PROVIDING PALLIATIVE CARE TO STRUCTURALLY VULNERABLE PATIENTS AND COMMUNITIES

UBC Division of Palliative Care and Victoria Hospice Society
Palliative Care: “Better Together”

Drs. Douglas McGregor and Ashley Heaslip
October 7, 2019
THANKS TO THE FOLLOWING

Ashley Mollison & Kelli Stajduhar

Simon Colgan & Ashley Humeniuk & Amy Fowler

Fraser Black
LEARNING OBJECTIVES

• To understand the complexities of delivering care to traumatized vulnerable people
• To mitigate barriers that exist at every level to delivery of care
• What safe prescribing means in an unsafe environment
AGENDA

- Introductions: who is in the room?
- Overview of what is happening so far in Canada
- A look at some of the barriers
  • Structural
  • Prescribing
  • Mitigating barriers – some thoughts on trauma informed care
- Case discussion (if time permits)
- Questions and answers
FACULTY / PRESENTER DISCLOSURE

Faculty: Ashley Heaslip, Douglas McGregor

Relationships with commercial interests:
Not Applicable
DISCLOSURE OF COMMERCIAL SUPPORT

No commercial support
MITIGATING POTENTIAL BIAS

Not applicable
WHAT IS HAPPENING IN CANADA?

Unique models of care have emerged in different cities – Ottawa, Toronto, Calgary, Vancouver, Victoria

Passionate individuals who can work in teams

Coordinating function (often nursing)
Medical component (prescribing physicians)
Nursing component
Counselling
Addictions / substance use disorders
Social work / housing
OTTAWA, ONTARIO

21 bed facility opened in 2001

24 hour palliative nursing care

Team of physicians, nurses, allied health providers
TORONTO, ONTARIO

The team includes Dr. Dosani, a nurse practitioner, a registered nurse and recently, a second palliative care physician. Provides mobile care on the streets and in shelters in collaboration with Toronto CCAC

Palliative Education and Care for the Homeless

a supportive palliative service fostered by Inner City Health Associates aims to meet the needs of homeless and vulnerably housed patients with life limiting illnesses. Founded July 2014
October 2016       The goals of CAMPP are:
1. To provide education and advocacy to improve the care of people living with a life limiting condition who experience complex service needs and multiple barriers in accessing existing services
2. To provide early integrated palliative care consultation to clients and support persons with formal and informal health and social services as well as those living in the streets
3. To educate, support, and build capacity among healthcare providers and inner city health, housing/shelter, and social services about palliative approaches to care in marginalized and vulnerable populations
4. To act as a liaison between existing services while addressing any gaps in care that may exist for vulnerable populations

Staffing: Nurse/ Community Navigator and Program Coordinator  0.6 FTE
          Palliative Consultant Physician  0.2 FTE
          MOA  0.6 FTE
VANCOUVER, BRITISH COLUMBIA
Early work from 2011 evolving still

The survival imperative
The normalization of death
Recognizing the need for palliative services
Silos to bring down, cracks to fill
Risk management as a barrier to aging and dying at home

Staffing: Nurse Consultant 0.6 FTE
Consultant Palliative Physician 0.3 FTE
Uvic Researchers 0.1 FTE
Admin support through Cool Aid and
PALLIATIVE CARE AND ADDICTION MEDICINE WORKING GROUP (VICTORIA)

• Team of 6 physicians representing palliative care, family medicine and addiction medicine
• Over past 1.5 years, have been working to put together a draft document/tool to allow for assessing and addressing risk when prescribing opioids within the context of previous, current or probable substance use disorders and palliative diagnosis
• Funded by the South Island Facilities Engagement Initiative (Si-Fei)
• Extensive literature review conducted by family medicine residents
WHAT ARE SOME OF THE BARRIERS?
Exploring levers and barriers to accessing primary care for marginalised groups and identifying their priorities for primary care provision: a participatory learning and action research study

