Heart Disease Community of Practice Series

Models of care in the Home Care Setting

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Host: Dr. José Pereira

Presenters: Dr. Leah Steinberg, Dr. Caroline McGuinty & Shane Vandenameele

Date: February 9, 2022

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

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Project ECHO Palliative Care - Canada BY Pallium Canada

Introductions

Host

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Professor and Director, Division of Palliative Care, Department of Family Medicine, McMaster University, Hamilton, Canada
Scientific Officer, Pallium Canada

Presenters

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Assistant Professor, Division of Palliative Care, University of Toronto

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Shane Vandenameele, RN
Saskatoon Home Care, Seniors First program

Disclosure

Relationship with Financial Sponsors:

Pallium Canada

- Not-for-profit
- Funded by Health Canada

Disclosure

This program has received financial support from:

- Health Canada in the form of a contribution program
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration fees

Host/ Presenters:

- Dr. José Pereira: Scientific Officer, Pallium Canada
- Dr. Leah Steinberg: Pallium Canada (education material), HPCO (clinical advisory committee, educator)
- Dr. Caroline McGuinty: Servier (consulting fees), Novartis (speaker fees)
- Shane Vandenameele: None

Disclosure

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of program content

Welcome and Reminders

- Please introduce yourself in the chat!
- Your microphones are muted. There will be time during this session for questions and discussion.
- You are also welcome to use chat function to ask questions, add comments or to let us know if you are having technical difficulties, but also feel free to raise your hand!
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session
- This 1-credit-per hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **4 Mainpro+** credits and by the Royal College of Physicians and Surgeons of Canada for a maximum of 4.00 hours

Objectives of this Series

After participating in this program, participants will be able to:

- Describe what others have done to integrate palliative care services into their cardiac clinics
- Describe how to integrate palliative care into the cardiac programs and services they offer
- Share knowledge and experience with their peers
- Describe existing and emerging models of care for various care settings, including home care, ambulatory care and in-patient settings

Overview of Topics

Session #	Session title	Date/ Time
Session 1	Overview of Models of Care in Different Care Settings	January 11, 2022 from 12-1pm ET
Session 2	Models of Care in the Home Care Setting	February 9, 2022 from 12-1pm ET
Session 3	Models of Care in the Ambulatory Setting	March 9, 2022 from 12-1pm ET
Session 4	Models of Care in the In-Patient Setting	April 13, 2022 from 12-1pm ET

Models of care in the Home Care Setting

Objectives of this Session

After participating in this session, participants will be able to:

- Learn techniques to manage patients at home with advanced heart failure.
- Appreciate the role of collaboration in managing patients at home with advanced heart failure.
- Understand the community supports available and how best to access them.

Advanced Heart Failure in the Community

Issues:

Who is a good fit?
Who is the team?
What are some symptom tools?

Will share from one team's experience but…
we are here to learn from each other!

Who is a good “fit” for home-based PC?

- Does your community team have specific requirements?
  - DNR? Deactivated ICD?

- How do you talk about expectations for care in the home?
  - Goal of therapy is to achieve comfort
  - Involves less monitoring of labs and creatinine

- What does a Goals of care conversation look like in this population?

Here is one approach – use of IV/SC diuretics

- This protocol is intended to relieve congestion in patients for whom the goal of care is to achieve symptom relief.

- It should be understood that the **intensity of monitoring** will not match that of an inpatient or emergency room encounter.

- Patients, their families and caregivers should have the understanding that with less monitoring, there is an **increased risk of metabolic abnormalities, however, the focus is on relief of symptoms and avoidance of emergency department visits.**

Transfer of information

- How is discharge handled?
- What information is helpful? In our setting, we try for this:
  - Name and contact of cardiologist or internist
  - Baseline weight
  - Typical diuretic doses and what was needed in hospital
  - Monitoring plan
  - PICC line in situ if has needed IV more than once in the past or unable to manage on PO furosemide

It isn’t for everyone

- Some patients don’t want to have ”hospital meds” at home
- Others prefer hospital as it has worked in the past
- Some need time – a few trips back and forth…
- People usually declare themselves!

