Heart Disease
Community of Practice Series 3

Collaboration Building: How to build collaboration with teams in your setting

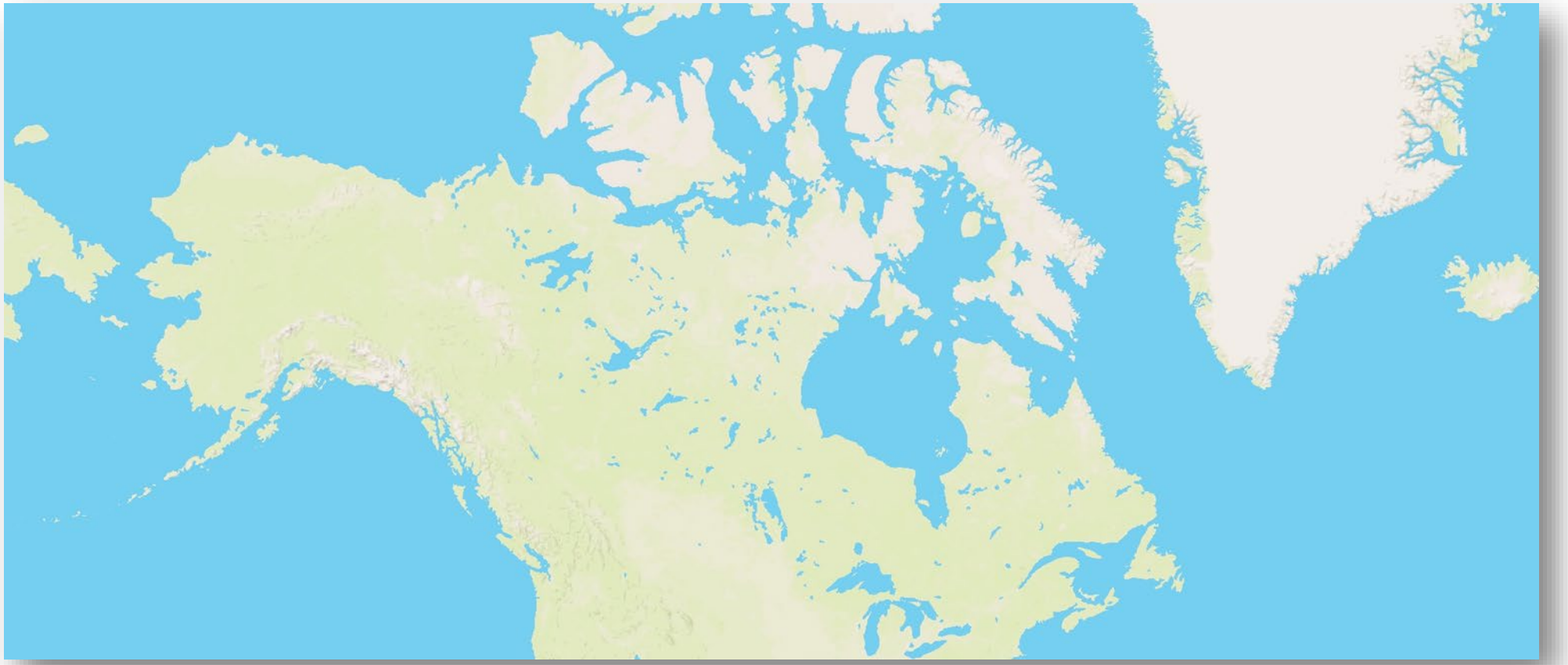
Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitator: **Diana Vincze, Pallium Canada**

Presenters: **Dr. Lynn Straatman, MD FRCPC**
Shannon Poyntz, NP-PHC, MN
Morgan Krauter, NP, CCN(C)

Date: **02 October 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.