**Patrick O’Donnell; Edel Tierney; Austin O’Carroll; Diane Nurse; Anne MacFarlane**

BARRIERS

**Home:** stable accommodation is a priority – perhaps *the* priority. Chemotherapy, HCC Nurse visits, known supports

**Two-tier healthcare system:** finding a GP who will take this population on. Prescription costs, dressings, equipment.

**Healthcare encounters:** poor communication, feeling judged or discriminated, re-traumatized by authority figures

**Complex (health) needs:** substance use disorders, HIV, Hep C, lifestyle related malignancies, multiple clinics and providers
ANOTHER WAY OF LOOKING AT BARRIERS

- Structural / environmental
- Operational
- Systems
- Personal / relational

Current State of Palliative Care for People Experiencing Homelessness in Canada: A Literature Review

Ashley Humeniuk
Amy Fowler
March 2019
HOW DO WE BEGIN MITIGATING THESE BARRIERS?
### What works in inclusion health: overview of effective interventions for marginalised and excluded populations.

Serena Luchenski, Nick Maguire, Robert W Aldridge, Andrew Hayward, Alistair Story, Patrick Perri, James Withers, Sharon Clint, Suzanne Fitzpatrick, Nigel Hewett

The Lancet 2018; 391: 266-80

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>1</td>
<td>Workshop and evidence review</td>
</tr>
<tr>
<td>Advocacy</td>
<td>2</td>
<td>Workshop and evidence review</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>3</td>
<td>Evidence review</td>
</tr>
<tr>
<td>Services for young people</td>
<td>4</td>
<td>Evidence review</td>
</tr>
<tr>
<td>Mental health</td>
<td>4</td>
<td>Workshop and evidence review</td>
</tr>
<tr>
<td>General practitioners and primary care</td>
<td>4</td>
<td>Workshop</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>5</td>
<td>Workshop and evidence review</td>
</tr>
<tr>
<td>Legal</td>
<td>5</td>
<td>Workshop</td>
</tr>
<tr>
<td>Training</td>
<td>5</td>
<td>Workshop and evidence review</td>
</tr>
<tr>
<td>Employment</td>
<td>6</td>
<td>Workshop and evidence review</td>
</tr>
<tr>
<td>Pharmacological</td>
<td>7</td>
<td>Evidence review</td>
</tr>
<tr>
<td>Case management</td>
<td>7</td>
<td>Evidence review</td>
</tr>
<tr>
<td>Specialist care</td>
<td>7</td>
<td>Workshop</td>
</tr>
<tr>
<td>Disease prevention</td>
<td>8</td>
<td>Evidence review</td>
</tr>
<tr>
<td>Physical health</td>
<td>8</td>
<td>Workshop</td>
</tr>
<tr>
<td>Interventions tailored to women</td>
<td>9</td>
<td>Evidence review</td>
</tr>
<tr>
<td>Reintegration</td>
<td>10</td>
<td>Workshop</td>
</tr>
<tr>
<td>Dental care</td>
<td>10</td>
<td>Workshop</td>
</tr>
<tr>
<td>Other interventions</td>
<td>11</td>
<td>Evidence review</td>
</tr>
</tbody>
</table>
Primary health care
- Primary health-care programmes specifically tailored to homeless individuals might be more effective than standard care and are more likely to achieve higher patient-rated quality of care.

Mental health care
- Standard case management with coordination of services improves housing outcomes.
- Assertive community treatment for individuals with severe mental illnesses improves housing outcomes and reduces psychiatric symptoms.
- Housing provision with mental health support is superior to mental health care alone.
- Critical time intervention services are effective for individuals transitioning into housing.
- Housing First, with immediate provision of housing in independent units with support, improves outcomes for individuals with serious mental illnesses.
- Homeless-specific services provided by non-governmental organisations with a few mental health professionals as staff can improve access to services and respond to immediate needs, but health-care organisations with special provisions for serving homeless individuals are more effective in provision of high quality mental health care.
- All mental health programmes for homeless individuals should have an integrated approach that accommodates and meets the needs of people with co-occurring mental illness and substance misuse disorders.

Medical respite
- Medical respite programmes that provide homeless patients with a suitable environment for recuperation and follow-up care on leaving the hospital reduce the risk of readmission to hospital and the number of days spent in hospital.

