Heart Disease Community of Practice Series 2

Complex case management and patients with complex goals of care

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitator: Diana Vincze

Presenter: Drew Stumborg

Date: March 15, 2023

Territorial Honouring

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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The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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Project ECHO Palliative Care - Canada BY Pallium Canada

Introductions

Facilitator

Diana Vincze,
Palliative Care ECHO Project Manager, Pallium Canada

ECHO Support

Aliya Mamdeen
Program Delivery Officer, Pallium Canada

Presenter

Drew Stumborg, RN
Saskatchewan Health Authority

Introductions

Panelists

Dr. Lynn Straatman, MD FRCPC
Clinical Assistant Professor, UBC
Department of Medicine (Cardiology and Palliative Care)
Department of Pediatrics (Adolescent Health)
Medical Director, Cardiac Function Clinic
Co-chair Physician Diversity, Equity and Inclusion Committee, VCH

Dr. Leah Steinberg, MD, CFPC, FCFP, MA
Palliative Care Clinician, Sinai Health System
Assistant Professor, Division of Palliative Care, University of Toronto

Morgan Krauter, NP, CCN(C)
Nurse Practitioner, Heart Function

Dr. Caroline McGuinty, MD FRCPC
Cardiologist, Advanced Heart Failure and Transplantation, Cardiac Palliative Care
University of Ottawa Heart Institute
Assistant Professor, University of Ottawa

Shannon Poyntz, NP-PHC, MN
Nurse Practitioner, Supportive Care

Dr. Michael Slawnych, MD FRCPC
Clinical Assistant Professor
Department of Cardiology, St Paul's Hospital
University of British Columbia

Disclosure

Relationship with Financial Sponsors:

Pallium Canada

- Not-for-profit
- Funded by Health Canada
- Boehringer Ingelheim supports Pallium Canada through an in-kind grant to expand interprofessional education in palliative care.

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.
- An educational grant or in-kind resources from Boehringer Ingelheim.

Facilitator/ Presenter/Panelists:

- Diana Vincze: Palliative Care ECHO Project Manager at Pallium Canada
- Drew Stumborg: None to disclose.
- Dr. Leah Steinberg: Pallium Canada (education material), HPCO (clinical advisory committee, educator)
- Dr. Caroline McGuinty: Servier (consulting fees), Novartis (speaker fees)
- Dr. Lynn Straatman: Servier, Novartis, Astra Zeneca, BI, Medtronic, Pfizer, Eli Lilly, Bayer, Merck (clinical trials)
- Morgan Krauter: None to disclose.
- Shannon Poyntz: None to disclose.

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 **6 Mainpro+** credits.

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 practice.
- Share knowledge and experience with their peers.
- Increase their knowledge and comfort around integrating a palliative care approach for their patients with advanced heart failure.

Overview of Topics

Session #	Session title	Date/ Time
Session 1	Update to medical management of HF decompensations in the community, including Cardiorenal dysfunction: how to manage with a palliative approach to care	November 16, 2022 from 12-1pm ET
Session 2	Demystifying ICDs – do you always need to deactivate?	January 18, 2023 from 12-1pm ET
Session 3	Complex case management/ Patients with complex goals of care	March 15, 2023 from 12-1pm ET
Session 4	Diuretic management in the community: Lasix, Metolazone and Bumetanide	May 17, 2023 from 12-1pm ET
Session 5	Multi-morbidity and Heart Failure- Managing Patients with Multiple Illnesses	September 20, 2023 from 12-1pm ET
Session 6	De-prescribing cardiac and other medications: palliative care in people with advanced heart failure	November 15, 2023 from 12-1pm ET

Learning Objectives of this Session

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

- Explore the approach to management when patients have complex goals
- Increase their comfort by learning some strategies to maintain flexibility and coordination of care in the face of complex cases.

How to Approach Management of Patients with Complex Goals and Complex Case Management

Associated Diagnoses

- Hypercholesterolemia
- Diabetes
- Atrial fibrillation
- Angina
- Heart attack
- Heart Failure
- Congenital Heart disease
- Cardiac arrest
- Valvular heart disease
- Vascular Cognitive impairment
- Arrhythmias
- Atherosclerosis
- Cardiomyopathy
- Endocarditis
- Coronary heart disease
- Heart block
- Kawasaki’s disease
- Marfan syndrome
- Pericarditis
- Rheumatic Heart disease
- Spontaneous Coronary Artery Dissection

Goal Setting

Goals Setting

- Break down long term goals into steps.
- Prioritize goals by importance.
- Develop SMART goals.
- Respect the individuals' preferences.
- Continue to educate and encourage goals that have potential for positive health outcomes and enhancement to quality of life.

People often confuse goals and values.

- Goals tend to be specific and achievable, and they can be ticked off and completed.
- Values represent what is important in life and tend to be ongoing — they don't have an end point.
- Goals are only successful when based on our values.

Goals of Care

Goals of care are the outcomes that clients place the highest value on and would hope to achieve in relation to their illness.

- What would they like to see happen with their illness?
- What are the things they value as the most important in their lives?
- Would they rather focus on maintaining their quality of their life even if it means that the quantity of their life would decrease?

A goals of care conversation is where you can learn about a clients understanding, beliefs, hopes, and fears for the future.

- Goals or care can be changed at anytime – should be reassessed as your medical condition changes.
- Goals of care do not replace a consent for treatments, surgery, or any other intervention.

Decision Making

Exploring Decision Making

Evidenced based informed decision making

Vs

Values Based decision Making

- Give information about the disease and the treatment options
- Elicit values and goals
- Both are needed for informed shared decision making

Values Based Decision Making

- Think about what you feel is acceptable and what is tolerable.
- People don’t envision their future in the terms of treatments or lab results.
- Think about the outcomes of the treatments not the treatments themselves.
- People imagine what life would look like and how their life will be impacted by the illness and the treatment.

