6098

Vancouver Island Centre 250.519.5500

PHSA improves the health of British Columbians by seeking province-wide solutions to specialized health care needs in collaboration with BC health authorities and other partners. Learn more about our agencies and services.

Supplementary Resource 6: SPIKES Protocol for Breaking Bad News
http://ubccpd.ca/sites/ubccpd.ca/files/SPIKES%20Protocol%20for%20Breaking%20Bad%20News.pdf



SPIKES protocol for breaking bad news

The following summary is adapted from:

- Baile, W. et al. SPIKES – A six step protocol for delivering bad news: application to the patient with cancer. The Oncologist 2000; 5:302-311.
- Buckman, R. Breaking bad news: the S-P-I-K-E-S strategy. Community Oncology 2005; 2: 183-142.

The SPIKES protocol for breaking bad news has four objectives:

- Gathering information from the patient
- Transmitting the medical information
- Providing support to the patient
- Eliciting patient's collaboration in developing a strategy or treatment for the future.

Strategy for breaking bad news

Meeting the above goals can be accomplished by completing six tasks, each of which is associated with specific skills.

Six Steps of SPIKES:

S – Setting
- Arrange for some privacy
- Involve significant others
- Sit down
- Make connection and establish rapport with the patient
- Manage time constraints and interruptions.

P – Perception of condition/seriousness
- Determine what the patient knows about the medical condition or what he suspects.
- Listen to the patient's level of comprehension
- Accept denial but do not confront at this stage.

I – Invitation from the patient to give information
- Ask patient if s/he wishes to know the details of the medical condition and/or treatment
- Accept patient's right not to know
- Offer to answer questions later if s/he wishes.

K – Knowledge: giving medical facts
- Use language intelligible to patient
- Consider educational level, socio-cultural background, current emotional state
- Give information in small chunks
- Check whether the patient understood what you said

Supplementary Resource 7: BC Government Advanced Care Planning

http://www2.gov.bc.ca/gov/DownloadAsset?assetId=8DB72E7B80A545CD94F04FD03570B12C

What to do with your advance care plan

Keep it at home in an easily found location - e.g. placed in a folder and attached to the fridge with a magnet.

Be sure to give a copy to your close family, health care provider, your Representative (if you named one) and any others close to you.

What if you change your mind?

Circumstances change. Even your beliefs, values and wishes can change. As long as you are capable of making your own decisions, you can cancel or change any part of your advance care plan.

Download the provincial advance care planning guide and workbook at: www.gov.bc.ca/advancecare

For more information on advance care planning, call HealthLink BC at 8-1-1.

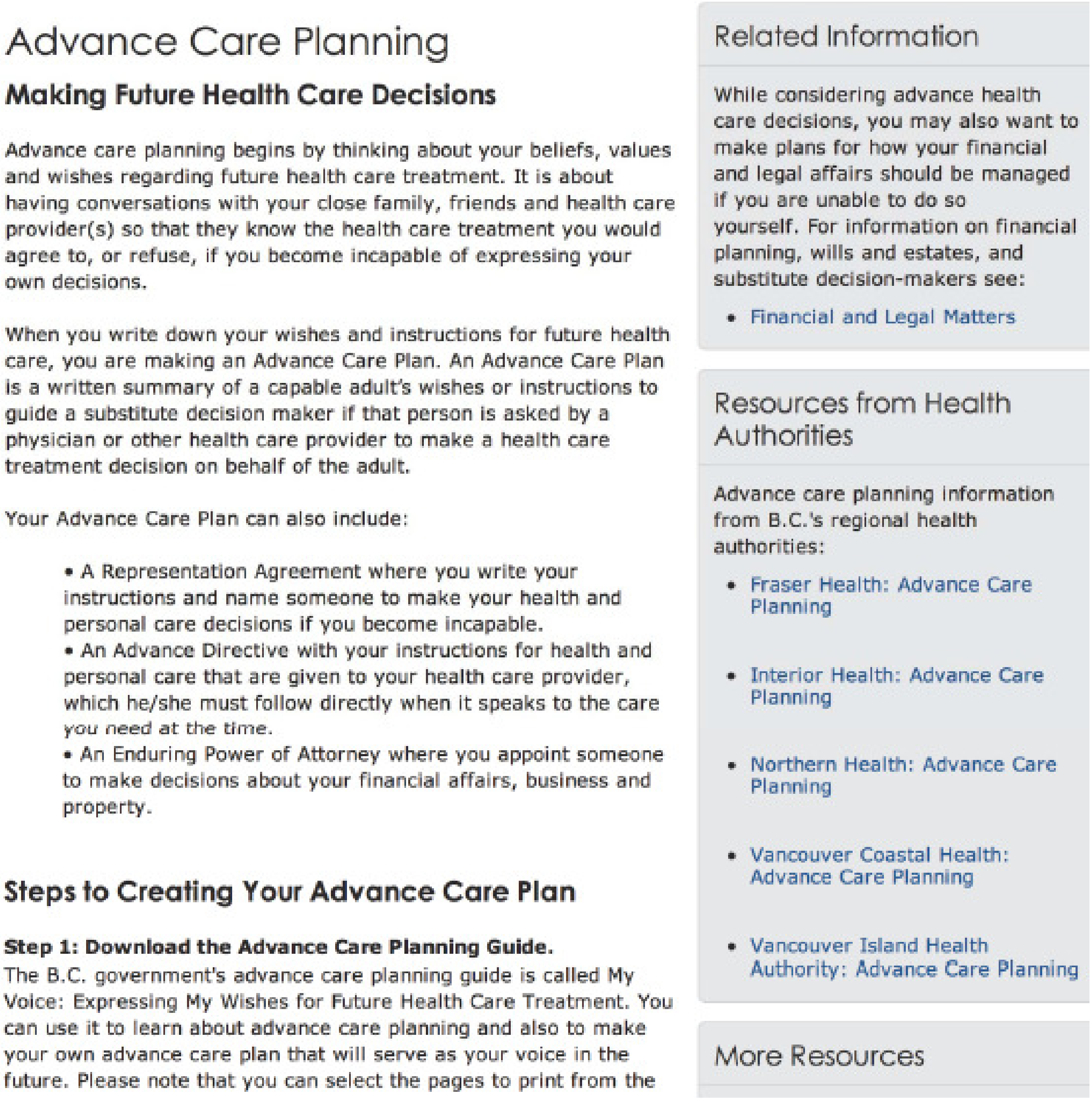
Advance Care Planning

Expressing your wishes and instructions for future health care treatment

By planning ahead, you have a voice in your future health care decisions and will be sure your wishes are respected.

Every capable adult should think about making an advance care plan.

Supplementary Resource 7.1: Government Advanced Care Planning
http://www2.gov.bc.ca/gov/topic.page?id=E7A581A9BC0A467E916CFC5AD2D3B1E8



Advance Care Planning

Making Future Health Care Decisions

Advance care planning begins by thinking about your beliefs, values and wishes regarding future health care treatment. It is about having conversations with your close family, friends and health care provider(s) so that they know the health care treatment you would agree to, or refuse, if you become incapable of expressing your own decisions.

When you write down your wishes and instructions for future health care, you are making an Advance Care Plan. An Advance Care Plan is a written summary of a capable adult's wishes or instructions to guide a substitute decision maker if that person is asked by a physician or other health care provider to make a health care treatment decision on behalf of the adult.

Your Advance Care Plan can also include:

- A Representation Agreement where you write your instructions and name someone to make your health and personal care decisions if you become incapable.
- An Advance Directive with your instructions for health and personal care that are given to your health care provider, which he/she must follow directly when it speaks to the care you need at the time.
- An Enduring Power of Attorney where you appoint someone to make decisions about your financial affairs, business and property.

Steps to Creating Your Advance Care Plan

Step 1: Download the Advance Care Planning Guide.
The B.C. government's advance care planning guide is called My Voice: Expressing My Wishes for Future Health Care Treatment. You can use it to learn about advance care planning and also to make your own advance care plan that will serve as your voice in the future. Please note that you can select the pages to print from the

Related Information

While considering advance health care decisions, you may also want to make plans for how your financial and legal affairs should be managed if you are unable to do so yourself. For information on financial planning, wills and estates, and substitute decision-makers see:

- Financial and Legal Matters

Resources from Health Authorities

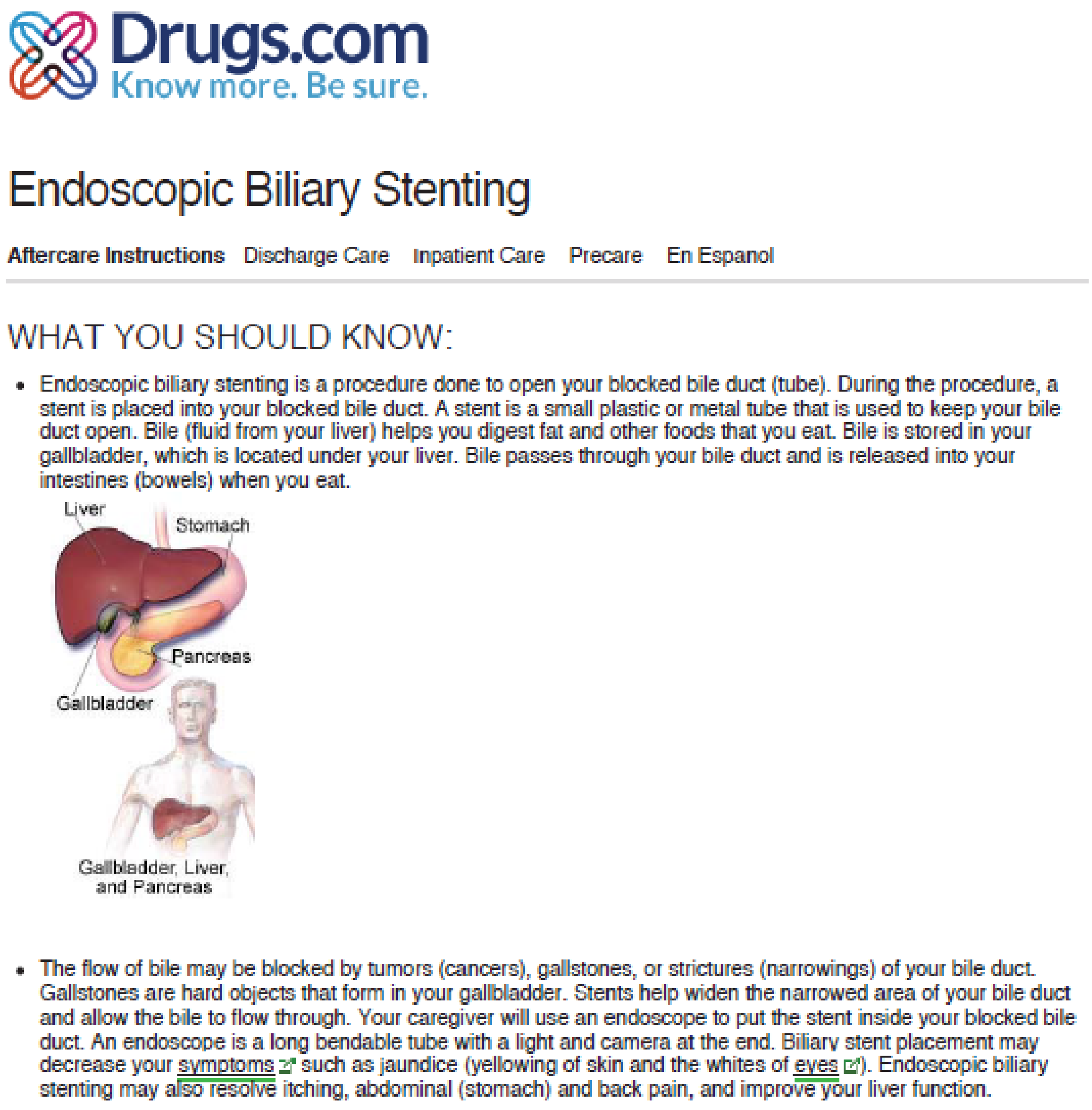
Advance care planning information from B.C.'s regional health authorities:

- Fraser Health: Advance Care Planning
- Interior Health: Advance Care Planning
- Northern Health: Advance Care Planning
- Vancouver Coastal Health: Advance Care Planning
- Vancouver Island Health Authority: Advance Care Planning

More Resources

Supplementary Resource 8: Endoscopic Biliary Stenting

http://www.drugs.com/cg/endoscopic-biliary-stenting-aftercare-instructions.html



Drugs.com
Know more. Be sure.

Endoscopic Biliary Stenting

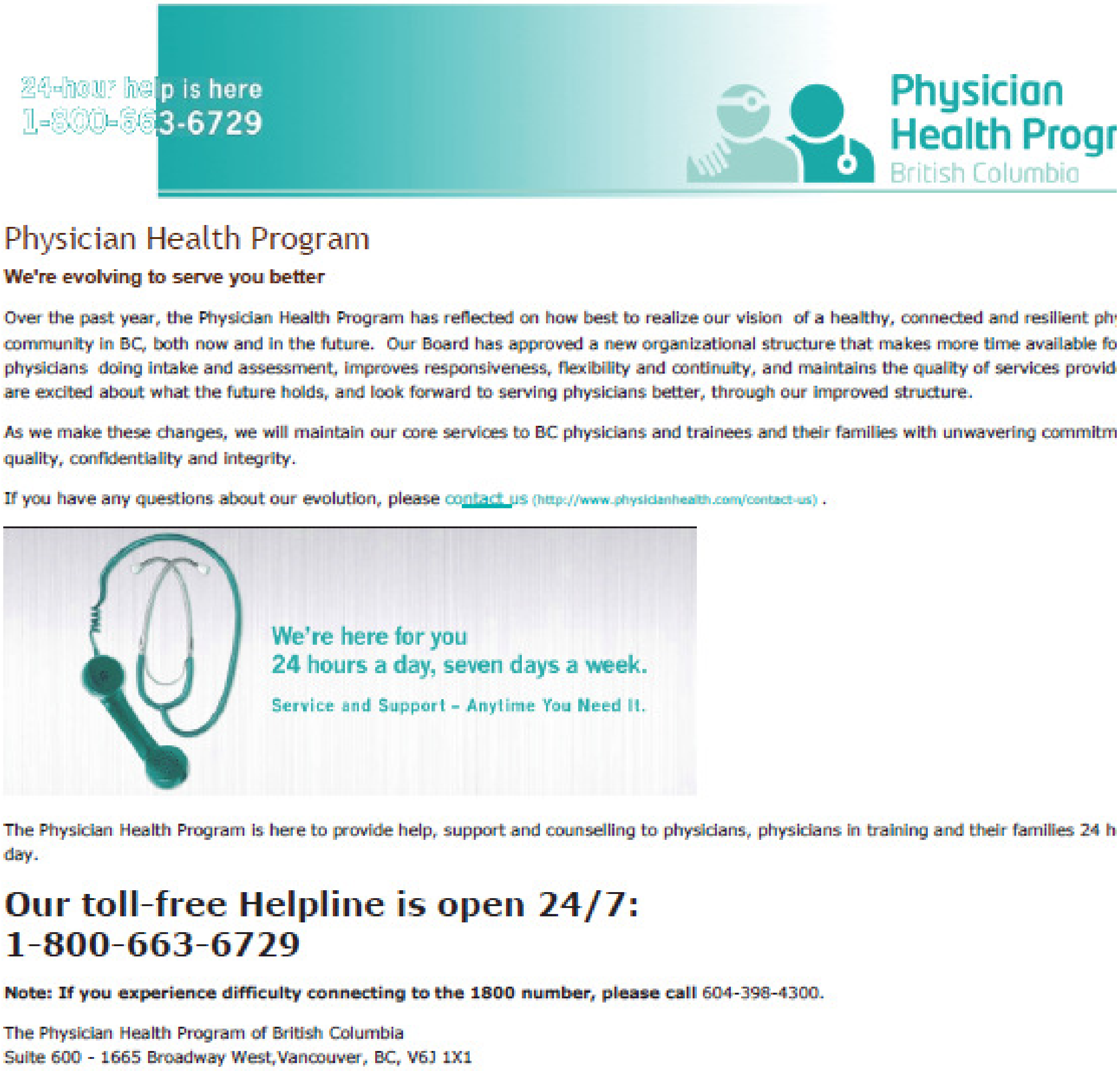
Aftercare Instructions Discharge Care Inpatient Care Precare En Espanol

WHAT YOU SHOULD KNOW:

- Endoscopic biliary stenting is a procedure done to open your blocked bile duct (tube). During the procedure, a stent is placed into your blocked bile duct. A stent is a small plastic or metal tube that is used to keep your bile duct open. Bile (fluid from your liver) helps you digest fat and other foods that you eat. Bile is stored in your gallbladder, which is located under your liver. Bile passes through your bile duct and is released into your intestines (bowels) when you eat.

- The flow of bile may be blocked by tumors (cancers), gallstones, or strictures (narrowings) of your bile duct. Gallstones are hard objects that form in your gallbladder. Stents help widen the narrowed area of your bile duct and allow the bile to flow through. Your caregiver will use an endoscope to put the stent inside your blocked bile duct. An endoscope is a long bendable tube with a light and camera at the end. Biliary stent placement may decrease your symptoms such as jaundice (yellowing of skin and the whites of eyes). Endoscopic biliary stenting may also resolve itching, abdominal (stomach) and back pain, and improve your liver function.

Supplementary Resource 9: BC College of Physicians and Surgeons Contact Information
http://www.physicianhealth.com/



Physician Health Program

We're evolving to serve you better

Over the past year, the Physician Health Program has reflected on how best to realize our vision of a healthy, connected and resilient ph community in BC, both now and in the future. Our Board has approved a new organizational structure that makes more time available fo physicians doing intake and assessment, improves responsiveness, flexibility and continuity, and maintains the quality of services provid are excited about what the future holds, and look forward to serving physicians better, through our improved structure.

As we make these changes, we will maintain our core services to BC physicians and trainees and their families with unwavering commitm quality, confidentiality and integrity.

If you have any questions about our evolution, please contact us (http://www.physicianhealth.com/contact-us) .

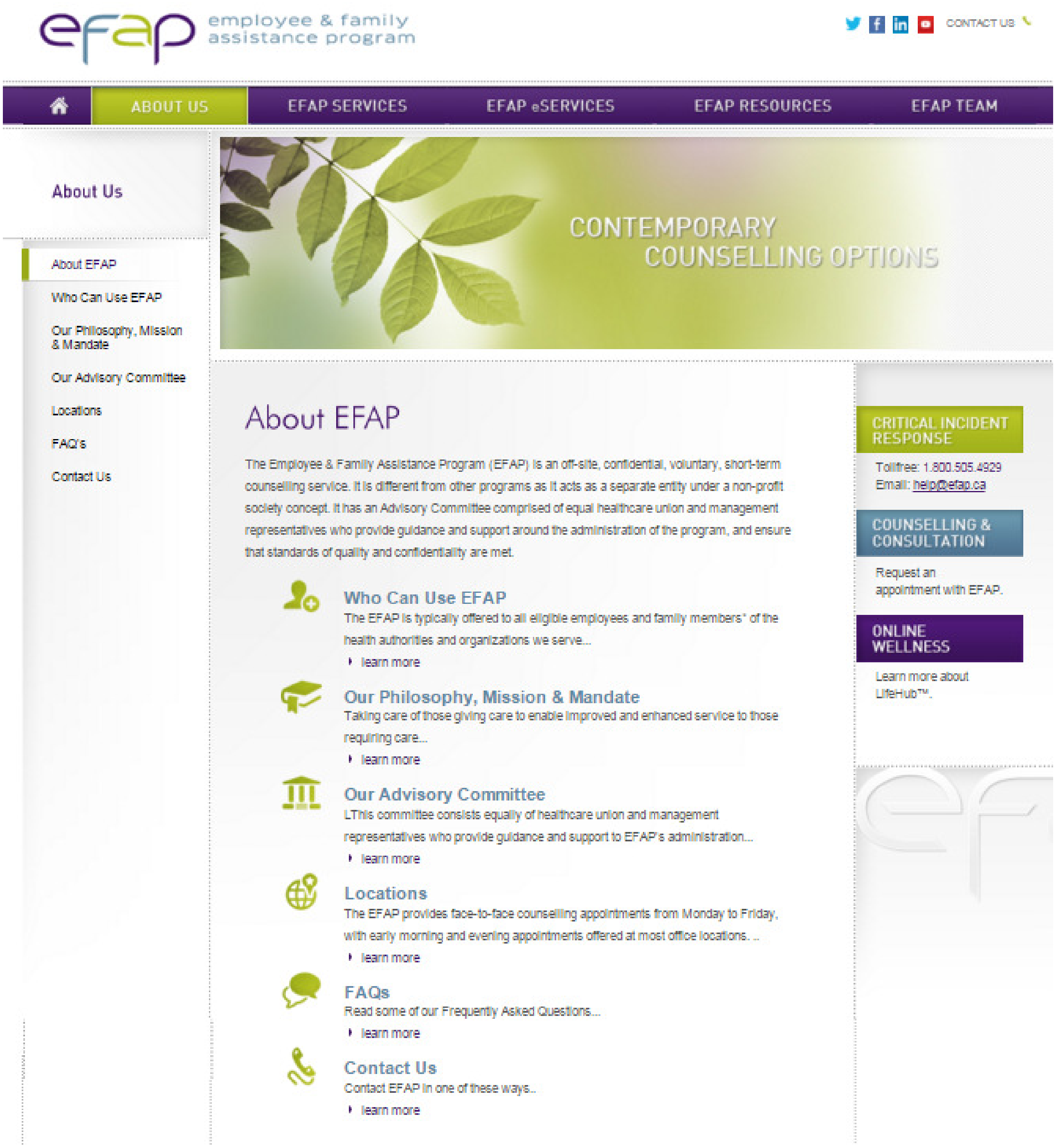
The Physician Health Program is here to provide help, support and counselling to physicians, physicians in training and their families 24 h day.

Our toll-free Helpline is open 24/7:
1-800-663-6729

Note: If you experience difficulty connecting to the 1800 number, please call 604-398-4300.

The Physician Health Program of British Columbia
Suite 600 - 1665 Broadway West,Vancouver, BC, V6J 1X1

Supplementary Resource 10: Employee & Family Assistance Program
http://www.efap.ca/about/



About EFAP

The Employee & Family Assistance Program (EFAP) is an off-site, confidential, voluntary, short-term counselling service. It is different from other programs as it acts as a separate entity under a non-profit society concept. It has an Advisory Committee comprised of equal healthcare union and management representatives who provide guidance and support around the administration of the program, and ensure that standards of quality and confidentiality are met.

Who Can Use EFAP
The EFAP is typically offered to all eligible employees and family members* of the health authorities and organizations we serve...
learn more

Our Philosophy, Mission & Mandate
Taking care of those giving care to enable improved and enhanced service to those requiring care...
learn more

Our Advisory Committee
LThis committee consists equally of healthcare union and management representatives who provide guidance and support to EFAP's administration...
learn more

Locations
The EFAP provides face-to-face counselling appointments from Monday to Friday, with early morning and evening appointments offered at most office locations. ..
learn more

FAQs
Read some of our Frequently Asked Questions...
learn more

Contact Us
Contact EFAP in one of these ways..
learn more

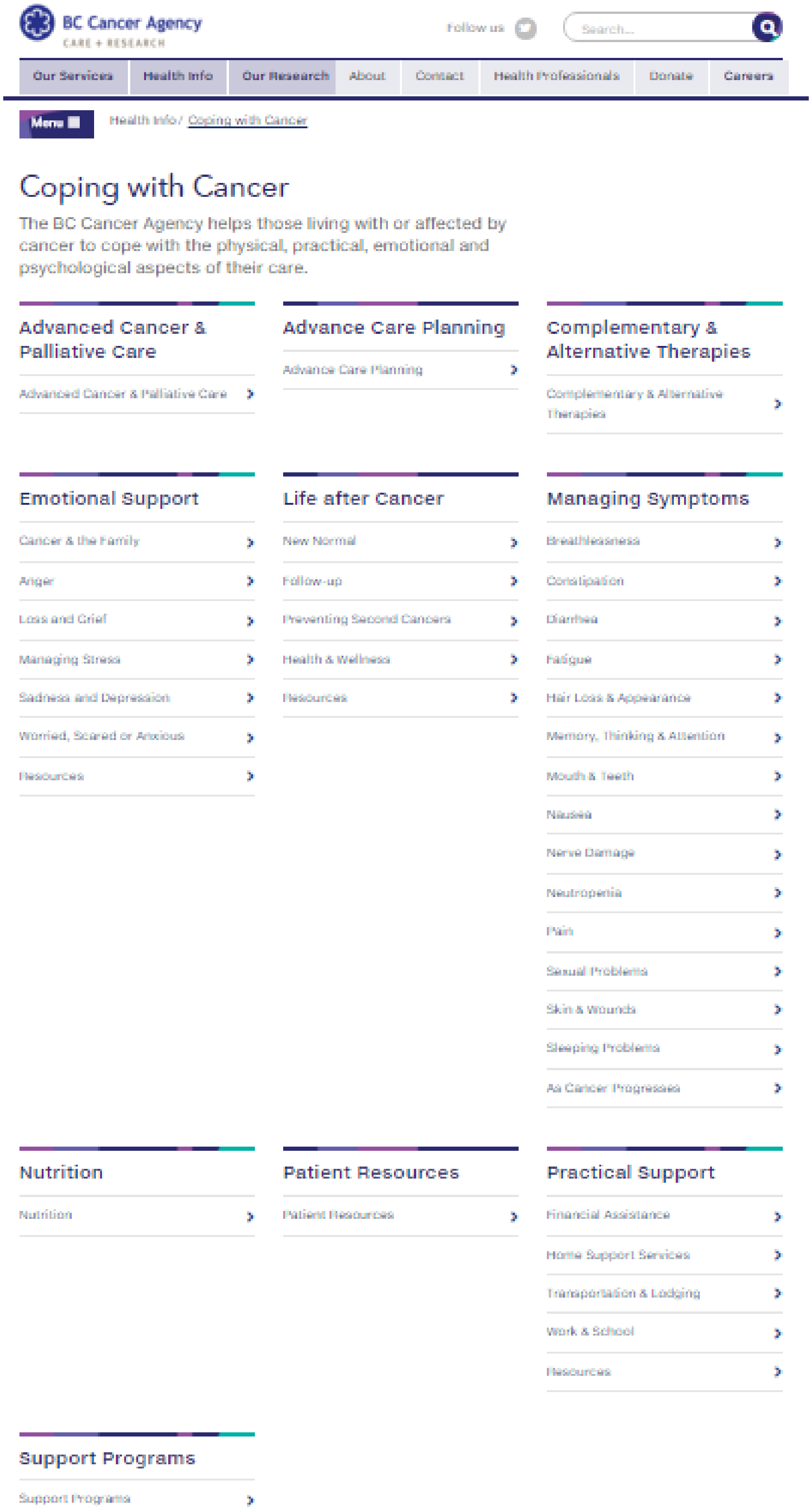
Tollfree: 1.800.505.4929
Email: help@efap.ca

Request an appointment with EFAP.