Substance misuse
- Standard case management with coordination of services reduces substance misuse.
- Many interventions are effective in the reduction of substance misuse compared with no intervention, but there is little evidence to indicate the superiority of any particular programme over another.
- There is debate regarding the desirability of interventions that emphasise abstinence from substance misuse versus those that adopt a harm-reduction approach. Contingency management for cocaine users and supervised injection centres for injection drug users are examples of effective interventions based on abstinence and harm reduction, respectively.

Homeless young people
- The evidence base for interventions for homeless young people is relatively weak, and most studies have focused on outcomes such as short-term reductions in substance use or risky sexual behaviour.
- Interventions using cognitive-behavioural methods seem to be the most promising.

Permanent supportive housing
- For homeless individuals with chronic alcoholism and frequent emergency department use, case management with supportive housing that permits drinking is effective in ending of homelessness and reduction of service costs.
<table>
<thead>
<tr>
<th>Priority Issue</th>
<th>Identified by</th>
<th>Specific solutions suggested to address the priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>• Travellers • Homeless &amp; Sex workers</td>
<td>• Need satisfactory accommodation for any effective primary care engagement to happen • Supports afforded by stable accommodation needed to continue</td>
</tr>
<tr>
<td>Two-tier system</td>
<td>• Young mothers • Migrants</td>
<td>• Need for flexibility around eligibility and referral criteria for primary care services • Increased availability of information on entitlements and ways to engage with primary care</td>
</tr>
<tr>
<td>Healthcare encounters</td>
<td>• Migrants • Travellers • Migrants &amp; Drug users • All groups</td>
<td>• Better communication in primary care, including availability of trained interpreters • Better communication in primary care; awareness of general literacy and health literacy of patients • Educating professionals on communication skills and empathy • Understanding adversity faced by patients • Show more empathy with the patient</td>
</tr>
<tr>
<td>Complex health needs</td>
<td>• Young mothers • Travellers • All groups</td>
<td>• Improved knowledge of and availability of community mental health services • Promotion of tolerance and awareness of prejudice • Supports to access primary care including engaging peer advocates or key workers; modelled on the Traveller group advocacy role</td>
</tr>
</tbody>
</table>
TRAUMA INFORMED CARE (AND PRACTICE)

What is it?
• An organization structure and treatment framework
• A way of being in relation to patients, rather than specific treatment interventions or programs
• Involves understanding, recognizing and responding to the effects of all forms of trauma
• Gives priority to patient’s safety, choice and control
  • Relationship with harm reduction
WHAT IS TRAUMA?

• An experience that overwhelms an individual’s capacity to cope
• Inadequate resources to cope
• Life event’s that are outside of one’s control and often have devastating effects
TYPES OF TRAUMA

• Single incident trauma (example: MVA)
• Ongoing abuse (example: domestic violence)
• Developmental trauma (example: childhood trauma)
• Historical trauma (example: genocide, colonialism)
EFFECTS OF TRAUMA

• Psychological
• Developmental
• Physiological
• Behavioural
• Interpersonal
• Spiritual
‘MALADAPTIVE’ BEHAVIOURS IN CLINICAL SETTINGS

• Disengagement
• Challenges with rapport
• Aggression or poor impulse control
• Minor events may = catastrophic reactions
"WHAT HAS HAPPENED TO YOU?"

“At its core, the trauma-informed model replaces the labeling of clients or patients as ‘sick’, resistant or uncooperative with that of being affected by an ‘injury’. Viewing trauma as an injury shifts the conversation from asking ‘What is wrong with you?’ to ‘What has happened to you?’”

- Klinic Community Health Centre, 2013
RESPOND FROM A PLACE OF TRAUMA INFORMED CARE

• Reinterpret through the lens of trauma exposure
  • ‘What has happened to you?’
• Notice your own internal reactions
• Validate the patient’s experience
• Provide safety (verbal support, grounding techniques)
• Strengthen empowerment and collaboration
• Ensure that the patient understands the medical intervention and reasons for recommending it
SUMMARY – TRAUMA INFORMED CARE

• Avoid re-traumatization
  • Take care with conversations around past trauma.
    Be respectful when a patient avoids a topic.
• Empowerment
  • Ensure the patient is given choices
  • Respect autonomy
  • Focus on strengths and skills-building
• Work collaboratively, with flexibility
  • Avoid confrontational approaches
• Work to establish safe connections and a relationship of trust
• Take care of yourself to enable you to care for others
OPIOID MANAGER

The Opioid Manager is designed to be used as a point of care tool for providers prescribing opioids for chronic non-cancer pain. It condenses key elements from the Canadian Opioid Guideline and can be used as a chart insert.

