
Community delivery of Palliative Care in a Pandemic
Cathy Faulds CCFP, FCFP, CAC (PC)
October 2020

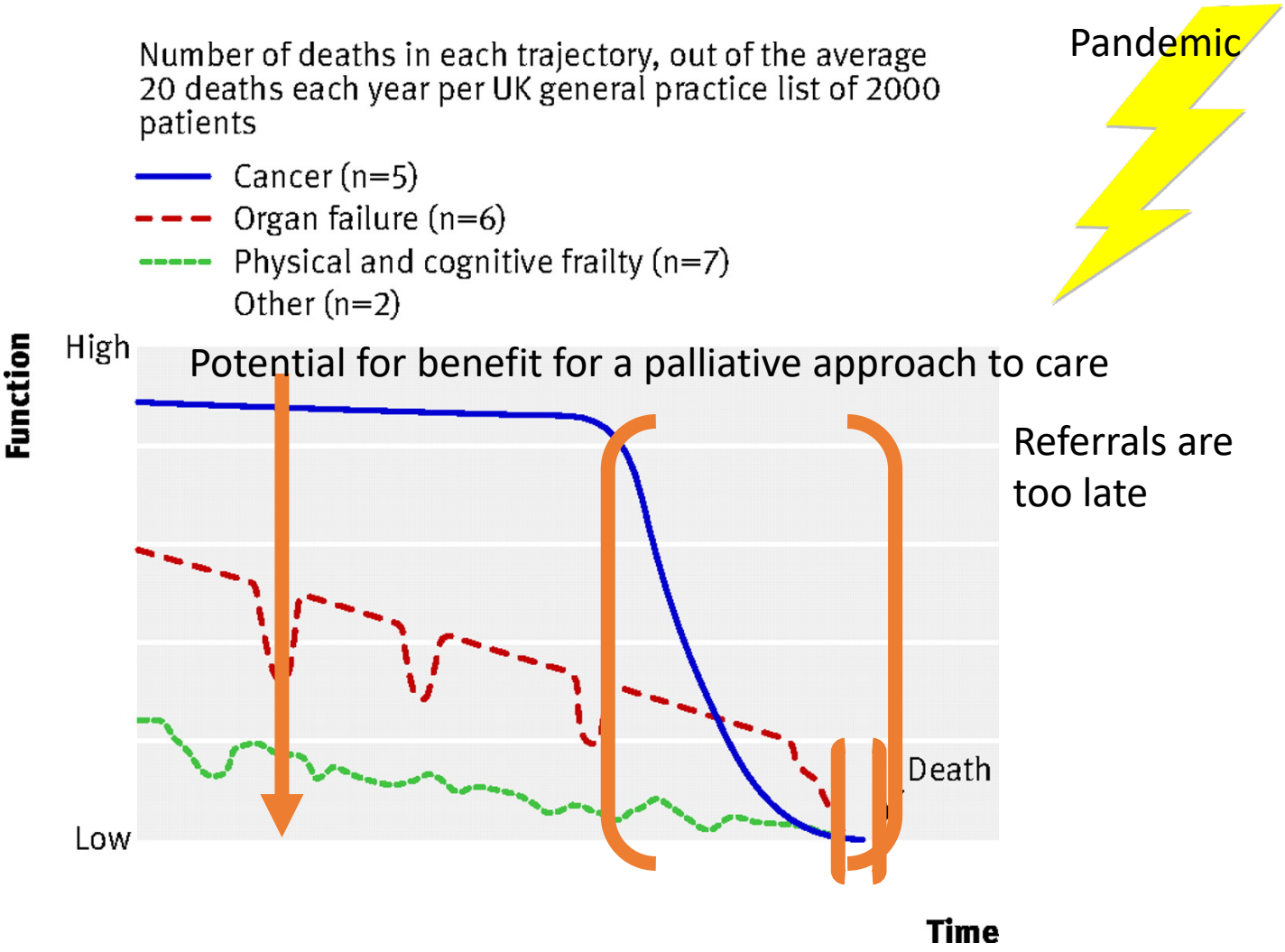
Community Palliative Care

Objectives:

