Community-Based Primary Palliative Care Community of Practice Series 3

What is in store for Palliative Care in Canada: policy, advocacy and implementation

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitator: Dr. Haley Draper
Guest Speaker: Dr. James Downar
Date: June 5, 2024

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 and their families.

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

Project ECHO Palliative Care - Canada BY Pallium 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 the CFPC and Royal College.

Pallium Canada

LEAP CORE

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-core

Objectives of this Series

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

- Augment their primary-level palliative care skills with additional knowledge and expertise related to providing a palliative care approach.
- Connect with and learn from colleagues on how they are providing a palliative care approach.

Overview of Sessions

Session #	Session Title	Date/ Time
Session 1	Communication: Part 1	Oct 25, 2023 from 12:30-1:30pm ET
Session 2	Communication: Part 2	Nov 29, 2023 from 12:30-1:30pm ET
Session 3	Managing the last hours of life	Dec.20, 2020 from 12:30-1:30pm ET
Session 4	Palliative care for the structurally vulnerable	Jan 24, 2024 from 12:30-1:30pm ET
Session 5	Procedural management of complex pain: Nerve blocks, vertebral augmentation, radiotherapy	Feb 21, 2024 from 12:30-1:30pm ET
Session 6	Terminal Delirium and Palliative Sedation	Mar 27, 2024 from 12:30-1:30pm ET
Session 7	Creative art therapy in palliative care	Apr 24, 2024 from 12:30-1:30pm ET
Session 8	What in store for Palliative Care in Canada: policy, advocacy and implementation	May 29, 2024 from 12:30-1:30pm ET
Session 9	Grief and Bereavement: Beyond the Basics	June 26, 2024 from 12:30-1:30pm 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 when you can unmute yourself for questions and discussion.
- You are welcome to use the Q&A function to ask questions.
- 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 **9 Mainpro+** credits.

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. Haley Draper: Nothing to disclose
- Dr. James Downar: Grant funding to study psilocybin, rTMS; financial interest in rTMS manufacturer

Disclosure

Mitigating Potential Biases:

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

Introductions

Facilitator:

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

Panelists:

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

Dr. Roger Ghoche, MDCM CCFP-PC, MTS
Palliative Care and Rehabilitation Medicine, Mount Sinai Hospital- Montreal

Jill Tom, BSN CHPCN ©
Nurse Clinician for palliative Home Care
Mount Sinai Hospital, Montreal

Introductions

Panelists (continued):

Elisabeth Antifeau, RN, MScN, CHPCN(C), GNC(C)
Regional Clinical Nurse Specialist (CNS-C), Palliative End of Life Care
IH Regional Palliative End of Life Care Program
Pallium Canada Master Facilitator & Coach, Scientific Consultant

Thandi Briggs, RSW MSW
Care Coordinator, Integrated Palliative Care Program
Home and Community Care Support Services Toronto Central

Claudia Brown, RN BSN
Care Coordinator, Integrated Palliative Care Program
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Rev. Jennifer Holtslander, SCP-Associate, MRE, BTh
Spiritual Care Provider

ECHO Support

Diana Vincze
Palliative Care ECHO Project Manager, Pallium Canada

Introductions

Guest Speaker:

James Downar, MDCM, MHSc (Bioethics), FRCPC
Head and Professor, Division of Palliative Care, uOttawa
Clinical Research Chair in Palliative and End-of-Life Care, uOttawa
Adjunct Professor, Queensland University of Technology School of Law
Scientist, Bruyere Research Institute
Department of Critical Care, The Ottawa Hospital

Paradigmatic changes to Palliative Care in the coming decade

Session Learning Objectives

Upon completing the session, participants will be able to:

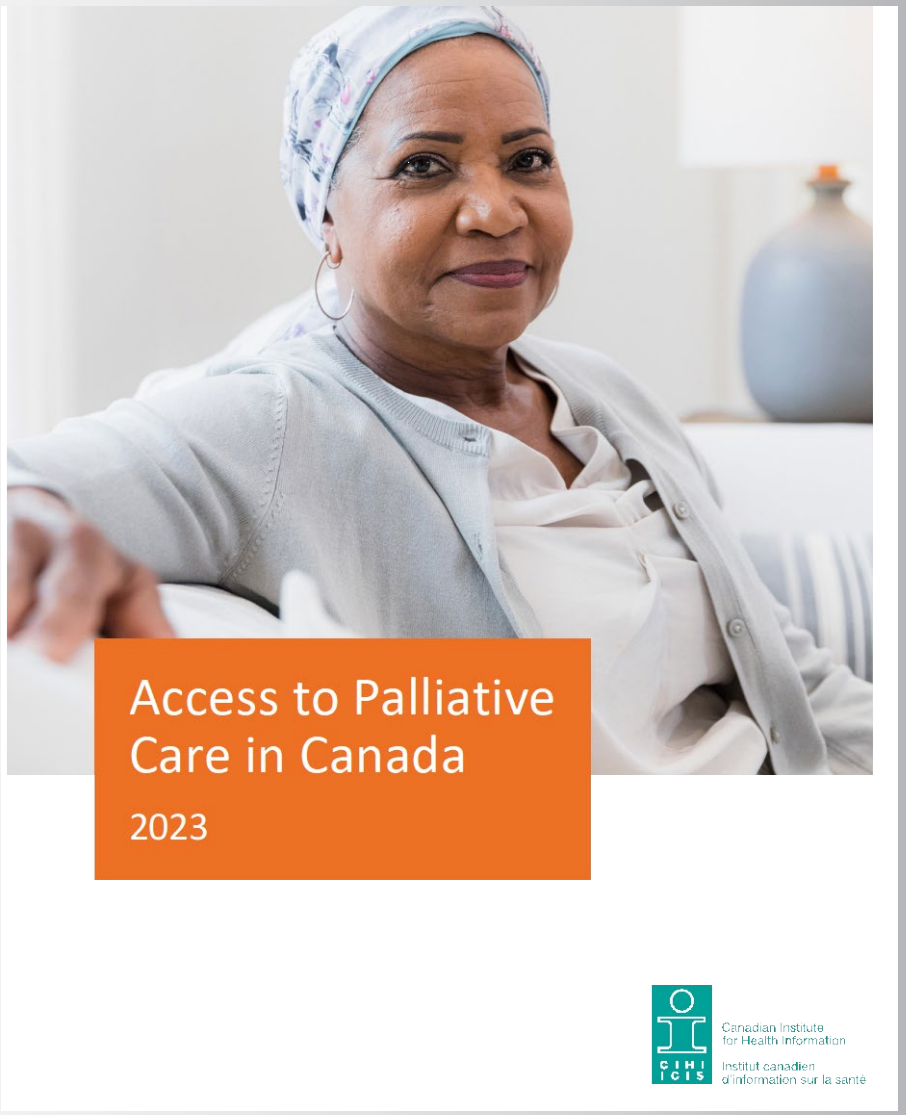
- Discuss coming changes in:
  - Who delivers Palliative Care
  - What Palliative Care looks like
  - When we deliver Palliative Care
  - Where people receive Palliative Care, and where they die
  - Why we deliver Palliative Care
  - How we deliver Palliative Care

Overview – Paradigmatic Changes

- Palliative Care is growing rapidly in Canada
- Palliative Care will be increasingly delivered by non-specialists, with specialist support
- Unmet palliative needs will be identified proactively and not reactively
- Palliative Care will be increasingly targeted towards more symptomatic individuals
  - “Timely”, not early
- Palliative Care providers will deliver novel techniques borrowed from other fields
  - Personalized Palliative Care, neuromodulation
- Palliative Care will become part of the solution to the ALC crisis

Palliative Care utilization is growing rapidly

- Changes from 2016-2022
  - PC in any setting
    - 52% → 59%
  - PC in home care
    - 15% → 24%
  - Died at home with PC
    - 7% → 16%
- Hospice beds in Ontario 2x since 2016



BMJ Open

Access to palliative care by disease trajectory: a population-based cohort of Ontario decedents

Hsien Seow,[1] Erin O'Leary,[1] Richard Perez,[2] Peter Tanuseputro[3]

