crucial conversations

about death, dying, obesity & more

CALGARY ZONE WEBINAR | APRIL 22, 2024

WEBINAR SERIES: LAND ACKNOWLEDGEMENT

In the spirit of reconciliation, we acknowledge that we work, play and live on the traditional territories of the people of the Treaty 7 region in Southern Alberta, which include the Blackfoot Confederacy (comprised of the Siksika, the Piikani, and the Kainai First Nations), the Tsuut'ina First Nation and the Stoney Nakoda (including the Chiniki, Bearspaw, and Goodstoney First Nations). The Calgary Area is home to the Métis Nation of Alberta, Districts 1, 4, 5 and 6.

HOT TOPICS: AGENDA

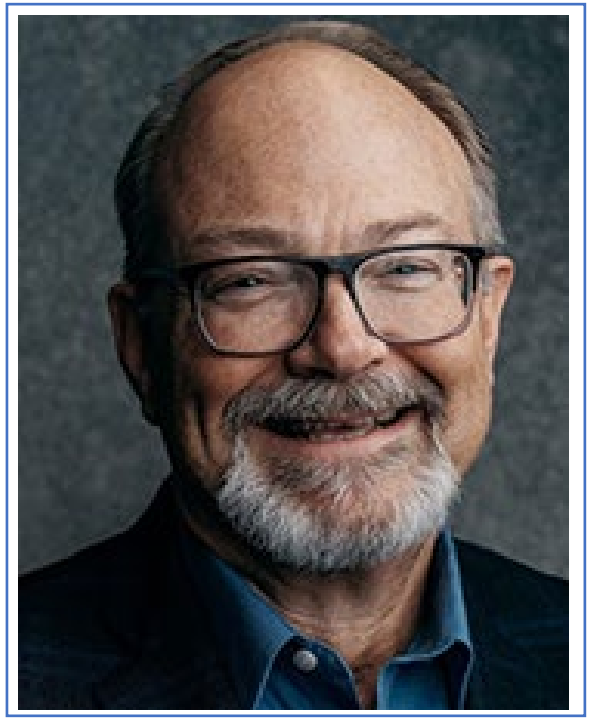
Calgary Zone webinar series: Mental health & hot topics

Time	Topic	Speaker
6-6:05 p.m.	Welcome, overview	Dr. Rick Ward
6:05-6:35 p.m.	Obesity	Dr. David Lau
6:35-6:45 p.m.	Obesity Q&A	
6:45-7:15 p.m.	Medical Assistance in Dying (MAID)	Dr. Jilian Arnold
7:15-7:25 p.m.	MAID Q&A	
7:25-7:55 p.m.	Primary care hot topics, including panel funding/stabilization and more	Dr. Christine Luelo
7:55-8 p.m.	Next webinar	Dr. Rick Ward

PRESENTER: DISCLOSURE/CONFLICTS

Calgary Zone webinar series: Mental health & hot topics

Title: Welcome, overview, next webinar



Financial sponsors

- Alberta Health Services (Medical Director, Primary Care)

Disclosures

- Shire
- Pfizer
- Merck
- BI
- AZ
- Janssen
- Takeda
- Servier
- BMS

Dr. Rick Ward
Family Physician
Crowfoot Village Family Practice
Medical Director, Primary Care,
Alberta Health Services (Calgary Zone)

PROGRAM: DISCLOSURE

Calgary Zone webinar:
Crucial conversations and
other primary care hot topics

Financial support

- This program has received financial support from Calgary Zone Primary Care Networks
- This program has received in-kind support from the Calgary Zone Business Unit and Alberta Health Services in the form of logistical support and presenter time

Potential for conflict(s) of interest:

- N/A

PRESENTER: DISCLOSURE/CONFLICTS

Title: Update on obesity management

David C. W. Lau, MD, PhD, FRCPC, FTOS
Endocrinologist
Email: dcwlau@ucalgary.ca

Financial sponsors

- Clinical trial funding
  - Amgen, Boehringer Ingelheim, Novo Nordisk
- Membership on advisory boards or speakers' bureau
  - Amgen, Bayer, Boehringer Ingelheim, Eli Lilly, Novartis, Novo Nordisk, Viatris, Zealand Pharma
- Expert testimony honoraria: Gowling WLG, Connect Experts