- Understand this is a necessary scope for the family doctor/NP
- Understand that it takes place in office settings **and** homes
- Understand house calls are needed for community palliative care
- Understand how to provide house calls safely in a pandemic
- **Understand that palliative care capacity is an upstream solution to prevent an overwhelmed hospital system and deal with a surge**
- Improve the number of family doctors/NP who talk about end of life care with their patients before end of life care is needed = **Goal-congruent care**

  https://jamanetwork.com/journals/jama/fullarticle/2763952

Figure 1: The three main trajectories of decline at the end of life



Murray, S. A et al. BMJ 2008;336:958-959

Pandemic Response

Triad leadership of Hospital, Non- Hospital and Public health

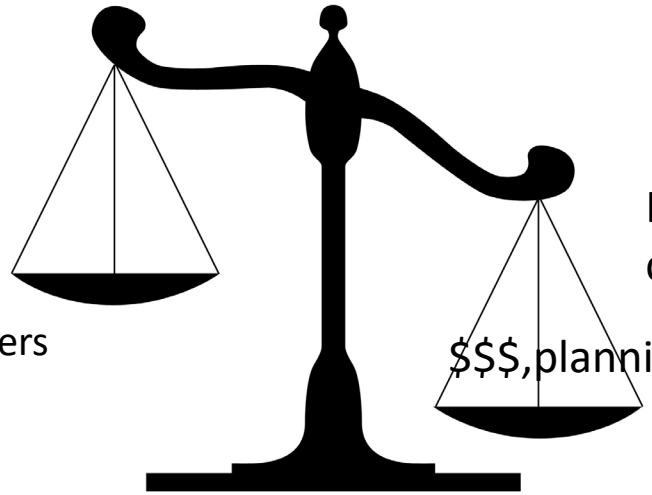
PPE
IPAC
Staffing

Testing
Assessment centers
Contract tracing

LTC, RH

Agri Sector

Schools



Hospital = ICU and Acute bed capacity (90%)

Congregate living spaces, Shelters

$$$,planning, resources

Community care, Palliative care

LTC lost capacity with 3,4 bed wards
Crisis ALC rising in Community
Home care HHR crisis

Created capacity by discharge to LTC
Discharge ALC from hospital to LTC ahead of community
Working down surgical back logs

The story of Cathy……age 62

Pandemic observations

- Palliative care capacity in the community is limited in many pockets of Ontario
- Models of care delivery in the community are not adequately resourced
- Importance of transitions in care is heightened – ER to Palliative, Palliative to ER, Palliative admissions
- Care-giver and visitor policy results in patients staying home, in the community – Higher PPS referred
- Accelerated need for Advanced care planning and goals of care
- Increased use of Anti psychotic medications
- Increased fractures in my practice
- Increased care giver burnout – lack of respite beds, day programs, volunteer services

Guidance for Home and Community care Providers

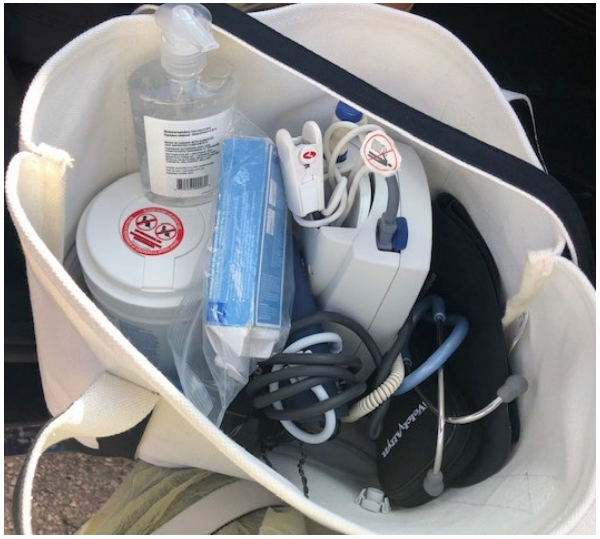
- http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_home_community_care_guidance.pdf

Pandemic protocols - Preparing your home for essential providers

http://healthcareathome.ca/southwest/en/Documents/2020_HCC_home_EN_V2.pdf

- Hand hygiene
- Cleaning high touch surfaces
- Virtual care – definitions and instructions
- Physical/social distancing
- Masks
- Education on patient safety with all measures taken by providers
- Screening required for people in the home before the visit
- Public health Ontario resources given as handouts

