CHCA Project ECHO
Home-Based Palliative Care

All Teach, All Learn

Bridging the Knowledge Gap in
Home-Based Palliative Care

Unpacking the Principles of a Palliative Approach to Care:

Understanding the Interdisciplinary Team

Teaching Presentation: Dr. Gordon McDonald, Palliative Care Physician, NB
Case Study: Elisabeth Antifeau, Interior Health Regional Palliative End of Life Care Program

Host: Jennifer Campagnolo, Canadian Home Care Association
October 9, 2024

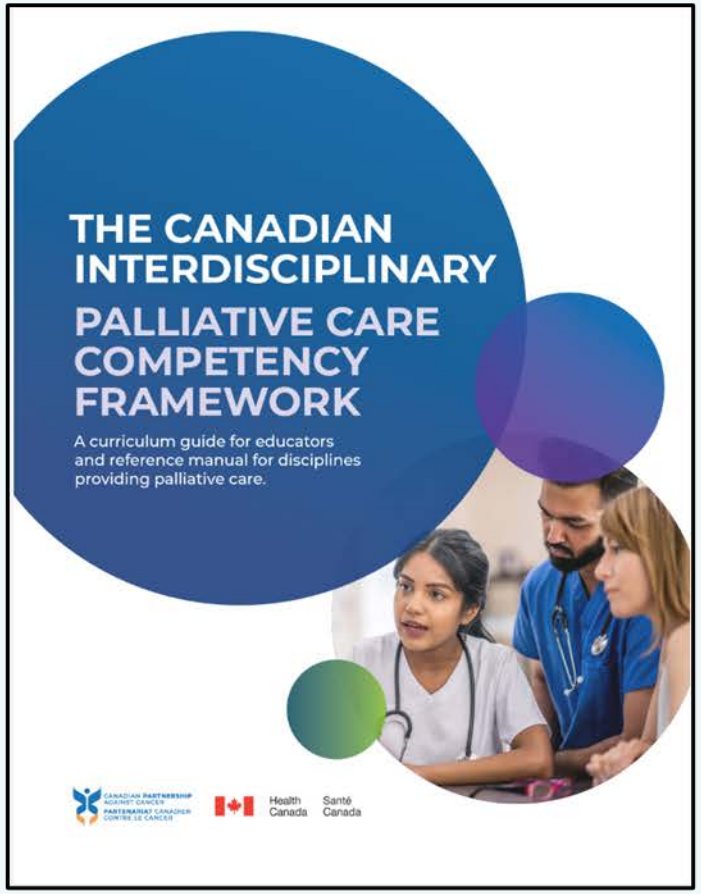
The Canadian Home Care Association (CHCA) is pleased to be a hub partner of the Palliative Care ECHO Project led by Pallium Canada. The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Land Acknowledgement

Artist Credit: Patrick Hunter

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

THE CANADIAN INTERDISCIPLINARY PALLIATIVE CARE COMPETENCY FRAMEWORK



Unpacking the Principles of a Palliative Approach to Care

Domain 1:
Principles of a palliative approach to care

Palliative care aims to improve the quality of life of people with life-limiting conditions and their designated families or caregivers. This person-centred care ideally begins at diagnosis, continues into bereavement, and is for people of any age.[1]

[1] Canadian Partnership Against Cancer & Health Canada. *The Canadian Interdisciplinary Palliative Care Competency Framework.* Toronto, ON: 2021.

Unpacking the Principles of a Palliative Approach to Care

Understanding the Interdisciplinary Team[1]

For members of the Interdisciplinary Team (nurses, SW, PSWs, generalist physicians and volunteers) this means recognizing, understanding and integrating:

- The scope, expertise and roles of all members of an integrated team (home care, primary and acute care, specialist palliative care teams, family caregivers, and volunteers).
- The role and function of the interdisciplinary care team in fostering a caring environment in palliative care.
- When to seek and utilize specialist palliative care resources.

[1] Canadian Partnership Against Cancer & Health Canada. *The Canadian Interdisciplinary Palliative Care Competency Framework.* Toronto, ON: 2021.

Learning Objectives

Describe

how the roles of various team members (primary care, home care teams, nurses, PSWs, SW, etc) collaborate to create a caring environment in palliative care.