Before You Write the First Script

Patient Name: ____________
Pain Diagnosis: ____________
Date of Onset: ____________

Overdose Risk

Patient Factors
- Elderly
- Opioid-naive
- Respiratory impairment
- Recent surgery
- Recent stroke
- Sleep apnea
- Sleep disorders
- Cognition impairment

Provider Factors
- Incomplete assessments
- Rapid titration
- Combining opioids and sedating drugs
- Failure to monitor dosage
- Insufficient information given to patient and/or relatives

Opioid Factors
- Codeine & Tramadol: lower risk
- Opioids: formulations higher risk than IR
- Opioids guidelines vary

Prevention
- Assess for Risk Factors
- Educate patients, families, and caregivers
- Start low, titrate gradually
- Monitor frequently
- Avoid combination therapy
- Avoid opioid rotation
- Avoid benzodiazepines
- Avoid concurrent benzodiazepines

Stepped Approach to Opioid Selection

Step 1: Milder to Moderate Pain
- First line: acetylsalicylic acid or tramadol
- Second line: morphine, oxycodone, or hydrocodone

Step 2: Severe Pain
- First line: morphine, oxycodone, or hydrocodone
- Second line: fentanyl
- Third line: methadone

Initiation Trial Chart

Date: ____________

Opioid prescribed: ____________

Dose:
- Start with a small dose
- Titrate as needed

Daily dose:
- Start with a small dose
- Titrate as needed

Pain intensity:
- Start with a small dose
- Titrate as needed

Goals achieved:
- Yes, No, Partially

To access the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain and to download the Opioid Manager visit http://nationalpaincentre.mcmaster.ca/opioid/
# Maintenance & Monitoring

## Morphine Equivalence Table

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Equivalent Doses (mg)</th>
<th>Conversion to MEQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>Codeine</td>
<td>200</td>
<td>0.15</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>20</td>
<td>1.5</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>300</td>
<td>0.1</td>
</tr>
<tr>
<td>Methadone</td>
<td>Doses Equivalents Unavailable</td>
<td></td>
</tr>
<tr>
<td>Transdermal Fentanyl</td>
<td>60 – 134 mg morphine = 25 mcg/h</td>
<td>105 – 224 mg = 50 mcg/h</td>
</tr>
<tr>
<td></td>
<td>270 – 314 mg = 75 mcg/h</td>
<td>315 – 359 mg = 87 mcg/h</td>
</tr>
<tr>
<td></td>
<td>360 – 404 mg = 100 mcg/h</td>
<td></td>
</tr>
</tbody>
</table>

### Switching Opioids:

- **If previous opioid dose was:**
  - **High:** 50% or more of previous opioid (converted to morphine equivalent)
  - **Moderate or Low:** 60-75% of the previous opioid (converted to morphine equivalent)

## Maintenance & Monitoring Chart

<table>
<thead>
<tr>
<th>Date</th>
<th>Opioid Prescribed</th>
<th>Daily Dose</th>
<th>Daily Morphine Equivalent</th>
<th>Goals Achieved</th>
<th>Pain Intensity</th>
<th>Functional Status</th>
<th>Adverse Effects</th>
<th>Complications?</th>
<th>Aberrant Behaviour</th>
<th>Urine Drug Screening</th>
<th>Other Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

- **Goals achieved: Yes, No, Partially**
- **Pain intensity:**
  - **0 = None**
  - **1 = Limits ADLs**
  - **2 = Prevents ADLs**
- **Functional status:**
  - **Improved, No Change, Worsened**
- **Adverse effects:**
  - Nausea
  - Constipation
  - Dizziness/Vomiting
  - Other?
- **Complications? (Reviewed: Y/N)**
- **Aberrant Behaviour (Reviewed: Y/N)**
- **Urine Drug Screening (Y/N)**

