Community-Based Primary Palliative Care Community of Practice Series

Community Palliative Resources

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitator: Dr. Nadine Gebara
Case Presenter: Dr. Haley Draper

Guest Speakers: Dianne Stockwell (RN), Amanda Tinning (NP), Dr. Roger Ghoche, Claudia Brown (RN), Thandi Briggs (RSW), Jill Yu Tom (RN)

Date: June 22nd, 2022

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.

Stay connected: www.echopalliative.com

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.

Health Canada Santé Canada

LEAP Core

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Taught by local experts who are experienced palliative care clinicians and educators.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) who provides care for patients with life-threatening and progressive life-limiting illnesses.
- Accredited by CFPC and Royal College.

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LEAP CORE

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-core

Overview of Sessions

Session #	Session Title	Date/ Time
Session 1	Symptom Management	Feb. 16, 2022 from 1-2pm ET
Session 2	Managing Complex Pain	Mar. 2, 2022 from 1-2pm ET
Session 3	Managing the Last Hours of Life in the Home	Mar 16, 2022 from 1-2pm ET
Session 4	Beyond the Essential Communication Skills- Part 1	Mar 30, 2022 from 1-2pm ET
Session 5	Beyond the Essential Communication Skills- Part 2	Apr 13, 2022 from 1-2pm ET
Session 6	Beyond the Essential Communication Skills- Part 3	Apr 27, 2022 from 1-2pm ET
Session 7	Grief and Bereavement: Identifying and Managing Complex Grief	May 11, 2022 from 1-2pm ET
Session 8	Teamwork in Primary Palliative Care	May 25, 2022 from 1-2pm ET
Session 9	Grief in Children	Jun 8, 2022 from 1-2pm ET
Session 10	Community Palliative Resources	Jun 22, 2022 from 1-2pm ET
Session 11	Organizing Practices to Provide Primary Palliative Care	Jul 6, 2022 from 1-2pm ET

Welcome & Reminders

- Please introduce yourself in the chat! Let us know what province you are joining us from, your role and your work setting
- Your microphones are muted. There will be time during this session for questions and discussion.
- You are welcome to use the chat function to ask questions, if you have any comments or are having technical difficulties, but also please 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 **11 Mainpro+** credits.

Introductions

Facilitator:

Dr. Nadine Gebara, MD CCFP- PC

Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

Case Presenter

Dr. Haley Draper, MD CCFP- PC
Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

Support Team

Gemma Kabeya
Education Research Officer, Pallium Canada

Holly Finn, PMP
National Lead, Palliative Care ECHO Project, Pallium Canada

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

Facilitator/ Presenters:

- Dr. Nadine Gebara: No conflicts to disclose
- Dr. Haley Draper: No conflicts to disclose
- Dianne Stockwell (RN): No conflicts to disclose
- Amanda Tinning (NP): No conflicts to disclose
- Dr. Roger Ghoche: No conflicts to disclose
- Claudia Brown (RN): No conflicts to disclose
- Thandi Briggs (RSW): No conflicts to disclose
- Jill Yu Tom (RN): No conflicts to disclose

Disclosure

Mitigating Potential Biases:

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

Session Learning Objectives

Upon completing the session, participants will be able to:

- Describe resources available to support their community palliative care practice
- Describe the role of inpatient palliative settings (i.e., hospice/ PCU)

Meet Mr. Terry Carson

Mr. Terry Carson - Background

- 67M being referred to your caseload. He is currently admitted to the nearest Cancer Centre.
- Dx Glioblastoma Multiforme in 2021 after collapsing and having a seizure in the grocery store. He underwent debulking surgery and chemo/radiation in the fall of 2021.
- Stopped working as mechanic since diagnosis
- Status post-Tx: ambulatory, although has right-sided weakness; independent for his ADL's; received support from his adult children and current partner for his iADL's.

Acute Change

- Stable until 3 weeks ago, when he became aphasic while talking to his daughter on the phone.
- Daughter called EMS and on arrival, first responders found Terry unable to speak and dense right hemiplegia.
- Terry was transferred from home to his local hospital.
- CT head showing marked disease progression with edema surrounding the tumour.
- Terry was started on high dose dexamethasone and the following day air-lifted to the nearest Cancer Centre.

Terry's Course in Hospital

Function:

- Terry 's aphasia improve moderately, enough to engage in goals of care discussions.
- Unfortunately, his mobility did not improve significantly. With assistance, he was able to transfer to commode and wheelchair at bedside. He was unable to ambulate. Hi course was complicated by PE, required FiO2 and anticoagulation.