Recognize

appropriate situations to seek and involve specialist palliative care teams and resources in order to provide optimal and holistic care for patients.

Consider

strategies that support collaboration among members of the interdisciplinary care team, enhancing the caregiving experience of people, families, caregivers and teams involved.

Introductions

Dr. Gordon McDonald MD, FRCPC
Palliative Care Physician
New Brunswick

Elisabeth Antifeau, RN, MScN, CHPCN(C), GNC(C)
Regional Clinical Nurse Specialist (CNS-C),
IH Regional Palliative End of Life Care Program

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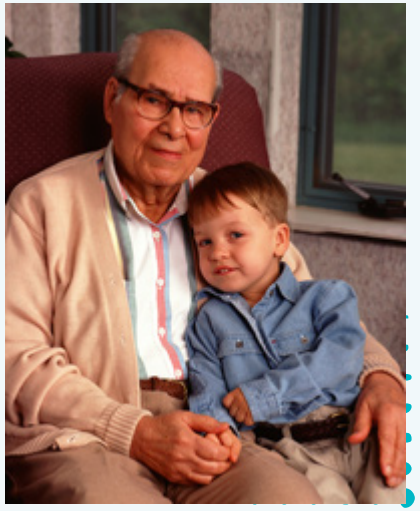
Introducing Mr.George K

- 72 year old man, living with adenocarcinoma of the esophagus, with metastases to liver and lungs
- Past Medical History:
  - Hypertension
  - CAD and PVD; angina; hypercholesterolemia
  - Smoked cigarettes since age 15; quit on diagnosis

Mr.George K

- Retired Mill worker
- Lives in small rural town, 3.5 hours away from closest largest health centre
- Lives with his wife Adele and 2 dogs
- Has 3 married adult daughters and 4 grandchildren, all of whom live several hours away



Objectives

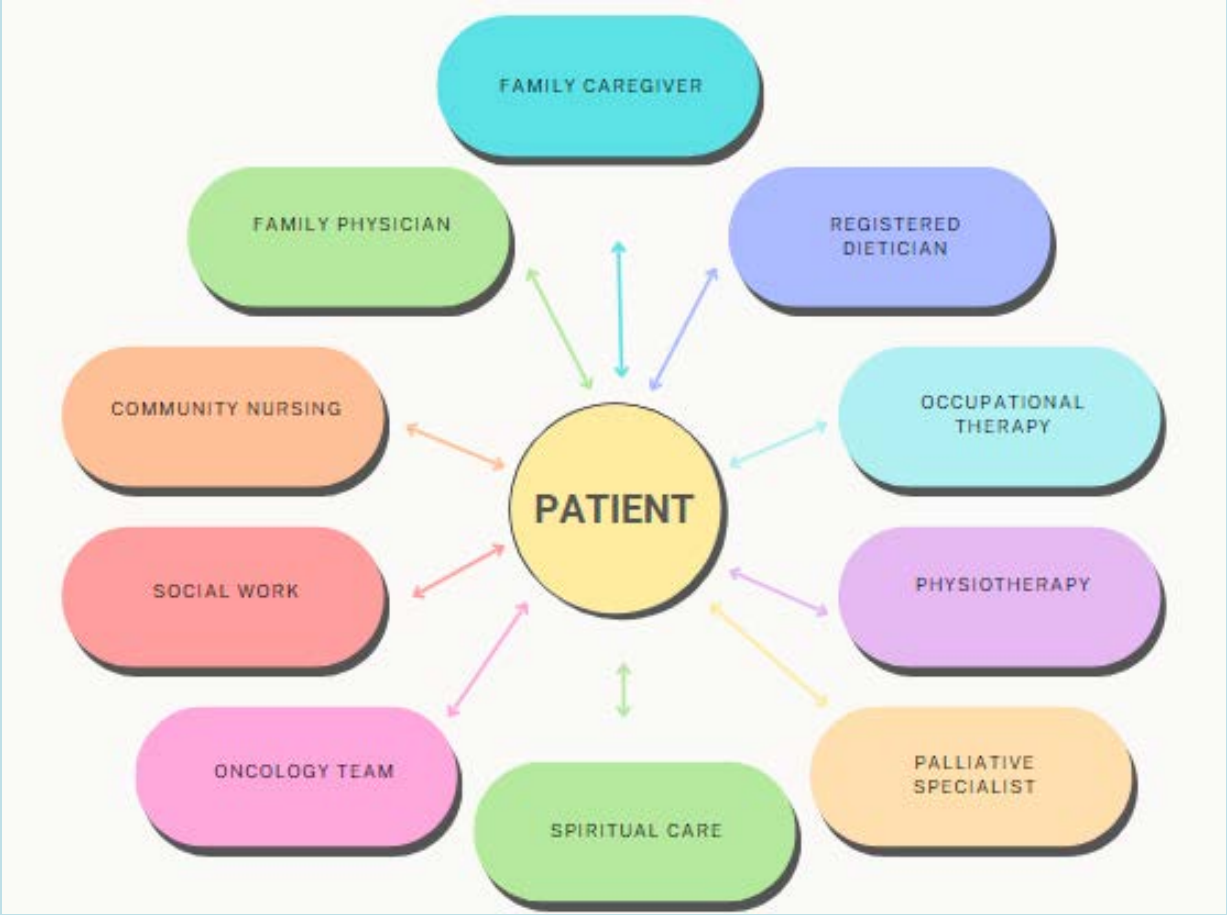
- Core principle
  - Understanding the interdisciplinary team (IDT)
- How does this influence:
  - Our care and relationships?
  - Our team interactions?
  - Outcomes?