Learn more about LifeHub™.

Supplementary Resource 11: BC Cancer Agency Coping with Cancer

http://www.bccancer.bc.ca/health-info/coping-with-cancer



Coping with Cancer

The BC Cancer Agency helps those living with or affected by cancer to cope with the physical, practical, emotional and psychological aspects of their care.

Advanced Cancer & Palliative Care

- Advanced Cancer & Palliative Care

Advance Care Planning

- Advance Care Planning

Complementary & Alternative Therapies

- Complementary & Alternative Therapies

Emotional Support

- Cancer & the Family
- Anger
- Loss and Grief
- Managing Stress
- Sadness and Depression
- Worried, Scared or Anxious
- Resources

Life after Cancer

- New Normal
- Follow-up
- Preventing Second Cancers
- Health & Wellness
- Resources

Managing Symptoms

- Breathlessness
- Constipation
- Diarrhea
- Fatigue
- Hair Loss & Appearance
- Memory, Thinking & Attention
- Mouth & Teeth
- Nausea
- Nerve Damage
- Neutropenia
- Pain
- Sexual Problems
- Skin & Wounds
- Sleeping Problems
- As Cancer Progresses

Nutrition

- Nutrition

Patient Resources

- Patient Resources

Practical Support

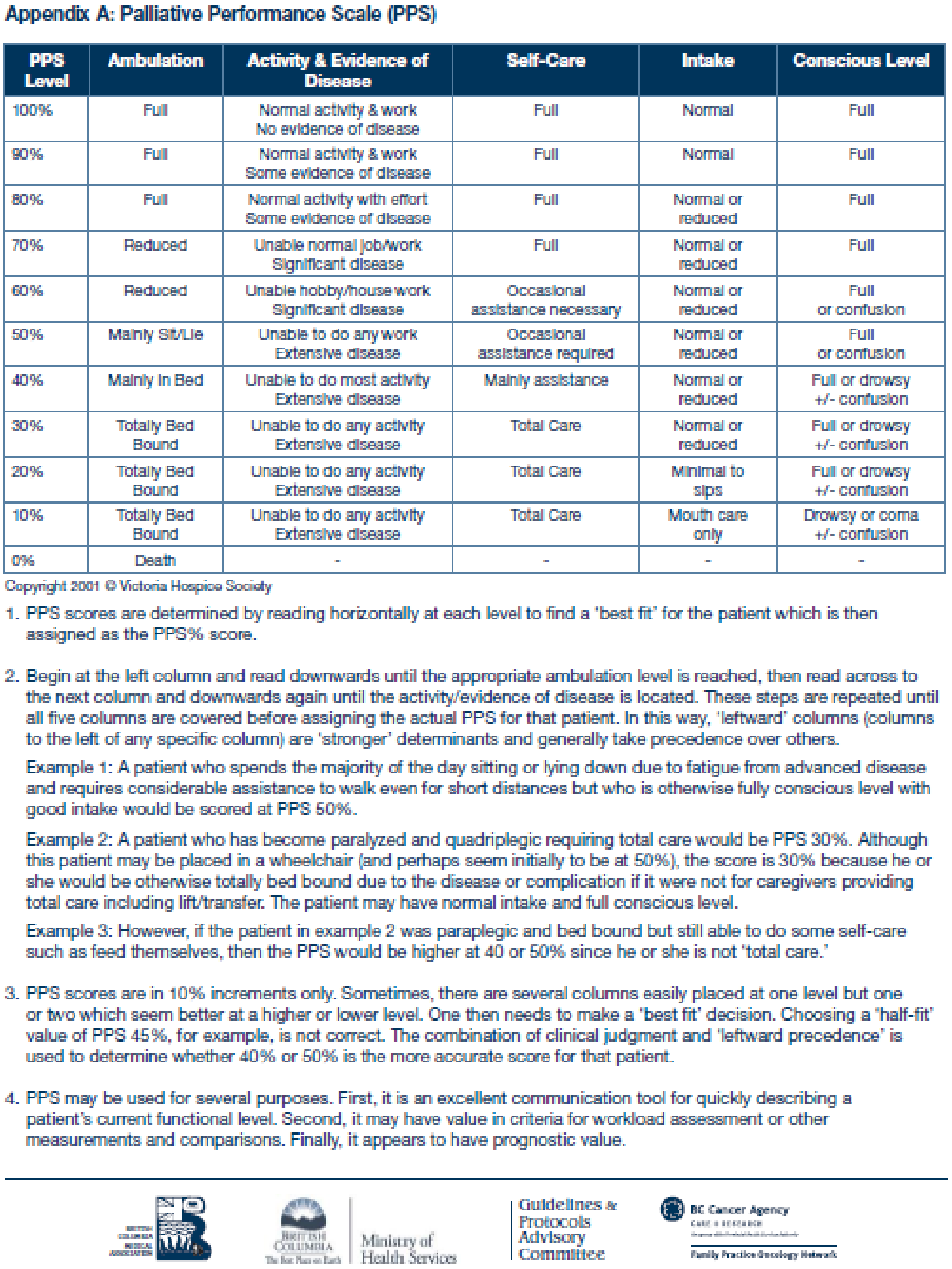
- Financial Assistance
- Home Support Services
- Transportation & Lodging
- Work & School
- Resources

Support Programs

- Support Programs

Supplementary Resource 12: Palliative Performance Scale (PPS)

http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative1_appendix_a.pdf



Appendix A: Palliative Performance Scale (PPS)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
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
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
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Occasional 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
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
0%	Death	-	-	-	-

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.

2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.

   Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.

   Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.

   Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not 'total care.'

3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.

4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

British Columbia Medical Association
British Columbia The Best Place on Earth | Ministry of Health Services
Guidelines & Protocols Advisory Committee
BC Cancer Agency CARE + RESEARCH
Family Practice Oncology Network

Supplementary Resource 13: BC Ministry of Health Palliative Care Benefits Program- Physician Guide
http://www2.gov.bc.ca/assets/gov/health/health-drug-coverage/pharmacare/palliative-physguide.pdf

BRITISH COLUMBIA | Ministry of Health

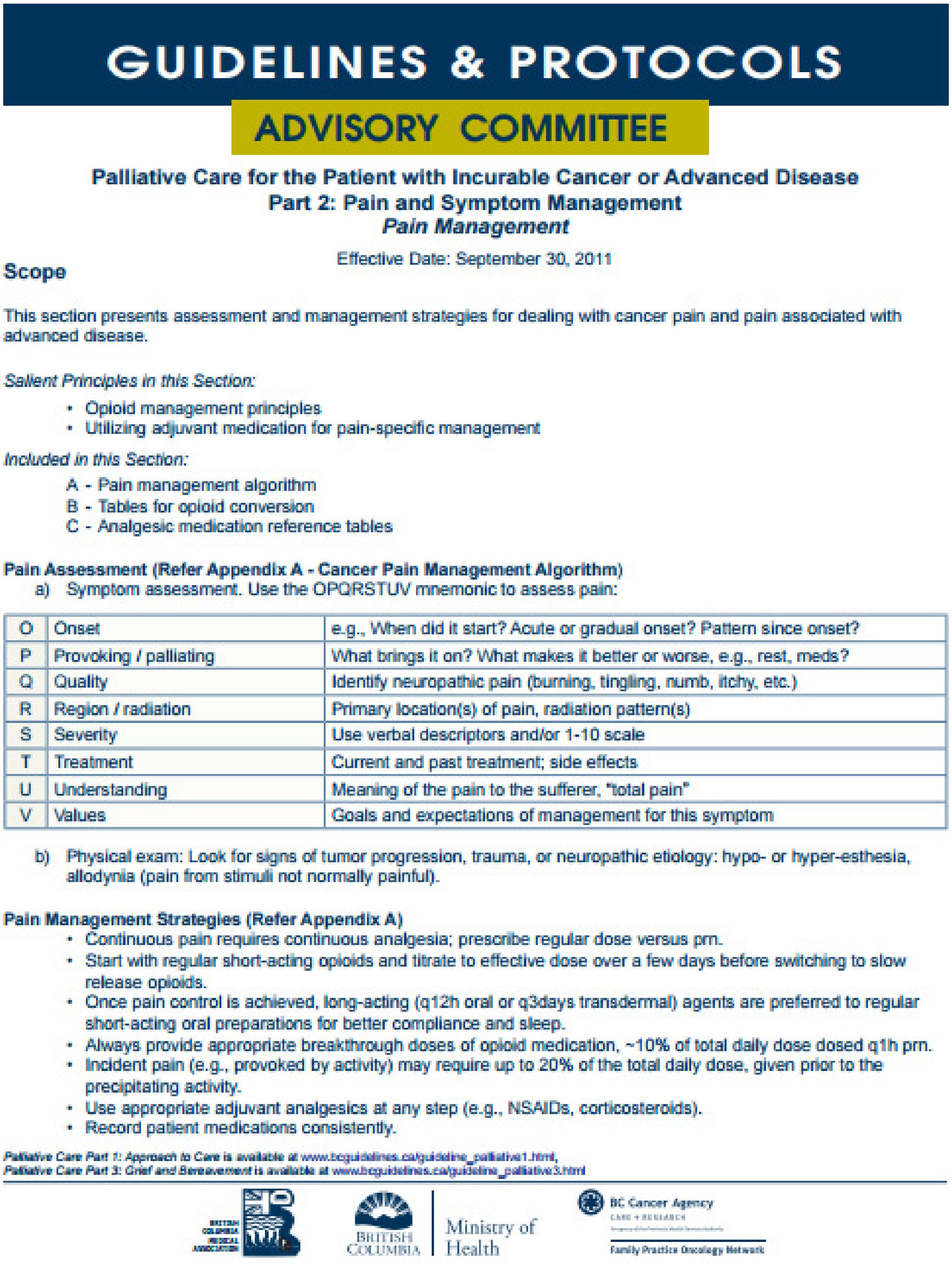
BC PALLIATIVE CARE BENEFITS

PRESCRIBER GUIDE

VERSION 2.5

OCTOBER 29, 2015

Supplementary Resource 14: GPAC Guidelines- Pain Management
http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/palliative-pain-management#part2-pain



GUIDELINES & PROTOCOLS

ADVISORY COMMITTEE

Palliative Care for the Patient with Incurable Cancer or Advanced Disease
Part 2: Pain and Symptom Management
Pain Management

Effective Date: September 30, 2011

Scope

This section presents assessment and management strategies for dealing with cancer pain and pain associated with advanced disease.

Salient Principles in this Section:

- Opioid management principles
- Utilizing adjuvant medication for pain-specific management

Included in this Section:

A - Pain management algorithm
B - Tables for opioid conversion
C - Analgesic medication reference tables

Pain Assessment (Refer Appendix A - Cancer Pain Management Algorithm)

a) Symptom assessment. Use the OPQRSTUV mnemonic to assess pain:

O	Onset	e.g., When did it start? Acute or gradual onset? Pattern since onset?
P	Provoking / palliating	What brings it on? What makes it better or worse, e.g., rest, meds?
Q	Quality	Identify neuropathic pain (burning, tingling, numb, itchy, etc.)
R	Region / radiation	Primary location(s) of pain, radiation pattern(s)
S	Severity	Use verbal descriptors and/or 1-10 scale
T	Treatment	Current and past treatment; side effects
U	Understanding	Meaning of the pain to the sufferer, "total pain"
V	Values	Goals and expectations of management for this symptom

b) Physical exam: Look for signs of tumor progression, trauma, or neuropathic etiology: hypo- or hyper-esthesia, allodynia (pain from stimuli not normally painful).

Pain Management Strategies (Refer Appendix A)

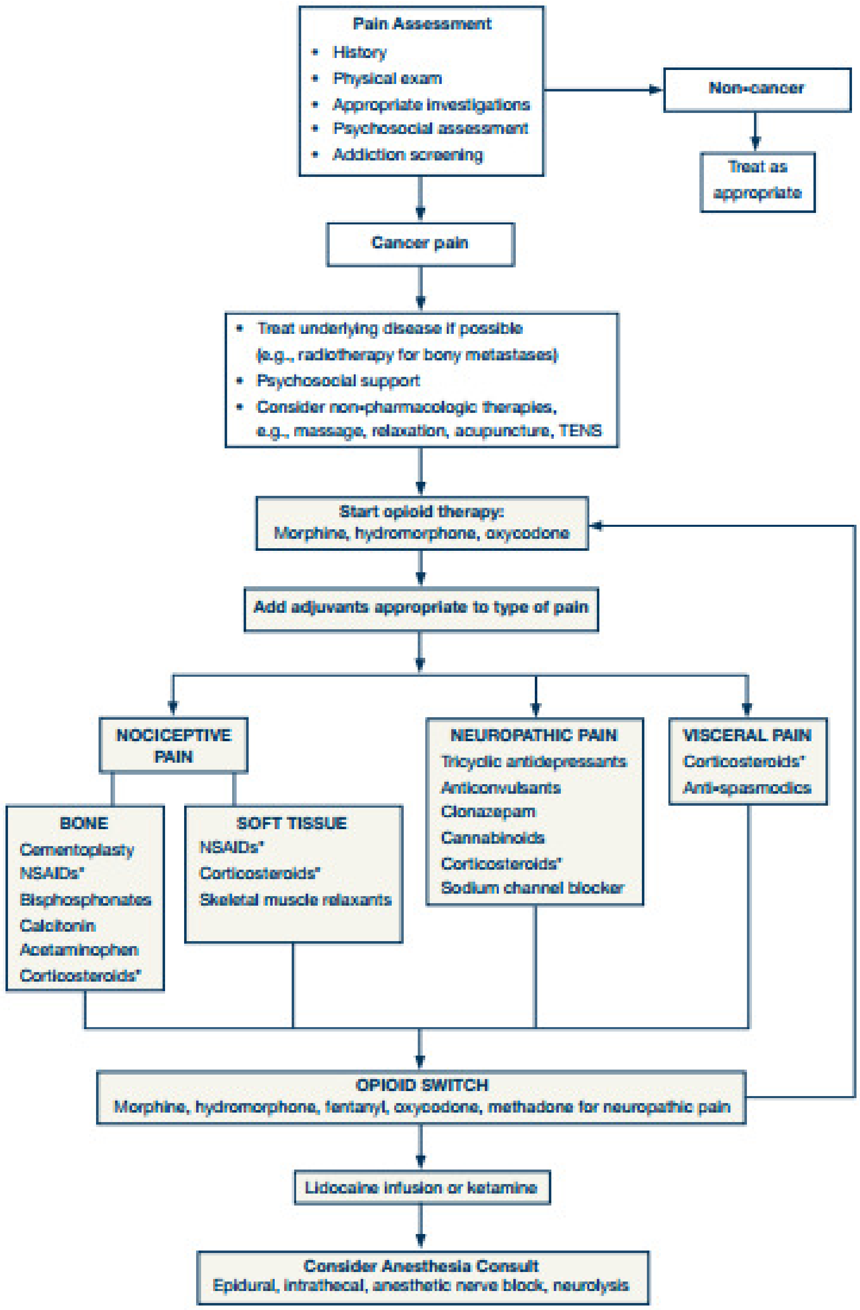
- Continuous pain requires continuous analgesia; prescribe regular dose versus prn.
- Start with regular short-acting opioids and titrate to effective dose over a few days before switching to slow release opioids.
- Once pain control is achieved, long-acting (q12h oral or q3days transdermal) agents are preferred to regular short-acting oral preparations for better compliance and sleep.
- Always provide appropriate breakthrough doses of opioid medication, ~10% of total daily dose dosed q1h prn.
- Incident pain (e.g., provoked by activity) may require up to 20% of the total daily dose, given prior to the precipitating activity.
- Use appropriate adjuvant analgesics at any step (e.g., NSAIDs, corticosteroids).
- Record patient medications consistently.

Palliative Care Part 1: Approach to Care is available at www.bcguidelines.ca/guideline_palliative1.html,
Palliative Care Part 3: Grief and Bereavement is available at www.bcguidelines.ca/guideline_palliative3.html

British Columbia Medical Association
British Columbia | Ministry of Health
BC Cancer Agency
Family Practice Oncology Network

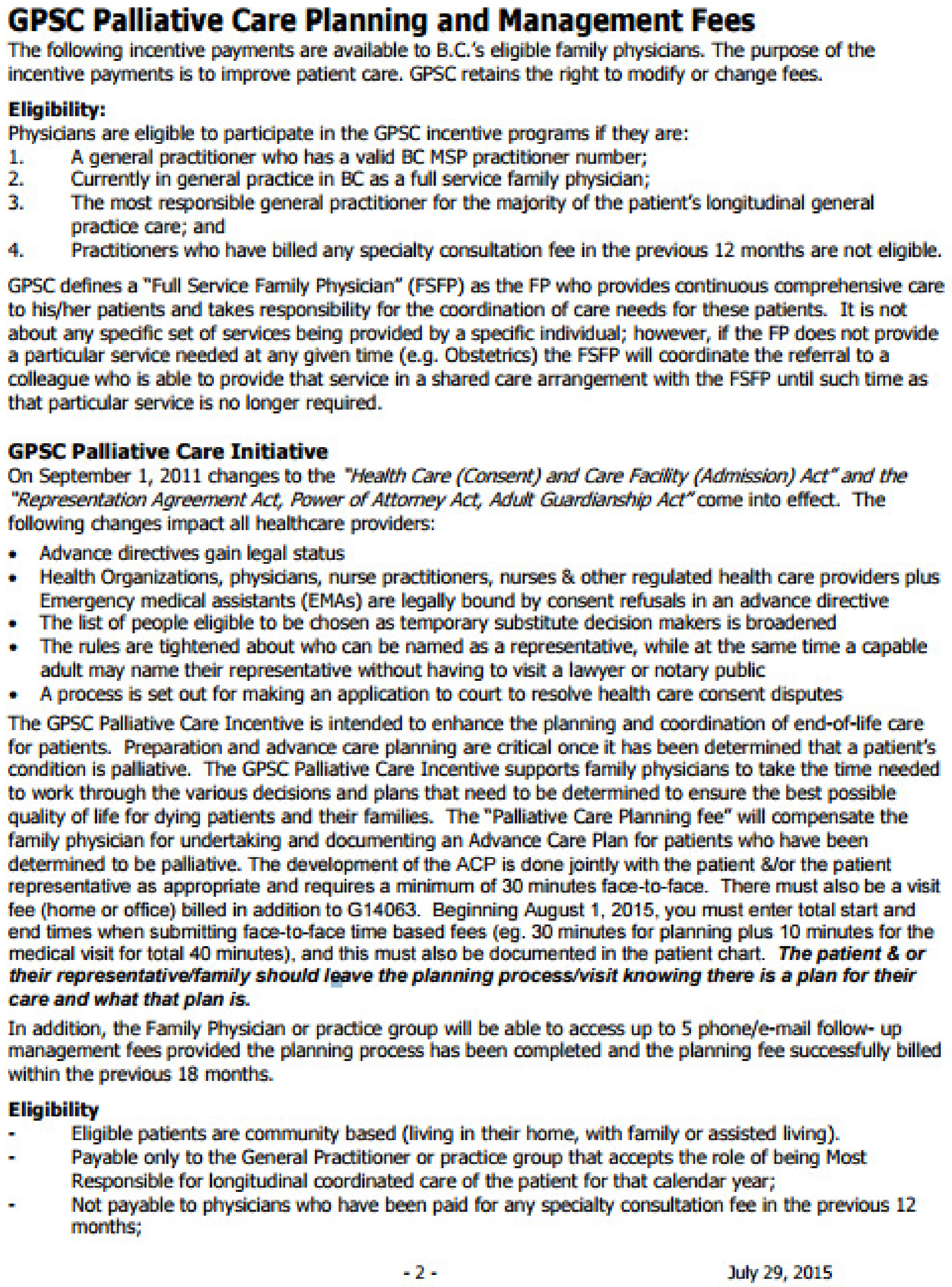
Supplementary Resource 15: GPAC Guidelines Pain Management Algorithm
http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative2_pain_appendix_a.pdf

Appendix A: Cancer Pain Management Algorithm



*Use gastric cytoprotection *(refer Appendix C - Medications Used in Palliative Care: Gastric Cytoprotection)*

Supplementary Resource 16: GP Services Committee Palliative Care Incentives
http://www.gpscbc.ca/sites/default/files/uploads/GPSC%20Billing%20Guide%20-%20Pallative%20Care%20201507.pdf



GPSC Palliative Care Planning and Management Fees

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. GPSC retains the right to modify or change fees.

Eligibility:

Physicians are eligible to participate in the GPSC incentive programs if they are:

1. A general practitioner who has a valid BC MSP practitioner number;
2. Currently in general practice in BC as a full service family physician;
3. The most responsible general practitioner for the majority of the patient's longitudinal general practice care; and
4. Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g. Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.

GPSC Palliative Care Initiative

On September 1, 2011 changes to the *"Health Care (Consent) and Care Facility (Admission) Act" and the "Representation Agreement Act, Power of Attorney Act, Adult Guardianship Act"* come into effect. The following changes impact all healthcare providers:

- Advance directives gain legal status
- Health Organizations, physicians, nurse practitioners, nurses & other regulated health care providers plus Emergency medical assistants (EMAs) are legally bound by consent refusals in an advance directive
- The list of people eligible to be chosen as temporary substitute decision makers is broadened
- The rules are tightened about who can be named as a representative, while at the same time a capable adult may name their representative without having to visit a lawyer or notary public
- A process is set out for making an application to court to resolve health care consent disputes

The GPSC Palliative Care Incentive is intended to enhance the planning and coordination of end-of-life care for patients. Preparation and advance care planning are critical once it has been determined that a patient's condition is palliative. The GPSC Palliative Care Incentive supports family physicians to take the time needed to work through the various decisions and plans that need to be determined to ensure the best possible quality of life for dying patients and their families. The "Palliative Care Planning fee" will compensate the family physician for undertaking and documenting an Advance Care Plan for patients who have been determined to be palliative. The development of the ACP is done jointly with the patient &/or the patient representative as appropriate and requires a minimum of 30 minutes face-to-face. There must also be a visit fee (home or office) billed in addition to G14063. Beginning August 1, 2015, you must enter total start and end times when submitting face-to-face time based fees (eg. 30 minutes for planning plus 10 minutes for the medical visit for total 40 minutes), and this must also be documented in the patient chart. ***The patient & or their representative/family should leave the planning process/visit knowing there is a plan for their care and what that plan is.***

In addition, the Family Physician or practice group will be able to access up to 5 phone/e-mail follow- up management fees provided the planning process has been completed and the planning fee successfully billed within the previous 18 months.