Create the team in your community

- Determine who is going to be responsible for:
  - Diuretic changes
  - Anti-coagulation
  - Primary care needs
  - Responding semi-urgently (within a day to changes)
- What are they able to provide…
  - IV medications?
  - can they manage a PICC line?
- Do you have access to a magnet?

Symptoms

- Most symptoms are managed the same as regular palliative care….but dyspnea, edema and hypotension are different.

Symptomatic Treatment for Dyspnea

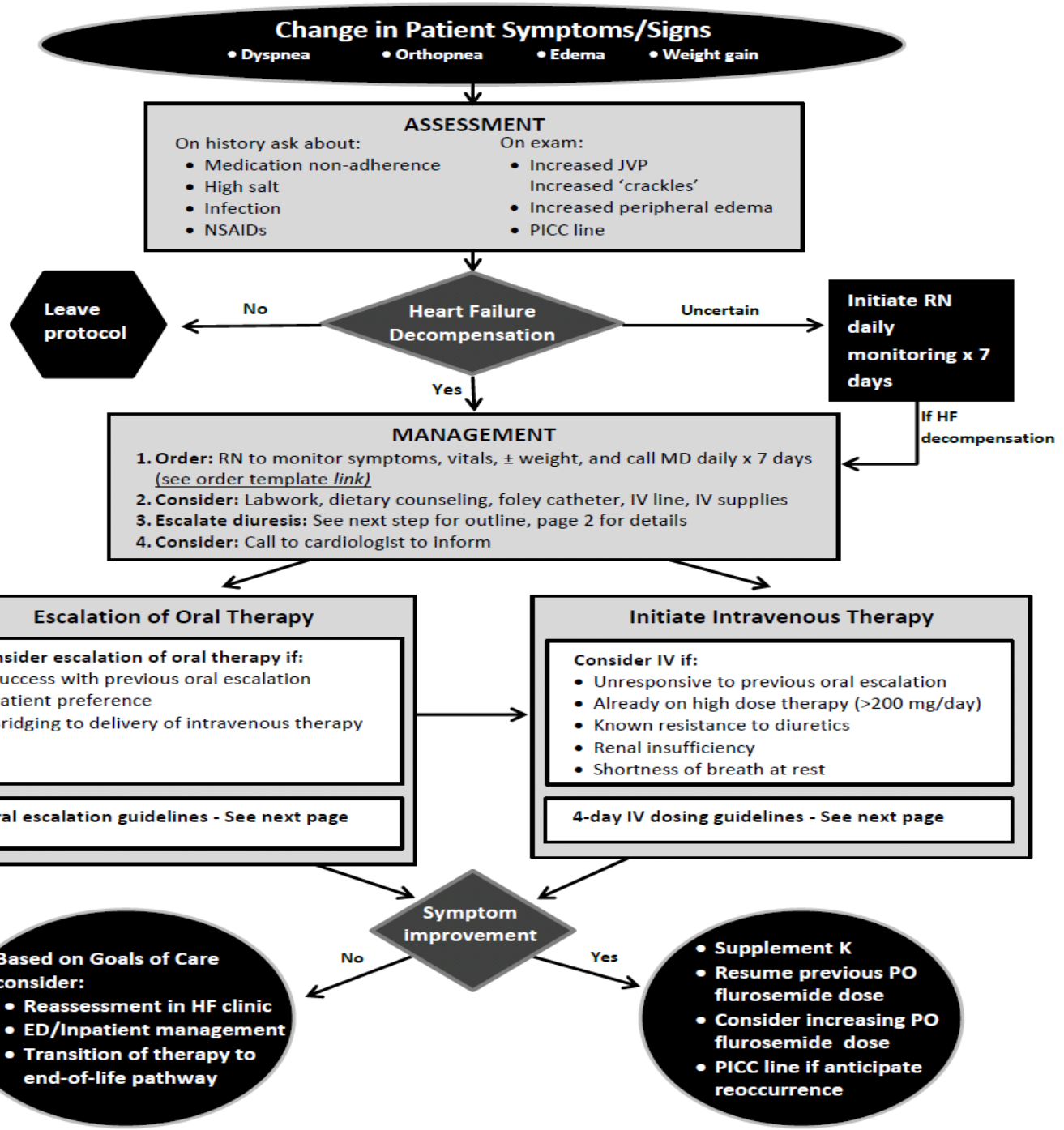
- Maximize HF medications
- Adjust diuretics as frequently as needed, allowing BUN/creatinine to rise
- Once all medications maximized, use opioid for refractory dyspnea.
- Assess and treat other symptoms
- Eliminate unnecessary medications
- Sodium/Fluid restriction