What are the key elements?

- Core Philosophy
  - Reduce suffering in those with life-limiting illness
  - Do the best to ensure care when and where needed
  - Suffering and distress are multidimensional
  - Not limited to the experience of the person only

Team

- The needs of the individual cannot be addressed in silos
- Each domain of distress and need is supported by multiple members
- A PC specialist physician is only one member of the team



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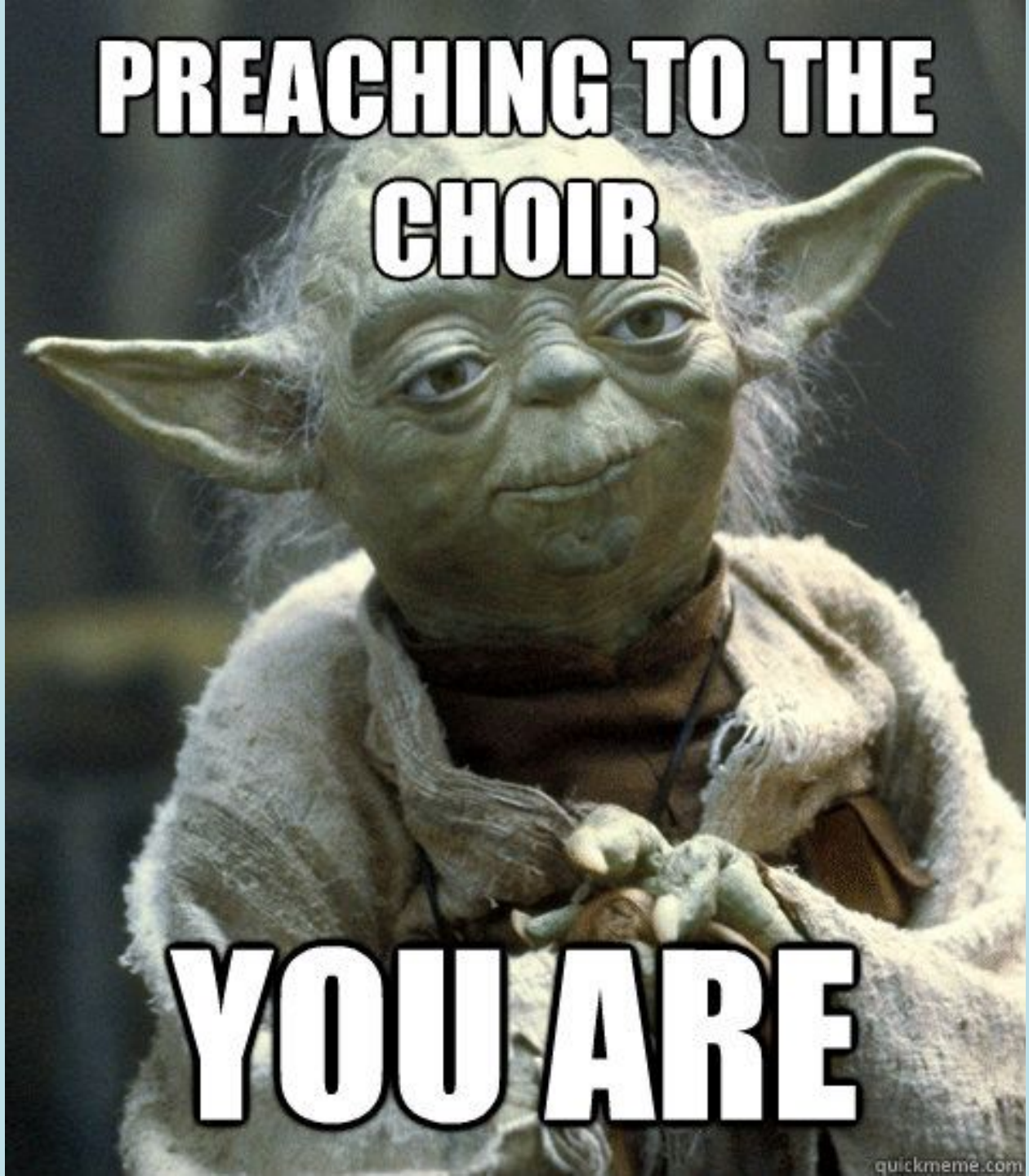