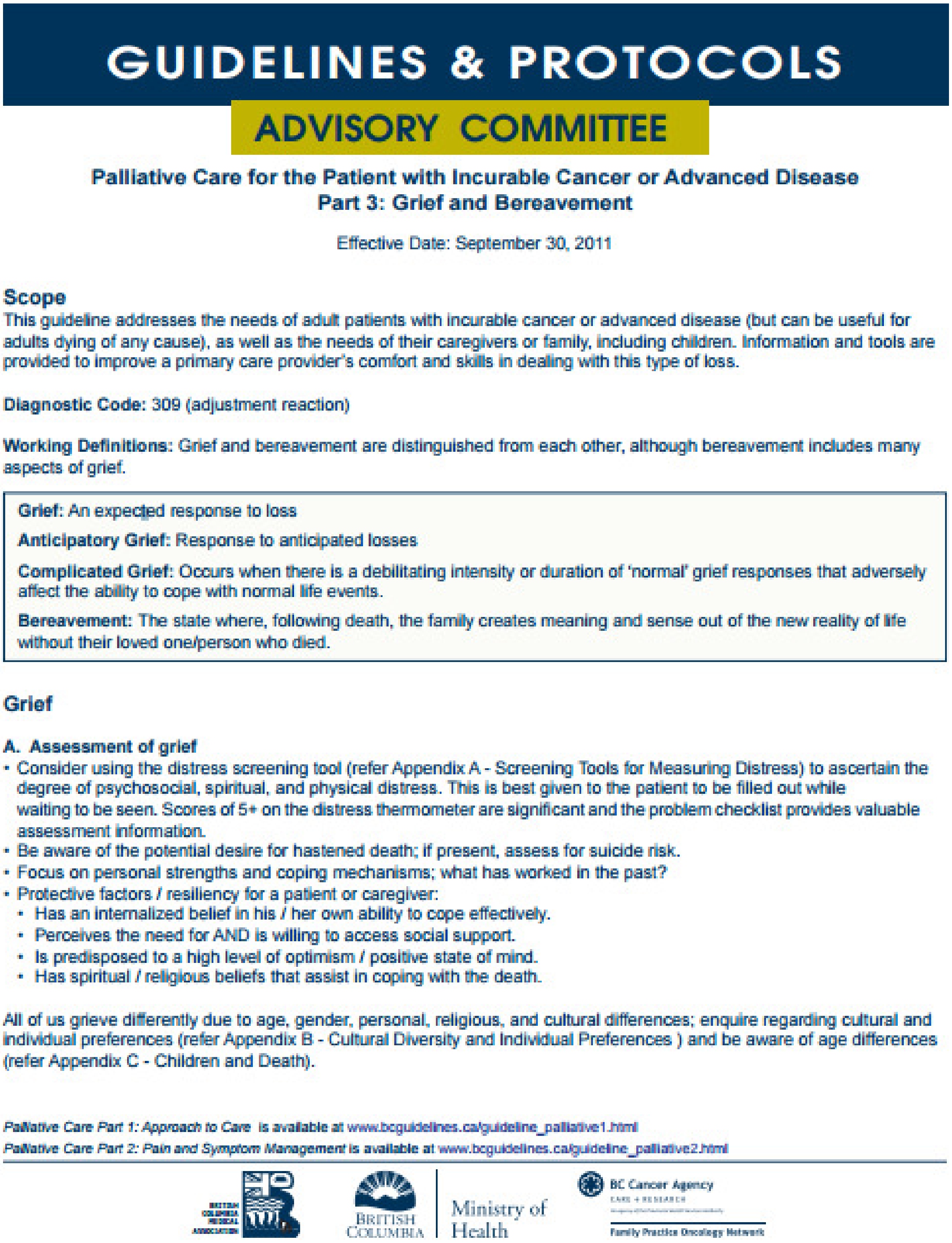
Eligibility

- Eligible patients are community based (living in their home, with family or assisted living).
- Payable only to the General Practitioner or practice group that accepts the role of being Most Responsible for longitudinal coordinated care of the patient for that calendar year;
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months;

- 2 -   July 29, 2015

Supplementary Resource 17: GPAC Guidelines- Grief & Bereavement

http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative3.pdf



GUIDELINES & PROTOCOLS

ADVISORY COMMITTEE

Palliative Care for the Patient with Incurable Cancer or Advanced Disease
Part 3: Grief and Bereavement

Effective Date: September 30, 2011

Scope

This guideline addresses the needs of adult patients with incurable cancer or advanced disease (but can be useful for adults dying of any cause), as well as the needs of their caregivers or family, including children. Information and tools are provided to improve a primary care provider's comfort and skills in dealing with this type of loss.

Diagnostic Code: 309 (adjustment reaction)

Working Definitions: Grief and bereavement are distinguished from each other, although bereavement includes many aspects of grief.

Grief: An expected response to loss

Anticipatory Grief: Response to anticipated losses

Complicated Grief: Occurs when there is a debilitating intensity or duration of 'normal' grief responses that adversely affect the ability to cope with normal life events.

Bereavement: The state where, following death, the family creates meaning and sense out of the new reality of life without their loved one/person who died.

Grief

A. Assessment of grief

- Consider using the distress screening tool (refer Appendix A - Screening Tools for Measuring Distress) to ascertain the degree of psychosocial, spiritual, and physical distress. This is best given to the patient to be filled out while waiting to be seen. Scores of 5+ on the distress thermometer are significant and the problem checklist provides valuable assessment information.
- Be aware of the potential desire for hastened death; if present, assess for suicide risk.
- Focus on personal strengths and coping mechanisms; what has worked in the past?
- Protective factors / resiliency for a patient or caregiver:
  - Has an internalized belief in his / her own ability to cope effectively.
  - Perceives the need for AND is willing to access social support.
  - Is predisposed to a high level of optimism / positive state of mind.
  - Has spiritual / religious beliefs that assist in coping with the death.

All of us grieve differently due to age, gender, personal, religious, and cultural differences; enquire regarding cultural and individual preferences (refer Appendix B - Cultural Diversity and Individual Preferences) and be aware of age differences (refer Appendix C - Children and Death).

Palliative Care Part 1: Approach to Care is available at www.bcguidelines.ca/guideline_palliative1.html
Palliative Care Part 2: Pain and Symptom Management is available at www.bcguidelines.ca/guideline_palliative2.html

BRITISH COLUMBIA MEDICAL ASSOCIATION

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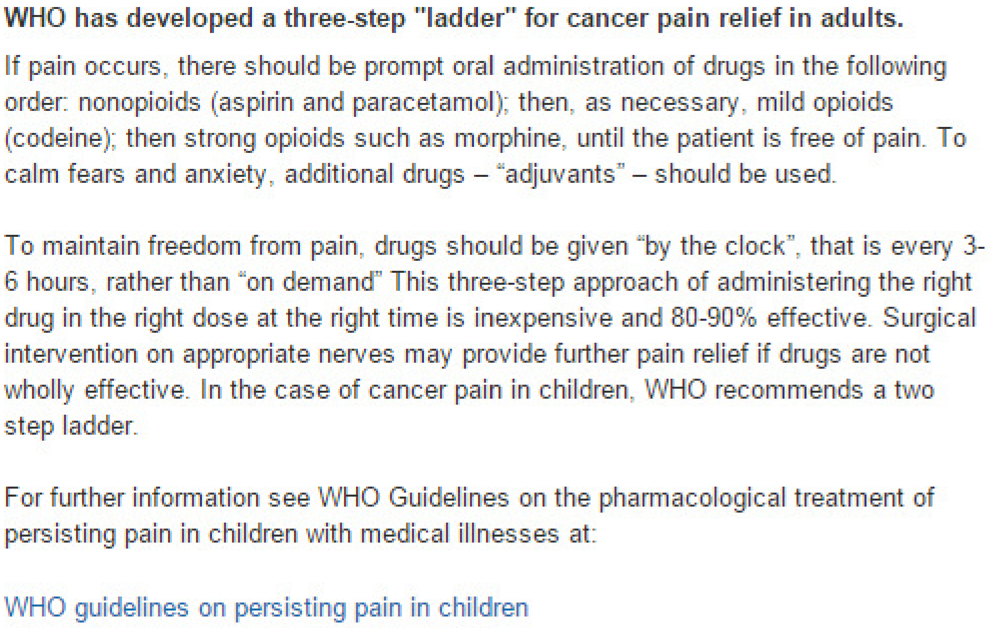
BC Cancer Agency
CARE + RESEARCH

Family Practice Oncology Network

Supplementary Resource 18: World Health Organization's Cancer Pain Ladder for Adults
http://www.who.int/cancer/palliative/painladder/en/#



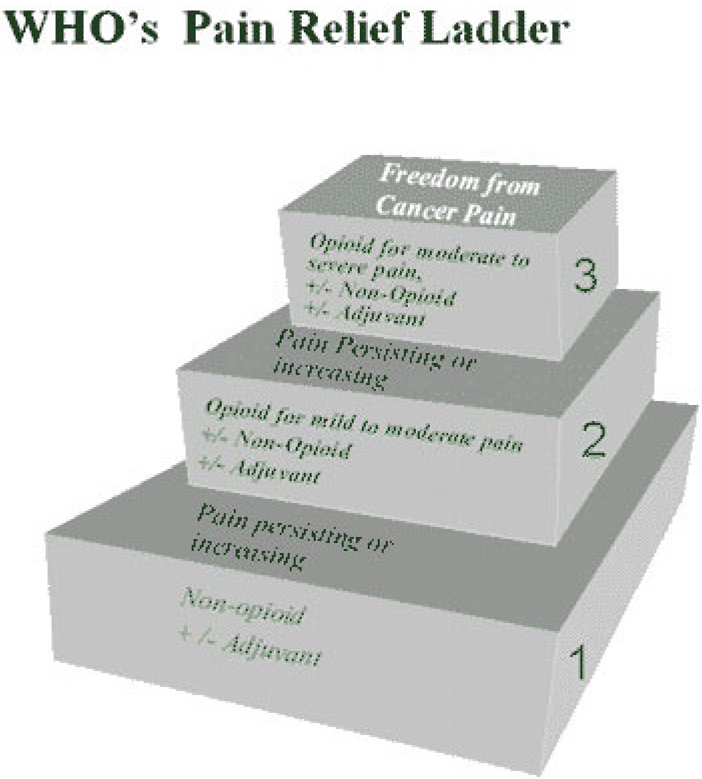
WHO has developed a three-step "ladder" for cancer pain relief in adults.

If pain occurs, there should be prompt oral administration of drugs in the following order: nonopioids (aspirin and paracetamol); then, as necessary, mild opioids (codeine); then strong opioids such as morphine, until the patient is free of pain. To calm fears and anxiety, additional drugs – "adjuvants" – should be used.

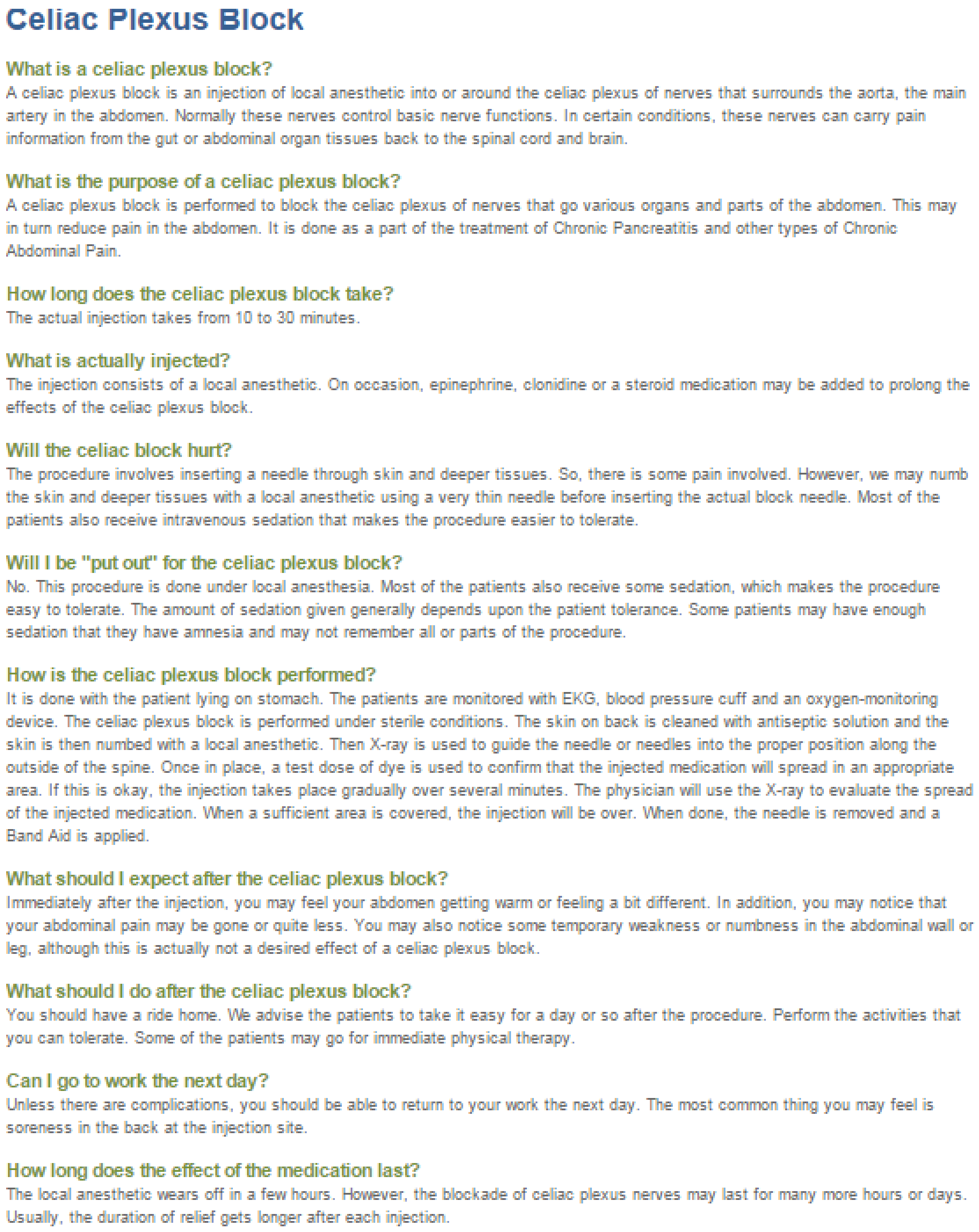
To maintain freedom from pain, drugs should be given "by the clock", that is every 3-6 hours, rather than "on demand" This three-step approach of administering the right drug in the right dose at the right time is inexpensive and 80-90% effective. Surgical intervention on appropriate nerves may provide further pain relief if drugs are not wholly effective. In the case of cancer pain in children, WHO recommends a two step ladder.

For further information see WHO Guidelines on the pharmacological treatment of persisting pain in children with medical illnesses at:

WHO guidelines on persisting pain in children



Supplementary Resource 19: Ohio Health Celiac Plexus Block
http://www.medcentral.org/Main/CeliacPlexusBlock.aspx



Celiac Plexus Block

What is a celiac plexus block?

A celiac plexus block is an injection of local anesthetic into or around the celiac plexus of nerves that surrounds the aorta, the main artery in the abdomen. Normally these nerves control basic nerve functions. In certain conditions, these nerves can carry pain information from the gut or abdominal organ tissues back to the spinal cord and brain.

What is the purpose of a celiac plexus block?

A celiac plexus block is performed to block the celiac plexus of nerves that go various organs and parts of the abdomen. This may in turn reduce pain in the abdomen. It is done as a part of the treatment of Chronic Pancreatitis and other types of Chronic Abdominal Pain.

How long does the celiac plexus block take?

The actual injection takes from 10 to 30 minutes.

What is actually injected?

The injection consists of a local anesthetic. On occasion, epinephrine, clonidine or a steroid medication may be added to prolong the effects of the celiac plexus block.

Will the celiac block hurt?

The procedure involves inserting a needle through skin and deeper tissues. So, there is some pain involved. However, we may numb the skin and deeper tissues with a local anesthetic using a very thin needle before inserting the actual block needle. Most of the patients also receive intravenous sedation that makes the procedure easier to tolerate.

Will I be "put out" for the celiac plexus block?

No. This procedure is done under local anesthesia. Most of the patients also receive some sedation, which makes the procedure easy to tolerate. The amount of sedation given generally depends upon the patient tolerance. Some patients may have enough sedation that they have amnesia and may not remember all or parts of the procedure.

How is the celiac plexus block performed?

It is done with the patient lying on stomach. The patients are monitored with EKG, blood pressure cuff and an oxygen-monitoring device. The celiac plexus block is performed under sterile conditions. The skin on back is cleaned with antiseptic solution and the skin is then numbed with a local anesthetic. Then X-ray is used to guide the needle or needles into the proper position along the outside of the spine. Once in place, a test dose of dye is used to confirm that the injected medication will spread in an appropriate area. If this is okay, the injection takes place gradually over several minutes. The physician will use the X-ray to evaluate the spread of the injected medication. When a sufficient area is covered, the injection will be over. When done, the needle is removed and a Band Aid is applied.

What should I expect after the celiac plexus block?

Immediately after the injection, you may feel your abdomen getting warm or feeling a bit different. In addition, you may notice that your abdominal pain may be gone or quite less. You may also notice some temporary weakness or numbness in the abdominal wall or leg, although this is actually not a desired effect of a celiac plexus block.

What should I do after the celiac plexus block?

You should have a ride home. We advise the patients to take it easy for a day or so after the procedure. Perform the activities that you can tolerate. Some of the patients may go for immediate physical therapy.

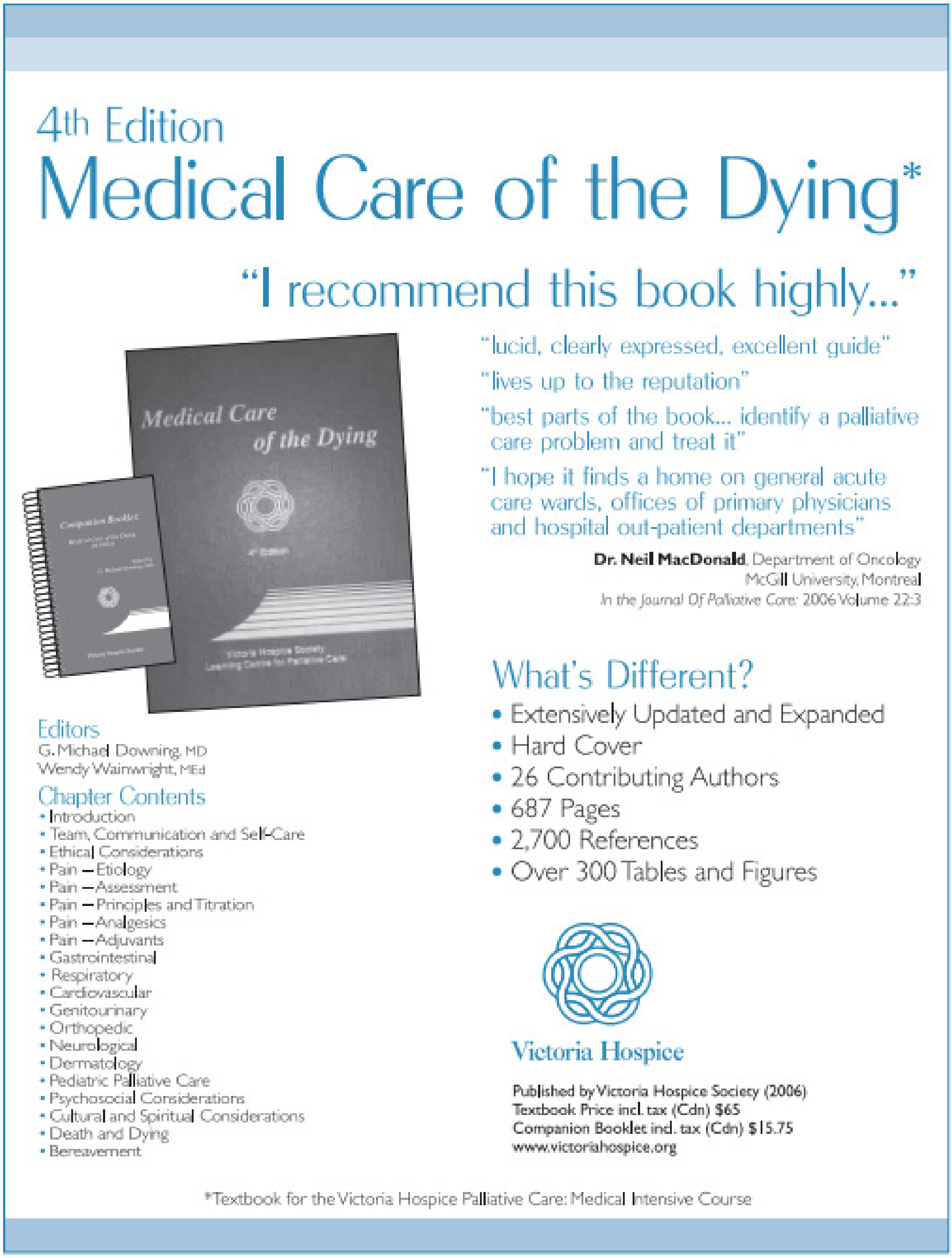
Can I go to work the next day?

Unless there are complications, you should be able to return to your work the next day. The most common thing you may feel is soreness in the back at the injection site.

How long does the effect of the medication last?

The local anesthetic wears off in a few hours. However, the blockade of celiac plexus nerves may last for many more hours or days. Usually, the duration of relief gets longer after each injection.

Supplementary Resource 20: Victoria Hospice Handbook "Medical Care of the Dying" Flyer
http://www.victoriahospice.org/sites/default/files/docs/products/medcaredyingad2011.pdf



4th Edition

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"lucid, clearly expressed, excellent guide"
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Dr. Neil MacDonald, Department of Oncology
McGill University, Montreal
In the Journal Of Palliative Care: 2006 Volume 22:3

Editors
G. Michael Downing, MD
Wendy Wainwright, MEd

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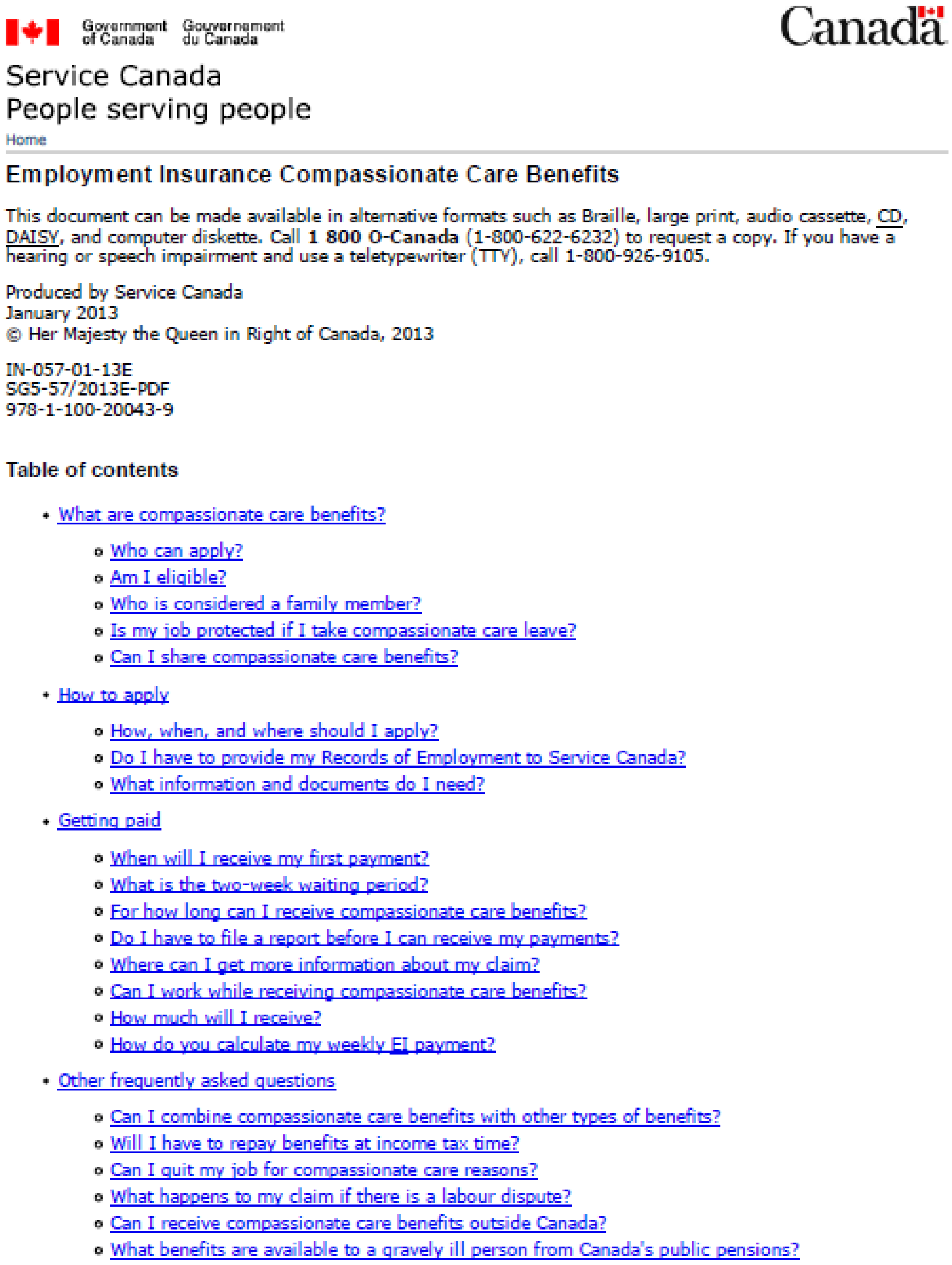
Victoria Hospice

Published by Victoria Hospice Society (2006)
Textbook Price incl. tax (Cdn) $65
Companion Booklet incl. tax (Cdn) $15.75
www.victoriahospice.org

*Textbook for the Victoria Hospice Palliative Care: Medical Intensive Course

Supplementary Resource 21: BC Government Employment Insurance Compassionate Care
http://www.servicecanada.gc.ca/eng/ei/types/compassionate_care.shtml