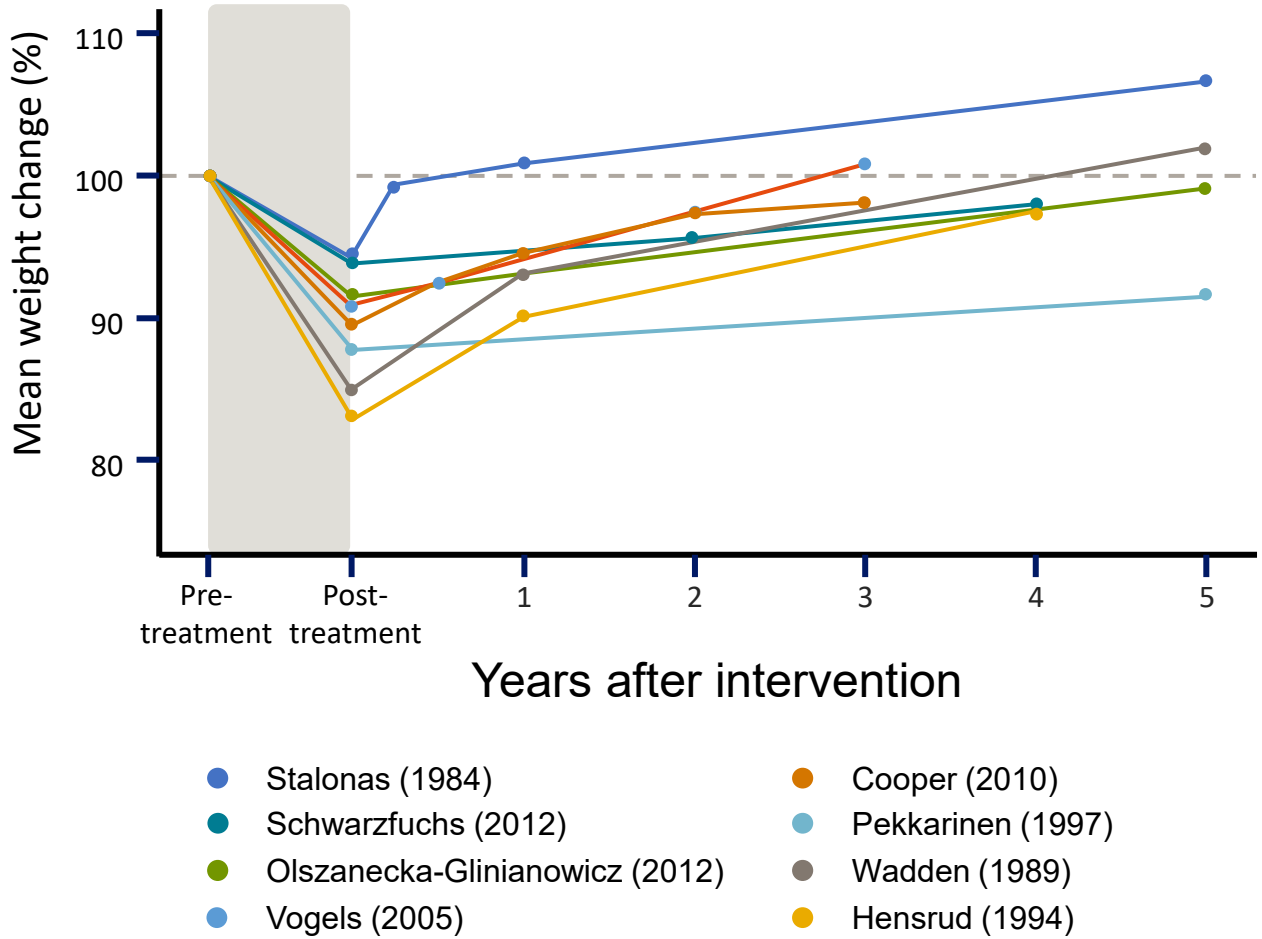
Potential for conflict(s) of interest:

- Products discussed in this presentation:
  - Semaglutide (Ozempic, Wegovy)
  - Tirzepatide (Mounjaro)
  - Liraglutide (Saxenda)
  - Bupropion/Naltrexone (Contrave)
  - Orlistat (Xenical)
  - Lisdexamfetamine (Vyvanse)

OBESITY: WEIGHT LOSS OUTCOMES

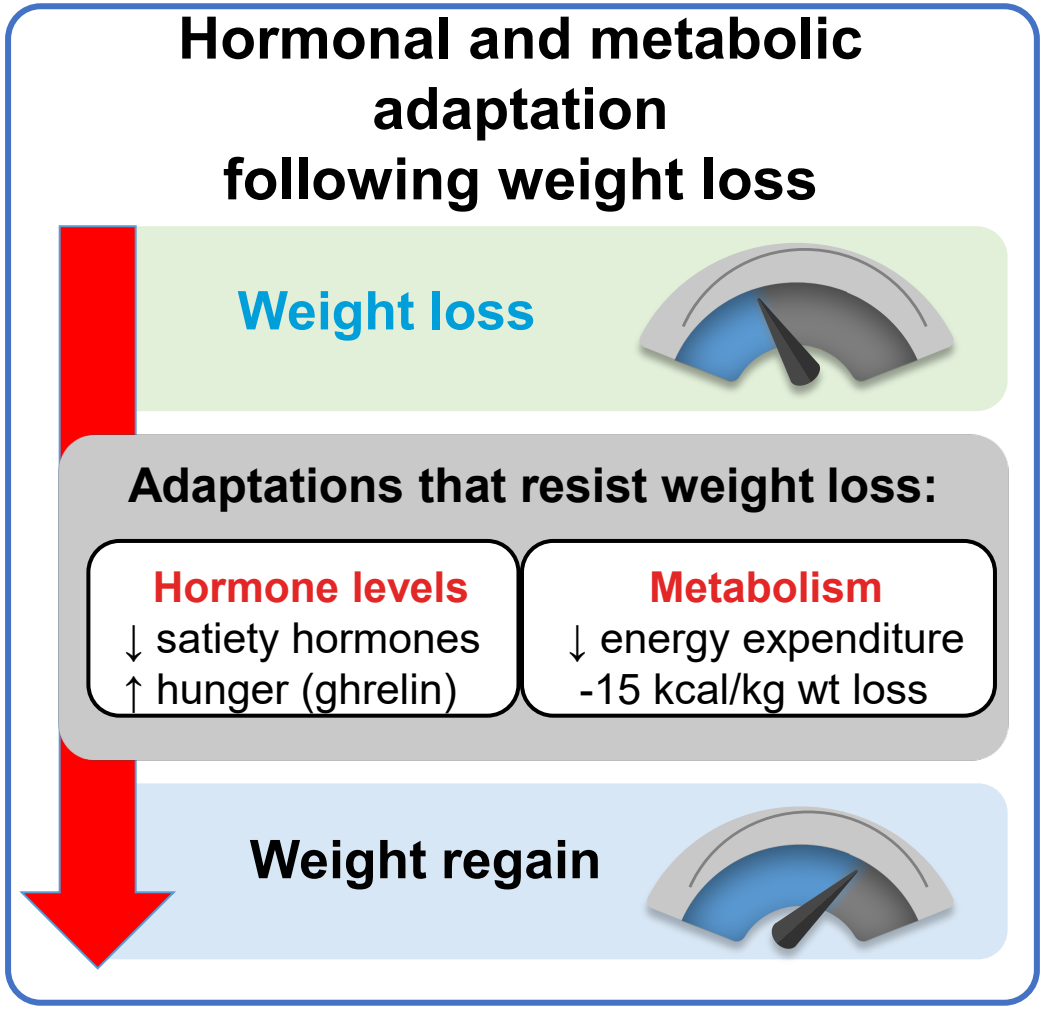
Weight loss increases hunger, hormonal and metabolic adaptation