Setting of PC	Terminal Illness (n=75657)	Organ Failure (n=72363)	Frailty (n=67513)
Any palliative care	88%	44.4%	32.4%
PC in community	68.6%	17.2%	15.1%
Median days between first PC and death (IQR)	107 (33, 246)	22 (6, 124)	24 (6, 132)
% of days receiving PC	37%	25%	23%

Seow H, et al. BMJ Open 2018;**8**:e021147

PC Delivery by non-specialists

- Most future growth in PC will be in non-cancer
  - Prognosis, trajectory less clear
  - Symptomatic role for disease-modifying treatments
- Moving from final days to final weeks, from final weeks to final months
- Education and support
  - Mentorship
  - Feedback and auditing of practice
  - 5-year plan to change practice of those referring to PC

Identifying unmet needs- proactive, not reactive

- Palliative care currently delivered in response to sentinel events, protocolized referral
- Automated, reliable process to identify people at high risk of unmet needs
  - Identify people when they have needs, but before sentinel events
  - Nudges to prompt screening
  - Auditable
  - The “Denominator Problem” – QI initiatives

HOMR

The Hospital-patient one year mortality risk
uses data available at hospital admission to

PREDICT RISK OF DEATH IN THE NEXT YEAR.

HOMR

When a patient at high risk of death is identified by the HOMR tool, clinicians are prompted to:

1. Conduct a symptom assessment
2. Conduct an Advance Care Planning assessment
3. Address unmet palliative needs

Results to Date (n=6 hospitals)

	Pre (n=744)	Post (n=704)	p-value
Mean Age – Years (SD)	83	84	
Sex - % Female	48	51	
^Disease Trajectory – n (%)			
Frailty	304 (40.9%)	256 (36.4%)	0.0758
Organ Failure	194 (26.1%)	199 (28.3%)	0.0402
Terminal Illness	109 (14.7%)	109 (15.5%)	0.0182
Other	137 (18.4%)	140 (19.9%)	0.0310
Symptom Assessment – n (%)			
Any documented assessment (% yes)	504 (67.7%)	600 (85.2%)	<0.0001
Completed ESAS assessment (% yes)	23 (3.1%)	338 (48.0%)	<0.0001
*ESAS score >6	4 (17.4%)	187 (55.3%)	0.0005
ACP Assessment – n (%)			
Any documented assessment (% yes)	206 (27.7%)	374 (53.1%)	<0.0001
Completed 4-Item ACP (% yes)	58 (7.8%)	341 (48.4%)	<0.0001
****Readiness to Talk to Doctor about ACP – n (%)**			
Haven't thought about it or not ready	10 (17.2%)	75 (22.0%)	0.5023
Already completed or ready	11 (19.0%)	201 (58.9%)	<0.0001
Not sure	29 (50.0%)	46 (13.5%)	<0.0001
Refused	8 (13.8%)	7 (2.1%)	0.0012
Missing	0 (0.0%)	12 (3.5%)	0.2806

^Standard Mean Difference provided rather than p-value

*Percentages calculated using the total # of people who responded to the ESAS assessment

**Percentages calculated using the total # of people who completed the 4-item ACP assessment

Key Points

- HOMR is very good at identifying people with frailty and organ failure – complements physician judgement
- Rates of documented symptom assessments and ACP assessments increased significantly post-HOMR implementation
- 55% of patients flagged by HOMR had a severe, uncontrolled symptom
- Only 2% of patients refused to talk about ACP – patients want to have these discussions!

PCPCRC
CRPCSP

Results to Date (n=6 hospitals)