Oncology Plan:

- Terry's case was reviewed by Neurosurgery + Neuro-Oncology + Radiation Oncology services
- No further Tx options
- Oncology teams recommended referral to Pall Care for optimization of quality of life and coordination of palliative care services at home.

Mr. Terry Carson

Past Medical History

- COPD
- COVID-19 pneumonia in March 2022
- Vaccination x 3 for COVID-19
- Hypertension
- Ex-smoker

Medications

- Dexamethasone 8mg po qam
- Hydromorphone 0.5mg po q1h PRN for shortness of breath
- Tinzaparin
- Spiriva
- O2

Terry's Social History

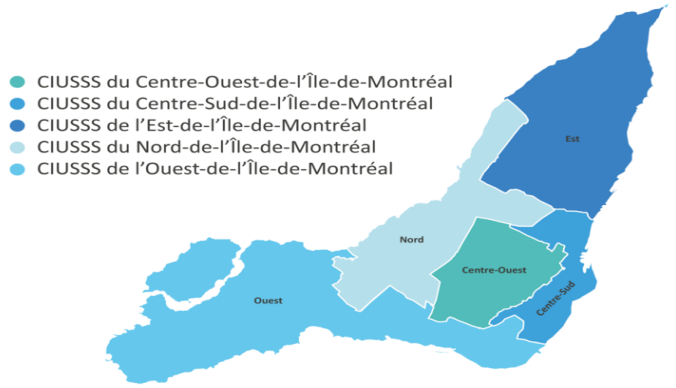
- Lives in bungalow with partner of 4 years, Janice.
- 2 adult children from a previous marriage. Sherry, his daughter, has two young children and lives in the neighbourhood. Kevin, his son, lives on the west coast of Canada and works as a bush pilot. The relationship between Janice and Terry's children is strained.
- Values: Terry loves to hunt and fish and spend time with his family, particularly his grand kids.
- POA/SDM: has not appointed a Power of Attorney for personal care. He has not finalized a will, an executor nor any funeral arrangements.

Care Needs At Home

- Hospital bed
- FiO2 2L/min via NP
- Administration of injectable medication daily (LMWH)
- Thickened diet

What would Roger and Jill do?

Community Palliative care



- Hospital will send a DSIE (Demande de services inter-establishment) to the CLSC for homecare services
- DSIE to be sent to SRAD (soins respiratoire a domicile)
- Referral to be made to Non-profit organizations (NOVA, Mount Sinai, Maison St-Raphael)

Our community Palliative team depends on collaboration between Government organization and Non-profit organizations.

Teamwork and networking are key for the support that we are able to provide.

Community palliative care (Government organization)

CLSC (local community service Centre) homecare services:

- Nursing services 8AM-8PM and after hour emergency line services (with access to MD if needed)
- Occupational Therapist (for home safety evaluation and equipment)
- Social Worker and Psychologist
- Dietician
- Physiotherapist
- Aid services and respite (up to 42 hours per week depending on the needs of the patient)
- Physician

SRAD (Home respiratory care)

- Home Oxygen
- Nursing if needed
- Inhalotherapist

Non-profit organizations

NOVA Montreal:

- Specialized Nursing services with emergency line after hours (with MD if needed)
- Massage therapy (8 free session for free)
- SW for caregivers and family (Limited Bereavement visits)
- Spiritual care
- Respite services (12 hours free of charge) and charges after based on Income

Mount Sinai Hospital Home care

- Specialized Nursing
- MD (MDs are government funded)
- Magic Moment (*to fulfill the last wishes of Palliative care patient)*

Maison St- Raphael: Day center for

- Acupuncture; Art therapy; Massage therapy; Music therapy; Therapeutic baths; Meals (on site or to take away); Zootherapy; Social work; Creative Journal; Support groups; Meditative walk; Virtual reality; Conferences; Training; Thematic discussions

Non-Profit Organizations in Other Sectors

Nova West Island

- Specialized Nursing services and on-call emergency line
- Bereavement support
- Transport to medical appointment.