Weight regain following weight loss



Nordmo M et al. *Obes Rev* 2020;21:e12949

Hormonal and metabolic adaptation following weight loss

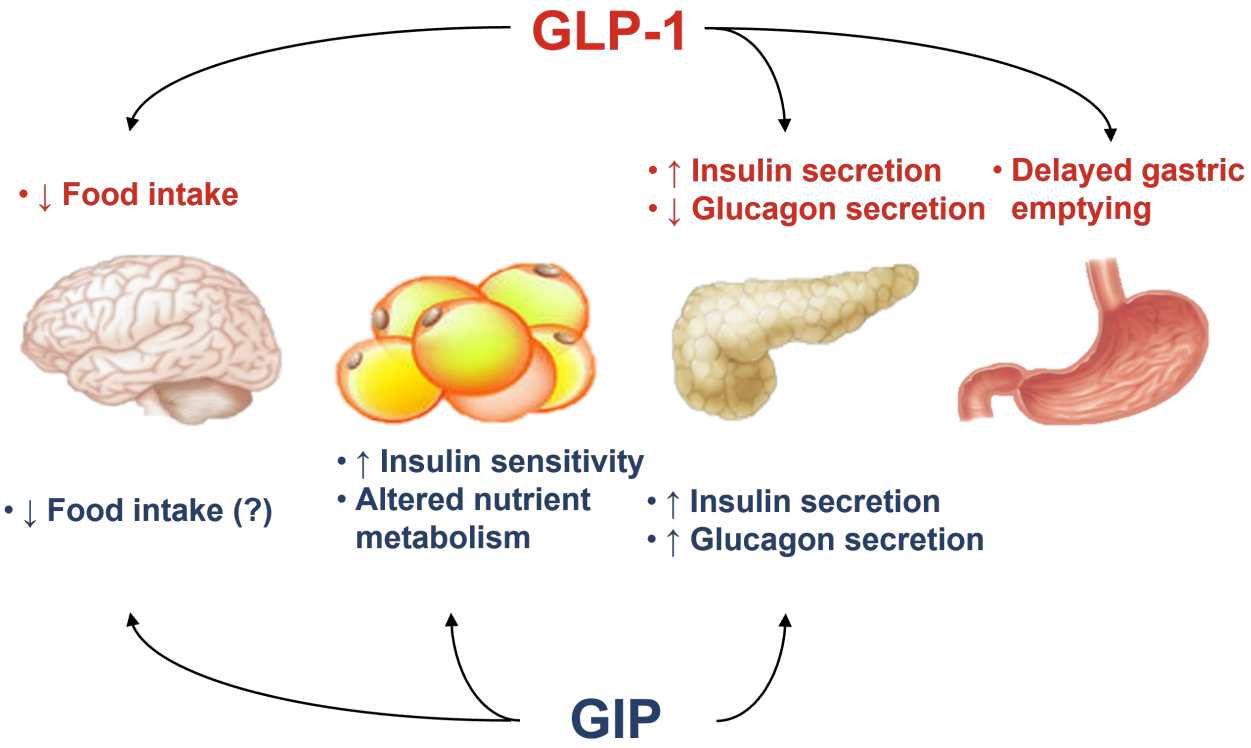


Sumithran P et al. *N Engl J Med*. 2011;365:1597-1604
Schwartz A, Doucet E. *Obes Rev.* 2010;11:531–547

OBESITY: GLP-1 AND GIP

GLP-1 Receptor Agonist and GIP: Potential mechanism of action

- GLP-1 has suggested direct actions in the central nervous system (CNS), islets, and stomach[1,2]
- GIP has shown potential actions in the CNS (preclinical), and adipose tissue and islets (clinical and preclinical)[2-4]
- A single-molecule GIP/GLP-1 receptor agonist may enable therapeutic actions that are improved over the sum of GIP and GLP-1 single-receptor agonism[5,6]



CNS, central nervous system; GLP-1, glucagon-like peptide-1; GIP, glucose-dependent insulinotropic polypeptide