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Home

Employment Insurance Compassionate Care Benefits

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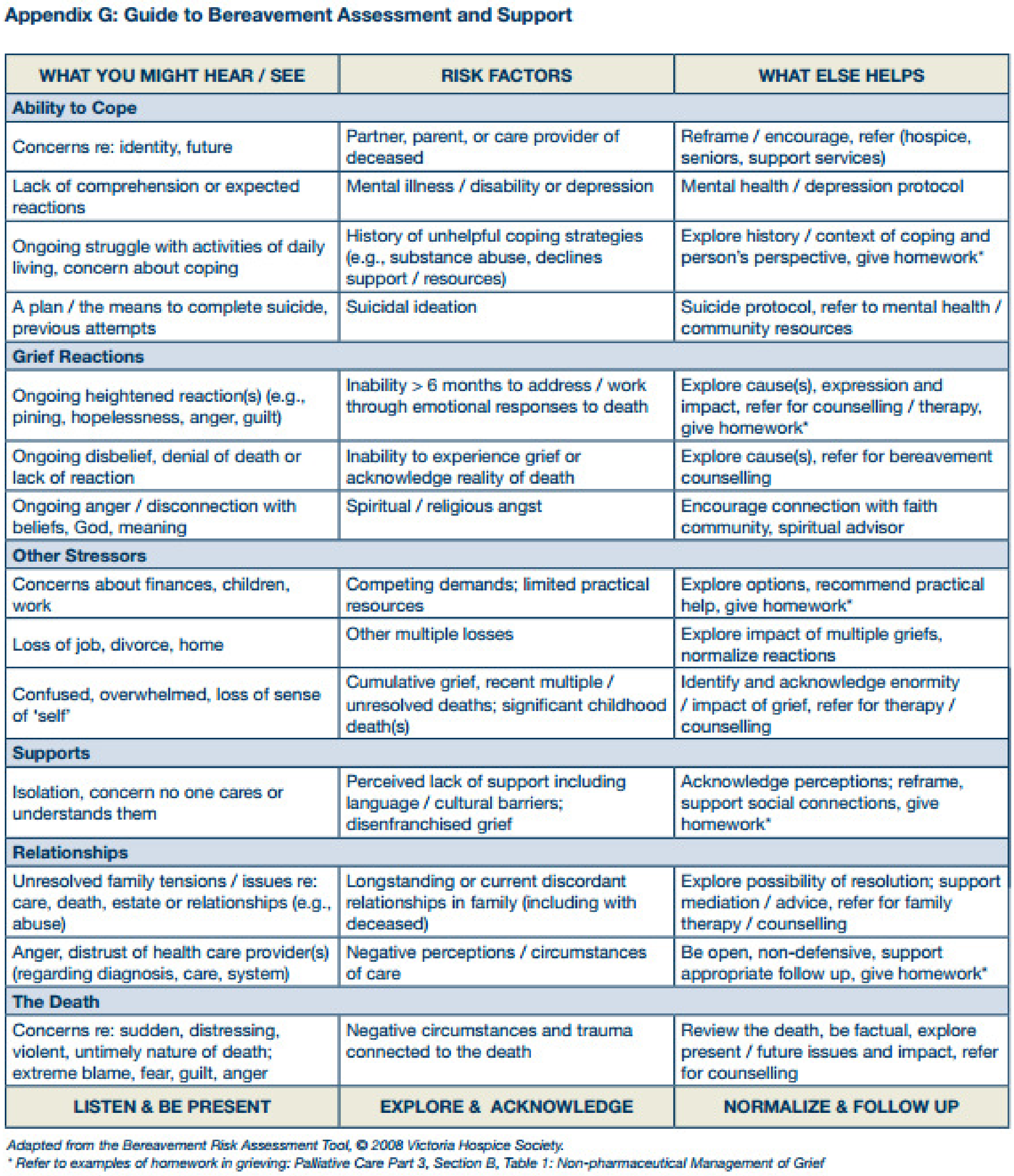
http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative3_appendix_g.pdf



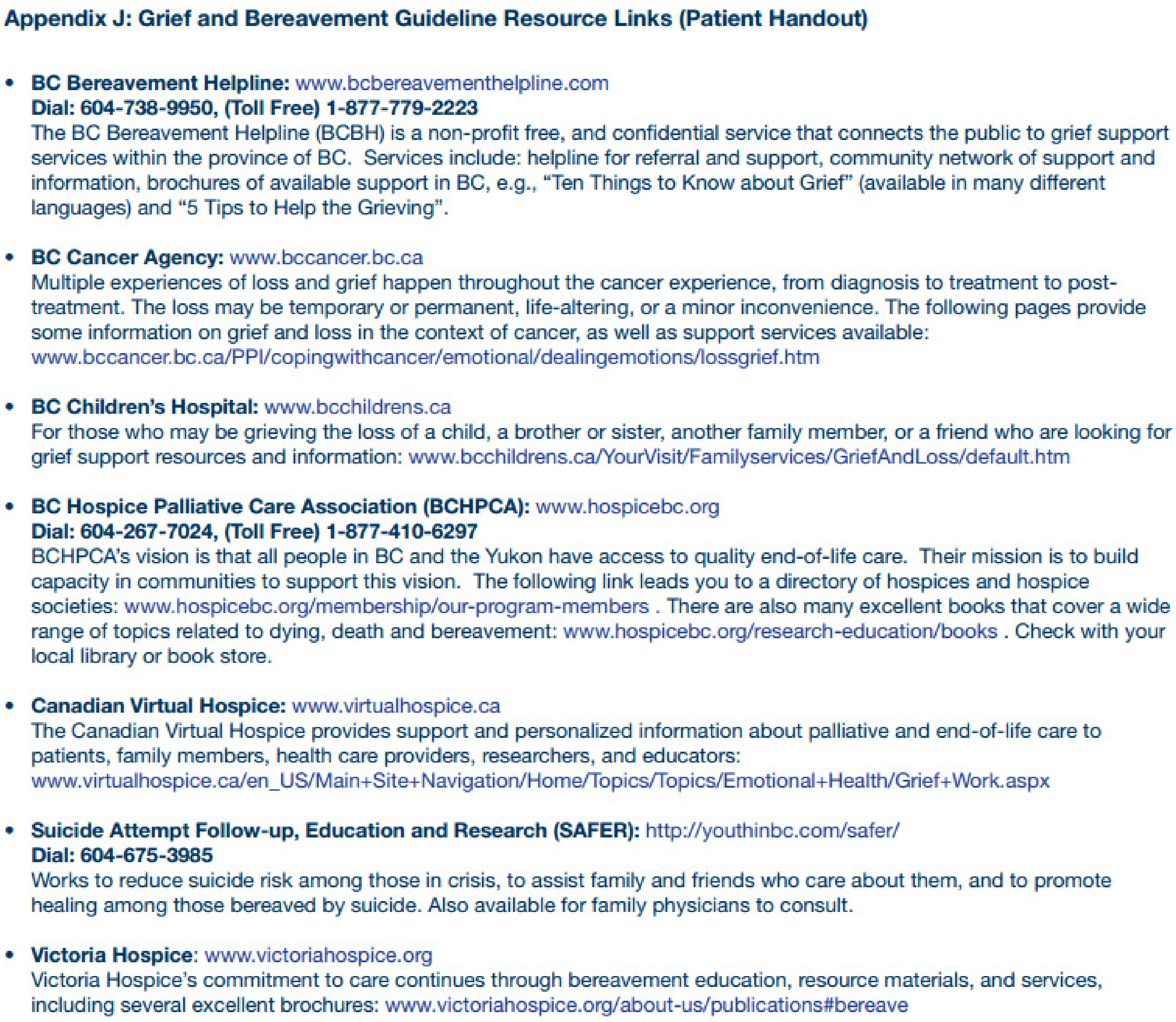
Appendix G: Guide to Bereavement Assessment and Support

WHAT YOU MIGHT HEAR / SEE	RISK FACTORS	WHAT ELSE HELPS
Ability to Cope		
Concerns re: identity, future	Partner, parent, or care provider of deceased	Reframe / encourage, refer (hospice, seniors, support services)
Lack of comprehension or expected reactions	Mental illness / disability or depression	Mental health / depression protocol
Ongoing struggle with activities of daily living, concern about coping	History of unhelpful coping strategies (e.g., substance abuse, declines support / resources)	Explore history / context of coping and person's perspective, give homework*
A plan / the means to complete suicide, previous attempts	Suicidal ideation	Suicide protocol, refer to mental health / community resources
Grief Reactions		
Ongoing heightened reaction(s) (e.g., pining, hopelessness, anger, guilt)	Inability > 6 months to address / work through emotional responses to death	Explore cause(s), expression and impact, refer for counselling / therapy, give homework*
Ongoing disbelief, denial of death or lack of reaction	Inability to experience grief or acknowledge reality of death	Explore cause(s), refer for bereavement counselling
Ongoing anger / disconnection with beliefs, God, meaning	Spiritual / religious angst	Encourage connection with faith community, spiritual advisor
Other Stressors		
Concerns about finances, children, work	Competing demands; limited practical resources	Explore options, recommend practical help, give homework*
Loss of job, divorce, home	Other multiple losses	Explore impact of multiple griefs, normalize reactions
Confused, overwhelmed, loss of sense of 'self'	Cumulative grief, recent multiple / unresolved deaths; significant childhood death(s)	Identify and acknowledge enormity / impact of grief, refer for therapy / counselling
Supports		
Isolation, concern no one cares or understands them	Perceived lack of support including language / cultural barriers; disenfranchised grief	Acknowledge perceptions; reframe, support social connections, give homework*
Relationships		
Unresolved family tensions / issues re: care, death, estate or relationships (e.g., abuse)	Longstanding or current discordant relationships in family (including with deceased)	Explore possibility of resolution; support mediation / advice, refer for family therapy / counselling
Anger, distrust of health care provider(s) (regarding diagnosis, care, system)	Negative perceptions / circumstances of care	Be open, non-defensive, support appropriate follow up, give homework*
The Death		
Concerns re: sudden, distressing, violent, untimely nature of death; extreme blame, fear, guilt, anger	Negative circumstances and trauma connected to the death	Review the death, be factual, explore present / future issues and impact, refer for counselling
LISTEN & BE PRESENT	**EXPLORE & ACKNOWLEDGE**	**NORMALIZE & FOLLOW UP**

Adapted from the Bereavement Risk Assessment Tool, © 2008 Victoria Hospice Society.
** Refer to examples of homework in grieving: Palliative Care Part 3, Section B, Table 1: Non-pharmaceutical Management of Grief*

Supplementary Resource 23: GPAC Grief and Bereavement Guideline Resource Links for Patient Handout

http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative3_appendix_j.pdf



Appendix J: Grief and Bereavement Guideline Resource Links (Patient Handout)

- **BC Bereavement Helpline:** www.bcbereavementhelpline.com
  Dial: 604-738-9950, (Toll Free) 1-877-779-2223
  The BC Bereavement Helpline (BCBH) is a non-profit free, and confidential service that connects the public to grief support services within the province of BC. Services include: helpline for referral and support, community network of support and information, brochures of available support in BC, e.g., "Ten Things to Know about Grief" (available in many different languages) and "5 Tips to Help the Grieving".

- **BC Cancer Agency:** www.bccancer.bc.ca
  Multiple experiences of loss and grief happen throughout the cancer experience, from diagnosis to treatment to post-treatment. The loss may be temporary or permanent, life-altering, or a minor inconvenience. The following pages provide some information on grief and loss in the context of cancer, as well as support services available: www.bccancer.bc.ca/PPI/copingwithcancer/emotional/dealingemotions/lossgrief.htm

- **BC Children's Hospital:** www.bcchildrens.ca
  For those who may be grieving the loss of a child, a brother or sister, another family member, or a friend who are looking for grief support resources and information: www.bcchildrens.ca/YourVisit/Familyservices/GriefAndLoss/default.htm

- **BC Hospice Palliative Care Association (BCHPCA):** www.hospicebc.org
  Dial: 604-267-7024, (Toll Free) 1-877-410-6297
  BCHPCA's vision is that all people in BC and the Yukon have access to quality end-of-life care. Their mission is to build capacity in communities to support this vision. The following link leads you to a directory of hospices and hospice societies: www.hospicebc.org/membership/our-program-members . There are also many excellent books that cover a wide range of topics related to dying, death and bereavement: www.hospicebc.org/research-education/books . Check with your local library or book store.

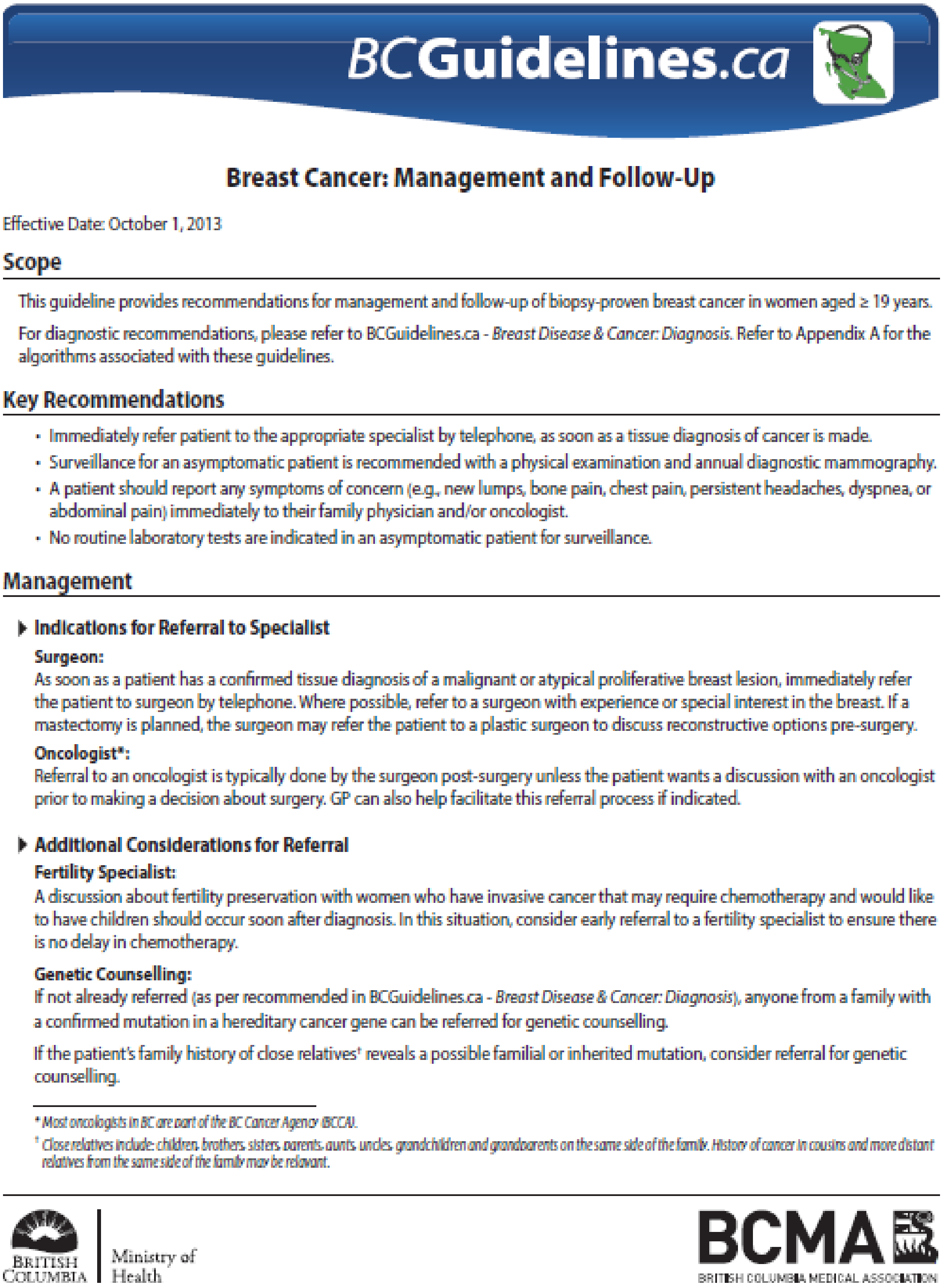
- **Canadian Virtual Hospice:** www.virtualhospice.ca
  The Canadian Virtual Hospice provides support and personalized information about palliative and end-of-life care to patients, family members, health care providers, researchers, and educators: www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Topics/Topics/Emotional+Health/Grief+Work.aspx

- **Suicide Attempt Follow-up, Education and Research (SAFER):** http://youthinbc.com/safer/
  Dial: 604-675-3985
  Works to reduce suicide risk among those in crisis, to assist family and friends who care about them, and to promote healing among those bereaved by suicide. Also available for family physicians to consult.

- **Victoria Hospice**: www.victoriahospice.org
  Victoria Hospice's commitment to care continues through bereavement education, resource materials, and services, including several excellent brochures: www.victoriahospice.org/about-us/publications#bereave

Supplementary Resource 24: BC Ministry of Health Oncologist Follow-up Plan

http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/brcancer.pdf



BCGuidelines.ca

Breast Cancer: Management and Follow-Up

Effective Date: October 1, 2013

Scope

This guideline provides recommendations for management and follow-up of biopsy-proven breast cancer in women aged ≥ 19 years.

For diagnostic recommendations, please refer to BCGuidelines.ca - *Breast Disease & Cancer: Diagnosis*. Refer to Appendix A for the algorithms associated with these guidelines.

Key Recommendations

- Immediately refer patient to the appropriate specialist by telephone, as soon as a tissue diagnosis of cancer is made.
- Surveillance for an asymptomatic patient is recommended with a physical examination and annual diagnostic mammography.
- A patient should report any symptoms of concern (e.g., new lumps, bone pain, chest pain, persistent headaches, dyspnea, or abdominal pain) immediately to their family physician and/or oncologist.
- No routine laboratory tests are indicated in an asymptomatic patient for surveillance.

Management

▶ Indications for Referral to Specialist

Surgeon:
As soon as a patient has a confirmed tissue diagnosis of a malignant or atypical proliferative breast lesion, immediately refer the patient to surgeon by telephone. Where possible, refer to a surgeon with experience or special interest in the breast. If a mastectomy is planned, the surgeon may refer the patient to a plastic surgeon to discuss reconstructive options pre-surgery.

Oncologist*:
Referral to an oncologist is typically done by the surgeon post-surgery unless the patient wants a discussion with an oncologist prior to making a decision about surgery. GP can also help facilitate this referral process if indicated.

▶ Additional Considerations for Referral

Fertility Specialist:
A discussion about fertility preservation with women who have invasive cancer that may require chemotherapy and would like to have children should occur soon after diagnosis. In this situation, consider early referral to a fertility specialist to ensure there is no delay in chemotherapy.

Genetic Counselling:
If not already referred (as per recommended in BCGuidelines.ca - *Breast Disease & Cancer: Diagnosis*), anyone from a family with a confirmed mutation in a hereditary cancer gene can be referred for genetic counselling.

If the patient's family history of close relatives[†] reveals a possible familial or inherited mutation, consider referral for genetic counselling.

---

* *Most oncologists in BC are part of the BC Cancer Agency (BCCA).*

[†] *Close relatives include: children, brothers, sisters, parents, aunts, uncles, grandchildren and grandparents on the same side of the family. History of cancer in cousins and more distant relatives from the same side of the family may be relevant.*

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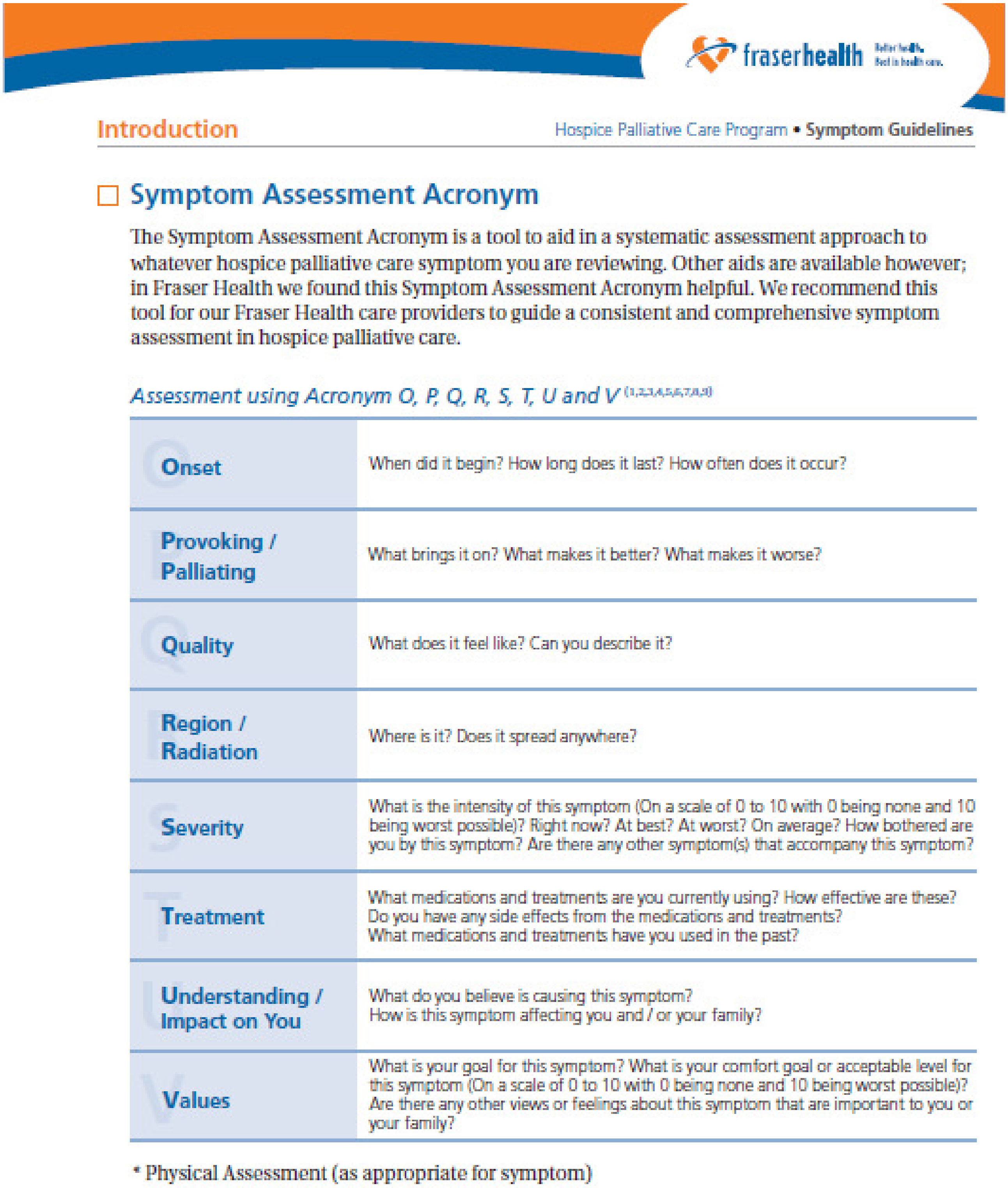
Supplementary Resource 25: Fraser Health Symptom Acronym "OPQRSTUV"

http://www.fraserhealth.ca/media/SymptomAssessmentRevised_Sept09.pdf



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Introduction

Hospice Palliative Care Program • **Symptom Guidelines**

☐ Symptom Assessment Acronym

The Symptom Assessment Acronym is a tool to aid in a systematic assessment approach to whatever hospice palliative care symptom you are reviewing. Other aids are available however; in Fraser Health we found this Symptom Assessment Acronym helpful. We recommend this tool for our Fraser Health care providers to guide a consistent and comprehensive symptom assessment in hospice palliative care.

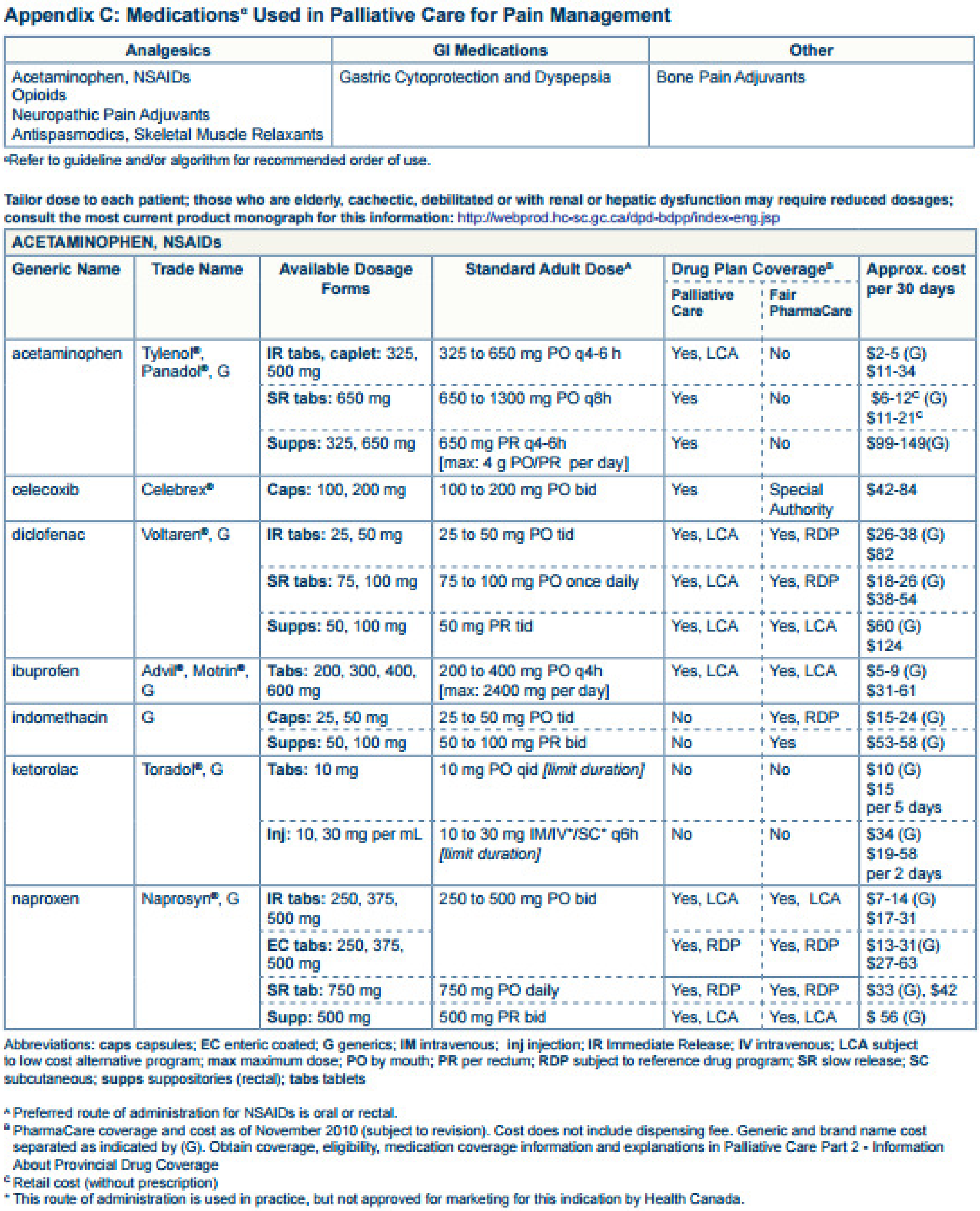
Assessment using Acronym O, P, Q, R, S, T, U and V (1,2,3,4,5,6,7,8,9)

Onset	When did it begin? How long does it last? How often does it occur?
Provoking / Palliating	What brings it on? What makes it better? What makes it worse?
Quality	What does it feel like? Can you describe it?
Region / Radiation	Where is it? Does it spread anywhere?
Severity	What is the intensity of this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Right now? At best? At worst? On average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom?
Treatment	What medications and treatments are you currently using? How effective are these? Do you have any side effects from the medications and treatments? What medications and treatments have you used in the past?
Understanding / Impact on You	What do you believe is causing this symptom? How is this symptom affecting you and / or your family?
Values	What is your goal for this symptom? What is your comfort goal or acceptable level for this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Are there any other views or feelings about this symptom that are important to you or your family?