Minimizing risk for house calls



Type and level of group activity	Low occupancy			High occupancy		
	Outdoors and well ventilated	Indoors and well ventilated	Poorly ventilated	Outdoors and well ventilated	Indoors and well ventilated	
Wearing face coverings, contact for short time						
Silent						
Speaking						
Shouting, singing						
Wearing face coverings, contact for prolonged time						
Silent						
Speaking		*		*		
Shouting, singing						
No face coverings, contact for short time						
Silent						
Speaking						
Shouting, singing						
No face coverings, contact for prolonged time						
Silent						
Speaking						
Shouting, singing						

Risk of transmission

Low

* Borderline case that is highly dependent on quantitative definitions

Virtual visits – how to incorporate

- Virtual visits can be **video**, secure email, text and phone
- Secure email, text and phone used pre pandemic but increased
- Virtual visits can shorten the face to face time of a home visit during a pandemic by doing the history virtually
- Virtual visits can reduce risk of COVID exposure to patient, care giver and provider by reducing the number of face to face visits
- Virtual visits can not replace the need for a face to face visit – physical examination with vitals, visualize the home to assess risk and case management
- Percent virtual for me – 10% to 30% over the pandemic

Pandemic Protocols – Screening Patients

- http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_patient_screening_guidance.pdf
- Over the phone screening processes should be established and performed consistently by a personal support worker or administrative support
- If phone screening is not possible due to client limitations, screening should be conducted upon arrival at the client's home from a safe distance of at minimum 2 metres.
- If phone screening took place, but the care provider would like further confirmation or clarity on screening responses, the care provider should ask more questions upon arrival at the client's home using a safe distance of at minimum 2 metres.
- Clients should be asked whether they have a mask or face covering available to them to wear (where tolerated) for source control during their appointment. If the client does not have their own mask, one should be provided to them.
- Care providers should also ask about any other person(s) who will be in the home during the appointment and where appropriate, screen those persons too.

Barriers

PALLIATIVE CARE TEAMS WITH SKILLS - DUE TO RAPID TURNOVER OF TEAM MEMBERS OFTEN MISSING – PALLIUM (LEAP, CAPSE)

HOME CARE CAPACITY - ”MISSED CARE”, LACK OF PSW, NOT ENOUGH 24/7 CALL CAPACITY IN MANY REGIONS ESPECIALLY WITH POTENTIAL PANDEMIC NUMBERS (TRIAGE DOCUMENT)

OHIP FUNDED LAB WORK FOR HOUSE BOUND PATIENTS

HOSPITAL INTEGRATION TO CARE PATHWAYS: ADMIT AND DISCHARGES WITH ER, DIRECT ADMIT TO MEDICAL/SERVICES AND PCU

DEATH CERTIFICATES - DRIVING A PAPER COPY FOR DELIVERY

Facilitators/Expanders of home visits - “not replacement”

- **Telemedicine** may also help primary care and specialists “see” more home-bound patients
- Using **paramedics or nurse practitioners** to perform monitoring, exams and tests while connected with family physicians or specialists to provide guidance and advice
- **Shared care models** of focus practice physicians in Care of the elderly or palliative care with family physicians/NPs (MRPs)

Pearls from those delivering house calls

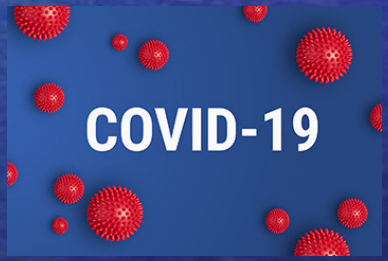
- *"When you go into someone's home, it is a different power relationship."*
- *"Respectful of the choices that our patients make and when cock roach infested do not set your bag down"*
- *"The team we work with is being eroded both in skill and numbers…..this needs provincial attention at the level of hospital importance"*
- *"Where do I start about medical records – You need strong IT skills to do this role. I currently have 5 that I need to be well versed on to do this role…..can someone please get one EMR for the community that services home care, primary care and palliative care specialty services and connects to hospitals?"*
- *"Having medications in the home early is important. SRK kits allow more care options for patients than simply go to ER"*
- *"Advanced care planning is critical but especially in a pandemic…..goals of care will change based on health care system delivery choices……essential caregiver and visitor policy has dictated care choices in Wave 1"*

Parting thought….