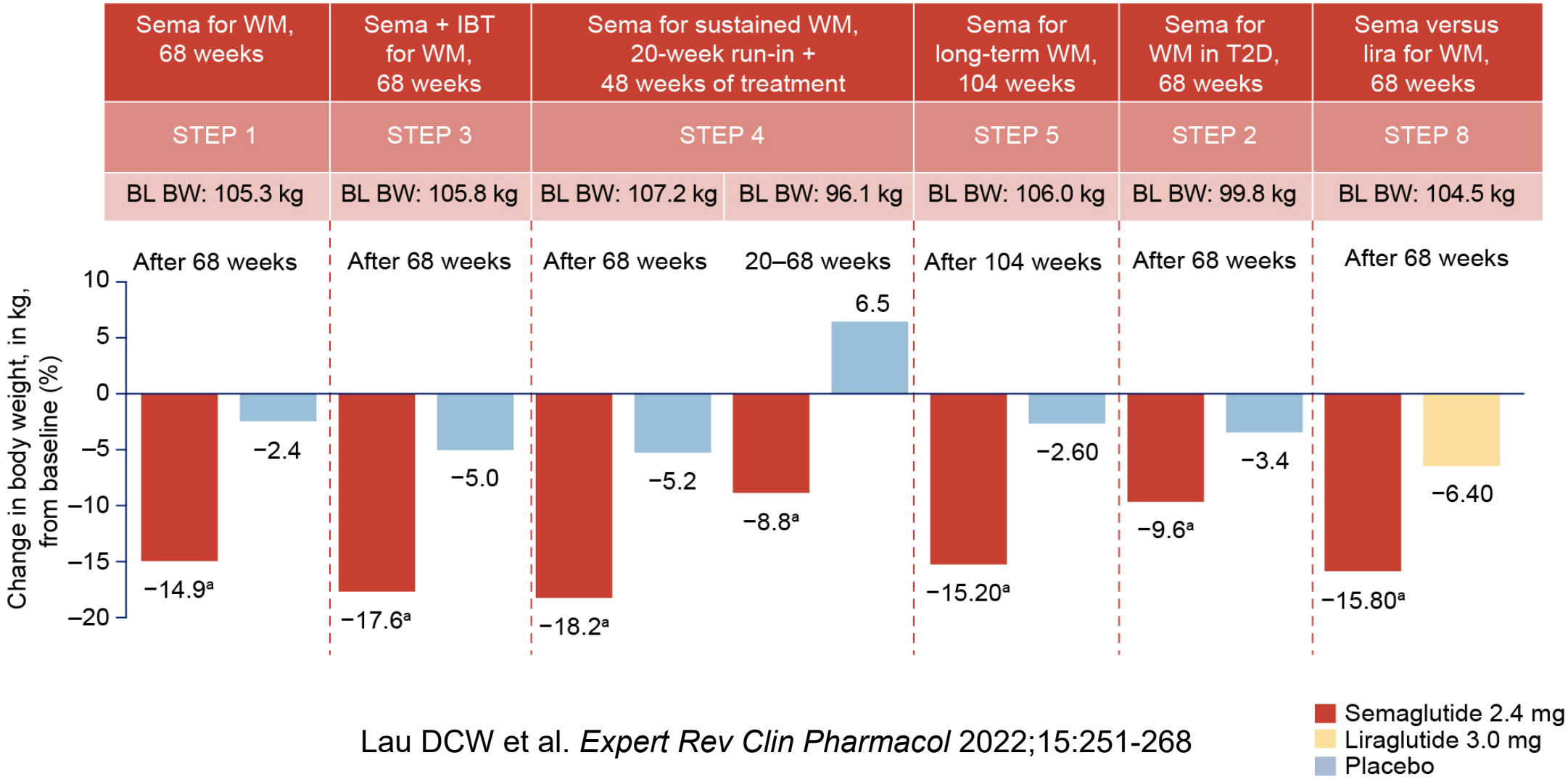
[1]Müller TD, et al. *Mol Metab*. 2019;30:72-130. [2]Seino Y, et al. *J Diabetes Investig*. 2010;1(1-2):8-23. [3]Fukuda M. *Diabetes*. 2021;70(8):dbi210001.
[4]Nauck MA, et al. *Diabetes Obes Metab*. 2021;23(3):5-29. [5]Samms RJ, et al. *Trends Endocrinol Metab*. 2020;31(6):410-421.
[6]Bastin M, et al. *Diabetes Metab Syndr Obes*. 2019;12:1973-1985.

