



WELCOME

Palliative Care in the Home: Lessons From COVID

Host and Moderator: Dr. José Pereira MBChB, CFPC (PC), MSc, FCFP

Panelists:

Dr. J. David Henderson MD, CCFP (PC)

Dr. Hollis Roth BSc, MD, CCFP (PC)

Dr. Stephen Singh MD, CCFP (PC)

Dr. Samantha Winemaker BSc, MD, CCFP (PC), FCFP

The webinar will begin soon (please note your microphone is muted).
Please use the Q&A function to submit questions.



Housekeeping

- Your microphones are muted.
- Use the Q&A function at the bottom of your screen to submit questions. Please do not use the chat function for questions.
- This session is being recorded and will be emailed to webinar registrants next week.

Presenters

Host and Moderator

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Presenters

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Declaration of conflicts

Pallium Canada

- Non-profit
- Generates funds to support operations and R&D from course registration fees and sales of the Pallium Palliative Pocketbook
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Learning objectives

Upon completing this webinar, you should be able to:

- Describe the impact that the COVID-19 pandemic has had on the provision of palliative care in the home, in general and specifically for your team;
- Describe strategies used by teams across the country to manage patients with palliative care needs in their homes during the COVID-19 pandemic;
- Adapt your community palliative care services to ensure optimal provision of home-based palliative care moving forward during the next phase of the pandemic.

What impact has COVID had on palliative care in the home (and family clinics)?

Palliative Care Specialist Team Triage/Priority Guidelines

PRIORITY	DESCRIPTION	SERVICE LEVEL DESCRIPTION
<p>A_{1,2,3}</p>	<ul style="list-style-type: none"> • Patients transitioning to end of life, or deemed to be imminently dying at home (PPS⁴ ≤ 30); • Patients with non-curative disease and palliative goals of care who have severe acute or poorly controlled symptom burden needing urgent evaluation by specialist palliative care; • High level of psychological distress for the patient, family or caregiver and/or caregiver burn-out or crisis is present. • Patients requiring admission or transfer to the in-patient palliative care unit. In areas without a palliative care unit, this may include facilitating hospital admission for an existing patient. 	<ul style="list-style-type: none"> • Patients are more likely to require direct, in-person care regardless of setting. • These patients will require more urgent conversations about their goals and plan of care. • May also include consultative phone support to the MRP to ensure patient receives recommended interventions as soon as possible.

B^{1,2,3}

- Patients actively followed by the palliative care team requiring follow-up for moderate severity symptoms, and/or those with anticipated decline from disease burden over next 4-12 weeks
 - Patients experiencing moderate severity symptoms that can be managed by their primary care team and can wait days to weeks for an appointment (PPS usually 30-60%)
 - Psychological distress for the patient, family or caregiver and/or caregiver burnout or crisis is present.
- Patients will be offered virtual care appointment for consultation or follow-up appointments.
 - Patients usually can be managed in their current setting either by direct, in person care or virtually.
 - Once consultation has occurred and if stable with adequate supports in place, can be returned to referring service for monitoring.

C²

- Patients have stable or mild symptoms and have supports in place for routine follow-up by their health care team.
- Patients with a PPS > 60% with few symptoms who are transitioning off of chemotherapy/oncology follow-up.
- Patients currently followed by palliative care may continue with their current care plan as directed by the palliative care team.
- All new, non-urgent consults normally seen electively in a palliative care clinic or home will not be seen at this time and this will be communicated in writing to the referring source/s.
- Phone consultation with referring physicians managing care is offered and always welcomed.
- Patients triaged as non-urgent should be provided with clear information by their referring health care provider about what changes in their health status they should be monitoring and how to access care should any of these changes occur. Virtual care options will be particularly valuable if contact with these patients is required.