- We the healthcare workers are not your front liners any longer. We are your last line of defense. You, my fellow people, are the front liners now. The pandemic has shifted to the community and it is up to you. This cannot be won in the confines of the hospital…..let that sink in…….

- Dr. B. Calinawagan,Cardiologist

Developing a Local Strategy to Optimize Long-Term Care During a Global Pandemic: Successes & Challenges



Allan Grill MD, CCFP (COE), MPH, FCFP, CCPE

Chief, Department of Family Medicine, Markham Stouffville Hospital
Lead Physician, Markham Family Health Team
Associate Professor, DFCM, UofT

Toronto Geriatrics Virtual Update, Oct. 30, 2020, 09:00-09:45

Faculty/Presenter Disclosure

Faculty: **Dr. Allan Grill**

I have the following relevant financial relationships to disclose (past 2 years):

Relationships with financial sponsors:

- The Lung Association – Planning committee (COPD & Asthma CME program)
- CADTH – Member, Canadian Drug Expert Committee
- ON Ministry of Health – Chair, Committee to Evaluate Drugs
- CCO-ON Renal Network – Provincial Medical Lead (Primary Care)
- CFPC – Physician Advisor, Dept. of Practice & Program Support
- Markham FHT – Lead Physician
- Markham Stouffville Hospital – Chief, Dept. of Family Medicine

- **All of the above organizations are not-for-profit**

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I have the following relevant financial relationships to disclose (past 2 years):

Relationships with financial sponsors:

- Speaker – OCFP - Annual Scientific Assembly; C of P webinar
- Speaker – Vital FM Update
- Speaker – Kidney 2020 conference
- Speaker – Respiratory Health Forum

- Relationships with commercial interests:
  - I have no financial relationships with the pharmaceutical industry

Learning Objectives

- To recognize factors associated with Long-Term Care (LTC) facilities that increase risk of COVID-19 transmission
- To examine strategic collaborative primary care efforts that can be applied locally to help prevent COVID-19 outbreaks in LTC
- To explore ways to improve medical services in LTC homes across Canada (e.g. access to clinical resources, prioritizing advance care planning, balancing virtual vs. in-person assessments)

Tweet Tweet

- @allan_k_grillMD

+++ Media Attention re: LTC Homes

MONTREAL | News

Police investigation underway after 31 seniors die at residence in Montreal's West Island