## Aberrant Drug Related Behaviour (Modified by Paol, Kish et al 2002)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altering the route of delivery</td>
<td>Injecting, spraying or crushing formulations</td>
</tr>
<tr>
<td>Accessing opioids from other sources</td>
<td>Taking the drug from friends or relatives, sharing the drug from the &quot;street&quot;, double doctoring</td>
</tr>
<tr>
<td>Unsanctioned use</td>
<td>Multiple unapproved dose escalations, binge rather than scheduled use</td>
</tr>
<tr>
<td>Drug seeking</td>
<td>Recent prescription losses, aggressive complaining about the need for higher doses, manipulating staff to fill scripts or fill-in appointments, Nothing else &quot;works&quot;</td>
</tr>
<tr>
<td>Repeated withdrawal symptoms</td>
<td>Multiple unapproved dose escalations, binge rather than scheduled use</td>
</tr>
<tr>
<td>Accompanying conditions</td>
<td>Current addiction to alcohol, cocaine, benzodiazepines, or other drugs, Underlying mood or anxiety disorders not responsive to treatment</td>
</tr>
<tr>
<td>Social features</td>
<td>Deterioration of social function, Concern expressed by family members</td>
</tr>
<tr>
<td>Views on the opioid medication</td>
<td>Sometimes acknowledges being addicted, Strong resistance to tapering or switching opioids, May exhibit mood disordering effect, May acknowledge decreasing withdrawal symptoms</td>
</tr>
</tbody>
</table>

* = Behaviours more indicative of addiction than the others.
Assessing and Addressing Risk
IN PRESCRIBING FOR PALLIATIVE CARE PATIENTS

This tool is designed to identify risk factors and mitigating strategies for those who may be an increased risk for prescription drug misuse prescribed for life-limiting illness. Please review the risks below, and with increasing **RED FLAGS** consider increasing the controls used to reduce risk for the patient, prescriber, and community.

### RED FLAGS

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Dose</td>
<td>More than 90mg oral morphine equivalent</td>
</tr>
<tr>
<td>Opioid Use Disorder</td>
<td>Present</td>
</tr>
<tr>
<td>Aberrant behaviour (inc dbll doctoring, binge, alt route)</td>
<td>History or current concern of this behaviour</td>
</tr>
<tr>
<td>Concurrent Prescription of Restricted Substances</td>
<td>Present</td>
</tr>
<tr>
<td>OPIOID RISK TOOL COMPONENTS (HIGHER RISK ONLY)</td>
<td></td>
</tr>
<tr>
<td>Family History of substance abuse - Alcohol</td>
<td>Present</td>
</tr>
<tr>
<td>Family History of substance abuse - Illegal drugs</td>
<td>Present</td>
</tr>
<tr>
<td>Family History of substance abuse - Prescription drugs</td>
<td>Present</td>
</tr>
<tr>
<td>History of Substance Use Disorder (tobacco, alcohol, illegal drugs, In drugs)</td>
<td>Present</td>
</tr>
<tr>
<td>History of pre-adolescent sexual abuse</td>
<td>Present</td>
</tr>
<tr>
<td>Psychological disease - ADHD, OCD, Bipolar or Schizophrenia</td>
<td>Present</td>
</tr>
<tr>
<td>Prognosis</td>
<td>More than One Year</td>
</tr>
<tr>
<td>Cognition/Capacity/Insight</td>
<td>No Capacity</td>
</tr>
<tr>
<td>Trauma history</td>
<td>Present</td>
</tr>
<tr>
<td>Risk of Exploitation by Others</td>
<td>High Risk</td>
</tr>
<tr>
<td>Risk of Diversion of Medications</td>
<td>High Risk</td>
</tr>
<tr>
<td>Social Supports</td>
<td>Restricted or Unstable Connections</td>
</tr>
<tr>
<td>Primary Care Team</td>
<td>Absent</td>
</tr>
<tr>
<td>Housing</td>
<td>Unstable/Absent</td>
</tr>
<tr>
<td>Poverty</td>
<td>Present</td>
</tr>
<tr>
<td>Coping Skills</td>
<td>Limited</td>
</tr>
</tbody>
</table>