What has it highlighted or exposed in this setting? (good and bad)

- The Good

- What a great team
- People being able to adapt quickly
- Decisions being made quickly
- Great patients
- More people at home to care for family.
- More people learning that a home death can be a good thing.
- Virtual visits

- The Bad:

- Distanced from team
- Fear
- Aggravated distress
- Family visits (lack there of)
- More limited resources
- Virtual visits

What changes have your services/teams and your colleagues (including primary care providers made to respond to the pandemic?

Changes:

- Almost everything
- Increased awareness of trauma and trauma informed care
- Much more attention to infection prevention
- Increased communication with primary care teams
- Increased efficiency in some areas

What should be considered to ensure good palliative care in the community/home going forward?

- Ensuring good palliative care:
 - You can't see all on zoom
 - In person visits allow you to see what you can't hear.
 - Easier to hear what isn't being said when in person.
 - Once relationship is established, virtual visits can be very useful.
 - As always, good communication is key.

Palliative care program – Lethbridge, Alberta

- Part South Zone, Alberta Health services
 - Covering the SW area
- Team members:
 - Physicians
 - Nurse consultants
 - Social work
 - Pharmacist
 - Occupational therapist
 - Child life specialist
 - Partnered with home care

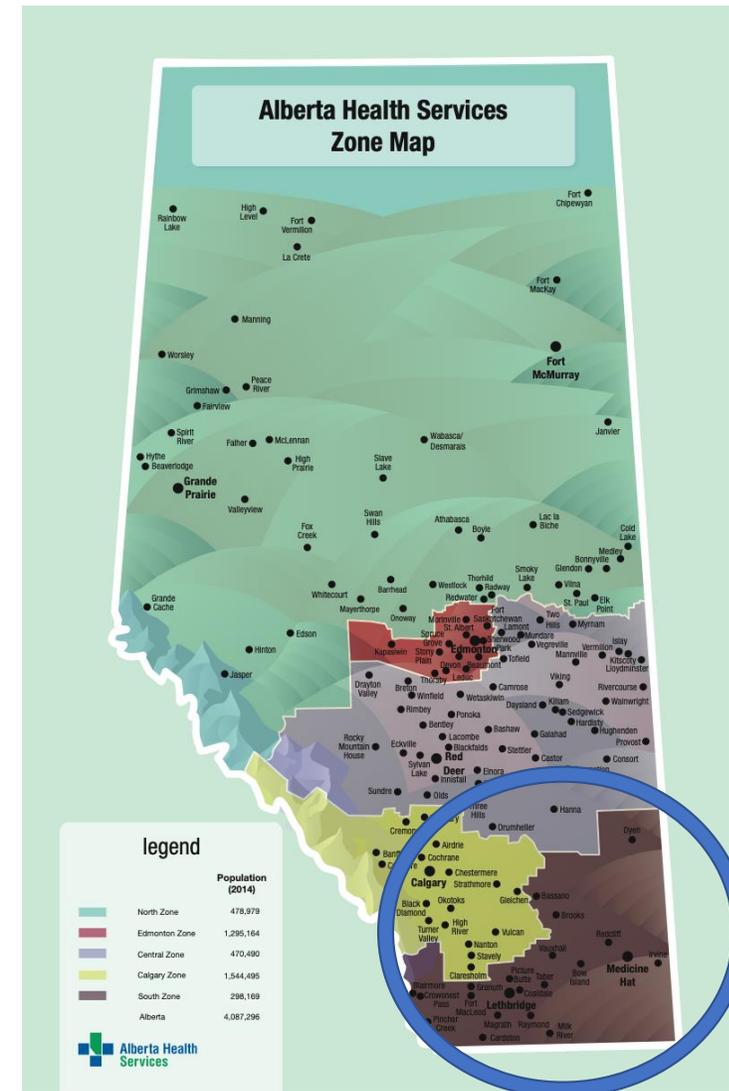


Image: Alberta Health Services
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COVID-19 Pandemic response