Management Advanced Heart Failure

- Daily weights
  - **Weight increase of 2kg per day means a change is needed**

Managing diuretics in the community

- Range of comfort – might need clinician education
- In Toronto, we created a home-based diuretic protocol for the clinicians.
- Also gave some education sessions and mentoring
- Here is quick summary – but full information is available
- https://www.cfp.ca/content/63/9/674.abstract


Change in Patient Symptoms/Signs
• Dyspnea • Orthopnea • Edema • Weight gain
ASSESSMENT
On history ask about:
• Medication non-adherence
• High salt
• Infection
• NSAIDs
On exam:
• Increased JVP
Increased 'crackles'
• Increased peripheral edema
• PICC line
Heart Failure Decompensation
No
Leave protocol
Uncertain
Initiate RN daily monitoring x 7 days
If HF decompensation
Yes
MANAGEMENT
1. Order: RN to monitor symptoms, vitals, ± weight, and call MD daily x 7 days (see order template link)
2. Consider: Labwork, dietary counseling, foley catheter, IV line, IV supplies
3. Escalate diuresis: See next step for outline, page 2 for details
4. Consider: Call to cardiologist to inform
Escalation of Oral Therapy
Consider escalation of oral therapy if:
• Success with previous oral escalation
• Patient preference
• Bridging to delivery of intravenous therapy
Oral escalation guidelines - See next page
Initiate Intravenous Therapy
Consider IV if:
• Unresponsive to previous oral escalation
• Already on high dose therapy (>200 mg/day)
• Known resistance to diuretics
• Renal insufficiency
• Shortness of breath at rest
4-day IV dosing guidelines - See next page
Symptom improvement
No
Based on Goals of Care consider:
• Reassessment in HF clinic
• ED/Inpatient management
• Transition of therapy to end-of-life pathway
Yes
• Supplement K
• Resume previous PO flurosemide dose
• Consider increasing PO flurosemide dose
• PICC line if anticipate reoccurrence

Escalation of Oral Therapy

Suggested dose increases	
Current Daily Dose	**Suggested New Dose**
<40 mg/d	40 mg BID
40 to 120 mg/d	80 mg qAM/40 mg qPM OR 80 mg BID
120 to 240 mg/d	120-160 mg BID Consider add on therapy
>240 mg/d	160 mg BID Consider add on therapy
Day 3-5 Reassessment	
Weight Decreasing Patient improving	Continue current dose Administer kdur Can consider stepping down oral therapy
Weight Unchanged or Increasing	Continue current dose Consider add on therapy
Day 7 Reassessment	
Weight Decreasing Patient improving	Continue current dose Administer kdur Can consider stepping down oral therapy
Weight Unchanged or Increasing	Increase current dose Consider add on therapy Consider IV diuresis

Add on therapies to consider	
Metolazone	2.5-5mg/d x 3 days 2.5-5mg/d, M, W, F Metolazone can be very effective Limit to short trials and reassess
Hydrochlorthiazide	12.5-50 mg/d