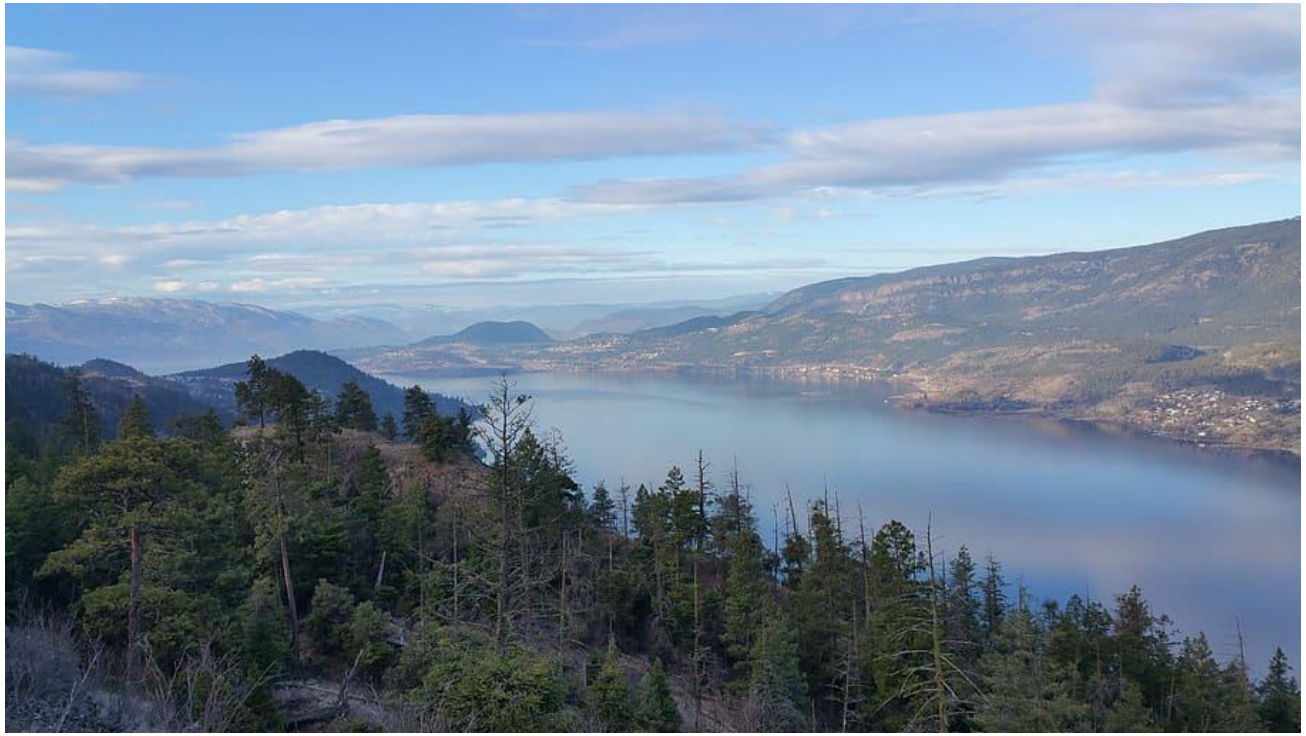
The Palliative Home-Care Society of Greater Montreal

- Specialized nursing services and on-call emergency line
- Psychologist for pt and/or caregivers
- Respite services
- Volunteers providing transportation to medical appointments, supports, and even massage therapy

What would Dianne do?

Interior Heath
Palliative Care Program Central Okanagan

- Population catchment area 250,000ish
- Kelowna is the Tertiary Care Center
- Most of **Interior Health is rural and remote**