OBESITY: SUMMARY

Calgary Zone webinar series: Mental health & hot topics

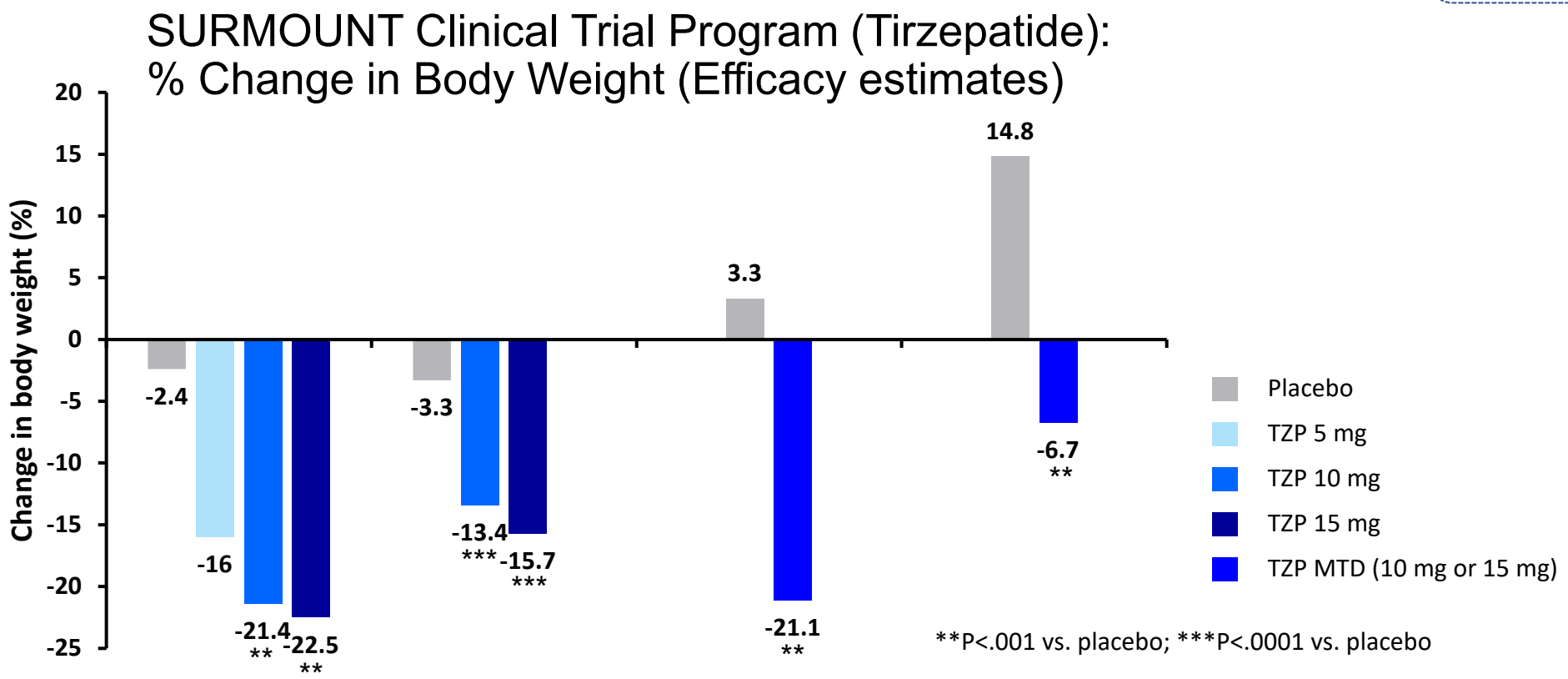
Weight loss across STEP 1-5 and 8 trials