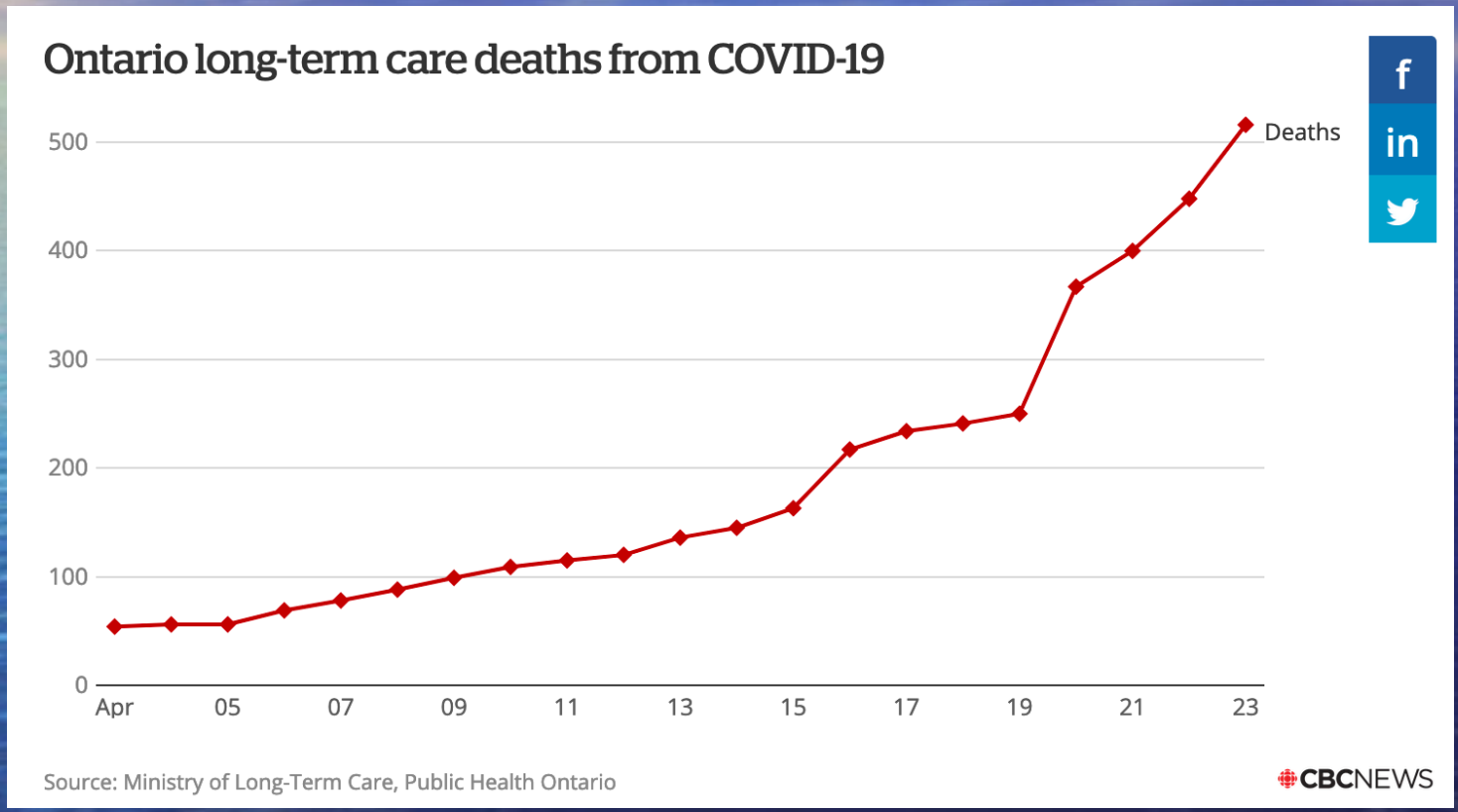
COVID-19 death toll at Ontario long-term care homes nears 1,000, hospitalizations on the rise

HEALTH

List of seniors' homes and health-care facilities at centre of B.C.'s coronavirus outbreak

CANADA | News

Nearly half of known COVID-19 deaths in Canada linked to long-term care homes: Tam


Ontario long-term care deaths from COVID-19
Deaths
500
400
300
200
100
0
Apr
05
07
09
11
13
15
17
19
21
23
Source: Ministry of Long-Term Care, Public Health Ontario
CBCNEWS

- 79% of deaths related to COVID-19 in Canada are connected to LTC and retirement homes (April 29/20)
- 954/1216 deaths in Ontario are related to LTC and retirement homes (May 3/20)
- 212 outbreaks in LTC homes in Ontario at present (May 4/20)

- Elderly patients have weakened immune systems
- Physical distancing is a challenge (up to 4 residents in 1 room)
- Cognitively impaired patients tend to wander – difficult to isolate in rooms
- Staff tend to work in multiple facilities

'I don't want to go through this ever in my life again,' LTC resident tells inquiry

