

Home-based palliative care in Canada: time for this to be an option for everyone

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In Alberta and Ontario, only 1 in 6 people who died in 2016–2017 received publicly funded palliative home care.¹ Patients who had end-stage lung or heart disease, whose prognosis may have been as poor as that of patients with advanced cancer, were less likely to receive palliative care than those with cancer.¹

Many patients with end-stage heart failure experience a gradual, progressive decline during their last years of life. However, their course of illness is usually punctuated by intermittent bouts of severe shortness of breath from which they often recover after medical treatment. These episodes frequently lead to presentations to the emergency department and admissions to hospital despite patients' wishes to remain at home if possible.

In a related article, Quinn and colleagues show that, among patients who died with heart failure, a home-based palliative care model that involved primary care providers, cardiologists and palliative care specialists, was associated with fewer visits to the emergency department, admissions to hospital and intensive care near the end of life, and a lower likelihood of dying in hospital (41% v. 78%) than usual care.² These findings underscore the importance of scaling up access to high-quality home-based palliative care.

The intervention that was studied emphasized advance care planning; home-based management of heart failure; standardized protocols for clinical care; ongoing education of patients, families and clinicians;³ and collaboration among primary care providers, cardiologists and palliative care specialists.

The palliative care competencies needed to manage patients with heart failure at home include discussing prognosis and facilitating advance care planning, psychosocial assessment and support, and the ability to manage symptoms, particularly shortness of breath. It is unlikely there will ever be enough palliative care specialists to provide such care to all patients who need it, and many patients would prefer to receive this care from their primary care physician. For this reason, the model studied by Quinn and colleagues, based on collaborative care, is attractive. The challenge is to replicate similar models across the country.

One of the barriers to acceptance of palliative care is the misconception, including among some clinicians, that palliative care means minimalist care. It is worth noting that more than half of patients cared for in the collaborative care model described in

the related research did visit the emergency department and were admitted to hospital after enrolment in the model. This is because, although most patients whose death is imminently foreseeable prefer to be managed at home, many wish to be admitted to hospital if symptoms can be managed more effectively there. Having the patient's cardiologist and primary care physician as part of the same care team provides most patients with reassurance that, in addition to symptom management, all disease-specific treatments are being considered.

Although Quinn and colleagues excluded patients living in long-term care facilities from their study, the findings are relevant to that population, many of whom have heart failure as well as cognitive impairment. As long-term care facilities are often severely understaffed, patients with an episode of acute shortness of breath are often transferred to an emergency department. These institutions should receive the resources they need to be able to provide the same level of collaborative palliative care provided to patients enrolled in the related study.

Patients who received care under the team-based model were seen more frequently at home or as outpatients by physicians and palliative care nurses than the patients who received usual care. Thus, although implementing this model showed decreased use of hospital resources, if scaled, it would increase the work of clinicians and health care professionals in the community.

Many successful local or regional interventions do not spread across Canadian health systems. Hopefully, that will not be the case here. The cost of the increase in required community resources appears to be more than offset by the acute care avoided. Therefore, overall cost should not be a barrier to widespread implementation of home-based palliative care. However, resources will need to be reallocated, and in Canada's siloed health care systems this often turns out to be difficult. One potential approach would be to change funding models. For example, the fee a hospital receives for managing patients admitted with heart failure could include postdischarge care, with hospitals sharing funding with community partners who would assume responsibility for coordinating and delivering that care. A performance metric could be the frequency of readmissions.

Changing models of care also requires trust among providers from different specialties. Trust is developed locally, and top-down edicts are rarely effective on their own. My hope is that Quinn and colleagues will widely share the details of their care pathways and training modules, and that practitioners and health care managers in regions across the country will see the benefits of providing high-quality collaborative palliative care at home for patients with severe heart disease (and other diseases). It's time to make this happen.

References

1. *Access to palliative care in Canada*. Ottawa: Canadian Institute for Health Information; 2018. Available: <https://www.cihi.ca/sites/default/files/document/access-palliative-care-2018-en-web.pdf> (accessed 2022 Sept. 8).
2. Quinn KL, Stukel TA, Campos E, et al. Regional collaborative home-based palliative care and health care outcomes in adults with heart failure. *CMAJ* 2022;194:E1274-82.
3. Graham C, Schonnop R, Killackey T, et al. Exploring health care providers' experiences of providing collaborative palliative care for patients with advanced heart failure at home: a qualitative study. *J Am Heart Assoc* 2022;11:e024628.

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