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Division of Palliative Care

Coronavirus Disease (COVID-19) and Palliative Care in the Community: Top Priorities

Community Palliative Care Physician Advisory Group
Division of Palliative Care, Department of Family Medicine, McMaster University

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Background:

In response to the COVID-19 pandemic, the Division of Palliative Care in the Department of Family Medicine at McMaster University has convened a group of practicing community palliative care physicians to identify challenges and needs they are experiencing or may experience in the context of COVID-19. This document outlines 8 urgent priorities for clinical service leaders in the region. Future documents will provide suggestions and strategies for addressing these priorities. Due to the acuity of the current crisis, all in receipt of this document are encouraged to identify and implement strategies to address each priority in their own communities now.

Recommendations:

1. ***Ensure access to personal protective equipment (PPE) for all direct care providers in the home, including nurses, personal support workers (PSW) and caregivers.***

The group expressed concerns about the availability of PPE for all direct care providers in the home. Insufficient quantities not only place health care professionals at risk, but also patients and families with the potential of spreading the virus from home to home. Similar to other health care environments, all clinicians visiting patients at home and working in hospice should be expected and able to satisfy the Ministry of Health PPE standards. A national shortage in PPE as well as lack of affiliation with essential service institutions remain barriers to access.

Community teams across the region are taking immediate action to protect the health and safety of their patients and colleagues. This includes COVID-19 screening of patients prior to encounters; limiting non-essential in-person encounters and adopting virtual visit platforms; reducing the number of clinicians and visitors/caregivers directly involved in patient visits; and dividing teams to prevent clinicians from working in multiple settings (homes, hospice, hospital) to prevent cross-contamination.

2. ***Define criteria for essential, in-person visits within the community and ensuring appropriate use of PPE.***

Many questions were raised around the criteria for essential, in-person visits within the community and ensuring appropriate use (selection and application) of PPE by clinicians. Guidelines around these issues will aid clinicians in prioritizing their time and energy as well as conserving valuable human and physical resources, including PPE. Education around the proper use of PPE is paramount, recognizing that different environments call for unique considerations.

3. ***Ensure access to and guidance on reliable virtual models of care.***

Individual clinicians in the group and teams are switching over to providing virtual care and have adopted virtual visit platforms including Ontario Telemedicine Network (OTN), Zoom, FaceTime, Skype and doxy.me. Virtual care is essential for ensuring continuity of patient care and the provision of palliative care to patients who need it, including access to specialist-level palliative care support when nurses and other physicians need it. Palliative care specialist-level resources have been limited even prior to this health care crisis. Virtual care promotes equity in access.

While this transition to virtual care has generally gone well, there are some noteworthy needs around this. For example, not all group members have access to the OTN virtual platform (and sometimes OTN is not working) and are having to make do with other encrypted or non-encrypted platforms. There is also a steep learning curve around such platforms and concerns exist around their reliability and privacy standards.

Help is needed to onboard more clinicians as well as community-based nurses to this approach. Remuneration models are also needed to ensure fair compensation of physicians providing care virtually. There has been much-needed movement on this recently by the Ministry, which will hopefully continue.

4. ***Home care teams need support urgently.***

Serious concerns were expressed by group members about the level of support for community-based home care palliative care teams. Anxiety amongst nurses has been expressed to group members, being uncertain of protocols and safety in the home with regard to PPE and social distancing. Given the key role of nurses and PSWs for patients receiving a palliative approach in the community and the work of our palliative care outreach teams, their sustainability is a key priority. Visiting nurses and personal support workers endure the highest levels of risk in the community setting. Access to and knowledge around PPE and virtual communication platforms are essential, in line with the comments above.

5. ***Ensure access to essential palliative care medications, equipment and devices.***

There are concerns medications, equipment and devices may be disproportionately allocated to acute care settings, leaving the community (where many patients will be cared for including COVID-positive patients transferred from hospitals) without the necessary materials and medications. This includes medication administration devices (CADD pumps) and PPE.

Ensuring an adequate and equitable supply of medications, infusion devices and other equipment will require intentional partnerships with hospitals and pharmacies within the region to balance the priorities of timely access and avoiding waste. These are important considerations when it comes to proposed solutions, such as stockpiling, emergency symptom management kits and order sets, the latter two of which require expert guidance and regular monitoring. Mechanisms also need to be in place for timely updates around medication shortages.

6. ***Supporting primary care clinicians and increasing capacity for a palliative approach to care.***

Palliative care physicians and teams are ready to support their primary care colleagues in this pandemic. Given their relatively small numbers, the most effective way to utilize this expertise is by way of providing consultative, just-in-time support to their primary care physician and nurse colleagues providing care in homes, LTC facilities and family clinics. Urgent attention needs to be placed on supportive mechanisms which build the capacity of all front-line workers to provide primary level palliative care. This includes centralized call lines, which connects the caller (primary care provider) rapidly to the palliative care team. In this tiered approach, anticipatory and real-time education and consultation through virtual means will be crucial, with the overriding goal of patients receiving the right care in the right place at the right time. This also requires the mobilization of family doctors and family health nurses to provide care in the home. Cases of high complexity may still require in-person visits by palliative care specialists in the community.

7. **Long-term care (LTC) needs must be addressed urgently.**

Several group members expressed significant concerns about the preparedness of many LTC homes in the region. One of the challenges appears to be no single regional or provincial body to coordinate a palliative care approach strategy. Another is the lack of palliative care training and approach amongst many staff, including physicians, nurses and PSWs. This is concerning because a large percentage of LTC residents have significant end-stage chronic illnesses and most require palliation for end-of-life care. These are some potential factors that contribute to high rates of transfers to hospitals at the end of life.

As is being witnessed internationally and in Canada, LTC and retirement homes have populations that are particularly vulnerable to COVID-19 related morbidity and mortality. Moving forward, it is crucial to implement plans that: a) ensure timely, 24/7 access (virtually and in person) to specialist-level palliative clinicians (physicians and nurses) to provide support to LTC physicians and staff; b) rapidly educate staff using virtual means to the palliative care approach; and c) ensure continued access to palliative medications, medical equipment as well as PPE for staff.

Concerns about the small number of community-based palliative care physicians has been noted; this has to be addressed. There are 34 LTC homes in close proximity to Hamilton, a relatively large population that is at risk during this pandemic. Primary care clinicians with enhanced skills in palliative care must also be mobilized to support LTC.

8. **Ensuring care placement for patients who are unable to stay at home and are inappropriate for hospital at end of life.**

Although difficult to quantify, mortality will increase significantly in communities either directly from COVID-19 deaths or as a consequence of an overburdened health care system unable to manage patients with chronic, progressive life-limiting illnesses. It will be difficult at times to differentiate these two populations with the significant symptom overlap between COVID-19 and end of life. Disposition

planning for these patients will be significantly threatened due to the following: insufficient beds in hospitals; policies preventing admission to hospice or other institutions for patients suspected or confirmed positive for COVID-19; and patients unable to stay home due to caregivers falling ill. Infrastructure is required to support these patients and their medical and quality of life needs. Particular considerations include, but are not limited to: staffing which accounts for the potential of high-needs care; accessible PPE for clinicians and caregivers; access to medications and related equipment; mental health support for patients and clinicians; and novel mechanisms for keeping in touch with family in a time of restrictive visitation policies.

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