* Physical Assessment (as appropriate for symptom)

Supplementary Resource 26: Medications Used in Pain Management

http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative2_pain_appendix_c.pdf



Appendix C: Medications[a] Used in Palliative Care for Pain Management

Analgesics	GI Medications	Other
Acetaminophen, NSAIDs Opioids Neuropathic Pain Adjuvants Antispasmodics, Skeletal Muscle Relaxants	Gastric Cytoprotection and Dyspepsia	Bone Pain Adjuvants

[a]Refer to guideline and/or algorithm for recommended order of use.

Tailor dose to each patient; those who are elderly, cachectic, debilitated or with renal or hepatic dysfunction may require reduced dosages; consult the most current product monograph for this information: http://webprod.hc-sc.gc.ca/dpd-bdpp/index-eng.jsp

ACETAMINOPHEN, NSAIDs

Generic Name	**Trade Name**	**Available Dosage Forms**	**Standard Adult Dose[A]**	**Drug Plan Coverage[B]**		**Approx. cost per 30 days**
				Palliative Care	**Fair PharmaCare**	
acetaminophen	Tylenol®, Panadol®, G	**IR tabs, caplet:** 325, 500 mg	325 to 650 mg PO q4-6 h	Yes, LCA	No	$2-5 (G) $11-34
		SR tabs: 650 mg	650 to 1300 mg PO q8h	Yes	No	$6-12[C] (G) $11-21[C]
		Supps: 325, 650 mg	650 mg PR q4-6h [max: 4 g PO/PR per day]	Yes	No	$99-149(G)
celecoxib	Celebrex®	**Caps:** 100, 200 mg	100 to 200 mg PO bid	Yes	Special Authority	$42-84
diclofenac	Voltaren®, G	**IR tabs:** 25, 50 mg	25 to 50 mg PO tid	Yes, LCA	Yes, RDP	$26-38 (G) $82
		SR tabs: 75, 100 mg	75 to 100 mg PO once daily	Yes, LCA	Yes, RDP	$18-26 (G) $38-54
		Supps: 50, 100 mg	50 mg PR tid	Yes, LCA	Yes, LCA	$60 (G) $124
ibuprofen	Advil®, Motrin®, G	**Tabs:** 200, 300, 400, 600 mg	200 to 400 mg PO q4h [max: 2400 mg per day]	Yes, LCA	Yes, LCA	$5-9 (G) $31-61
indomethacin	G	**Caps:** 25, 50 mg	25 to 50 mg PO tid	No	Yes, RDP	$15-24 (G)
		Supps: 50, 100 mg	50 to 100 mg PR bid	No	Yes	$53-58 (G)
ketorolac	Toradol®, G	**Tabs:** 10 mg	10 mg PO qid *[limit duration]*	No	No	$10 (G) $15 per 5 days
		Inj: 10, 30 mg per mL	10 to 30 mg IM/IV*/SC* q6h *[limit duration]*	No	No	$34 (G) $19-58 per 2 days
naproxen	Naprosyn®, G	**IR tabs:** 250, 375, 500 mg	250 to 500 mg PO bid	Yes, LCA	Yes, LCA	$7-14 (G) $17-31
		EC tabs: 250, 375, 500 mg		Yes, RDP	Yes, RDP	$13-31(G) $27-63
		SR tab: 750 mg	750 mg PO daily	Yes, RDP	Yes, RDP	$33 (G), $42
		Supp: 500 mg	500 mg PR bid	Yes, LCA	Yes, LCA	$ 56 (G)

Abbreviations: **caps** capsules; **EC** enteric coated; **G** generics; **IM** intravenous; **inj** injection; **IR** Immediate Release; **IV** intravenous; **LCA** subject to low cost alternative program; **max** maximum dose; **PO** by mouth; **PR** per rectum; **RDP** subject to reference drug program; **SR** slow release; **SC** subcutaneous; **supps** suppositories (rectal); **tabs** tablets

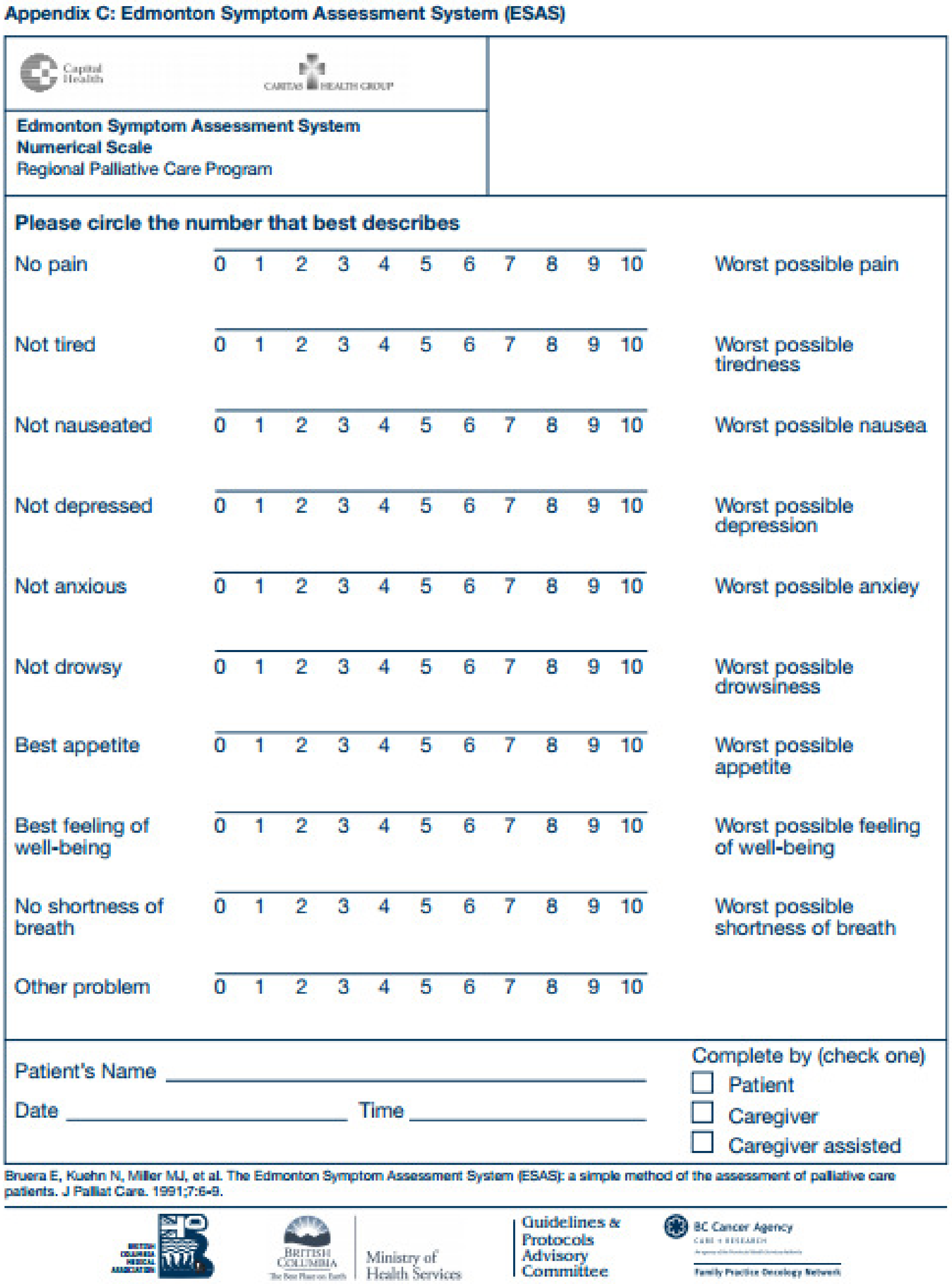
[A] Preferred route of administration for NSAIDs is oral or rectal.

[B] PharmaCare coverage and cost as of November 2010 (subject to revision). Cost does not include dispensing fee. Generic and brand name cost separated as indicated by (G). Obtain coverage, eligibility, medication coverage information and explanations in Palliative Care Part 2 - Information About Provincial Drug Coverage

[C] Retail cost (without prescription)

* This route of administration is used in practice, but not approved for marketing for this indication by Health Canada.

Supplementary Resource 27: Edmonton Symptom Assessment System (ESAS) Numerical Scale
http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative1_appendix_c.pdf



Appendix C: Edmonton Symptom Assessment System (ESAS)

Capital Health

CARITAS HEALTH GROUP

Edmonton Symptom Assessment System
Numerical Scale
Regional Palliative Care Program

Please circle the number that best describes

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not tired	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
Not nauseated	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
Not depressed	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
Not anxious	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiey
Not drowsy	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
Best feeling of well-being	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of well-being
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Other problem	0	1	2	3	4	5	6	7	8	9	10	

Patient's Name ______________________________

Date ____________________ Time ____________________

Complete by (check one)
☐ Patient
☐ Caregiver
☐ Caregiver assisted

Bruera E, Kuehn N, Miller MJ, et al. The Edmonton Symptom Assessment System (ESAS): a simple method of the assessment of palliative care patients. J Palliat Care. 1991;7:6-9.

British Columbia Medical Association

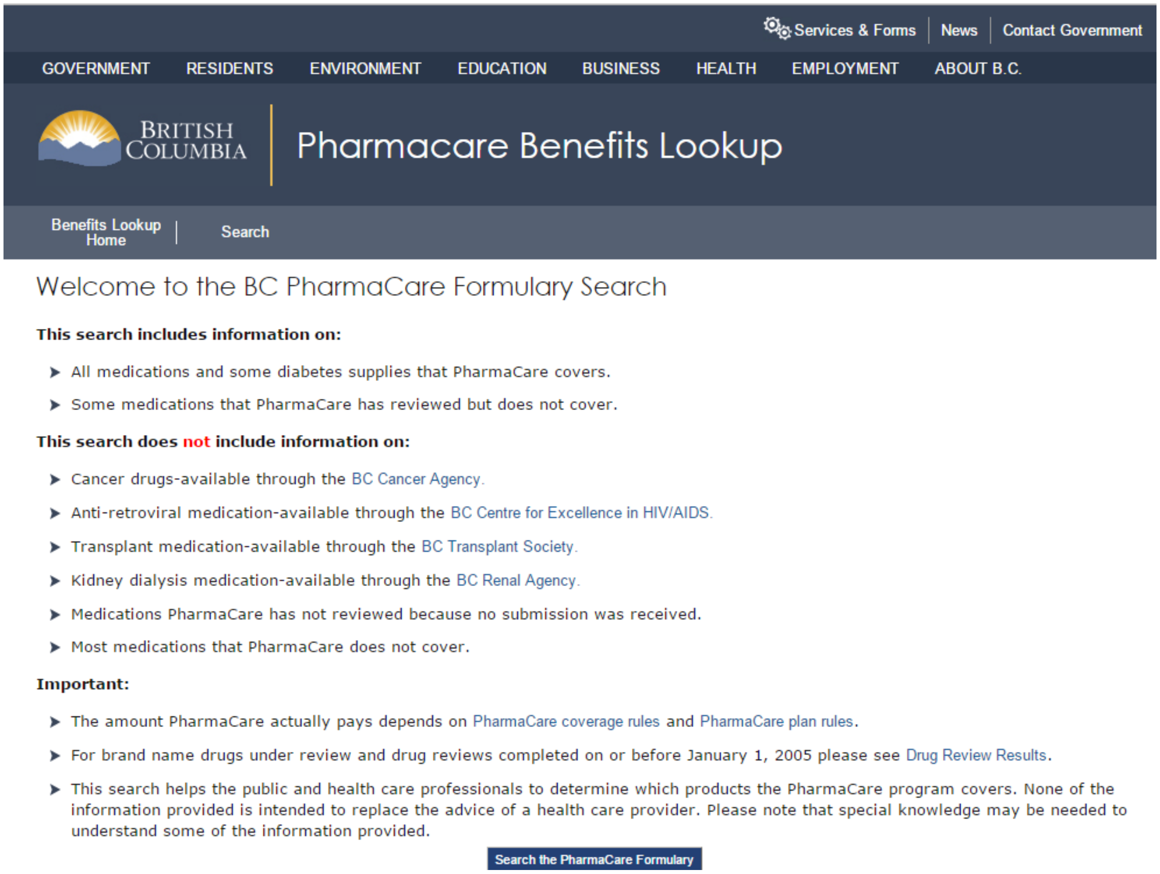
British Columbia · The Best Place on Earth | Ministry of Health Services

Guidelines & Protocols Advisory Committee

BC Cancer Agency CARE + RESEARCH
Family Practice Oncology Network

Supplementary Resource 28: Ministry of Health Pharmacare Covered Drugs

https://pcbl.hlth.gov.bc.ca/pharmacare/benefitslookup/



Welcome to the BC PharmaCare Formulary Search

This search includes information on:

- All medications and some diabetes supplies that PharmaCare covers.
- Some medications that PharmaCare has reviewed but does not cover.

This search does not include information on:

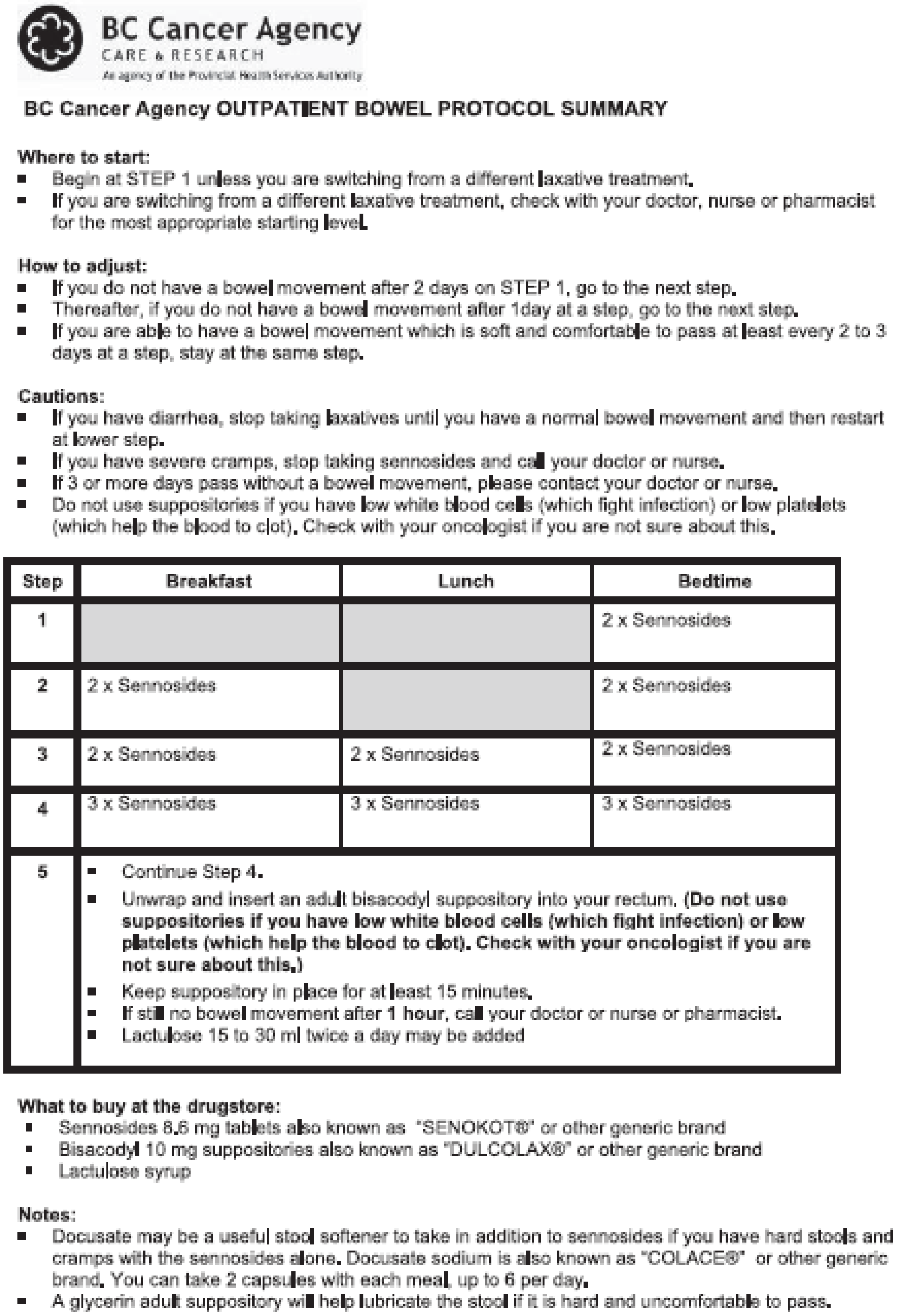
- Cancer drugs-available through the BC Cancer Agency.
- Anti-retroviral medication-available through the BC Centre for Excellence in HIV/AIDS.
- Transplant medication-available through the BC Transplant Society.
- Kidney dialysis medication-available through the BC Renal Agency.
- Medications PharmaCare has not reviewed because no submission was received.
- Most medications that PharmaCare does not cover.

Important:

- The amount PharmaCare actually pays depends on PharmaCare coverage rules and PharmaCare plan rules.
- For brand name drugs under review and drug reviews completed on or before January 1, 2005 please see Drug Review Results.
- This search helps the public and health care professionals to determine which products the PharmaCare program covers. None of the information provided is intended to replace the advice of a health care provider. Please note that special knowledge may be needed to understand some of the information provided.

Supplementary Resource 29: BC Cancer Agency Outpatient Bowel Protocol Summary

http://www.bccancer.bc.ca/family-oncology-network-site/Documents/BCCABowelProtocol.pdf



BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

BC Cancer Agency OUTPATIENT BOWEL PROTOCOL SUMMARY

Where to start:

- Begin at STEP 1 unless you are switching from a different laxative treatment.
- If you are switching from a different laxative treatment, check with your doctor, nurse or pharmacist for the most appropriate starting level.

How to adjust:

- If you do not have a bowel movement after 2 days on STEP 1, go to the next step.
- Thereafter, if you do not have a bowel movement after 1day at a step, go to the next step.
- If you are able to have a bowel movement which is soft and comfortable to pass at least every 2 to 3 days at a step, stay at the same step.

Cautions:

- If you have diarrhea, stop taking laxatives until you have a normal bowel movement and then restart at lower step.
- If you have severe cramps, stop taking sennosides and call your doctor or nurse.
- If 3 or more days pass without a bowel movement, please contact your doctor or nurse.
- Do not use suppositories if you have low white blood cells (which fight infection) or low platelets (which help the blood to clot). Check with your oncologist if you are not sure about this.

Step	Breakfast	Lunch	Bedtime
1	▨	▨	2 x Sennosides
2	2 x Sennosides	▨	2 x Sennosides
3	2 x Sennosides	2 x Sennosides	2 x Sennosides
4	3 x Sennosides	3 x Sennosides	3 x Sennosides
5	▪ Continue Step 4. ▪ Unwrap and insert an adult bisacodyl suppository into your rectum. **(Do not use suppositories if you have low white blood cells (which fight infection) or low platelets (which help the blood to clot). Check with your oncologist if you are not sure about this.)** ▪ Keep suppository in place for at least 15 minutes. ▪ If still no bowel movement after 1 hour, call your doctor or nurse or pharmacist. ▪ Lactulose 15 to 30 ml twice a day may be added		

What to buy at the drugstore:

- Sennosides 8.6 mg tablets also known as "SENOKOT®" or other generic brand
- Bisacodyl 10 mg suppositories also known as "DULCOLAX®" or other generic brand
- Lactulose syrup

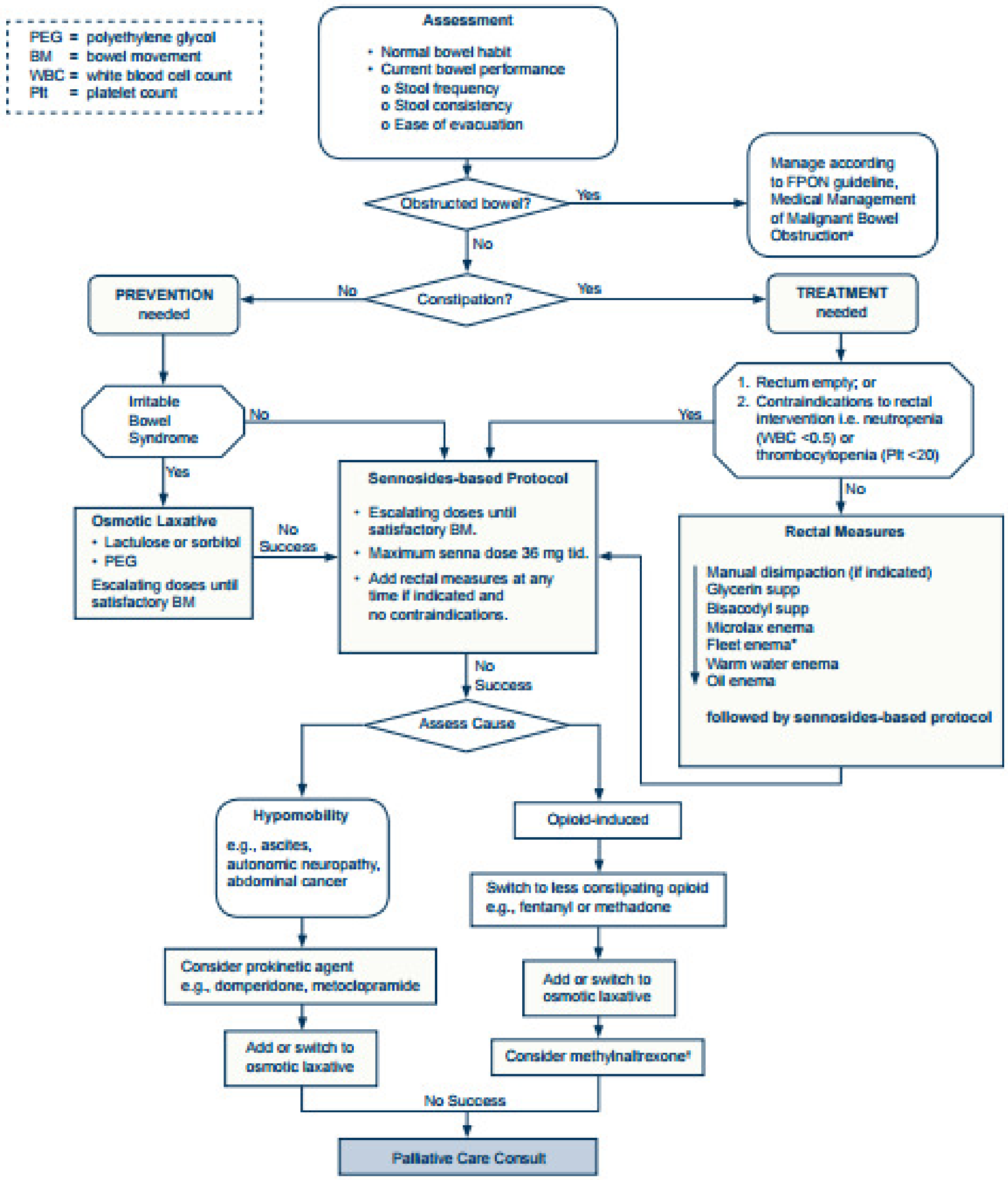
Notes:

- Docusate may be a useful stool softener to take in addition to sennosides if you have hard stools and cramps with the sennosides alone. Docusate sodium is also known as "COLACE®" or other generic brand. You can take 2 capsules with each meal, up to 6 per day.
- A glycerin adult suppository will help lubricate the stool if it is hard and uncomfortable to pass.