Palliative Care Interventions Initiated – n (%)			
Documented GoC/ACP Discussion	279 (37.5%)	323 (45.9%)	0.0012
Palliative Consult	113 (15.2%)	93 (13.2%)	0.2762
D/C with palliative follow-up	32 (4.3%)	35 (5.0%)	0.5262
D/C with palliative homecare	74 (9.9%)	25 (3.6%)	<0.0001
Invasive Procedures in Hospital – n (%)			
Intubation	9 (1.2%)	2 (0.3%)	0.0487
Lung/Liver Biopsy	3 (0.4%)	7 (1.0%)	0.1682
CPR	4 (0.5%)	3 (0.4%)	0.7839
COVID Status – n (%)			
Positive	32 (4.3%)	61 (8.7%)	0.0006
Negative	373 (50.1%)	502 (71.3%)	<0.0001
Unknown	339 (45.6%)	141 (20.0%)	<0.0001
Hospital Length of Stay			
Mean (SD)	12 (15.3)	15 (18.7)	0.0008
Median (IQR)	7.5 (10)	9 (12)	
Discharge Disposition – n (%)			
Died in Hospital	154 (20.7%)	104 (14.8%)	0.0034
Private Home	381 (51.2%)	340 (48.3%)	0.2700
Long-term Care	77 (10.3%)	92 (13.1%)	0.0972
Palliative Care Unit/Hospice	16 (2.2%)	17 (2.4%)	0.7988
*Complex Continuing Care	31 (3.9%)	69 (9.8%)	<0.0001
Retirement Home	69 (9.3%)	63 (8.9%)	0.7915
Other	17 (2.3%)	18 (2.6%)	0.7103
Unknown	1 (0.1%)	1 (0.1%)	1.0000

*Includes rehabilitation units/centres, sub-acute care unspecified, and transitional care units

Key Points

- The proportion of patients who had a documented goals of care discussion in-hospital significantly increased post-HOMR implementation
- While HOMR improved documentation of needs and goals of care discussions, this did not correlate with any increase in special palliative care service use
- Significantly fewer patients intubated post-HOMR implementation
- While hospital LOS increased post-implementation, a significantly lower proportion of patients died in hospital
  - Offset largely by increases in D/C to CCC and LTC
  - Likely influenced by pandemic practices

PCPCRC
CRPCSP

Targeting Specialized Referral

	Setting	No. of Studies	No. of Patients	Quality of Life SMD (95% CI)	Symptoms SMD (95% CI)	Mood SMD (95% CI)	Survival HR (95% CI)
Kavalieratos et al. 2016 [16]	IP/OP	11	1670	0.12 (−0.2, 0.27)	−0.14 (−0.39, 0.10)		0.82 (0.60, 1.13)
Gartner et al. 2017 [14]	IP/OP	5	828	0.20 (0.01, 0.38)	−0.21 (−1.35, 0.94)		
	OP (early only)	2	388	0.33 (0.05, 0.61)			
Haun et al. 2017 [15]	OP	7	1614	0.27 (0.15, 0.38)	−0.23 (−0.35, −0.10)	−0.11 (−0.26, 0.03)	0.85 (0.56, 1.28)
Heorger et al. 2019 [17]	OP	8	2092	0.18 (0.09, 0.28)			1y: 14.1% (6.5%, 21.7%)
Fulton et al. 2019 [18]	OP	10	2385	0.24 (0.13, 0.35)	−0.17 (−0.45, 0.11)	−0.09 (−0.32, 0.13)	0.84 (0.61, 1.18)

Abbreviations: CI, confidence interval; HR, hazard ratio; IP, inpatient; OP, outpatient; SMD, standardized mean difference.