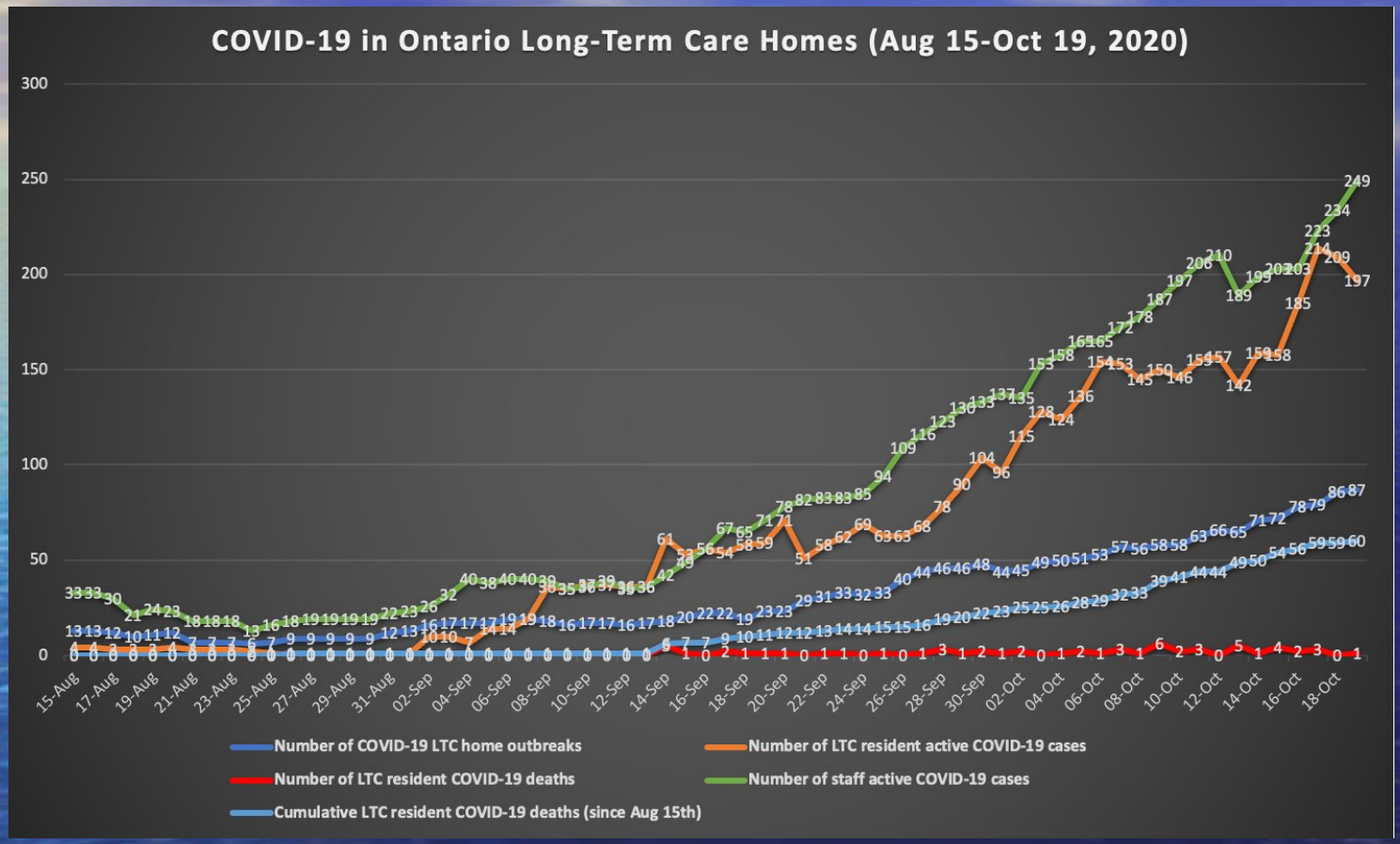
Residents urge governments to address isolation before 2nd wave of COVID-19 sweeps homes

Liam Casey · The Canadian Press · Posted: Oct 04, 2020 3:25 PM ET | Last Updated: October 4

Patient Ombudsman issues recommendations on 2nd wave of COVID-19, as long-term care complaints up 370%

CORONAVIRUS | News

Doctor warns some Canadian long-term care homes not ready for second wave



@NathanStall

Hindsight is 2020: specifically Saturday, March 21, 2020

- Urgent teleconference called by MSH CEO & Chief of Staff regarding a LTC facility that declared a COVID-19 outbreak
- Call included their Director of Care, senior staff & me
- Facility was looking for support – approach to managing the outbreak was unclear
- Concerns that staff would be scared to come to work
- YRPH made aware of the situation
- Early warning signal of what was to come
- MSH concerned about COVID-19 surge capacity re: admissions

Optimizing Care of the Elderly in LTC/Retirement Homes (Step 1)