Supplementary Resource 30: Constipation Management Algorithm

http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/palliative2_constipation_appendix_a.pdf

Appendix A: Constipation Management Algorithm



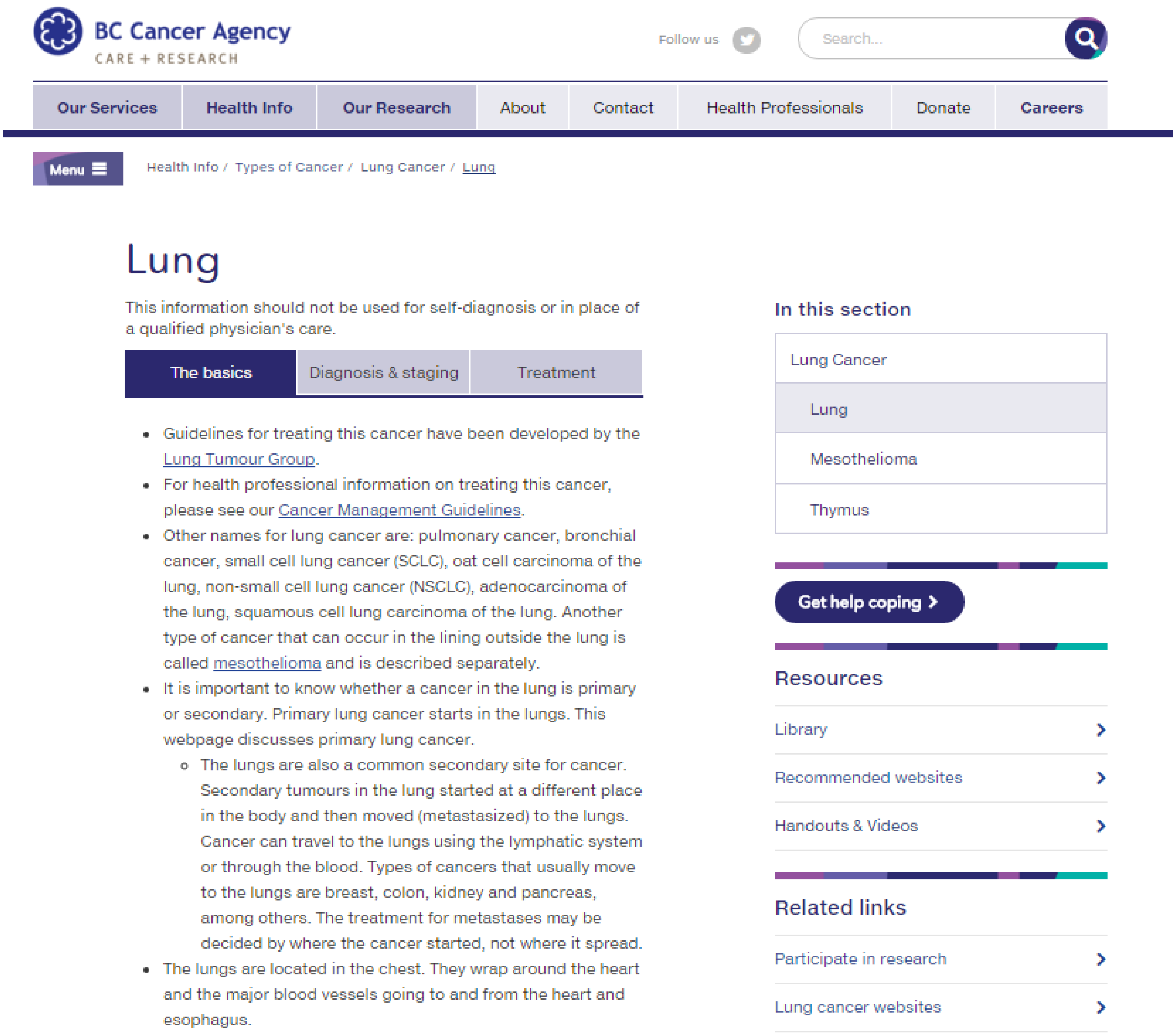
* available at www.bccancer.bc.ca/HPI/FPON

† contraindicated in patients with renal failure

‡ cancer, GI malignancy, GI ulcer, Ogilvie's syndrome and concomitant use of certain medications (e.g. NSAIDs, steroids and bevacizumab) may increase the risk of GI perforation in patients receiving methylnaltrexone.
[Health Canada MedEffect Notice: www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/medeff/advisories-avis/prof/2010/relistor_hpc-cps-eng.pdf]

Supplementary Resource 31: BC Cancer Agency Lung Cancer Symptoms

http://www.bccancer.bc.ca/health-info/types-of-cancer/lung/lung



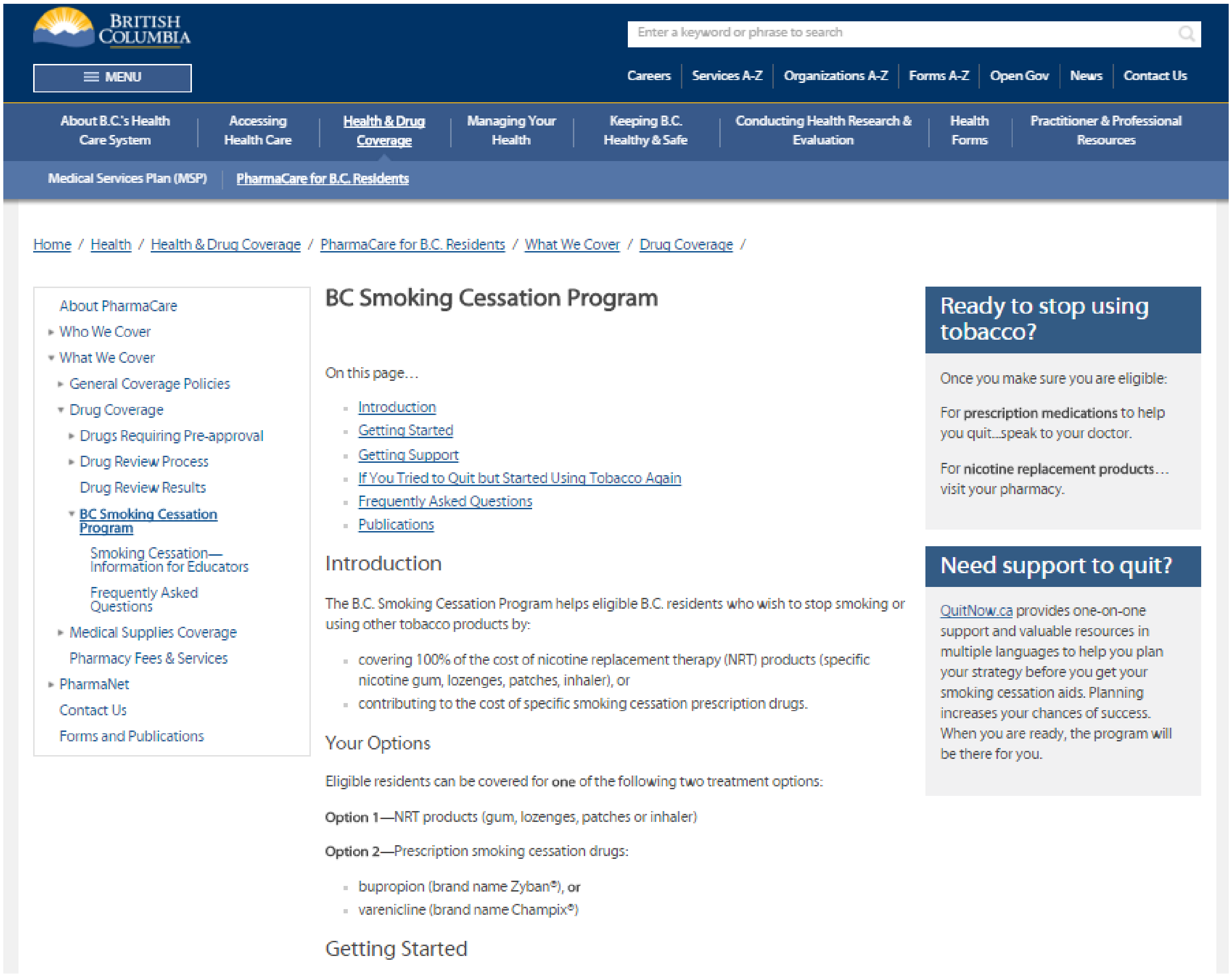
Lung

This information should not be used for self-diagnosis or in place of a qualified physician's care.

- Guidelines for treating this cancer have been developed by the Lung Tumour Group.
- For health professional information on treating this cancer, please see our Cancer Management Guidelines.
- Other names for lung cancer are: pulmonary cancer, bronchial cancer, small cell lung cancer (SCLC), oat cell carcinoma of the lung, non-small cell lung cancer (NSCLC), adenocarcinoma of the lung, squamous cell lung carcinoma of the lung. Another type of cancer that can occur in the lining outside the lung is called mesothelioma and is described separately.
- It is important to know whether a cancer in the lung is primary or secondary. Primary lung cancer starts in the lungs. This webpage discusses primary lung cancer.
  - The lungs are also a common secondary site for cancer. Secondary tumours in the lung started at a different place in the body and then moved (metastasized) to the lungs. Cancer can travel to the lungs using the lymphatic system or through the blood. Types of cancers that usually move to the lungs are breast, colon, kidney and pancreas, among others. The treatment for metastases may be decided by where the cancer started, not where it spread.
- The lungs are located in the chest. They wrap around the heart and the major blood vessels going to and from the heart and esophagus.

Supplementary Resource 32: BC Government Smoking Cessation Program

http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage/bc-smoking-cessation-program



BC Smoking Cessation Program

On this page…

- Introduction
- Getting Started
- Getting Support
- If You Tried to Quit but Started Using Tobacco Again
- Frequently Asked Questions
- Publications

Introduction

The B.C. Smoking Cessation Program helps eligible B.C. residents who wish to stop smoking or using other tobacco products by:

- covering 100% of the cost of nicotine replacement therapy (NRT) products (specific nicotine gum, lozenges, patches, inhaler), or
- contributing to the cost of specific smoking cessation prescription drugs.

Your Options

Eligible residents can be covered for **one** of the following two treatment options:

Option 1—NRT products (gum, lozenges, patches or inhaler)

Option 2—Prescription smoking cessation drugs:

- bupropion (brand name Zyban®), **or**
- varenicline (brand name Champix®)

Getting Started

Ready to stop using tobacco?

Once you make sure you are eligible:

For **prescription medications** to help you quit...speak to your doctor.

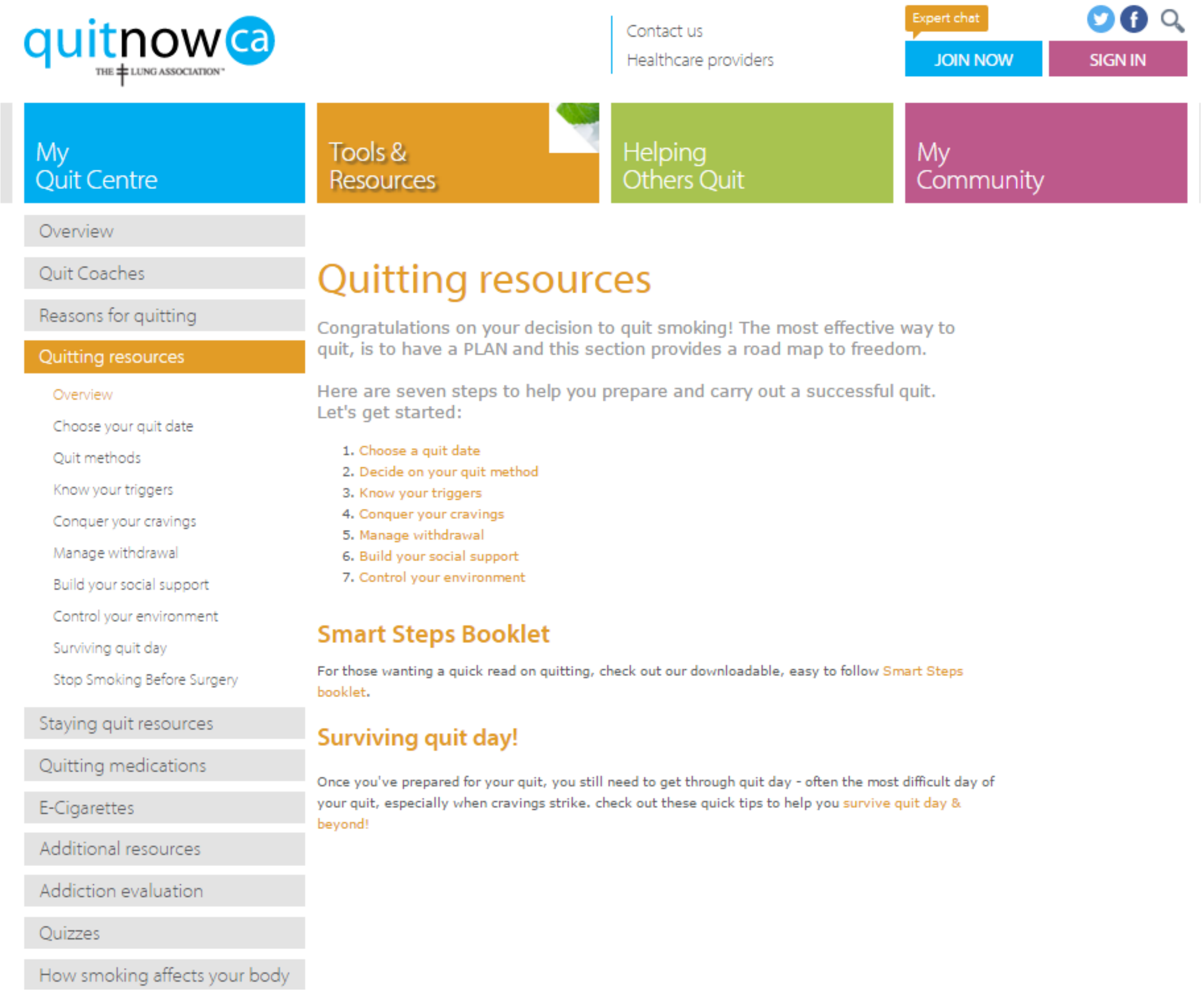
For **nicotine replacement products**… visit your pharmacy.

Need support to quit?

QuitNow.ca provides one-on-one support and valuable resources in multiple languages to help you plan your strategy before you get your smoking cessation aids. Planning increases your chances of success. When you are ready, the program will be there for you.

Supplementary Resource 33: The Lung Association Quit Now Smart Steps

https://www.quitnow.ca/tools-and-resources/quitting-resources.php



Quitting resources

Congratulations on your decision to quit smoking! The most effective way to quit, is to have a PLAN and this section provides a road map to freedom.

Here are seven steps to help you prepare and carry out a successful quit. Let's get started:

1. Choose a quit date
2. Decide on your quit method
3. Know your triggers
4. Conquer your cravings
5. Manage withdrawal
6. Build your social support
7. Control your environment

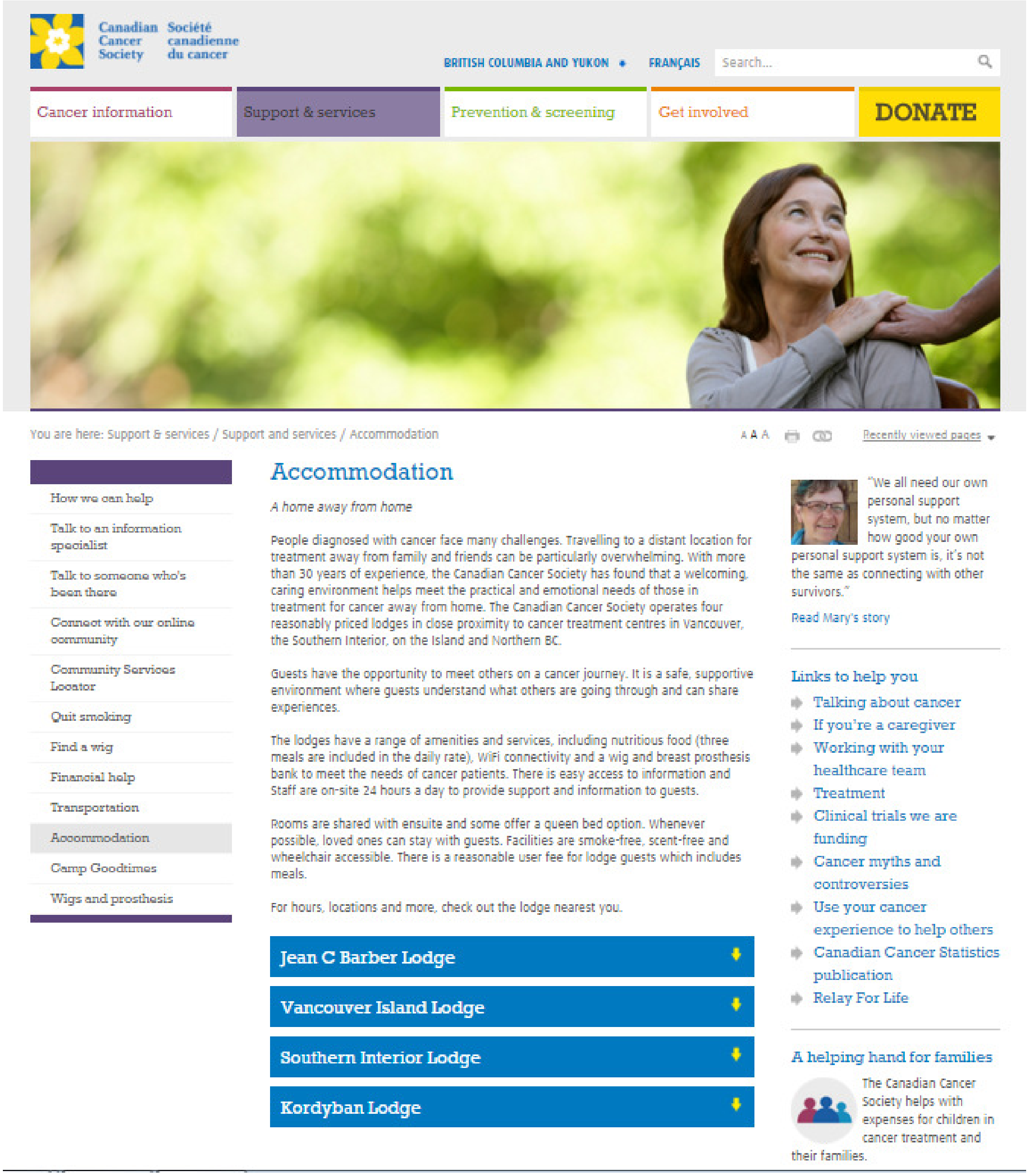
Smart Steps Booklet

For those wanting a quick read on quitting, check out our downloadable, easy to follow Smart Steps booklet.

Surviving quit day!

Once you've prepared for your quit, you still need to get through quit day - often the most difficult day of your quit, especially when cravings strike. check out these quick tips to help you survive quit day & beyond!

Supplementary Resource 34: Canadian Cancer Society Lodges
http://www.cancer.ca/en/support-and-services/support-services/travel-and-accommodations-bc/?region=bc



Accommodation

A home away from home

People diagnosed with cancer face many challenges. Travelling to a distant location for treatment away from family and friends can be particularly overwhelming. With more than 30 years of experience, the Canadian Cancer Society has found that a welcoming, caring environment helps meet the practical and emotional needs of those in treatment for cancer away from home. The Canadian Cancer Society operates four reasonably priced lodges in close proximity to cancer treatment centres in Vancouver, the Southern Interior, on the Island and Northern BC.

Guests have the opportunity to meet others on a cancer journey. It is a safe, supportive environment where guests understand what others are going through and can share experiences.

The lodges have a range of amenities and services, including nutritious food (three meals are included in the daily rate), WiFi connectivity and a wig and breast prosthesis bank to meet the needs of cancer patients. There is easy access to information and Staff are on-site 24 hours a day to provide support and information to guests.

Rooms are shared with ensuite and some offer a queen bed option. Whenever possible, loved ones can stay with guests. Facilities are smoke-free, scent-free and wheelchair accessible. There is a reasonable user fee for lodge guests which includes meals.

For hours, locations and more, check out the lodge nearest you.

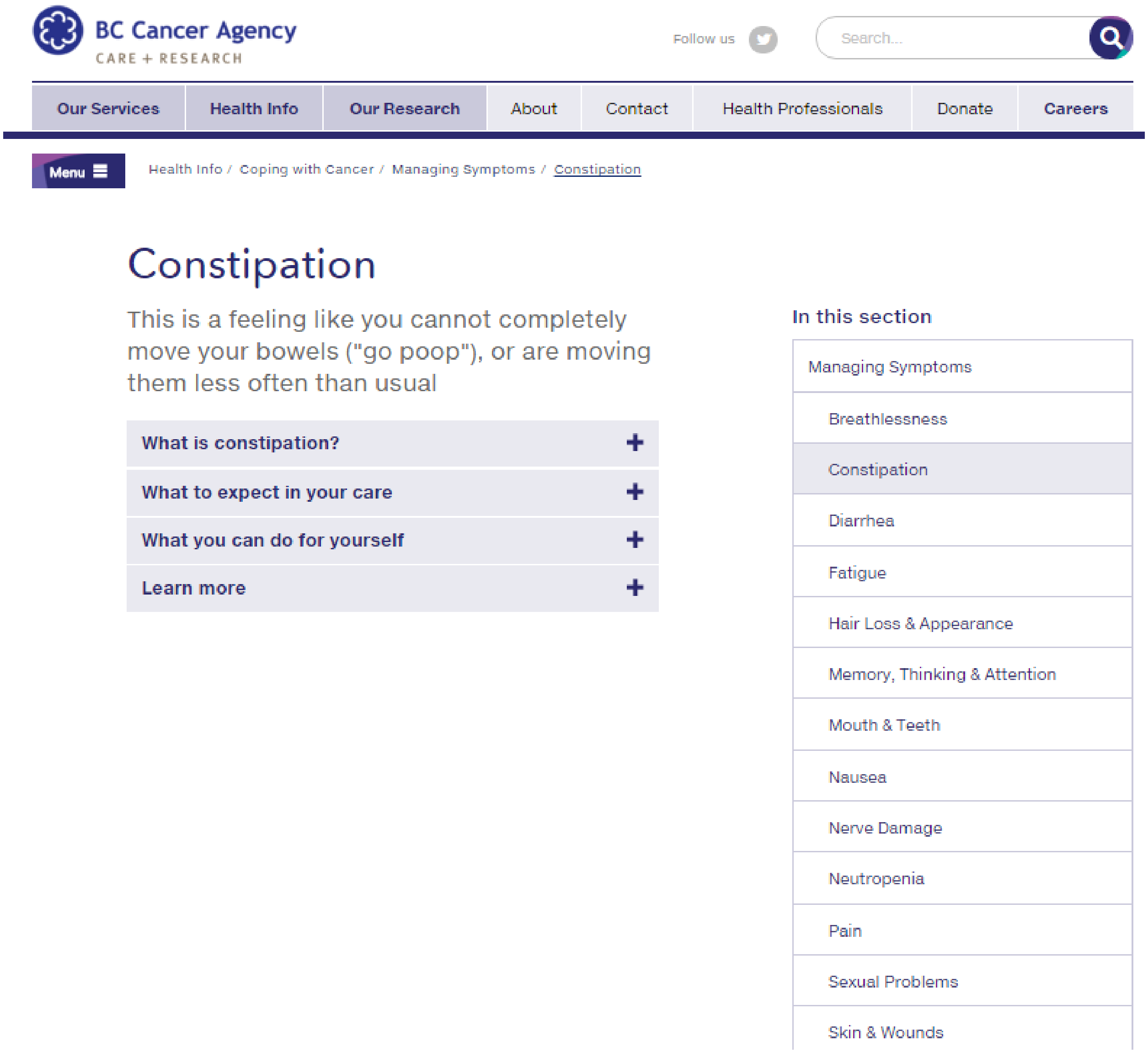
"We all need our own personal support system, but no matter how good your own personal support system is, it's not the same as connecting with other survivors."

Read Mary's story

The Canadian Cancer Society helps with expenses for children in cancer treatment and their families.

Supplementary Resource 35: BC Cancer Agency Bowel Protocol

http://www.bccancer.bc.ca/health-info/coping-with-cancer/managing-symptoms/constipation



Constipation

This is a feeling like you cannot completely move your bowels ("go poop"), or are moving them less often than usual

What is constipation? +

What to expect in your care +

What you can do for yourself +

Learn more +

In this section

- Managing Symptoms
  - Breathlessness
  - Constipation
  - Diarrhea
  - Fatigue
  - Hair Loss & Appearance
  - Memory, Thinking & Attention
  - Mouth & Teeth
  - Nausea
  - Nerve Damage
  - Neutropenia
  - Pain
  - Sexual Problems
  - Skin & Wounds

Supplementary Resource 36: The Bow Tie Model of 21st Century Palliative Care by Dr. P. Hawley
http://www.sciencedirect.com/science/article/pii/S088539241300609X

settings of care where quality measurement should be tailored (e.g., community-based palliative care[2]), and 4) the care models that transition across generalist and specialist palliative care.[3] Furthermore, we should expand into other important components of palliative care including transitions of care, support of caregivers, and patient and caregiver understanding of prognosis, among many others. We should be creative and rigorous in our approach, mirroring the methods from systematic research to evaluate generalizability and ability for implementation. Additionally, we should design quality measures that can inform dual goals of accountability (i.e., evaluating effectiveness of care for administrators and payers) and quality improvement (i.e., using data to inform areas for improvement) simultaneously.[4] Moreover, we should develop the infrastructure to aggregate and compare our experiences, ultimately utilizing our collective wisdom to refine and revolutionize our best practices.