Hui et al. *Cancers* 2022;14:1047

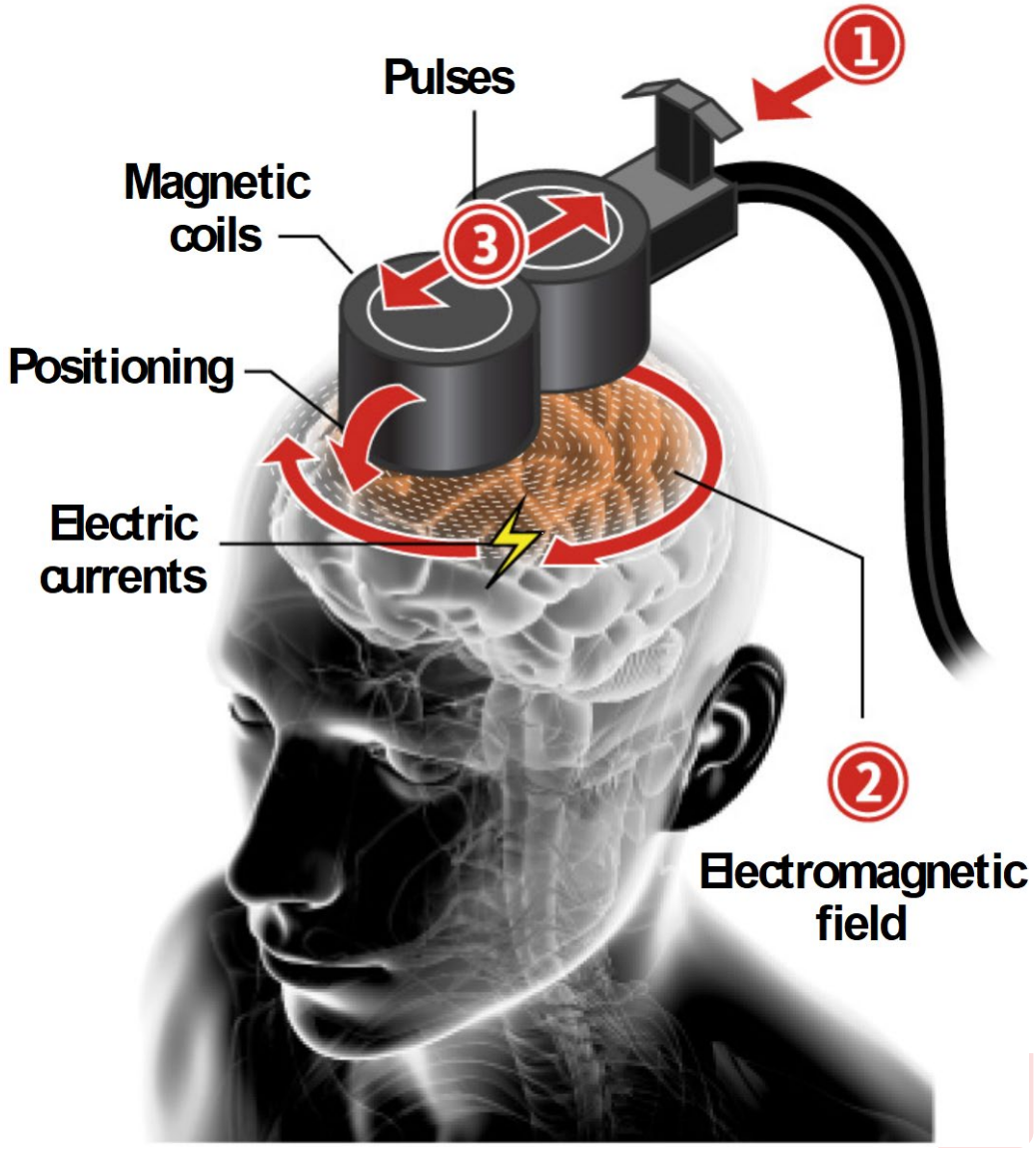
Targeting Specialized Referral

- Specialized PC consultation offers modest benefit above “usual care” in studies
- Need to identify
  - Ideal situation – when symptoms/QOL are more severe
  - How frequently to follow up
  - When follow up can be handed off to primary care/disease specialist
- Pragmatic strategies
- Which outcomes to focus on?