- Arranged weekly zoom meetings (09:30 & 17:30) to build a community of support
- Invited staff/physicians from LTC/retirement homes in Markham/Stouffville/Uxbridge
- Invited MSH/Uxbridge representatives (command centre; Geriatrics; ER; H2H; NLOT; Assessment Centre; community palliative care MDs; primary care lead – EYRND OHT)
- Invited local public health; Ontario Health Central Region reps (former LHIN); Hospice palliative care
- 1st meeting had approximately 50 people; most have 25-30 people
- Identified gaps in care and tried to fill them using a collaborative approach

Early Wins

- Expanded 24/7 virtual geriatric care support
- Created 24/7 virtual GIM on-call support
  - Modeled after the Toronto Central LHIN program; WCH
- Created an ER algorithm re: appropriate transfers
- Clarified referral process for palliative care support
- Shared resources for staffing – Health Force Ontario workplace matching portal; OMA BookJane; NPAO; RNAO

Early Wins

- Clarified contacts for PPE supplies
- Clarified contact info for YRPH/DRPH (direct phone #; email)
- Shared resources via DropBox – e.g. articles, guidelines, protocols – OLTCC daily updates
- Created a WhatsApp text group
- Emphasized ACP & GOC discussions early & often
- Invited to share best practices with Ontario Health Central region (250 participants)

April 15, 2020: ON MLTC – COVID-19 Action Plan - LTC Homes

Recap:

Strategic Framework

Guiding Principles

- Foster partnerships between congregate settings and Ontario Health
- Bolster supports for IPAC, staffing and testing.
- Continuous monitoring and active response to crisis and pre- crisis situations

Provincial Strategic Priorities and Goals

Aggressive testing, screening and surveillance

Goal:
- Increased testing of LTC home residents and staff

Managing outbreaks and spread of the disease

Goals:
- Reduce the number of outbreaks in LTC homes
- Contain outbreaks in LTC homes, so they do not affect as many residents

Growing our heroic long – term care workforce

Goals:
- Fewer long-term care homes reporting critical staffing challenges
- Limiting long-term care employees to work in only one location

Central Region Strategic Plan Priority Areas

- Testing
- Infection Prevention and Control (IPAC)
- Health Human Resources
- Surveillance and Ongoing Monitoring
- Virtual Care
- Communications

Ontario Health Central

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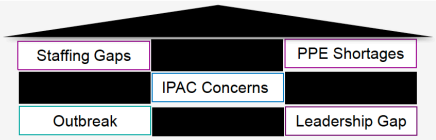
SWAT Team: Long – Term Care

Long – Term Care

Long – Term care home is identified in crisis and triggers a response from a local S.W.A.T. team



SWAT Team

Provide **rapid**, **needs – based support** to long – term care homes to stabilize operations.

Testing
- Leverage mobile assessment teams to provide testing
- Bolster on – site testing with re-deployed staff

IPAC
- Utilization of IPAC Extender team
- Complete risk assessment, provide recommendations and support implementation

HHR Redeployment
- Redeploy staff across the health system
- Monitor and track staff needs to be responsive

PPE
- Monitor and respond to PPE needs through regional PPE group

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MSH LTC Home Strategy Task Force & Mobile Team (Step 2)

- Emergency order to increase hospital support for LTC – April 24/20
- Task force & mobile team started April 27/20
  - now called IPAC Hub Task Force
- Daily 1 hour teleconferences (frequency varies)
- Chaired by MSH
- MSH: IPAC, OH&S, NLOT, Mobile Team (NP/RN x 4)
- YRPH, Ontario Health Central Region at the table
- Decision to expand to include all congregate settings
  - Lessons learned from Participation House (Dr. Jane Philpott)
  - Prioritize homes in **Red** (e.g. outbreaks)

Impact?

- Approximately 1000 patients living in these facilities
- Minimized transfers to MSH related to COVID-19
- Prevented additional pressure on hospital surge capacity
- Supports MSH "Care beyond our walls" strategic plan; "embracing our community" (pillar #2)
  - Created a sense of community around supporting this vulnerable population

Impact?