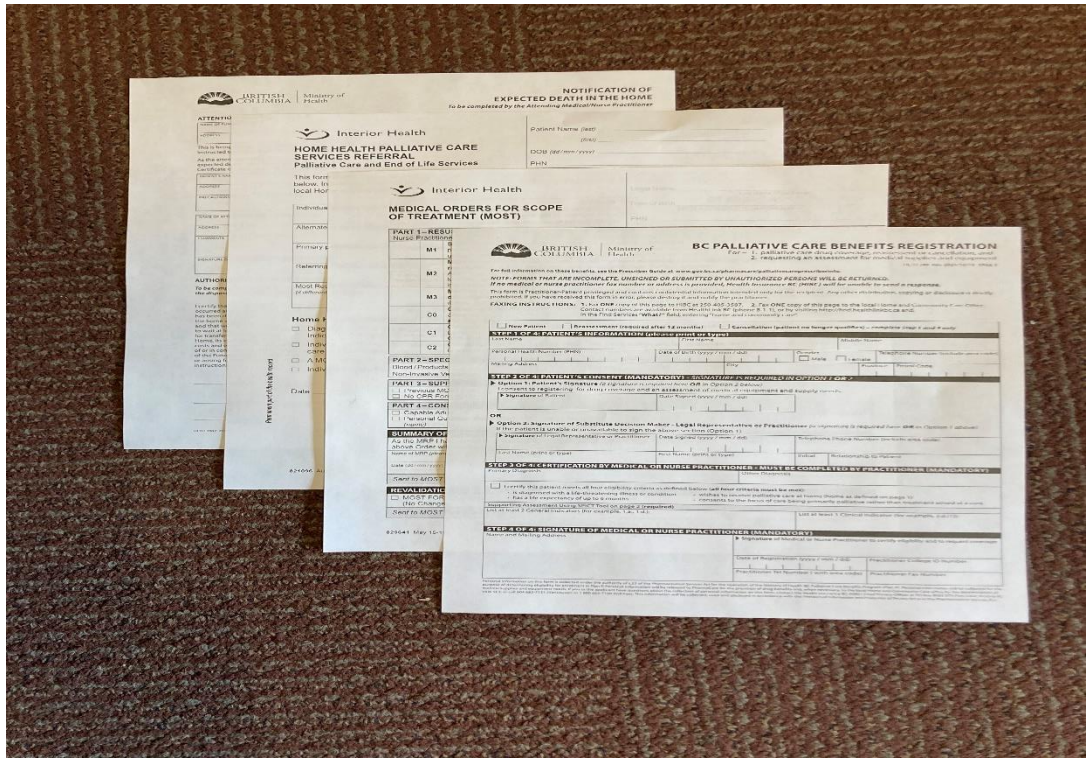


Admission to the Palliative care program

GP/ NP driven program

Hospital, physician office or internal community referral

Accompanied by “palliative paperwork”



Care in the Community

- Palliative Home Care Nurse - contact and visit within indicated time frame.
    - Able to visit 24/7 if needed - supported by palliative physician 24/7 ;
    - EOL Social Worker ACP (including POA and rep agreements), practical (financial) and psychosocial support
- Allied Health
    - OT/ PT for home safety and equipment as needed
    - RT for O2
    - SLP for swallowing assessment
- Home supports as needed (personal support worker) – up to 4 times per day
- Cancer BC - Pain and symptom management clinic (malignant disease only)
- Visiting volunteer client and caregiver support

Ongoing care

- Reviewing goals of care on a regular basis by PHCN and SW
  - Community hospice for P&SM, respite and EOL care or
  - Death at home

What would Amanda do?

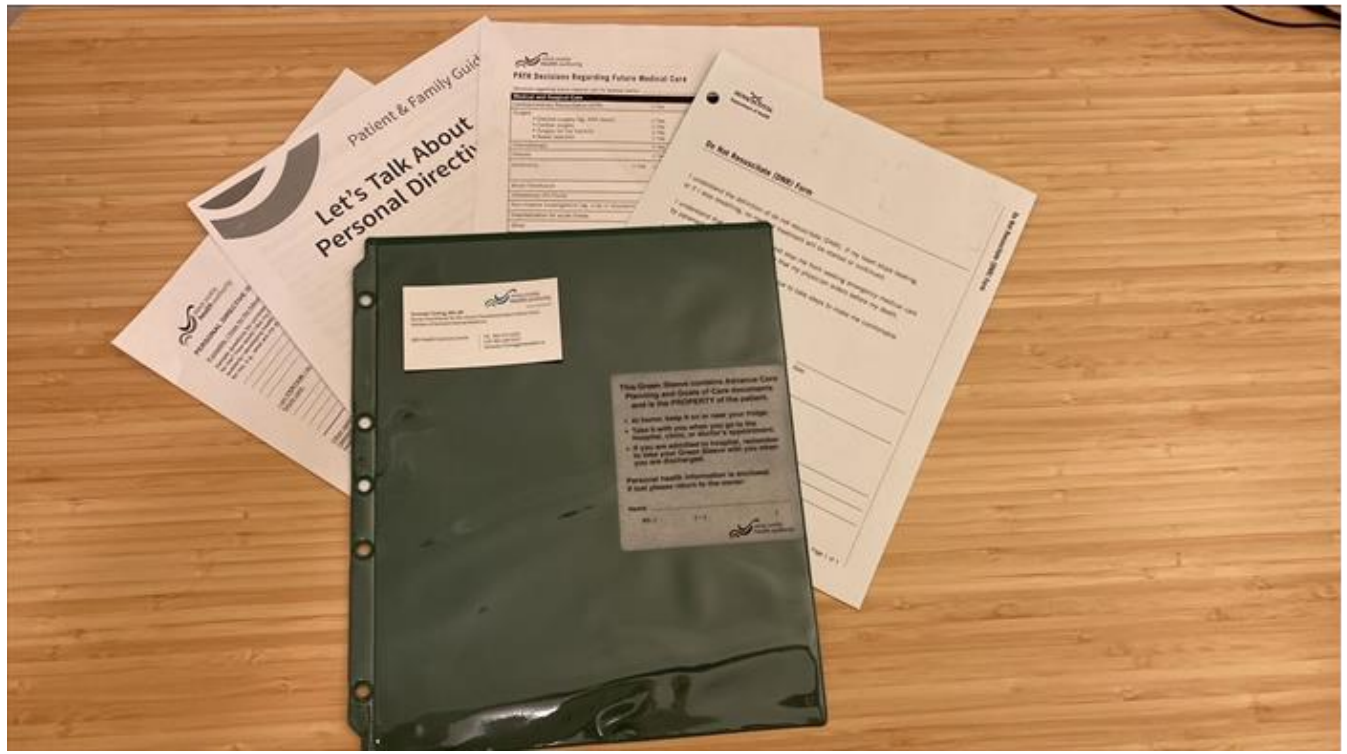
Community Palliative Supports in Halifax NS