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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

Presenters

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

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

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

Introductions

Panelists

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

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

Drew Stumborg, RN
Saskatchewan Health Authority

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

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
- Pallium Canada 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.
- Morgan Krauter: Novartis, Pfizer (speaker fees).
- Dr. Michael Slawnych: Novartis.
- 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).
- Shannon Poyntz: None to disclose.
- Drew Stumborg: 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 Q&A function to ask questions
- Add comments to the chator to let us know if you are having technical difficulties; 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.
- This event is also an Accredited Group Learning Activity through the Royal College of Physicians and Surgeons of Canada. You may claim a maximum of **6.00 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 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

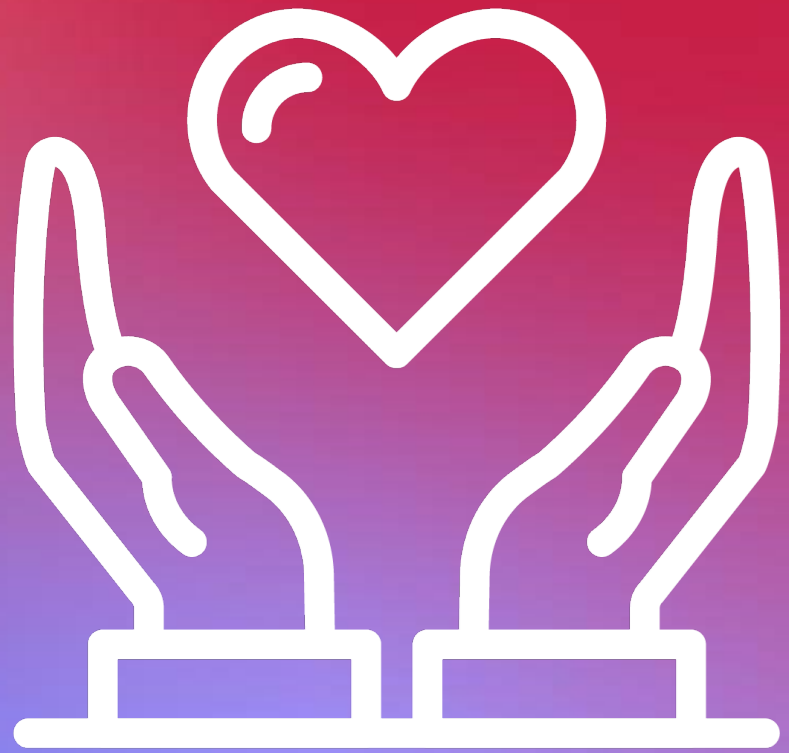
Session #	Session title	Date/ Time
Session 1	Collaboration Building: How to build collaboration with teams in your setting	October 2, 2024 from 12-1pm ET
Session 2	Diuretic management in an outpatient setting	December 11, 2024 from 12-1pm ET
Session 3	Challenging conversations	February 5, 2025 from 12-1pm ET
Session 4	De-prescribing cardiac and other medications: palliative care in people with advanced heart failure	April 30, 2025 from 12-1pm ET
Session 5	Non ischemic causes of heart failure	June 25, 2025 from 12-1pm ET
Session 6	Interaction of heart failure and lung disease	August 20, 2025 from 12-1pm ET

Objectives of this Session

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

- Appreciate how teams across Canada have built collaborations between cardiology and palliative care to provide a palliative approach to the care of patients with advanced heart failure.
- Discuss challenges in building collaborations in their community.
- Discuss pearls and resources to building collaborations in their own community.

Collaboration Building: How to build collaboration with teams in your setting



Example of Collaborative Care: Supportive Cardiology Clinic

- Multidisciplinary Team:
  - HFC RN and NPs, palliative care physician
  - Integration into existing community hospice services and home care

- Patient Services:
  - Initial assessment: comprehensive evaluation of symptom burden, functional status, existing home supports and care team
  - Personalized care plans: integration into primary care, additional palliative supports, and adjunct therapy to HF guideline-directed medical therapy tailored according to treatment preferences
  - Referral to patient and caregiver education programs, respite, and counselling

- Follow-up and Monitoring:
  - Regular check-ins to reassess progress with HFC team +/- palliative care physician

Example of Collaborative Care: Integration of Community Paramedics

Case Example: 62 year-old female with rheumatic heart disease, mechanical mitral valve, HFpEF, AF, COPD, and urothelial carcinoma. Lost to follow-up to HFC due to functional decline and inability to attend in-person clinic visits. Five HF-related hospitalizations and ED visits within 90 days.