- Prior to the pandemic:
 - Home visits
 - Rural visits to surrounding communities
 - Hospice
 - Hospital inpatient care
 - Clinic visits (continuity of care)
 - Call coverage: 1 in 4
- During the pandemic:
 - Home visits: if urgent
 - Rural visits: on hold
 - Hospice: split call schedule
 - Hospital inpatient care
 - Clinic visits: virtual care
 - Visitor restrictions:
 - Hospice and hospital (province-wide)
 - Call coverage: 1 in 3

COVID-19: Impact on care: clinic

- Zoom (HIA compliant) supported by AHS
- Telephone consults offered as well
- In person clinics restarted June 1: urgent and first appointments only
- Challenges:
 - Lack of clinical presence and opportunity to build trust and rapport
 - Technological challenges
 - Need to quickly pivot delivery of care



COVID-19: Impact on care: home

- Drastic increase in desired home deaths during the COVID-19 pandemic
- 2019 average = 10% home deaths
- 2020 (to date) = 19%
 - May 2020 = 41%
- Themes: fear of hospitalization and separation from family
- Challenges:
 - Difficulty quickly adapting to change in care delivery
 - Medication shortages
 - Limited ability to provide 24/7 in-home nursing support at end of life
 - Physician availability



COVID-19: Impact on care: hospice

- Decrease in admissions to hospice
- 2019: 71% bed occupancy/month average
- 2020 (to date): 62%
 - May 2020: 54%
- Main theme: fear of separation from family due to visitor restrictions
- Challenge:
 - Visitor restrictions in hospice have often been more strict than hospital due to sharing a building with LTC



COVID-19: Impacts on care: reflections

- Themes:
 - Significant moral distress experienced by caregivers and patients
 - Significant moral distress experienced by health care providers
 - Impact of visitor restrictions
 - Impact of isolation and loneliness
 - Ability to quickly change delivery of care when needed

Going forward

- Increased focus on care for planned home deaths
 - Potentially expanding this aspect of our program
- Potential continuation of virtual care for rural patients
- Focus on supporting families and patients through this difficult time

Brantford palliative outreach pre-COVID

- Referral from any MD or NP – anyone with life-limiting illness (not limited to oncology) with symptom management issues, any stage, any PPS, regardless of goals of care
- Shared-care with family MD/NP
- Consults and follow-ups done in person as a clinical nurse specialist / palliative care physician dyad
- Nurse/physician dyad on call for palliative issues after hours
- Physicians go into all care settings – home, hospice, hospital

Post-COVID – March-May 2020

- Our community largely spared from patients dying of COVID
- The usual consults coming in at roughly same rate
- Almost overnight, a switch from in-person visits to almost exclusively virtual visits for consults and follow-ups
- Three-way telephone calls, Zoom, Ontario Telemedicine Network, etc.
- Mainly visiting nursing and PSWs going into the home; relying on them as eyes and ears

Post-COVID – May 2020 Onwards

- In-home visits starting back up again, with full PPE (mask, face shield, gown/lab coat, gloves)
- Screening everyone in household by phone prior to going
- Nurse / physician dyad going into the patient's home
- Still doing many visits virtually also



Reflections during COVID

- Access to high-quality palliative care in Canada is postal-code dependent!
- We are relying even more on unpaid caregivers.
- We are seeing even more human resource shortfalls (e.g. visiting nursing, PSWs).
- Medication shortages (subcut opioids, midazolam, anticholinergics).
- Families avoiding hospice and PCU admission due to visitor restrictions: more home deaths.

White Coat, Black Art · DR. BRIAN'S BLOG

More support needed for unpaid caregivers in Canada



If paid, caregiving provided by family members and friends would add up to more than \$24 billion



Dr. Brian Goldman · CBC News · Posted: Mar 04, 2019 12:49 PM ET | Last Updated: March 4, 2019

Reflections during COVID

- Palliative care continues to be underfunded and under-resourced:
 - Community palliative on-call funding frozen in Ontario
 - Many areas do not have access to a palliative consultant after-hours
 - Service provider (in Ontario, the LHIN) not operating after-hours
 - Investing in community palliative care saves the healthcare system money and keeps people out of hospital

Invest in palliative care services now

Palliative care should be available in homes, hospices, hospitals, and long-term care centres throughout Canada — *but it's not!*

Availability depends on where you live, how old you are, and what you are dying from. Source: Highlights from the National Palliative Medicine Survey, 2015.