Novel Techniques

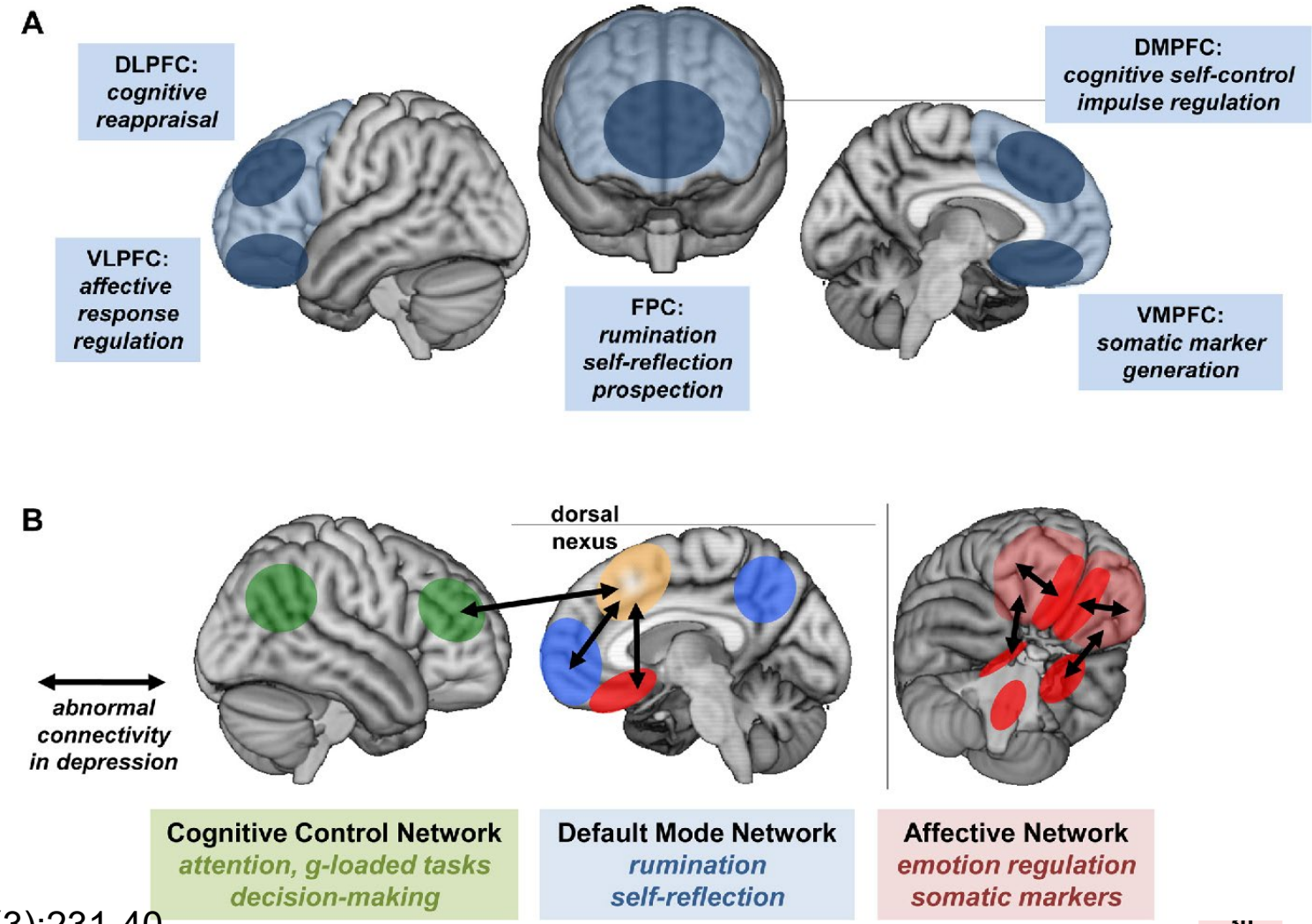
- Personalized Palliative Care
- Psychedelics
- Neuromodulation
  - Transcranial Magnetic Stimulation
  - Scrambler therapy
- AI
  - Natural language processing
  - Chat GPT therapy?