Planning

- What do people need?
  - Information
    - Disease specific
    - Treatment specific
    - Where can I reach out?
    - Questions
  - Supports
    - Education
    - Equipment
    - Psychologic
    - Spiritual

- What do people need?
  - Plans
    - For current care
    - For future needs
    - For sudden change
    - For expected changes

Key Elements Across Encounters

- Communication
  - Active listening
  - Adapting to individual
  - Challenging/Essential conversations
  - Care Planning
- Identifying Transitions
  - Care site
  - Interdisciplinary needs
  - Trajectory changes

OT Involvement

- Supporting ADLs
  - Feeding
  - Bathing
  - Dressing
  - Mobility
  - Toileting
  - Transferring
- Outcomes?
  - Maintain independence
  - Person may remain engaged
  - Support the family with tools and strategies
  - Support longer at home
  - Emotional/existential distress
  - Risk reductions?

PT Involvement

- Supporting
  - Balance
  - Strength
  - Respiratory benefit
  - Risk reduction
- Outcomes
  - Avoidance of falls
  - Reduction of fractures
  - Improved clearing of secretions and symptom reduction

https://doi.org/10.1136/spcare-2024-005132

Spiritual Care

- Complex distress
  - Purpose
  - Faith
  - Existential
  - Hope
- Outcomes
  - Strengthens support
  - Reduction of emotional distress
  - Improved spiritual dimension measures
    - (Meaning, peace of mind)

Gijsberts MHE, Liefbroer AI, Otten R, Olsman E. Spiritual Care in Palliative Care: A Systematic Review of the Recent European Literature. Med Sci (Basel). 2019 Feb 7;7(2):25. doi: 10.3390/medsci7020025. PMID: 30736416; PMCID: PMC6409788.

Clinical Dietician

- Varies depending on treatment goal
  - Earlier with disease targeting treatment?
  - Later with cachexia
- Depends on location, treatments

- Outcomes
  - Psychologic benefit
  - Social benefit
  - Support through aggressive treatments
  - Adjusting for comfort

https://doi.org/10.3390%2Fnu13020306

Additional Team Members

- Primary Care (FD/NP)
  - Early introduction
  - Symptom management
  - Building trust and plan
- Palliative Physician
- Family Caregiver
- Personal Support Worker

- Outcomes
  - Address symptoms early improves survival
  - Increased planning/discussion
  - Support as situation increases in complexity
  - Caregiver support to try to reduce burden/fatigue/burnout

The person?

- The person and family?
  - Your concerns are heard
  - Valued

- Outcome?
  - Patient satisfaction improves!
  - Schelin MEC, Fürst CJ, Rasmussen BH, Hedman C. Increased patient satisfaction by integration of palliative care into geriatrics-A prospective cohort study. PLoS One. 2023 Jun 22;18(6):e0287550. doi: 10.1371/journal.pone.0287550. PMID: 37347730; PMCID: PMC10286968.