Strategic investment in palliative care has been shown to:

- Reduce the cost of delivering care by about 30%.
- Free up scarce resources in acute care, such as beds in Intensive Care Units (ICUs), for patients who truly need them.
- Improve the quality of life and quality of care for patients with serious illnesses and their families. Source: Palliative care — A vital service with clear economic, health and social benefits. Canadian Society of Palliative Care Physicians, February 2017.

You have the power to change this!
Invest in palliative care

The Canadian Society of Palliative Care Physicians has developed recommendations to the federal, provincial and territorial governments on how to improve, monitor and evaluate quality and access to palliative care services across Canada. These recommendations are outlined in a November 2016 report: *How to Improve Palliative Care in Canada: Call to Action for Federal, Provincial, Territorial, Regional and Local Decision Makers.*



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Moving forward

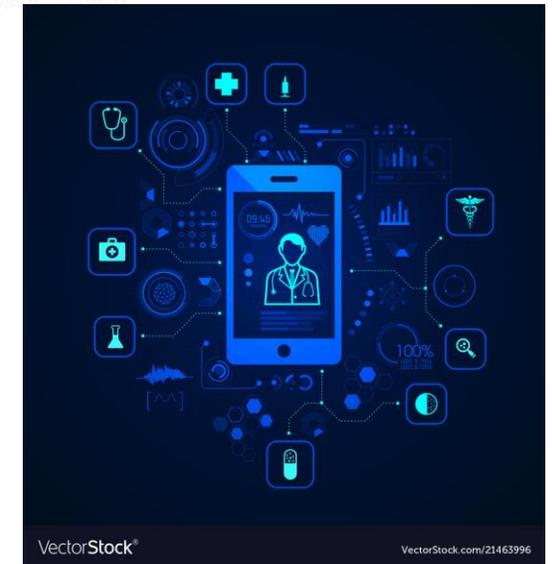
- Adequate PPE for in-person visits
- Provinces need to continue to fund virtual visits going forward
- Continue providing access to LEAP modules online after COVID
- Centralized medication management to mitigate local shortages



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Moving forward

- Office of Palliative Care needs to be established nationally to oversee equitable access to palliative care
- Provincially, reopen community palliative care on-call funding and allow new groups to form
- Properly fund frontline workers such as visiting nursing, PSWs, and currently unpaid caregivers (e.g. universal basic income)



More thoughts moving forward

- Virtual visits have broken down care setting walls
 - Blurring care setting boundaries
- Changing patterns in health care utilization
 - Lack of 'consumer confidence' in amassed care settings
 - Care extended in the home setting
 - Need for recalibration of resources to reflect needs of community care
- Need to develop competency in home based care
 - Articulate this unique skill
 - Mandatory training in home care setting for all health care providers



More thoughts moving forward

- Informal care teams
 - Our first responders
 - A role that is bestowed instead of negotiated
 - Need to articulate informed consent
 - What to expect
 - Action plans
 - Need for respite
 - Unique skill working with informal team



More thoughts moving forward

- Palliative care gets traction riding the wave
 - Medical Assistance in Dying 2017
 - COVID-19 2020
 - Next wave?
 - Does this strategy work?
 - New strategies for advocacy?
- Palliative care is 'everyone's business'
 - Our role as palliative care specialists has a new calling?
 - Coaching, mentoring, capacity building
 - How to make the shift?
 - Implications for training new PC specialists...



Q&A

Please use the Q&A function at the bottom of your screen to submit questions.

THANK YOU



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