Values Based Decision Making

- Examples include:
  - Feeling unwell from medication that may prolong life
  - Spending more time with health care providers than family and friends
  - How would you feel about no longer being able to communicate with your family and friends
  - How do you feel about repeatedly going to the hospital and receiving multiple tests

Our job as health care providers is to paint a picture of what life will look as their disease progresses. With this the person can compare that image to what is important to them, what is acceptable, and what is tolerable.

Conversation Guides

Conversation Guide

- **Prepare yourself** – know medical information, trajectory, treatment options
  - Put aside your agenda – the goal is to see the world as the client sees it
- **Explore illness understanding** – client should speak more than you
  - Encourage silence, reflection, and open ended questions
- **Inform** – give information that is clear and concise
  - Speak slow and be clear about how their illness impacts their life now and in the future
  - Pause often and expect emotional responses
  - Utilize Teach Back
- **Explore Values**
  - What is important to you?
  - What are you worried about?
- **Make recommendations** – for shared goals of care

Serious Illness Conversations

Asses understanding and preferences

- What is your understanding of heart disease and where you are at with your illness?
- What are your expectations of the future with this disease?
- How much information would you like me to share with you and your support persons about what lays ahead for you as your disease progresses?
- Are you interested in hearing my best estimate of how long I feel you have, or are you more interested in hearing about what life will be like for you going forward?

Allows you to assess their understanding and compare their expectations with the realities of their disease trajectory.

Serious Illness Conversations

Explore Key Topics

- **Goals** – “What are some of your most important goals as your health declines?”
- **Fears/worries** – “What are your biggest fears and worries about your future?”
- **Sources of strength** – “What gives you strength as you think about your future?”
- **Critical abilities** – “What are some of the abilities that you feel are so critical to your life that you can not imagine living without them?”
- **Tradeoffs** – “As your disease worsens, how much are you willing to go through for the possibility of gaining more time?”
- **Family/supports** – “How much does your family know about your wishes?”

“What do I need to know about you to provide the best possible care?”

Serious Illness Conversations

Making a recommendation may include

- Additional discussions
- A referral
- Engaging other stakeholders (i.e. Family)
- Changes in a medical plan of care
- Completion or changes to an Advanced Care plan
- Or even no changes at all

Keys to Complex Care Coordination

Complex Care Coordination

A person-centered approach to care that brings together patients and their families, the community, and the health care system to collaboratively improve health outcomes and well-being for people with complex health and social needs.

- Strives for health equity
- Keeps in mind determinants of health
- Need to look deeper into non-medical interventions
- Develop trusting relationship with your clients
- Be cognoscente of trauma
- Customize approach for minority populations

Principles of Complex Case Management

Collaboration

Multidisciplinary teams

Communication

Client education

Patient and family centered approach

Quality Care Transitions

Upstream Approach with a proactive care plan

Need solutions to address non-medical needs

Determinants of Health

- Work and home environment
- Income
- Education
- Social supports
- Genetics
- Accessibility to healthy food and water
- Accessibility to health care
- Childhood development
- Housing

Take-aways

- Utilize serious illness conversations guides
- Inform and explore to develop shared goals in a patient centered approach to care
- Be mindful of determinants of health
- Collaborate and communicate
- Think up stream and plan for the future

Case-Based Discussion

Case 1

Avoidance

58-year-old male who lives with his spouse. Has a history of diabetes and Afib with a past MI and cardiac arrest. When bringing up the idea of completed an advanced care directive the client says he does not want to talk about it. How would you proceed?

After some discussion you uncover that another practitioner has encouraged him in the past to establish a DNR/DNI status and he is not open to that idea. He survived ICU once and CPR saved his life.

- **Where do you start?**
- **What are the challenges you currently face?**
- **What can we strive to do differently?**

Discussion

- Explore why they do not feel able to talk about these issues.
- Ask them what are the positives and negatives of discussing this issue.
- Continue to explore their fears and gradually introduce the subject.
- Ensure the right people are in the room (or not in the room).
- If it is a bad time because of other events or stressors schedule a time to follow up if possible.
- Consider a mental health referral or adjusting treatment if the client has an apparent anxiety disorder that needs optimization.

Case 2

Home Bound

A 65 year old male who lives independently at home. Has worked as a truck driver his whole life and is upset that his license has been taken away as a result of his advanced cardiac history. He is bariatric and has become home bound with his decreased mobility. He continues to choose to drink electrolyte drinks as his primary form of hydration; exceeding his fluid restriction. He lives primarily on ready made frozen meals and continues to require hospitalizations. While in the hospital he is discharged on less Lasix than required at home. His obesity compounds problems as he can not weigh himself daily.

- **Where do you start?**
- **What are the challenges you currently face?**
- **What can we strive to do differently?**

Case 3

Protection

A 76 year old female with advanced renal failure related to her chronic heart disease. She has been declining overall in her health and mobility level. She has recently moved in with her daughter for enhanced support. She has been feeling more weak and sleeping more. On her last emergency visit her hemoglobin was found to be low at 68. As a result they transfused her two units PRBC and discharged her home. The discharge instructions recommended follow up blood transfusions if weekly CBC is less than 70.

- **Where do you start?**
- **What are the challenges you currently face?**
- **What can we strive to do differently?**

Discussion Questions

- Have you encountered similar situations in your community?
- What do you think worked well?
- Do you have other suggestions?

References

- Home - ACP in Canada | PPS au Canada (advancecareplanning.ca)
- Pallium Canada
- Serious Illness Care Program

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 on **Diuretic management in the community: Lasix, Metolazone and Bumetanide** **May 17, 2023 from 12–1:00 p.m. ET**

Thank You

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