What about the team?

- Intentional dialogue with consistent language
- Respectful conversations to plan across care settings
- Valued
- Strengthens communication and collaboration to move forward
- Allows for communication about strengths and areas for future gains

Team

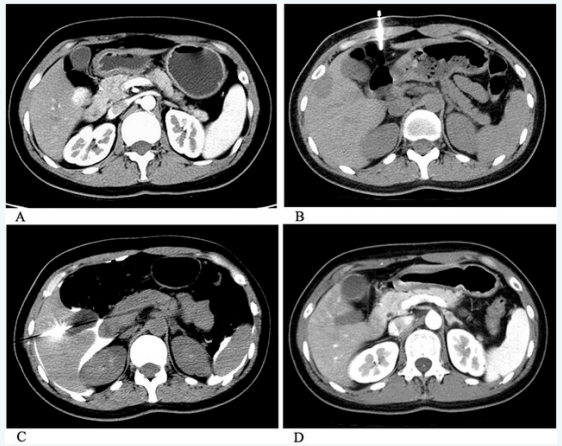
- Generalist
  - Communicate among team
  - Communicate family
  - Collaborate to identify gaps for individuals
- Specialist
  - Anticipate changes in complexity
  - Advocacy at individual, local levels and beyond
  - Educational roles
  - Identify gaps/challenges in systems needed to support

Who can benefit?

- Person
- Family
- Caregiver Team
- System

Mr. George K.

- Diagnosed 15 months ago, and initially determined to “fight it”, but after CT Scan confirmed advancing liver and lung mets, he elected to stop chemo and radiotherapy 6 weeks ago
- Referred to Home Health Nursing by Family GP 4 weeks ago
- On the BC Palliative Care Benefits
- MOST M1; Goals of Care: To die at home
- No ACP completed



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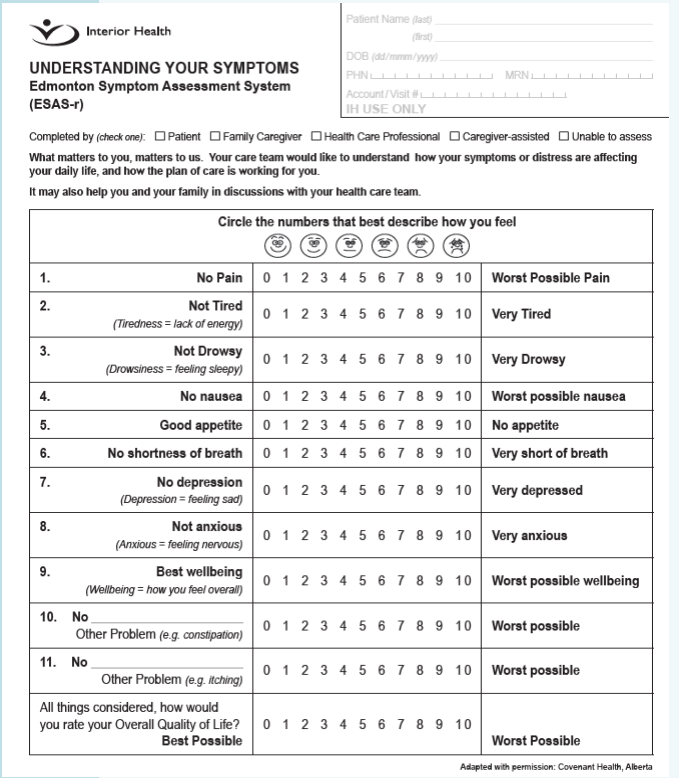
Meds at time of referral

- Tylenol#1 po tid for pain (little effect)
- Nitro patch during day with nitro spray PRN
- Rosuvastatin 10 mg PO qd
- Ramipril 5 mg po qd

Mr. George K.