- Review and document Terry's Goals of Care plan:
  - Symptom management / comfort/ home based Vs. Selective intervention
  - Confirm preferred location for EOL care
  - NS Green Sleeve

- EHS Special Patient Program
  - Symptom management needs
  - After hours support

Community Palliative Supports in Halifax NS

- Green Sleeve
  - Provincial Palliative Initiative
  - Includes relevant Palliative Doc's
  - Accompanies a client to any health interaction.



Community Palliative Supports in Halifax NS

- QOL as defined by individual
  - Worries
  - Joy
  - Goals
- Home supports:
  - Home Care NS –respite, personal care, Hospital Bed
  - Home OT/ PT
  - Red Cross Palliative equipment loan program
  - VON nursing support

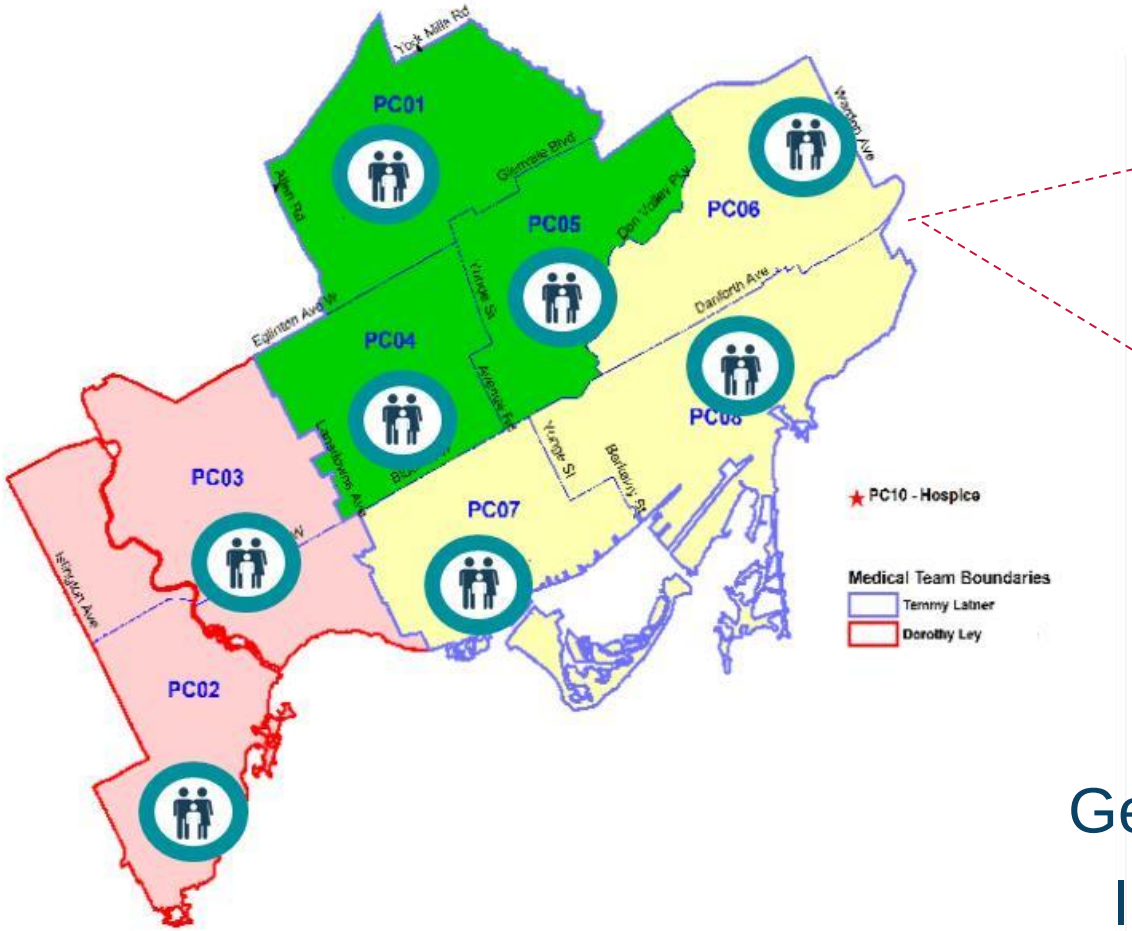
Community Palliative Supports in Halifax NS