- Highlights the strengths & resilience of primary care physicians & IHPs working in this space along with ongoing challenges
- Successful recruitment of in-house physicians to help manage facilities dealing with COVID-19 outbreaks
- Joint IPAC assessments with YRPH to develop tailored action plans
- Laying the groundwork for future work under via the EYRND OHT

cmaj BLOGS

May
28
2020

COVID-19, REFLECTIONS

FAMILY PHYSICIAN LEADERSHIP IN LONG-TERM CARE: COVID-19 SUCCESS AND A CALL TO ACTION

6 Comments

Allan Grill is the *Chief* of the Department of Family Medicine at Markham Stouffville Hospital and an *Associate Professor* at the University of Toronto.

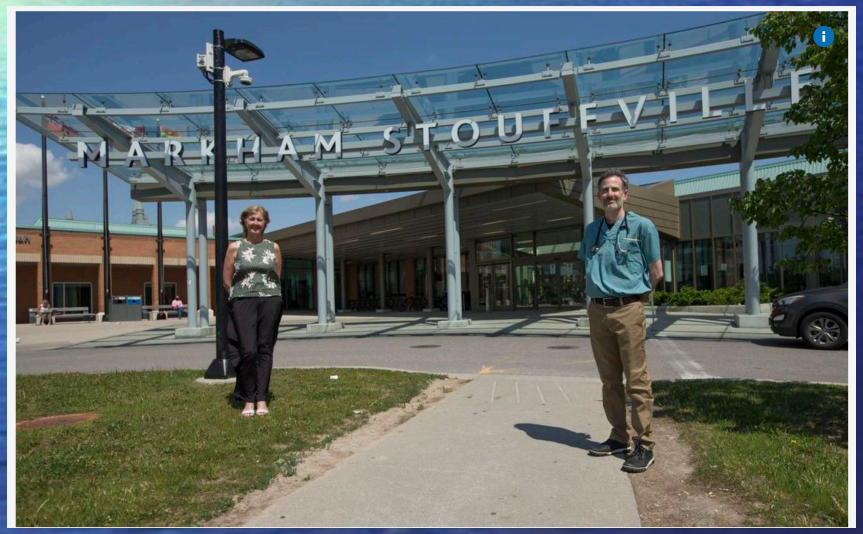
Since my first day as a family physician, I've looked after frail seniors living in long-term care (LTC) settings. I remain fascinated by the complex nature of their multiple medical conditions and the resiliency that accompanies them. I'm a strong supporter of interdisciplinary team-based care and the multitude of skills required to meet the daily care needs of this population. I've cared for many Canadian veterans from the Second World War and Korean War and have been touched by the personal stories they have shared.

It therefore saddened me greatly to hear about the devastating impact that the COVID-19 pandemic has inflicted on seniors' homes. Over 80% of all fatalities in Canada have been linked to these settings and, in Ontario alone, there have been about 250 institutional outbreaks. Challenges associated with physical distancing, difficulty isolating symptomatic residents with cognitive impairment, and staff working at multiple facilities have all been contributing factors.

CANADA

Markham Stouffville Hospital offered its COVID-19 expertise to nursing homes from the beginning — and it worked

By **Wanyee Li** Vancouver Bureau
Mon., June 8, 2020 | 4 min. read



THE STAR

CFP MFC
CANADIAN FAMILY PHYSICIAN • LE MÉDECIN DE FAMILLE CANADIEN
The official journal of the College of Family Physicians of Canada

STORY | Blog Post

Improving medical services in Canadian long term care homes

Rhonda Collins, MD BScN, Jocelyn Charles, MD MScCH, Andrea Moser, MD MSc, Brad Birmingham, MD, Allan Grill, MD MPH and Maureen Gottesman, MD MEd

October 07, 2020

Improving delivery of medical care in LTC

- Build a strong culture (e.g. Sunnybrook Veterans Centre)
  - Accountability (performance review); in-house Rota MD; On-call expectations; prevent unnecessary transfers; monthly meetings; CME; suture cart
  - ACP/GOC discussions – patient focused
  - Time commitment; adequate documentation
- Need appropriate compensation – recruitment/retention
- Investment in clinical resources (access to labs, DI, IVs, catheter care, specialists, IPAC)
- Credentialing