Repetitive Transcranial Magnetic Stimulation



Repetitive Transcranial Magnetic Stimulation

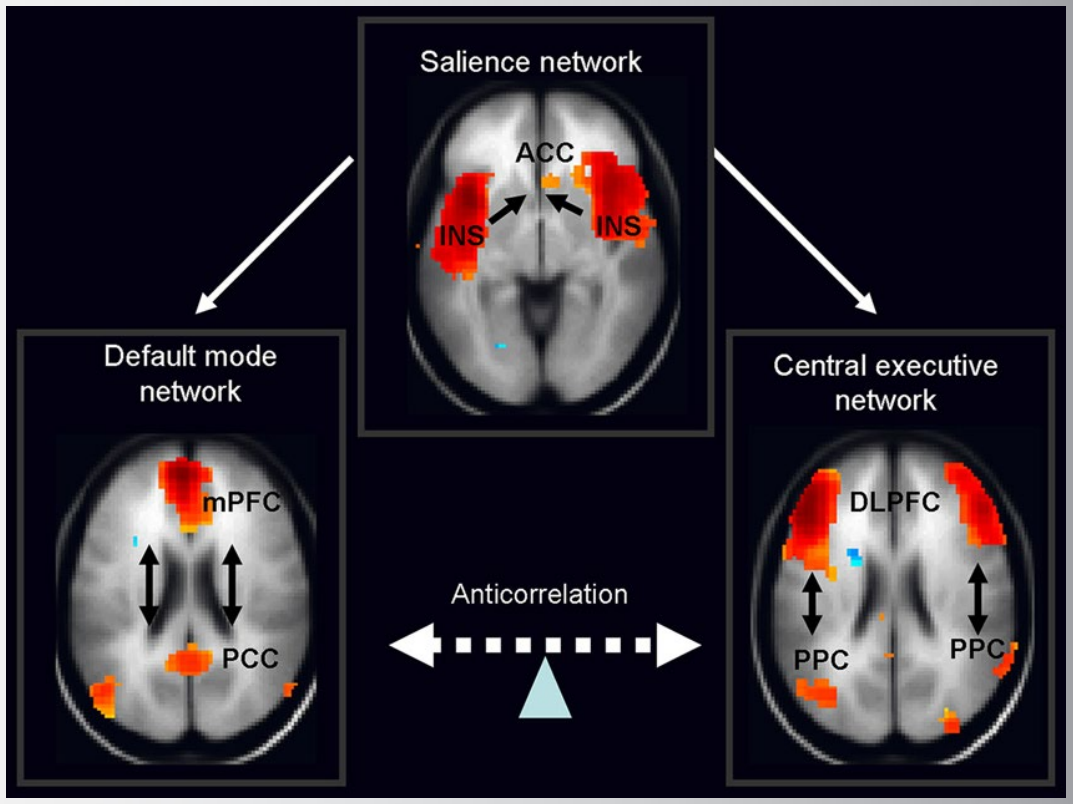
- Powerful, focused magnetic pulses via handheld inductor
- Changes activity of frontal lobe circuits involved in cognition and emotion
  - High frequency to L-DLPFC
  - Low frequency to R-DLPFC



Downar and Daskalaikis. Brain Stimul. 2013 May;6(3):231-40.

Repetitive Transcranial Magnetic Stimulation

- Activation of Salience Network (SN)
  - Emotional resilience to stressors
  - Cognitive control
  - Responsiveness to internal stimuli
- Reduces rumination on negative themes
- Reduces anehdonia



Siddiqi SH et al. Nature Human Behaviour. 2021 Jul 8;5(12):1707–16.
Peters SK, Dunlop K, Downar J. Frontiers in Systems Neuroscience. 2016 Dec 27;10.
Tadayonnejad R et al. Brain Stimulation. 2023 Sep;16(5):1374–6.
Siddiqi SH et al. American Journal of Psychiatry. 2020 May 1;177(5):435–46.

Psychedelic Medications

- "Serotonergic hallucinogens"
  - Psilocybin ("Magic mushrooms")
  - Lysergic Acid Diethylamide (LSD- "Acid")
  - N,N-dimethyltryptamine (DMT)
- Empathogens or entactogens – MDMA ("Ecstasy")
- Dissociative anesthetics – Ketamine ("Special K")

Byock. *J Palliat Med* 2018; **21**(4): 417-21.
Griffiths et al. *J Psychopharmacol* 2016; **30**(12): 1181-97.
Reiche et al. *Progress in Neuro-Psychopharmacology & Biological Psychiatry* 2018; **81**: 1-10.
Ross et al. *J Psychopharmacol* 2016; **30**(12): 1165-80.

- 436 participants
- Significant benefit (g=1.64)
    - Secondary depression (pts with “life-threatening illness”)
    - Self-reported scales
    - Older age, previous psychedelic use
- BUT- issues with metaregression, copying of SE vs. SD
- Expression of concern- may have overestimated effectiveness