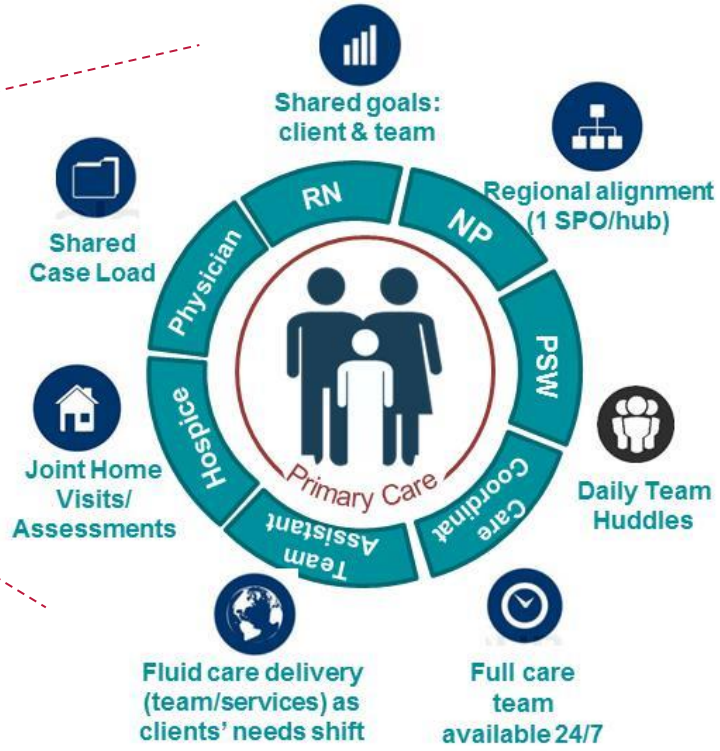
- Referral to Community Palliative Care if goal is EOL at home or Hospice.

- Review medication and symptom management
  - Add “reliever” Ventolin
  - Non-pharmacologic management: Dyspnea pace activity, distraction, bedside fan, positioning
  - Collaboration with Palliative Care for symptom management Ex. consider addition of acute seizure medication
  - NS palliative drug program- enrollment

What would Claudia & Thandi do?

Integrated Palliative Care in Toronto Central





Geographically- Based, Dedicated Integrated Palliative Care Teams

Admission Process

- Hospital to initiate home care referral
- Assessed in hospital or remotely by complex transition Care coordinator
- Hospital team would send referral for home palliative MD
- Home oxygen and equipment for home to be arranged prior to patient discharge home

Care Plan

- Palliative Nursing
- Occupational Therapist
- Personal Support Worker
- Equipment for home
- Expedited Home Visit by Palliative MD
- Case Management

Follow up at home

- Joint home visits at home by Pall MD and CC
- Ongoing discussions about goals of care, preferred place of death and Palliative care Unit
- Reassessment of home support and connect with community partners

Community of Practice Discussion

Session 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 emailed to registrants within the next week
- Please join us for the next and last session in this series:
  - Organizing Practices to Provide Primary Palliative Care
  - Presenter: Dr. Frances Kilbertus
  - July 6th, 2022 from 1-2pm ET

Thank You

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