- Initial Home Health nursing visit, PPS 50%
- ESASr introduced: multi-symptom burden
  - Multi-site Pain 5-7/10 (chest wall/abdomen)
  - Nausea 5/10
  - Appetite 6/10
  - Dyspnea 4/10 at rest; 7/10 with exertion
  - Anxiety 6/10
  - Depression 5/10
  - General Well-being 5/10
- Other:
  - Cough 4/10, productive for thick clear mucous
  - Difficulty swallowing 5/10



Interior Health

Patient Name (last) _____
(first) _____
DOB (dd/mmm/yyyy) _____
PHN _____ MRN _____
Account/Visit # _____
IH USE ONLY

UNDERSTANDING YOUR SYMPTOMS
Edmonton Symptom Assessment System (ESAS-r)

Completed by *(check one)*: ☐ Patient ☐ Family Caregiver ☐ Health Care Professional ☐ Caregiver-assisted ☐ Unable to assess

What matters to you, matters to us. Your care team would like to understand how your symptoms or distress are affecting your daily life, and how the plan of care is working for you.

It may also help you and your family in discussions with your health care team.

	Circle the numbers that best describe how you feel	
1. **No Pain**	0 1 2 3 4 5 6 7 8 9 10	**Worst Possible Pain**
2. **Not Tired** *(Tiredness = lack of energy)*	0 1 2 3 4 5 6 7 8 9 10	**Very Tired**
3. **Not Drowsy** *(Drowsiness = feeling sleepy)*	0 1 2 3 4 5 6 7 8 9 10	**Very Drowsy**
4. **No nausea**	0 1 2 3 4 5 6 7 8 9 10	**Worst possible nausea**
5. **Good appetite**	0 1 2 3 4 5 6 7 8 9 10	**No appetite**
6. **No shortness of breath**	0 1 2 3 4 5 6 7 8 9 10	**Very short of breath**
7. **No depression** *(Depression = feeling sad)*	0 1 2 3 4 5 6 7 8 9 10	**Very depressed**
8. **Not anxious** *(Anxious = feeling nervous)*	0 1 2 3 4 5 6 7 8 9 10	**Very anxious**
9. **Best wellbeing** *(Wellbeing = how you feel overall)*	0 1 2 3 4 5 6 7 8 9 10	**Worst possible wellbeing**
10. **No** _____ Other Problem *(e.g. constipation)*	0 1 2 3 4 5 6 7 8 9 10	**Worst possible**
11. **No** _____ Other Problem *(e.g. itching)*	0 1 2 3 4 5 6 7 8 9 10	**Worst possible**
All things considered, how would you rate your Overall Quality of Life? **Best Possible**	0 1 2 3 4 5 6 7 8 9 10	**Worst Possible**