Palliative care is maturing as a discipline simultaneously with large-scale changes in accountability and reimbursement in health care. We are learning how to demonstrate our value in the language of cost avoidance[5] and decreased hospital readmissions.[6] We also are defining the quality and research questions that need to be answered to move our field forward. Moreover, collaborations with other membership societies and large-scale initiatives like the Virtual Learning Collaborative and Primary Palliative Care Consensus Statement between the American Academy of Hospice and Palliative Medicine and the American Society of Clinical Oncology are further defining best practices and methods for implementing those practices. These are excellent first steps to demonstrate that we, as palliative medicine professionals, take ownership of issues of quality for all who suffer with chronic and serious illnesses. Now, more than ever, the shifting winds of health care reform earmark a time where palliative care must transition from saying "we're here" to "we're great," followed by one additional key phrase: "and here's how we prove it."

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http://dx.doi.org/10.1016/j.jpainsymman.2013.09.007

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The Bow Tie Model of 21st Century Palliative Care

To the Editor:

The World Health Organization's definition of palliative care[1,2] has evolved such that the recipient's illness is no longer required to be deemed incurable. Palliative care is now described as an approach applying to "life-threatening illness" and "applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life." This modern definition aims to include patients at a stage in their illness when cure may be unlikely, but not impossible. Despite this evolution in understanding of our specialty, public perception may be lagging behind.

The benefits of early integration of palliative care are well established; however, the challenges of actually achieving early integration are, unfortunately, equally well recognized.[3–5] Late referrals and inadequate resources are common in many palliative care programs and limit the programs' ability to achieve maximum potential both for the relief of suffering and for medical care cost containment.[6]

Despite the benefits of early integration, in many institutions palliative care is still only resorted to when all hope of cure or disease control has been lost. This image is often perpetuated by the media and even by some health care professionals. It may be understandable, given the relatively rapid development of the specialty and only recent demonstration of the benefits (including cost savings) of maximizing palliative care early in the course of serious illness. Confusion often results from the plethora of terms used to describe the many palliative care services offered throughout the disease process, such as *supportive care*, *hospice*, and *end-of-life care*. Many programs working toward earlier integration with disease management have even changed their names because of the association of the term *palliative care* with dying.[7]

If we cannot agree on consistent terms to describe what we do, how can we expect our colleagues and potential consumers of our services to understand?

Visual models can be helpful tools to explain complex concepts and have helped advance the understanding of palliative care since the term was coined in Canada over 30 years ago. An example of a helpful visual model is the recently presented house-shaped model describing a "climate of healing" used to facilitate complex discussions around goals of care.[8] Current visual models that aim to illustrate a gradual transition from curative intent treatment to palliative treatment are plentiful. A simple "Google pictures" search shows many versions of the horizontal, diagonally divided rectangle. Some include a tapering triangle of bereavement on the right and the diagonal line is often undulating or fuzzy.[9] A typical example is shown in Fig. 1. These models of the relationship between palliative care and disease-modifying treatments all either show a trajectory ending in death or having no trajectory at all.[10] Despite knowing at some level that they will die eventually, entering a pathway in which the only possible outcome is death is not inviting to patients and their families. If early integration of palliative care with disease management is the goal, then the possibility of cure must still be recognized when considering a referral, at least in the short term. If we cannot "get them in the door," much of the potential benefit of palliative care interventions could be lost. The excellent work that palliative care teams can do with patients who have difficulty accepting their own mortality, can only be done once we have contact with them.

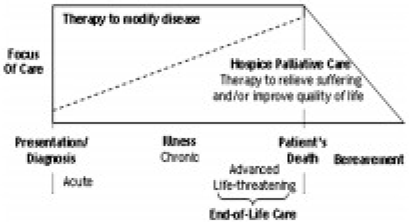

Fig. 1. Canadian Hospice Palliative Care Association model.

A new model to describe palliative care is needed to acknowledge the duality of an approach that prepares patients for the worst (death) but still allows hope for the best (cure). The goal of this model would be to help people see palliative care as a normal and essential part of medical care. It would describe a process in which the possibility of dying can be gently introduced at a time when patients' and families' thoughts may be consumed by hope of cure. Therefore, I propose the following model, which adheres to the scope *currently* defined by the World Health Organization. As shown in Fig. 2, the model consists of two overlapping triangles resembling a bow tie, with an arrow pointing from left to right. The first triangle represents disease management and the second triangle is palliative care. The base of the palliative care triangle (end of the model) includes both death and survival as possible outcomes. The arrow indicates that this is a dynamic process with a gradual switch in focus. The key difference between this and traditional

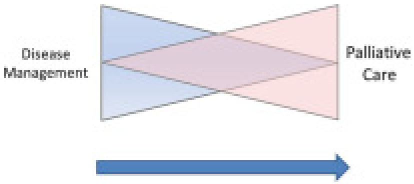

Fig. 2. Basic model of integrated palliative care.

models is that survivorship is included as a possible outcome.

The model's simplicity does not diminish its power as a communication tool, as it can be enhanced to explain complicated concepts for individual situations. The disease management triangle can be adapted for any illness. For example, it may be used to illustrate the role of supportive care interventions along with anti-cancer treatments (Fig. 3), while maintaining a visible reminder of the existence of the palliative care triangle and possibility of dying throughout. Similarly, as shown in Fig. 4, the palliative care triangle can be enhanced to illustrate where the various components of modern supportive and palliative care fit into the patient's journey. The contents of the triangle can be adapted to introduce and explain the services available and the terminology being used in the patient's particular setting. Additionally, the direction of the model can be reversed for cultures with a written language that reads from right to left. The adaptable and simple design makes it easier for care providers to generate it quickly for patients.

The brief examples shown here should not be seen as excluding any of the other vital aspects of palliative care, including psychological, spiritual and social support, advance care planning, music and art therapy, physiotherapy, respiratory therapy, etc. As with the myriad of available disease-modifying treatments, the many types of palliative care interventions are too numerous to list, but all interventions can be placed in one of the model's spaces. The labels can be added by the user to create a care map tailored to an individual patient's circumstances and needs. The map for a patient with chronic obstructive pulmonary disease may have very different labels than those of a cancer patient, but the anchor umbrella terms of *Disease Management* and *Palliative Care* include all kinds of services. This model is not meant to imply that all palliative care teams and hospices should provide rehabilitation and survivorship support. Its function is to show patients that these services are included as possible components of their care in the future and simplifies the language commonly used in medicine.

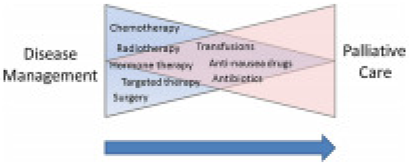

Fig. 3. Disease management-enhanced model.

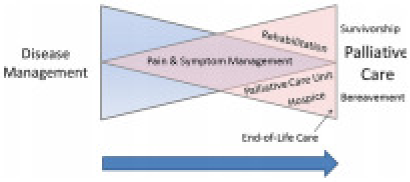

Fig. 4. Palliative care-enhanced model.

The word *survivorship* is most often understood to describe the state of being that follows only successful disease-targeted interventions, such as elimination of detectable cancer or following successful organ transplantation. However, as a medical term, it is starting to be used in reference to a type of service overlapping with or including palliative care, with widespread disagreement on the actual meaning. Survivorship is used here in its common form, as defined by the Oxford Dictionary: "a person who survives, especially a person remaining alive after an event in which others have died." It also is used to introduce the concept of using the term in reference to a type of service included as a palliative care intervention targeting quality of life but different than hospice or end-of-life care.

This model permits the early acceptance of a care pathway where the two approaches to care are integrated from the time of diagnosis, when the ultimate outcome (death or survivorship) may be too frightening for the patient to contemplate. My intention in communicating this "bow tie model" is to facilitate earlier acceptance of the role for palliative care for people diagnosed with serious illness, whether fatal or not. It would thereby maximize the proportion of time that people would benefit from the wide variety of palliative care interventions available. The model allows for an exit strategy other than death and facilitates early introduction of palliative care at a time when misconceptions and confusion in terminology may block access on both sides of the patient/caregiver partnership.

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Serial Prognostication: A New Look at an Old Tool

To the Editor:

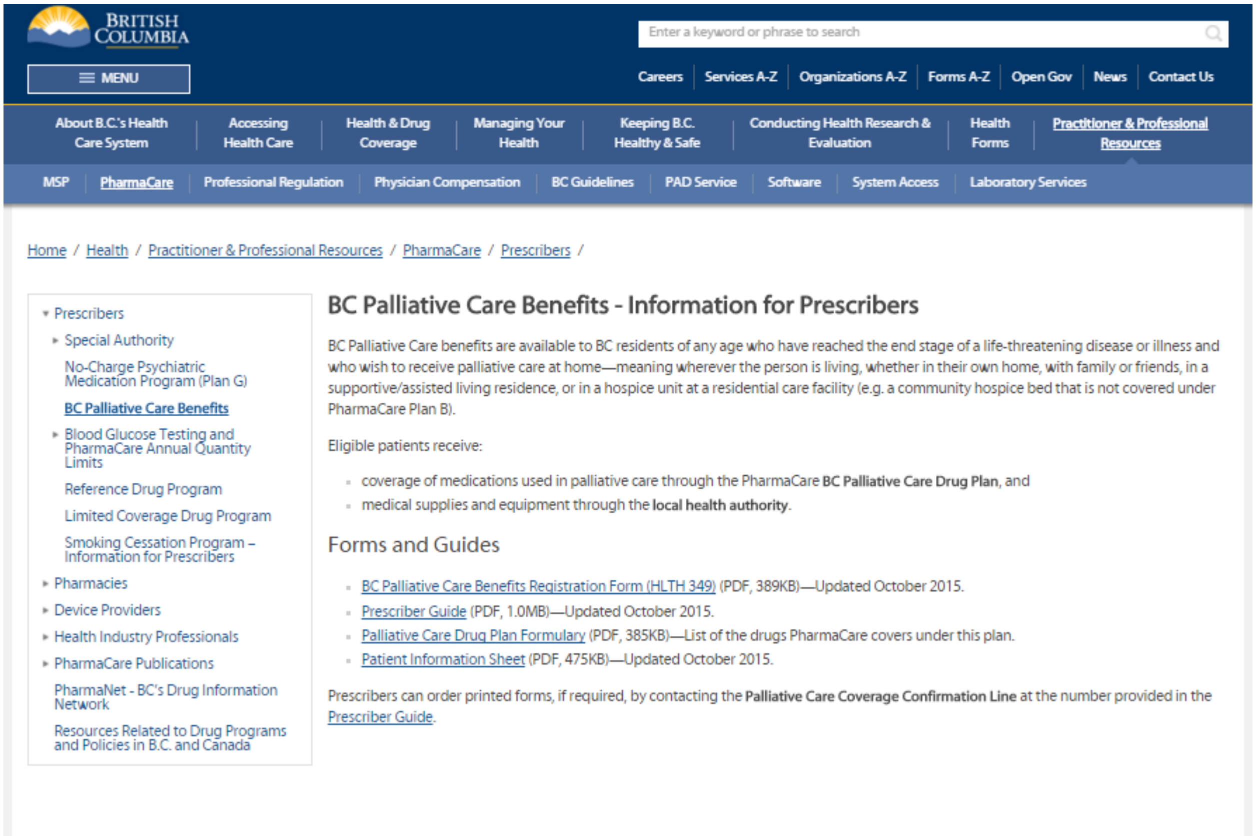
We read the article by Arai et al. with interest.[1] The authors conducted a retrospective study to examine the association between a change in the Palliative Prognostic Index (PPI) and survival in 374 cancer patients admitted to a palliative care unit in Japan. In multivariate analysis, they found a highly significant association between PPI change and survival (hazard ratio 6.6 per point increase in PPI; 95% CI, 4.9–9), independent of baseline PPI scores. This study suggests that the PPI is not only a prognostic tool but one that is sensitive to change, and importantly, the degree of change has prognostic utility.

Some additional information would help readers appreciate the significance of their findings. The PPI comprises five variables: the Palliative Performance Scale score, oral intake, dyspnea, delirium, and edema.[2] It would be useful to know the breakdown of PPI scores on admission and at follow-up. Did some of the PPI variables change more than others? Were some of the variables stable over this time period? Based on the data provided, the magnitude of PPI change appeared to be small (median = 0; interquartile range, 0–0.57). A better understanding of how the PPI evolves over time may facilitate future research in this area.

How the PPI data were collected also could have a major impact on the interpretation of study findings. Specifically, more information on the physician(s) who collected the data, and how each variable was assessed, would be crucial. How was dyspnea assessed especially in the context of delirium? Finally, because the PPI was assessed in the presence of other physiologic changes (e.g., death rattle), a prospective study adjusting for other prognostic variables would be needed.

The timing of the second data point raises some important questions. It would be helpful to learn how the authors decided that the PPI should be repeated five to seven days later, and if any exploratory analysis was done to examine the optimal timing related to a change in the PPI. We wonder if a shorter interval would have similar discriminatory power

Supplementary Resource 37: BC Ministry of Health Palliative Care Benefits Program
http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/prescribers/plan-p-bc-palliative-care-benefits-program



BC Palliative Care Benefits - Information for Prescribers

BC Palliative Care benefits are available to BC residents of any age who have reached the end stage of a life-threatening disease or illness and who wish to receive palliative care at home—meaning wherever the person is living, whether in their own home, with family or friends, in a supportive/assisted living residence, or in a hospice unit at a residential care facility (e.g. a community hospice bed that is not covered under PharmaCare Plan B).

Eligible patients receive:

- coverage of medications used in palliative care through the PharmaCare **BC Palliative Care Drug Plan**, and
- medical supplies and equipment through the **local health authority**.

Forms and Guides

- BC Palliative Care Benefits Registration Form (HLTH 349) (PDF, 389KB)—Updated October 2015.
- Prescriber Guide (PDF, 1.0MB)—Updated October 2015.
- Palliative Care Drug Plan Formulary (PDF, 385KB)—List of the drugs PharmaCare covers under this plan.
- Patient Information Sheet (PDF, 475KB)—Updated October 2015.

Prescribers can order printed forms, if required, by contacting the **Palliative Care Coverage Confirmation Line** at the number provided in the Prescriber Guide.

Supplementary Resource 38: Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer

http://www.nejm.org/doi/pdf/10.1056/NEJMoa1000678

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

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ABSTRACT

BACKGROUND

Patients with metastatic non–small-cell lung cancer have a substantial symptom burden and may receive aggressive care at the end of life. We examined the effect of introducing palliative care early after diagnosis on patient-reported outcomes and end-of-life care among ambulatory patients with newly diagnosed disease.

METHODS

We randomly assigned patients with newly diagnosed metastatic non–small-cell lung cancer to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone. Quality of life and mood were assessed at baseline and at 12 weeks with the use of the Functional Assessment of Cancer Therapy–Lung (FACT-L) scale and the Hospital Anxiety and Depression Scale, respectively. The primary outcome was the change in the quality of life at 12 weeks. Data on end-of-life care were collected from electronic medical records.

RESULTS

Of the 151 patients who underwent randomization, 27 died by 12 weeks and 107 (86% of the remaining patients) completed assessments. Patients assigned to early palliative care had a better quality of life than did patients assigned to standard care (mean score on the FACT-L scale [in which scores range from 0 to 136, with higher scores indicating better quality of life], 98.0 vs. 91.5; $P=0.03$). In addition, fewer patients in the palliative care group than in the standard care group had depressive symptoms (16% vs. 38%, $P=0.01$). Despite the fact that fewer patients in the early palliative care group than in the standard care group received aggressive end-of-life care (33% vs. 54%, $P=0.05$), median survival was longer among patients receiving early palliative care (11.6 months vs. 8.9 months, $P=0.02$).

CONCLUSIONS

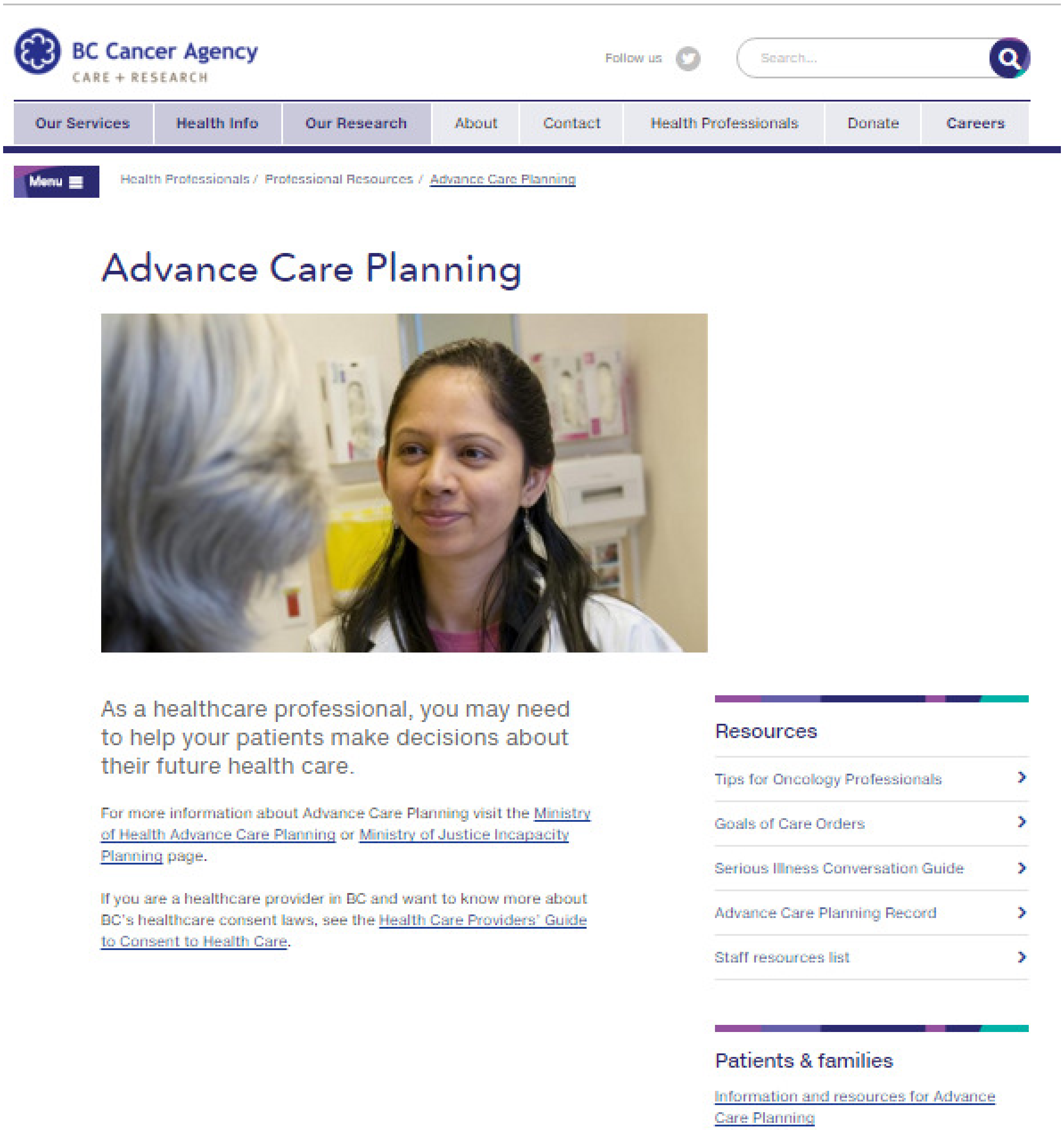
Among patients with metastatic non–small-cell lung cancer, early palliative care led to significant improvements in both quality of life and mood. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival. (Funded by an American Society of Clinical Oncology Career Development Award and philanthropic gifts; ClinicalTrials.gov number, NCT01038271.)

From Massachusetts General Hospital, Boston (J.S.T., J.A.G., A.M., E.R.G., V.A.J., C.M.D., J.J., W.F.P., J.A.B.); the State University of New York, Buffalo (S.A.); Adult Palliative Medicine, Department of Anesthesiology, Columbia University Medical Center, New York (C.D.B.); and Yale University, New Haven, CT (T.J.L.). Address reprint requests to Dr. Temel at Massachusetts General Hospital, 55 Fruit St., Yawkey 7B, Boston, MA 02114, or at jtemel@partners.org.

N Engl J Med 2010;363:733-42.

Supplementary Resource 39: BC Cancer Agency Advanced Care Planning: Making Decisions for Your Future

http://www.bccancer.bc.ca/health-professionals/professional-resources/advance-care-planning



Advance Care Planning

As a healthcare professional, you may need to help your patients make decisions about their future health care.

For more information about Advance Care Planning visit the Ministry of Health Advance Care Planning or Ministry of Justice Incapacity Planning page.

If you are a healthcare provider in BC and want to know more about BC's healthcare consent laws, see the Health Care Providers' Guide to Consent to Health Care.

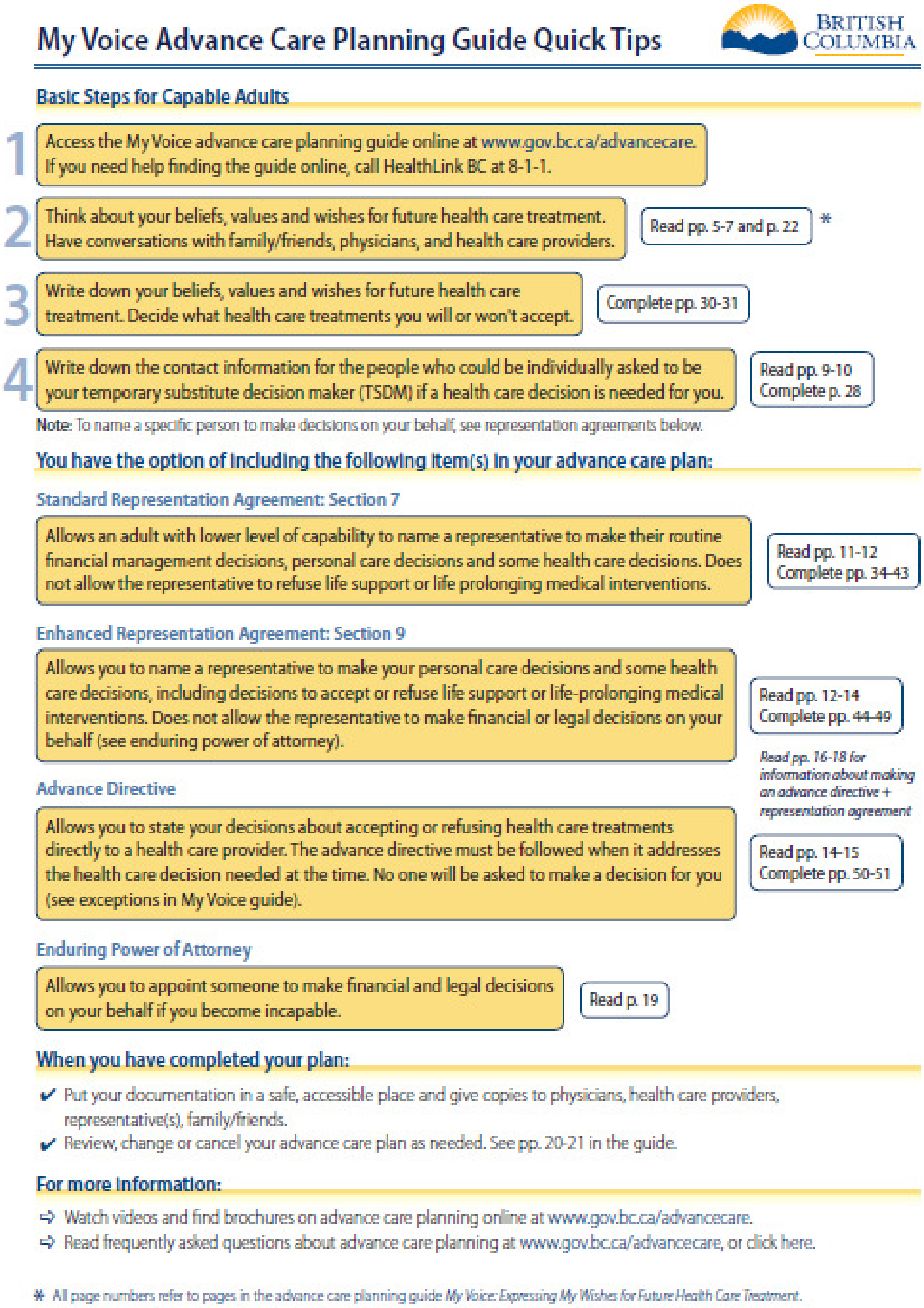
Resources

- Tips for Oncology Professionals
- Goals of Care Orders
- Serious Illness Conversation Guide
- Advance Care Planning Record
- Staff resources list

Patients & families

Information and resources for Advance Care Planning

Supplementary Resource 40: BC Government My Voice Advanced Care Planning Guide Quick Tips
http://www2.gov.bc.ca/gov/DownloadAsset?assetId=414769BBDA2F4E29AC2CECE82906C98A



My Voice Advance Care Planning Guide Quick Tips

BRITISH COLUMBIA

Basic Steps for Capable Adults

1 Access the My Voice advance care planning guide online at www.gov.bc.ca/advancecare. If you need help finding the guide online, call HealthLink BC at 8-1-1.