### INTERVENTIONS

**CONSIDER FOR ALL RISK LEVELS**

- Harm reduction supports (e.g., supervised consumption sites, Naloxone kits, etc.)
- Trauma-Informed approach to care
- Pharmacist check (at baseline and recurrent)

**PRESCRIBING**

- Opioid Contract: Encouraged
- Dispensing (Frequency, Witnessing, Blister Pack, Volume, Daily): **CONSIDER FOR ALL RISK LEVELS**
- Single Prescriber or Single Team
- PNR Restrictions: Avoid if necessary, daily dispensing of a few PNRs
- Urine Drug Screen (Baseline)
- Form of Drug (PO, IM, IV, SC, SL, PR, Topical)
- Selection of Opioid: Radian Preferentially

**SURVEILLANCE**

- PNR Counts: If not adding up, consider daily dispensing
- PNR Restrictions: **Daily Dispensing of a few PNRs**
- Urine Drug Screen (Periodic, Random)
- Assessment Schedule/Frequency/Intensification: **Weekly Assessments**
- Physician/NP/Prescriber Home Visit to Assess Risk/Support: At Least Monthly

**ADDITIONAL SUPPORTS**

- Additional (Counselling, Spiritual Health, Agencies, Peers): Engage whenever possible
- Addictions Consult: Recommend, if possible
- Coordination/Communication of Care Teams: Increase communication and coordination
THINGS WE THINK OF AS CARE PROVIDERS

- Limited resources (for our patients, our system and ourselves)
- Limited family/friends – caring for the patient and their family/chosen family
- History of trauma (often very significant) – and it’s relationship to physical and emotional pain
- Serious illness and it’s relationship to substance use
- Take some/sell some (survival trade)
- The importance of meeting patients ’where they are at’
- People die as they have lived
- Substance use exists across the continuum of care and lifespan, including end of life care
- The challenges with home and community supports – ‘don’t go there’
HOW WE APPROACH CARE

• Meet patient where they are - ‘goals of care’ and values
• Use the resources we do have (Pharmanet, opioid risk tool, colleagues, UDS where appropriate)
• Think about risk stratification (low, moderate, high)
• Utilize long-acting medications where possible (for all patients)
• Work with our pharmacy colleagues – daily dispense, witness ingestion, witness patch change
• Work within our interdisciplinary teams – utilize non pharmacologic approaches whenever possible
• Think systems level – addressing social determinants of health and psychosocial care
CASE DISCUSSION (IF TIME)

• 49 year old man with diagnosis of bipolar disorder, alcohol use disorder, hepatitis C
• History of IVDU (denies over past 10 years)
• Moved to Victoria from Calgary – previously employed in finance industry
• Self taper off psych meds, ‘event’ occurred, hospitalized – went back on meds
• Discharged but now homeless, unemployed, alcohol use increasing
• Directed to community health centre for ongoing care
• Eventually diagnosed with widely metastatic cancer – late in disease
• Does not want disease modifying treatment
• Having increasing symptoms of pain, dyspnea, anxiety, despair
  • Living in shelter
  • Limited contact with family and friends
  • Having difficult time attending medical appointments for follow up
CASE DISCUSSION CONTINUED

- Meeting our patient ‘where he is at’ – outreach care
- Individualize our approach, through a trauma-informed care lens
  – ‘what has happened?’
  - Trial of Kadian – daily witnessed ingestion (DWI) - work with pharmacy colleagues
  - Consideration of fentanyl patch (with witnessed patch change q3d)
  - Open discussion re: need for ongoing UDS
  - Connected to community palliative care team – attempts to address need for stable housing, food, etc.
  - Consideration of admission if patient willing – otherwise, do best to support dying in place
QUESTIONS
Text 604-250-2845

Contact:
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Ashley Heaslip: Ashley.heaslip@gmail.com