1. Double the oral dose to maximum 160 mg bid
2. Consider adjuvant if high dose
3. Reassess in 2 - 4 days

Initiate Intravenous Therapy

Day 1	
Current Dose	**Suggested New Dose**
≤120 mg/day >120 mg/day	40 mg IV BID 80 mg IV BID Consider add on therapy
Day 2 Reassessment	
Weight Decreasing Patient improving	Continue current dose Administer kdur
Weight Unchanged or Increasing	Continue current dose Consider add on Rx
Day 3 Reassessment	
Weight Decreasing Patient improving	Continue current dose Administer kdur Can consider stepping down to PO
Weight Unchanged or Increasing	Increase 40 BID to 80 BID Increase 80 BID to 120 iv BID Consider add on therapy
Day 4 Reassessment	
Weight Decreasing Patient improving	Continue current dose Administer kdur May step down to PO
Weight Unchanged or Increasing	Increase 40 BID to 80 BID Increase 80 to 120 BID Consider add on Rx Can continue beyond 4 days

Symptomatic Hypotension

- Stop calcium channel blockers
- Stop alpha blockers
- Reduce ACEi/ARB/beta blocker
- Stagger doses
- Review anticoagulation and other non-essential medications (statin)

Collaborative care

- Is there a regional champion who can support the home care teams?
- A cardiologist or internist who is comfortable with providing support if needed?

Home inotropes

- Useful in some patients to maintain good quality of life
- In some centres, patients go home with inotrope running...
  - Used for management of symptoms
  - ICD tachytherapies turned off
- If interest, something we can discuss in a separate ECHO.

Summary

- It takes a team!
- Prepared is better
- Adjusting diuretics is not hard, but might need education and mentorship
- Goals of care are variable in this population – need to move with them…don’t have same expectations as oncology patients
- Much more fragile patient population (??)

Case-Based Discussion

Shane Vandenameele RN
Saskatoon Home Care, Seniors First program

Case Presentation – Mr. Farmer

- 86 M
- PMHx: CHF, CAD (previous MI's previous stents and PCI's), COPD, CKD (baseline creatinine around 200), GERD, Depression, Dementia
- Presented to Hospital with generalized weakness and dyspnea, 5-6lb weight gain from baseline in two days and increased lower leg edema.
- Recently discharged with similar presentation, and this was his 3rd or 4th trip to the inpatient setting in 2021. He was discharged on continuous oxygen, had previously used PRN on exertion and nocturnal (rarely).
- In hospital he was diuresed "Judiciously" with IV lasix until day of discharge and sent home on 80mg PO BID.

What more do you want to know about Mr. Farmer to prepare for transition home?

Case Presentation – Mr. Farmer

- No goals of care discussion was had with John or his family and no “palliative” diagnosis was given.

- Previously lived at an assisted living level and was supported by Home Care nurses for medications and CCA’s for ADL’s. Now discharged to a transitional PCH bed awaiting a bed availability at his new PCH, as family/client feel independent living is not realistic given his increasing needs.

- 4 days following discharge, weight had increased by 4 KG from discharge weight. He would desaturate with any exertion going to 75% on 2.5L even just to stand for a weight. He was refusing to present back to hospital, preferring to stay at the care home.

What are your impressions and recommendations?

Case Presentation – Mr. Farmer

- For treatment of HF, metolazone was added and did manage to keep him out.

- When goals of care were discussed with the patient and his daughter, they both stated avoiding hospital and symptom management were their chief concerns. He and his daughter said they don’t anticipate him being here this time next year.

- His PCH won’t give HDC medications, and the hospice in Saskatoon isn't likely a viable option. His MRP is amazing but lacks the connection with our team to really effectively keep this man supported in the community.

Discussion questions

- What can we do better to support people with “end stage CHF” in that fragile post discharge period. He was sent home on oral lasix after having been on IV in hospital, no oral trial was done.
  - What has worked for the other participants in their community?

- How can we build the palliative care discussion formally into the discharge process for clients like this?

- If home isn't an option, what can we do for these people to better support them in the community?

Discussion questions

- What has worked for the other participants in their community? Should we anticipate failure and discharge with an order set to support it?

Session Wrap-up

Wrap Up

- Please fill out the feedback survey following the session! Link has been added into the chat
- A recording of this session will be e-mailed to registrants within the next week
- Please join us for the next session in this series:
  - **Models of Care in the Ambulatory Setting**
  - **March 9, 2022 from 12-1pm ET**
- If you would like to present a case at one of our upcoming sessions, contact echo@pallium.ca or let us know in the feedback survey

Thank You

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