2 Think about your beliefs, values and wishes for future health care treatment. Have conversations with family/friends, physicians, and health care providers. — Read pp. 5-7 and p. 22 *

3 Write down your beliefs, values and wishes for future health care treatment. Decide what health care treatments you will or won't accept. — Complete pp. 30-31

4 Write down the contact information for the people who could be individually asked to be your temporary substitute decision maker (TSDM) if a health care decision is needed for you. — Read pp. 9-10
Complete p. 28

Note: To name a specific person to make decisions on your behalf, see representation agreements below.

You have the option of including the following item(s) in your advance care plan:

Standard Representation Agreement: Section 7

Allows an adult with lower level of capability to name a representative to make their routine financial management decisions, personal care decisions and some health care decisions. Does not allow the representative to refuse life support or life prolonging medical interventions.

Read pp. 11-12
Complete pp. 34-43

Enhanced Representation Agreement: Section 9

Allows you to name a representative to make your personal care decisions and some health care decisions, including decisions to accept or refuse life support or life-prolonging medical interventions. Does not allow the representative to make financial or legal decisions on your behalf (see enduring power of attorney).

Read pp. 12-14
Complete pp. 44-49

Read pp. 16-18 for information about making an advance directive + representation agreement

Advance Directive

Allows you to state your decisions about accepting or refusing health care treatments directly to a health care provider. The advance directive must be followed when it addresses the health care decision needed at the time. No one will be asked to make a decision for you (see exceptions in My Voice guide).

Read pp. 14-15
Complete pp. 50-51

Enduring Power of Attorney

Allows you to appoint someone to make financial and legal decisions on your behalf if you become incapable.

Read p. 19

When you have completed your plan:

- ✔ Put your documentation in a safe, accessible place and give copies to physicians, health care providers, representative(s), family/friends.
- ✔ Review, change or cancel your advance care plan as needed. See pp. 20-21 in the guide.

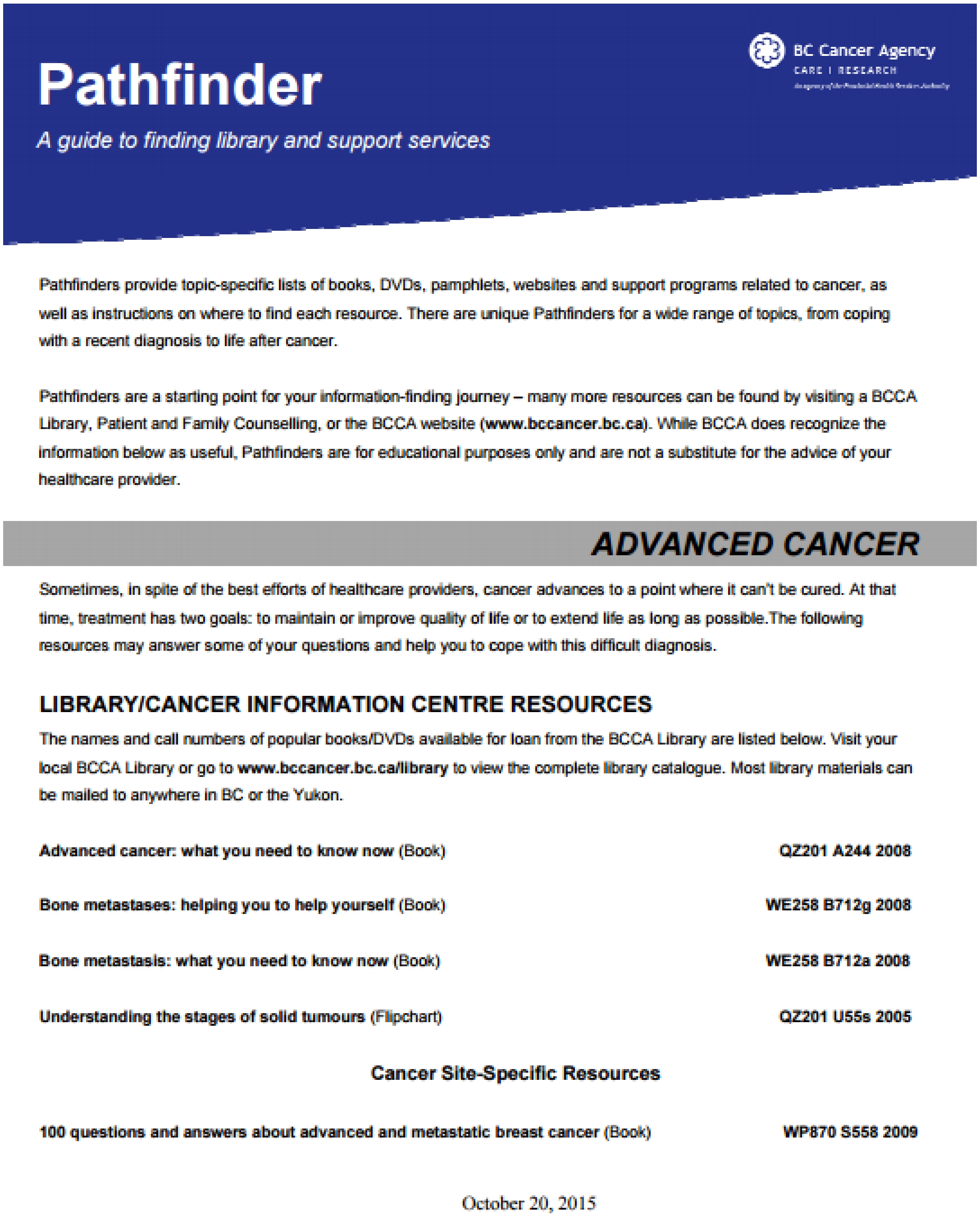
For more information:

- ➪ Watch videos and find brochures on advance care planning online at www.gov.bc.ca/advancecare.
- ➪ Read frequently asked questions about advance care planning at www.gov.bc.ca/advancecare, or click here.

* All page numbers refer to pages in the advance care planning guide *My Voice: Expressing My Wishes for Future Health Care Treatment.*

Supplementary Resource 41: BC Cancer Agency Advanced Cancer Pathfinder

http://www.bccancer.bc.ca/library-site/Documents/Advanced-General.pdf



BC Cancer Agency
CARE | RESEARCH

Pathfinder

A guide to finding library and support services

Pathfinders provide topic-specific lists of books, DVDs, pamphlets, websites and support programs related to cancer, as well as instructions on where to find each resource. There are unique Pathfinders for a wide range of topics, from coping with a recent diagnosis to life after cancer.

Pathfinders are a starting point for your information-finding journey – many more resources can be found by visiting a BCCA Library, Patient and Family Counselling, or the BCCA website (**www.bccancer.bc.ca**). While BCCA does recognize the information below as useful, Pathfinders are for educational purposes only and are not a substitute for the advice of your healthcare provider.

ADVANCED CANCER

Sometimes, in spite of the best efforts of healthcare providers, cancer advances to a point where it can't be cured. At that time, treatment has two goals: to maintain or improve quality of life or to extend life as long as possible.The following resources may answer some of your questions and help you to cope with this difficult diagnosis.

LIBRARY/CANCER INFORMATION CENTRE RESOURCES

The names and call numbers of popular books/DVDs available for loan from the BCCA Library are listed below. Visit your local BCCA Library or go to **www.bccancer.bc.ca/library** to view the complete library catalogue. Most library materials can be mailed to anywhere in BC or the Yukon.

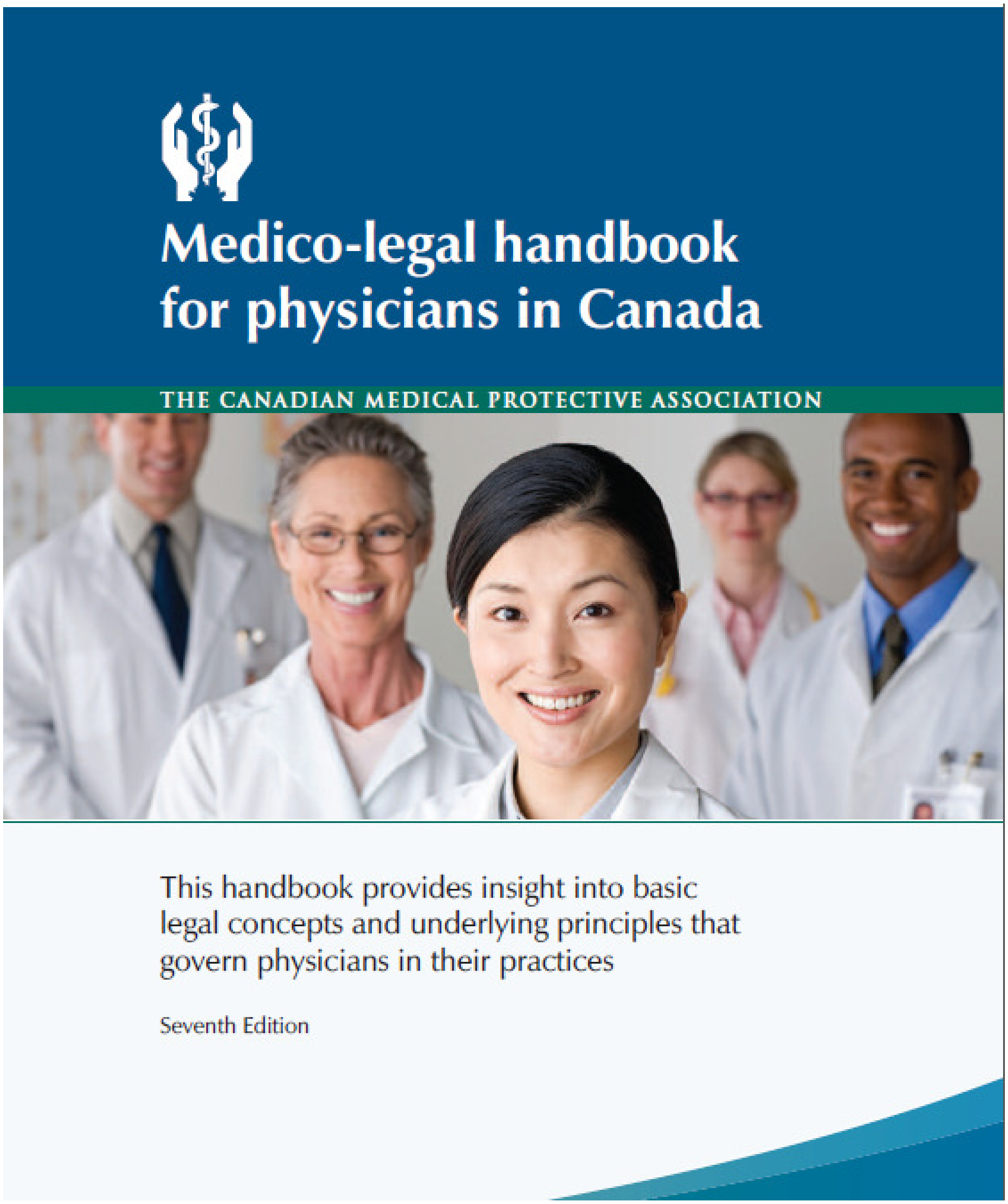
Advanced cancer: what you need to know now (Book)	**QZ201 A244 2008**
Bone metastases: helping you to help yourself (Book)	**WE258 B712g 2008**
Bone metastasis: what you need to know now (Book)	**WE258 B712a 2008**
Understanding the stages of solid tumours (Flipchart)	**QZ201 U55s 2005**

Cancer Site-Specific Resources

100 questions and answers about advanced and metastatic breast cancer (Book)	**WP870 S558 2009**

October 20, 2015

Supplementary Resource 42: The Canadian Medical Protective Association Medico-legal handbook for Physicians in Canada
https://www.cmpa-acpm.ca/web/guest/-/a-medico-legal-handbook-for-physicians-in-canada



Medico-legal handbook for physicians in Canada

THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION

This handbook provides insight into basic legal concepts and underlying principles that govern physicians in their practices

Seventh Edition

Supplementary Resource 43: Cancer Survivorship Defined

Additional notes: Cancer Survivorship

Primary care providers and oncology specialists work together to provide survivorship care. We have included "survivorship pearls" throughout the course syllabus, to be shared with participants.

What is survivorship?

Someone is a cancer survivor from the time of diagnosis and for the balance of life (National Coalition for Cancer Survivorship 2014). Survivorship includes the physical, psychosocial, and economic issues of cancer beyond the diagnosis and treatment phases. Survivorship also includes the ability to get health care and follow up treatment, late effects of treatment, second cancers, and quality of life. Family members, friends, and caregivers are also considered part of the survivorship experience.

The prevalence of cancer in BC is growing by approximately 3% per year and it is projected that by 2020 there will be 239,075 people in BC who have had a diagnosis of cancer at some point in their lives. (BC Cancer Agency Facts and Figures). Generally, 65% of adults and 80% of children diagnosed with cancer are expected to live at least five years post-diagnosis. Once cancer survivors are discharged from the BC Cancer Agency or BC Children's Hospital, they rely on their primary care providers for comprehensive, timely, and evidence-based survivorship care and surveillance.

A patient's survivorship experience will be influenced by a variety of factors, including age at diagnosis (survivors of pediatric cancers experience face an 80% chance of significant health complications and health risks in later life), health status, social status, and health literacy. Access to timely and comprehensive medical and psychosocial services is vital to the health and well-being of cancer survivors.

The *Supportive Care Framework* (Fitch, 1994, 2008) categorizes the needs of patients living with cancer and in survivorship:

Physical:
- Pain (surgical sites, radiation sites, neuropathy)
- Hair/skin changes
- Weight gain
- Decreased mobility (e.g. frozen shoulder , lymphedema)
- Medication side effects
- Erectile dysfunction
- Vaginal dryness
- Ostomy management
- Dental carries and mouth sores

Psychological:
- Self-worth
- Body image
- Coping
- Insomnia

Emotional:
- Anger
- Despair
- Fear of recurrence
- Anxiety
- Depression
- Post traumatic stress disorder
- Fear of dying
- Survivorship guilt

Informational:
- Disease
- Treatment
- Symptoms
- Coping skills
- Services and resources

Practical:
- Challenges with memory, attention, critical thinking
- Finances
- Child care
- Legal
- Return to work/school

Social:
- Family
- Intimacy
- Decline in socio-economic status/financial strain

Spiritual:
- Meaning of life
- Pain and suffering

BC Cancer Agency Facts and Figures (2015). http://www.bccancer.bc.ca/health-info/disease-system-statistics/bc-cancer-statistics/facts-and-figures
Fitch, MI. (2008). "Supportive Care Framework". Canadian Oncology Nursing Journal. Vol 18 No 1. Available from: http://canadianoncologynursingjournal.com/index.php/conj/article/view/248/251
National Coalition for Cancer Survivorship. http://www.canceradvocacy.org/about-us/our-mission/

PANCREATIC CANCER

CASE Q&A

1. What are the key areas that you need to check during this first visit?

Key point	Notes	Resources
Blood testing	Bloodwork recommended - Complete blood count (CBC) - Thyroid function (TSH) - Liver enzyme test - Lipase - HbA1c (rather than fasting blood sugar) Bl Glucose to screen for diabetes - Electrolytes (Lytes) - Blood urea nitrogen (BUN) - Creatinine (Cr) - Ferritin or B12 if indicated in diet history	Patient Referral Form
Complete physical exam (CPX)	- BP = 128/80 - P=68/min reg - All normal (N) Ask for more history of his symptoms e.g. early satiety, dyspepsia, acid reflux, nausea, back pain. In the early stages of this cancer these are all likely negative, but may emerge, so ask repeatedly	
Lifestyle counseling	Check: - Alcohol consumption - Sleep hygiene - Exercise - Setting boundaries at work - Smoking pack history - History of drug use	
History of stress	- Period of stress during a time of marital difficulty	
Schedule follow-up appointment	- To review results. Perhaps feeling a little better. See as needed (prn)	

2. What do you advise the couple?

Key point	Notes	Resources
Address anxiety	- Gently explain that this is only guesswork and we need to get to the root of the problem - Commit to do so urgently - Outline the next steps clearly and how you may be contacted if things change or deteriorate, especially what to do if he develops a fever. - In case of a fever the greatest concern is he	Coping with Anxiety Fact Sheet Screening for Measuring Distress Tool

	has developed “Ascending Cholangitis” which is a medical emergency. He should be counselled that if he develops a fever and some upper right abdominal pain he must go to the ER at once.	
Arrange further tests	• Start with an urgent abdominal U/S; this shows the biliary tree quite nicely and can often delineate the cause of jaundice or give a hint • CT scan sometimes has trouble seeing the cause of the dilatation • Urgent CBC, LFTs, Electrolytes, Blood urea nitrogen (BUN), Creatinine, international normalized ratio (INR), total bilirubin, Albumin, Partial thromboplastin time (PTT), Ferritin • Need to also consider meolysis in the differential unless the bilirubin is done and shown to be mostly the cause (often we only get total bili so unable to differentiate conjugated-liver/biliary from unconjugated-hemolysis/gilbert’s etc.) • Hepatitis serology - while waiting for the imaging • **Note:** Ca 19-9 investigation not encouraged as this marker can go up in cholangitis/biliary obstruction as well as cancer. Best practice is not to investigate for tumor markers unless masses are present and the marker is necessary to help narrow a differential diagnosis or follow response to therapy. These markers are not specific enough and at this point in Larry’s case, the result may be more confusing than helpful if he only had cholangitis.	Referral Form Lab Requisition Form

3. What further tests should be ordered? (Note: in rural settings this may be done by a radiologist)

Key point	Notes	Resources
Order ERCP & referral to GI specialist	• In some cases the pancreatic mass may be difficult to see on CT, so if there was any suggestion from the U/S that there was a mass, ordering a CT with “pancreas protocol” is advised • Once the results of the CT abdominal scan become available request a: endoscopic retrograde cholangiopancreatography (ERCP) and call for urgent consultation with a GI	Referral Form & Call Relevant Cancer Centre

	specialist • **Note**: Brushings from ERCP are often negative.	
Biopsy	• Biopsy of the lymph node or the pancreatic head mass (typically accessible) can usually be done with endoscopic ultrasound. Refer to a GI who can conduct this procedure • Larry should also be referred for HPB surgery if available (need specialized care to do optimal Whipple's if deemed resectable) • Ideally, the referral should go to a high volume centre. There is a movement away Whipple's being performed by physicians who only do them a few times a year and don't have a specialized multidisciplinary team available. • Once the mass and liver findings are confirmed, would do a CEA and Ca 19-9.	Order / referral form

4. How would you disclose the diagnoses to Larry?

Key point	**Notes**	**Resources**
Prior to the appointment	• Ask receptionist to call them in for last appointment of the day (not on a Friday) • Must have his wife present, probably not the children at this stage • Be clear about the facts and have the consult notes at hand • Ensure that referral to Cancer Agency is already underway to avoid delay • **Note**: a referral to the Cancer Agency is not the "be all end all". The most important referral for this man is to HPB surgery for management. They need to decide if this is resectable or not and this is not a call for a GP or a Med Onc to make. The para-aortic involvement is dependent on where along the course of the aorta they are, and they may be reactive as well depending on size and shape. Med Onc would be the referred doctor if referred to BCCA and we would need the opinion of HPB surgery before we could make any recommendations. If it is resectable up front then we are only needed post-op to consider adjuvant therapy. However, if borderline resectable, we may be referred to, to give neoadjuvant chemo to try and downstage to resectability	Referral Form & call relevant Cancer Centre

SPIKES	• Set up the interview, sit down, connect with Larry, allow for enough time • Assess patient's perception • Obtain patient's invitation • Knowledge – give (limited) facts and answer questions • Be genuine, honest and empathetic • Be clear about plan, follow up and availability • Summarise	SPIKES Protocol Inform family to bring recording device or a note pad

Survivorship pearl: Advance care planning is something that everyone should consider regardless of diagnosis or health status.

5. What are your next steps?

Key point	**Notes**	**Resources**
Management of stent	• Obtain and follow recommendations from the GI specialist	Endoscopic Biliary Stenting
Referral to a medical oncologist	• Urgent – best by phone if possible	Referral Form
Counseling support	• Check need with patient • Inform children's counselors • Legacy-making - depending on whether advanced care planning has been discussed	Referral Form BC Cancer Agency "Cancer and the Family: http://www.bccancer.bc.ca/health-info/coping-with-cancer/emotional-support/cancer-the-family
Practical support for child care	• Encourage the family to arrange alternate child care plans to provide respite for both patient and caregiver	BC Cancer Agency Patient and Family Counselling: http://www.bccancer.bc.ca/our-services/services/patient-family-counselling

DNA banking	- Contact the Hereditary Cancer Program for a requisition for DNA banking through the Cancer Genetics laboratory at the BC Cancer Agency - Discuss with patient and wife how DNA can be stored for future genetic testing if indicated, for assessment and diagnosis of a possible hereditary basis for this early-onset pancreatic cancer	CGL requisition HCP referral form

6. How can you deal with accusations or feelings of guilt?

Key point	Notes	Resources
Physician	- Talk to colleague / may need College Physician support team	Informal contact with older/ more experienced colleague BC College of Physicians and Surgeons Physician Health Program of BC 1-800-663-6729 (24/7) info@physicianhealth.com
Wife	- Offer counselling support	Employee & Family Assistance Program (EFAP) BCCA

7. Larry wants to know what you can do to alleviate his back pain. What are your next steps?

Key point	Notes	Resources
Palliative Performance Scale (PPS)	- Reassess Larry's functional, self-care, eating abilities & alertness level - Palliative Performance Scale (PPS): 50%	Palliative Performance Scale (PPS)
Palliative Benefits	- Register patient for Palliative Benefits	BC Palliative Care Benefits Program Application Form

		BC Ministry of Health (2013). BC Palliative Care Benefits Program - Physician Guide v2.4 1-877-711-5757 (24/7) Physician to physician palliative care consultation
Pain management	• Commence opioid treatment • Stance on medicinal cannabis or cannabinoid treatment	GPAC Guidelines - Pain Management GPAC Guidelines - Cancer Pain Management Algorithm
Nausea management	• Discuss non- pharmacological and pharmacological approaches (in guidelines)	GPAC Guidelines - Nausea & Vomiting
Reorder CT scan	• If the patient is receiving chemo, then the CT scan will be ordered by the oncologist • If there is a change in Larry's pain and you think imaging should be ordered soon, contact the oncologist to let them know as they can move the scan, if not already impending • **Note**: this will avoid the patient having multiple scans in close proximity- this can happen as there is no way of knowing who is ordering scans • Often if a scan is done at another facility, they will not have comparative images, so it will be a stand-alone scan that will not tell you how things are changing, just a "snap shot" in time.	Order form

8. What guidance would you offer Larry in making decisions and choices at this stage?

Key point	Notes	Resources
Quality of life issue discussion	• Decide with patient and wife	
Appointment length	• Long end of day appointment, or possibly a house call	

SPIKES protocol (again)	- Entering end-of-life phase discussions. ○ **Note**: Breaking bad news is a process, not an event, and may need to be repeated a number of times, either for patients to understand fully and process, or because the news changes	[SPIKES Protocol]()
Confirm Advance Care Planning	- Need to establish patient & wife's understanding of what is happening	
Anticipatory grief	- Be aware of the patient's, spouse's and family's needs in this area. Arrange SW counselor or school counselor if possible	[GPAC Guidelines - Grief & Bereavement]()
Need resources	- Inform patient and family about the resources available to them	Local knowledge required

Survivorship pearl: Family members, friends, and caregivers are part of the survivorship experience. They can access resources such as respite care, counselling, and support groups.

Key resources include:

- Respite Care in BC, available through regional health authorities: http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/caregiver-respite-relief
- Victoria Hospice: http://www.victoriahospice.org/
- Canadian Virtual Hospice: http://www.virtualhospice.ca/
- BC Cancer Agency list of support groups: http://www.bccancer.bc.ca/health-info/coping-with-cancer/support-programs

9. Would Larry benefit from block treatment?

Key point	Notes	Resources
Pain management	- When opioids are failing	WHO Pain Ladder - WHO website 4th step is "interventional" anaesthetics or radiology
Celiac Plexus Block	- Celiac plexus block is an anaesthetic injection into a deep mesh of nerves in the abdomen. It is intended to help the pain that comes from the tumour in that area. It involves an injection by an interventional radiologist or anaesthetist either through the back or via gastroscopy under light	Ohio Health Celiac Plexus Block

sedation

Survivorship pearl: *One of the most common side effects of opioids is constipation. It is important to ensure patients are on an adequate bowel protocol as constipation can lead to other side effects including urinary retention, increased pain, or confusion. The Victoria Bowel Performance Scale is available at http://www.victoriahospice.org/health-professionals/clinical-tools*

10. Larry wants to know what can be done to make him more comfortable. What do you advise him?

Key point	Notes	Resources
Management of malignant bowel obstruction	• Principles: ○ Control of nausea ○ Control of pain ○ Control of secretions ○ Psychological support for patient ○ Proximal vs distal lesion differences	Victoria Hospice book “Medical Care of the Dying”
Venting gastronomy	• Purpose and limitations arrange with surgeon	
Nausea	• As above	
Wife and children	• Psychological support for wife and children: • Federal Compassionate Benefits	Online
Bereavement support		GPAC Guidelines - Grief & Bereavement
Wife and children	• Information re: benefits etc. Anticipatory grief.	GPAC Guidelines - Grief & Bereavement
	• Make a follow-up appointment with the wife for a month later or so	
Appointments	• MOA should cancel all patient appointments	
Communication with other health care providers	• MOA should inform any other practitioners involved	

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