Adapted with permission: Covenant Health, Alberta

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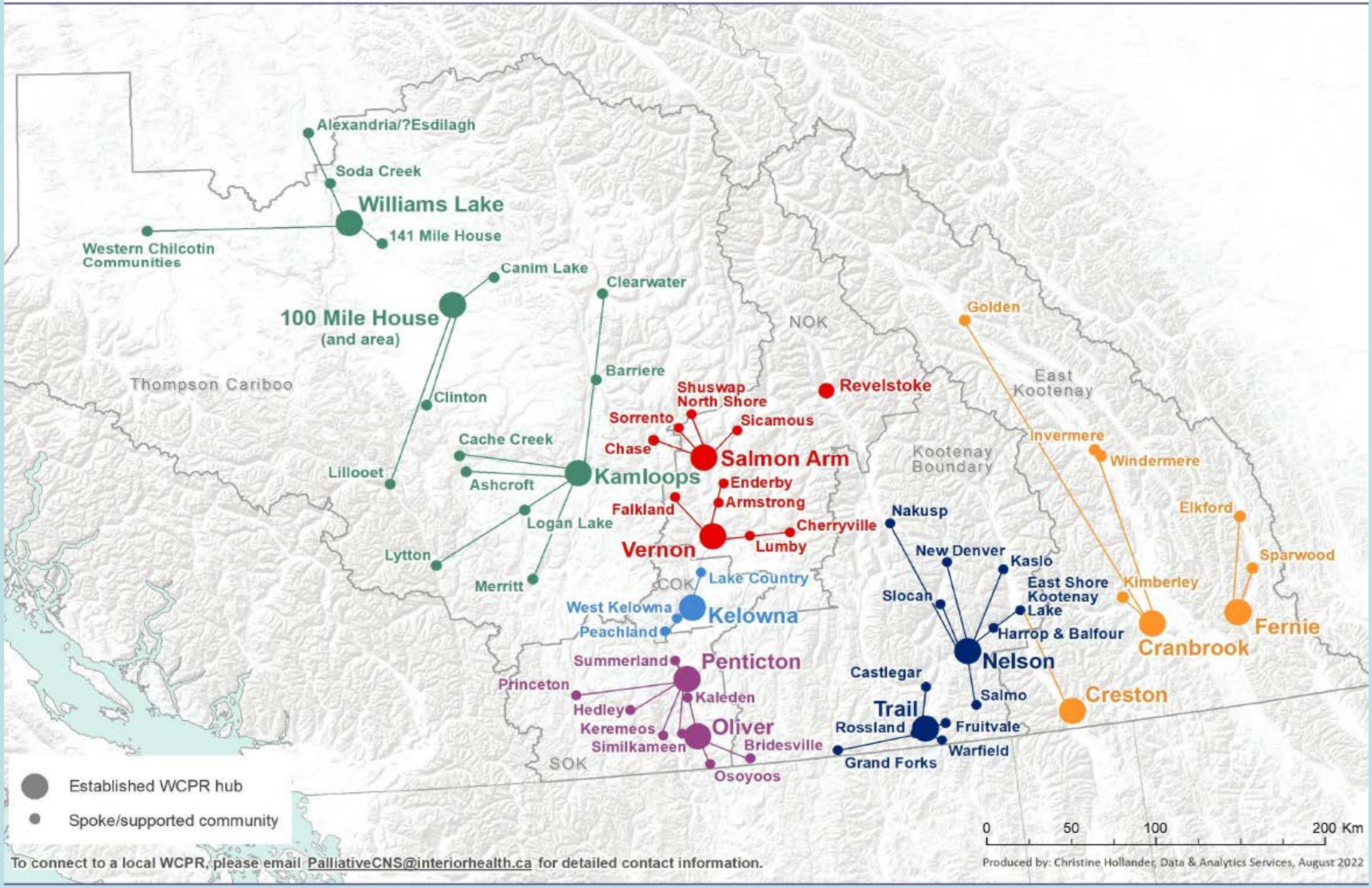
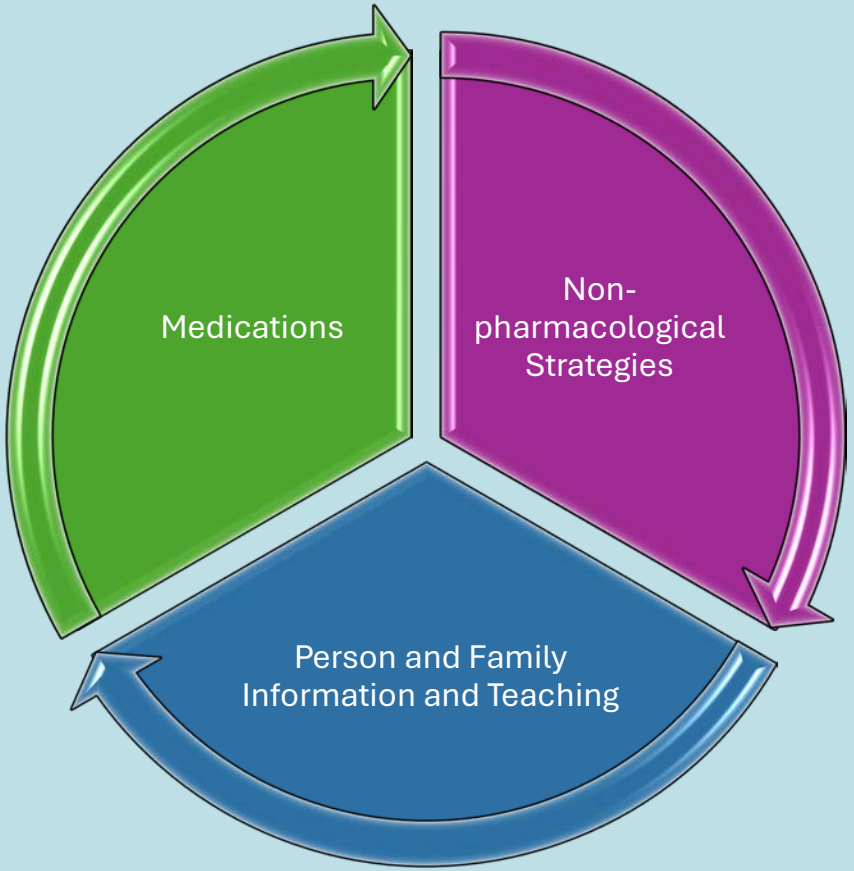
IH WCPR Hub and Spoke Model