BMJ 2024;385:e078084

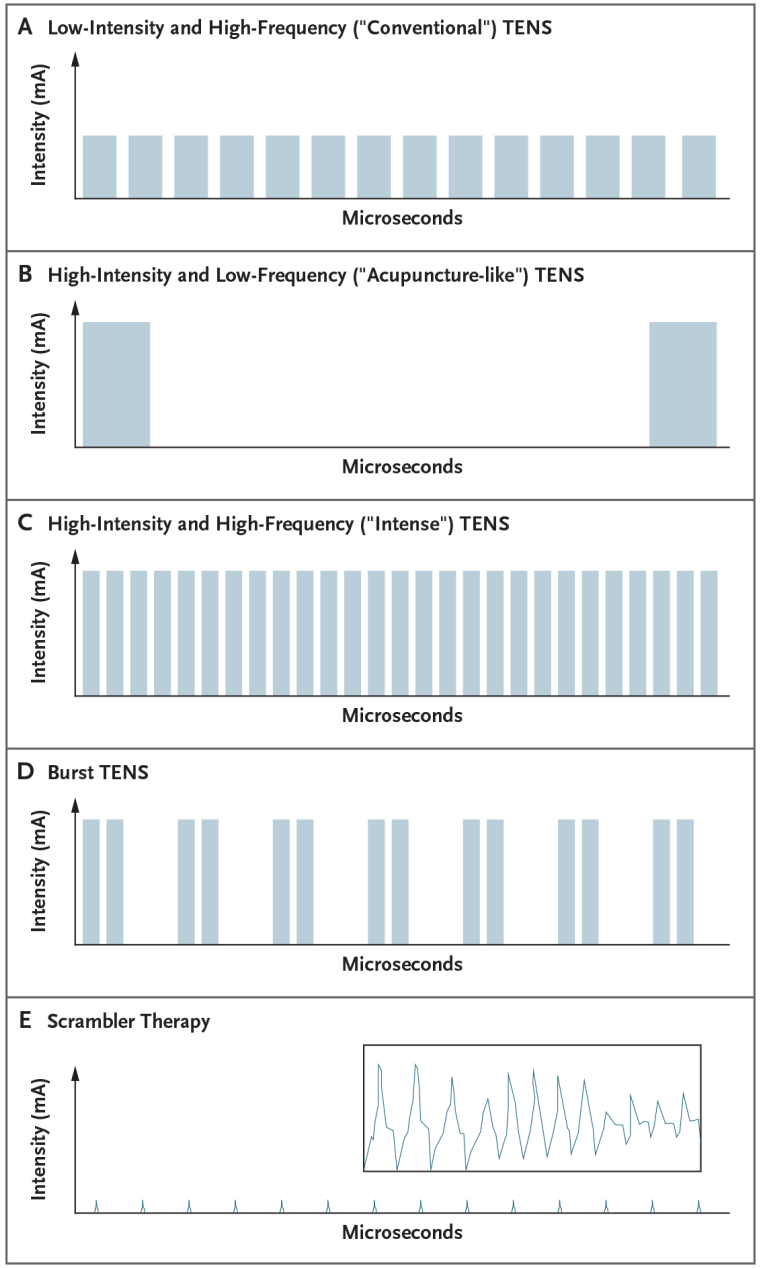
REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Cutaneous Electroanalgesia for Relief of Chronic and Neuropathic Pain

Thomas J. Smith, M.D., Eric J. Wang, M.D., and Charles L. Loprinzi, M.D.

CHRONIC PAIN, DEFINED AS PAIN THAT PERSISTS FOR MORE THAN 3 months, is a major global health problem and affects as many as 100 million adults in the United States alone. Besides the suffering, chronic pain costs the nation up to $894 billion each year in medical treatment and lost



Alternate Level of Care (ALC) and End-of-Life Care

- 17% of patients in acute care beds are ALC
- 40% of ALC days are for patients in final 3m of life
    - 190,000 patient-days – equivalent to 520 beds
    - 44% waiting for LTC
    - 24% waiting for residential hospice or palliative care units
    - 12% waiting for home care resources

  – 30% died before they were discharged – 3519 patients

Quinn, Isenberg, Downar et al. *Expensive Endings: Reining In the High Cost of End-of-Life Care in Canada*. CD Howe 2021.

Questions?

Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- We hope to see you again at our next session taking place **June 26th, 2024 from 12:30-1:30pm ET** on the topic of **Grief and bereavement: beyond the basics.**
- Thank you for your participation!

Thank You

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