Symptoms included SOBOE, orthopnea, lower extremity edema, abdominal bloating, anorexia, and constipation. Hypervolemic on exam. Undulation of tongue and cheeks resulting in mouth sores.

Medications: amitriptyline, atorvastatin, bisoprolol, diltiazem, duloxetine, furosemide, hydromorphone, oxycodone-acetaminophen, pantoprazole, pregabalin, spironolactone, warfarin (INR 1.4-5.4).

Role of Community Paramedics (CPs)

- Primary or advanced care paramedics that function outside of traditional emergency response role to increase access to primary and preventive care to vulnerable and high-resource use patients.

- Integration into HFC includes:
  - Video-based appointments for homebound patients
  - Enhanced physical exams that build on existing CP knowledge and skill
  - Point-of-care blood work or laboratory delivery where necessary
  - Electrocardiograms, point of care ultrasounds
  - Remote home monitoring
  - Administration of some medications

CP Case Example

- Since May 2024, q-4-6 week appointments facilitated by the CP with the HFC NP.
  - 1-hr appointment for the CP, 15-30 minutes appointment with the NP

- Outcomes:
  - No further ED or hospital visits
  - 1 activation of the exacerbation management line for symptoms
  - Regular RHM for diuretic titration; Lasix increased 40mg daily to BID and Spironolactone increased to 50mg daily
  - INR within range since connection with HFC pharmacist
  - In-home palliative care services with plans for home death
  - Deprescribing of futile cardiovascular therapies, i.e.statin
  - Tardive dyskinesia: amitriptyline +/- duloxetine +/- pregabalin
  - Patient and family education and support for HF management and EOL

Vancouver Model

Heart Function Clinic

- Established since 2009
- Consultative model (3 -12 months of follow up)
- 5 MDs, 3 NPs, 2 RNs, Pharmacist, 2 clerks
- Focus is investigation, medication optimization, patient education and self management and GOC as indicated

Nancy Chan Ambulatory Palliative Care Clinic

- Established in 2015 with a grant from foundation, cardiac focused half day added in 2018
- Consultative model with PCP (not time limited but prognosis
- 3 MDs, 1 RN, 1 SW, 1 clerk (NP starting October 1st for unattached patients
- Focus is symptom management, goals of care and EOL planning

Advantages of separate PC ambulatory clinic

- Not all cardiac palliative care is heart failure - ischemic heart disease, valvular heart disease, arrhythmias and adult congenital heart disease
  - Referrals from multiple subspecialty clinics (TAVI, amyloid, ACHD)
- Seamless transitions from the ambulatory clinic to home health palliative care team (joint visits virtually with home health) and to hospice - all share same EMR
- Many cardiac patients have multiple co-morbidities - COPD, renal failure -one clinic to serve all palliative care needs
- Developing expertise of community PC MDs in non malignant disease management (increased patient numbers for QI and research)

What We Learned?

- Choose your collaborators that have a similar vision of what palliative and symptomatic care is
- Expect it is going to take time to get everything up and running.
  - Pilot project money needed to show value but then you need to be able to make your case to funders - this takes time, data and tenacity
  - Expect push back from all sides - be prepared to mitigate and manage expectations
- You are going to need to educate your referring physicians
  - Do more pre-work before starting - survey potential referring physicians for opinions of palliative care, education of palliative care
  - Do more rounds, information sessions for non physician referring groups

Next Steps

Ongoing projects

1. QI project - A short term intervention for unattached patients with palliative and primary care needs (NP intervention)
2. QI project - Advance practices in Palliative Care - paracentesis, CADD pump S/C Lasix, ICD deactivation in home/hospice with magnet
3. QI project - Exploration of coordination of care for patients with Palliative Care needs and Opioid Use Disorder (many have non malignant disease including cardiomyopthy and valvular lesions)