To connect to a local WCPR, please email PalliativeCNS@interiorhealth.ca for detailed contact information.

Produced by: Christine Hollander, Data & Analytics Services, August 2022

Three-Prong Care Planning Approach for Symptom Management



Mr. George K.

- Brought forward to Whole Community Palliative Rounds (WCPR)for symptom management
- Discussion re:
  - Consult to palliative physician for better pain control (WCPR physician to contact GP with recommendations to shift to oral opioids for both pain and dyspnea)
  - Referral to dietician for swallowing assessment and recommendations for diet consistency;
  - ACP needs for SDM; (no social worker, nursing to follow up with George and Adele)
  - Offering contact with local hospice volunteer

Mr. George K. (2 weeks later)

- Over the next few weeks, symptoms stabilized:
  - Pain 3/10; Dyspnea 3/10;
  - Depression and anxiety decreased (3/10)
  - Nausea and appetite improved slightly to 4/10
- Completed ACP, naming his wife as Rep 9 and eldest daughter as ePOA;
- Declined hospice volunteer (“not there yet”)
- Dietician consult (3 weeks later) = adjusted texture and improved appetite (but lost 12 pounds)

Mr. George K. (3 weeks later)

- Continued disease progression over weeks
- Reported increasing fatigue and low energy
- Coughing a lot of mucous up, noted to be worse with eating and drinking – ? tumour-related burden, not originating in lungs
- PPS fluctuating 40-50%
- Requested MAID application; assessed & approved
- Continued weekly review at WCPR:
  - Adjusting meds for pain/cough symptom burden
  - Referral to OT for energy conservation
  - Nursing and Hospice collaborated to talk about legacy work

Mr. George K. (4 Weeks later)

- Increased sleeping, falling PPS to 30%
- Nurses anticipated the shift, use of Just-in-Case SMK over weekend;
- Symptom exacerbation:
  - Pain fluctuation (opioids titrated)
  - Continued weight loss, appearing very cachexic
  - Sets his MAID date for two weeks later on a Sunday so family can be present.

Mr. George K. (1 Week later)

- Consult to CNS re increasing nausea (6/10), with pain well controlled after recent titration;
- Discussed possible causes and restarted his PRN metoclopramide with good effect
- Adele reporting periods of confusion and restlessness; concerned he won't make his MAID date.
- Discussion and support re balance of keeping comfortable and supporting a natural death vs MAID – his goal of care was to die at home

Mr. George K. (5 days later)

- Falling PPS 10-20%, not going to make his MAID date, and pending natural death expected
- Using low dose glyco (0.2mg)tid SC for tumour mucous production & continued hydromorphone for pain
- George died peacefully at home in his own bed on Sunday (day he would have received MAID), wife and daughters at bedside
- Was receiving daily Home Health nursing supports
- HH nurse pronounced death that afternoon

Mr. George K. (5 days later)

- Questions?
- Discussion?
- Identifying the interdisciplinary members and approaches used within this rural setting of care.

Questions & Discussion

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Palliative Care Physician
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Upcoming TeleECHO Sessions

Unpacking the Principles of a Palliative Approach to Care:

Addressing Barriers to Care

November 13 2024, 12-1pm ET

Saving Limbs, Saving Lives: Consensus Guidelines for Wound Care

Breaking the Cycle: Optimizing Venous Ulcer Care and Prevention

November 6 2024, 11-12pm ET

Navigating Arterial Foot Ulcer Care: Practical Guidelines

November 19 2024, 11-12pm ET

Bridging Gaps in Diabetic Foot Ulcer Management: Care Strategies

December 11 2024 11-12pm ET

Register: cdnhomecare.ca/chca-project-echo