Case Study

Ms JA is a 77 year old woman with heart failure secondary to chemotherapy for lymphoma with

1. EF of 26% with poor tolerance of evidence based quad therapy
2. Progressive renal failure with GFR 12
3. Progressive lymphoma on 4th line chemotherapy/immunotherapy with lung mets
4. Pulmonary hypertension
5. Moderate Diastolic dysfunction
6. Moderate Pericardial effusion

Initially followed in Heart function clinic, chronic kidney disease clinic, pulmonary hypertension clinic oncology clinic and home health for palliative care. All three clinics had extensive goals of care conversations with patient but patient and family continued to want active care and some mixed messages with respect to prognosis.

Patient referred to Ambulatory Palliative Care Clinic with transition from other clinics.

Role of PC clinic:

1. Initially joint management of symptoms especially heart failure with transition to management of symptoms by PC clinic only and no further renal or heart failure clinic involvement. Change of focus to symptom management not numbers.
2. Increased involvement of home health as patient became less able to attend outpatient appointments. Joint virtual visits with CHN in home and clinic team.
3. Transfer to community PC physician for EOL in the home care. Team had access to all conversations from clinic and could reference discussions. Helped patient and family to focus.

What we learned

1. For patients seeing multiple subspecialty clinics - need one to manage symptoms especially complex fluid management.
2. Patients often hear “If your kidneys were better you could receive treatment X” If your heart was better you could receive treatment Y”
3. Subspecialty clinics/physicians need to have common language and explain palliative nature of treatment. To be explicit in language - talk about end of life. If something is not an option say it. ie You are not a candidate for dialysis due to your poor cardiac output.

NYGH Supportive Care Clinic

- Population: **Cardiology**, Respirology, Neurodegenerative Diseases
- Interdisciplinary Team (1 FT Palliative Care NP, 3 PT Palliative Care MDs)
- Dedicated Clinic Room within Heart Function Clinic
- Joint and Individual Appointments (in person, video, phone)
- Must be followed by NYGH Cardiologist
- No Geographical Boundaries
- Help with symptom management, home care supports, ACP and GOC conversations and caregiver support.
- Will follow our patients as inpatients when admitted to hospital.

Supportive Cardiology Referral Guidelines

Recurrent heart failure with NYHA class III/IV symptoms despite optimal therapy (see below)

AND 1 or more of the following:

A) Any one of the following comorbidities: advanced dementia, chronic renal failure, diabetes mellitus, cancer, cerebral vascular disease, interstitial pulmonary fibrosis, oxygen dependent COPD, HIV.
B) Repeated admissions with heart failure – 3 admissions in 6 months or 1 single admission if age 80 or over
C) ICU admission or CPR within the last year
D) Implantable defibrillator
E) Critical valvular disease not amenable to surgery/replacement
F) Patient has decreasing functional status and increasing dependence for most activities of daily living
G) Patients and/or families with unclear goals of care
H) You would not be surprised if this patient were to die in the next 6-12 months

What We Learned?

Pearls

- Buy-in
- Role Clarity
- Collaboration
- Clear Referral Criteria

Challenges

- Real Estate
- Change to ensure NYGH Cardiologist
- Lack of Geographical Boundaries
  - Different home care agencies
  - Different home visiting teams

Case Study

HPI: 92yr old female with a history of CHF assessed during joint Heart Function Clinic.
Known to Cardiology team. Worsening heart failure. Family concern about functional decline and reduced oral intake.

Cardiology

Serology done in lab prior to appointment

Vital Signs, weight and ECG performed by RN/NP

Pharmacist reviews medications

Physical assessment

Supportive Care Team

Assess Symptoms (ESAS)

Social History

ACP/GOC

Home Supports

Plan: Diuretics titrated by Cardiology team. Laxatives initiated by Supportive Care Team, DNRc provided and referral made to home care for PT and Nursing Visits. Follow up with Supportive Care Team in 1 week by phone and 6 weeks with joint visit.

Case-Based Discussion

Questions?

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 an outpatient setting** **December 11, 2024 from 12–1:00 p.m. ET.**

Thank You

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