Effects of semaglutide 2.4 mg once-weekly in subjects with overweight or obesity



Lau DCW et al. *Expert Rev Clin Pharmacol* 2022;15:251-268

OBESITY: SURMOUNT CLINICAL TRIAL PROGRAM



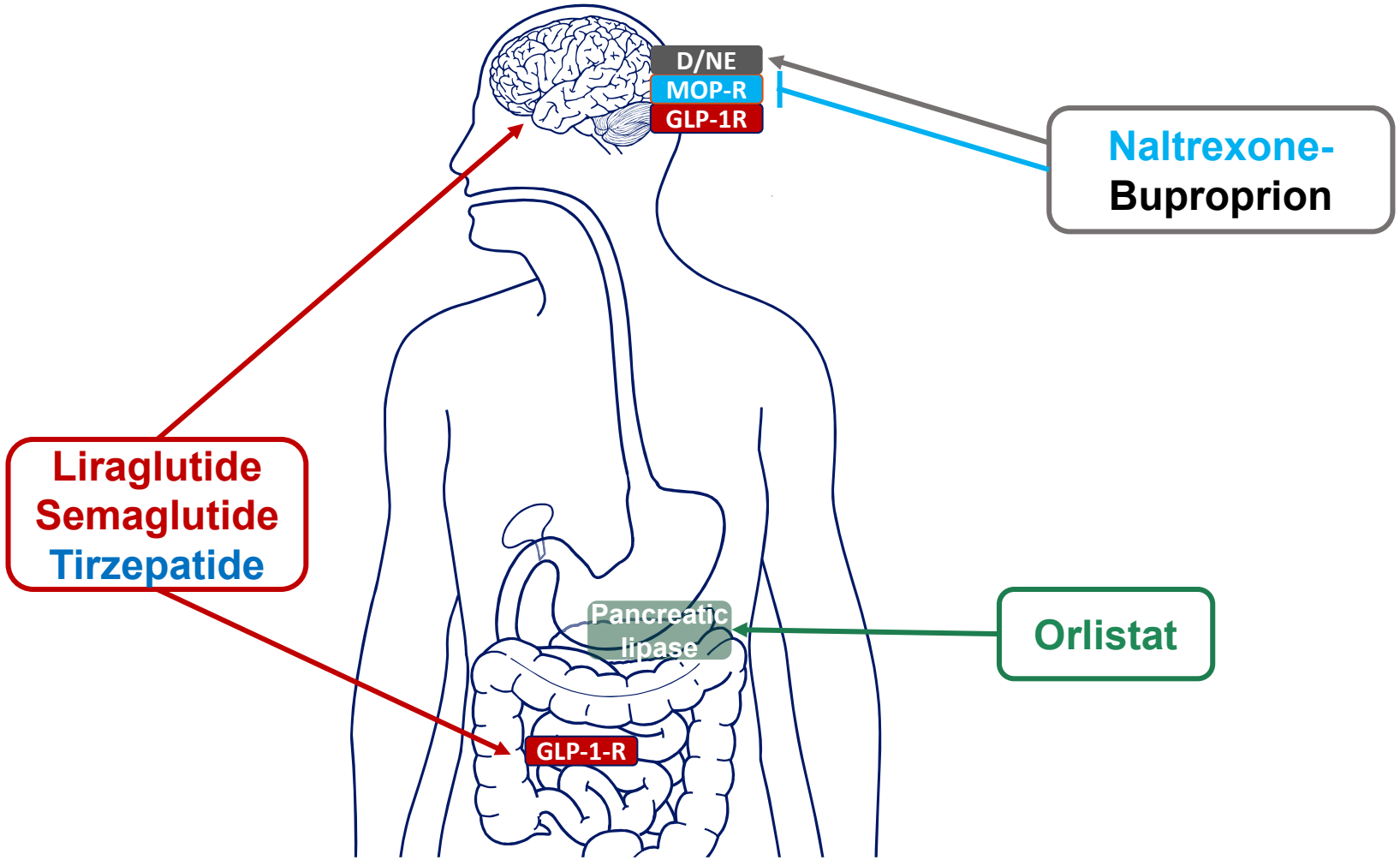
Study	SURMOUNT-1[1,a]	SURMOUNT-2[2,a]	SURMOUNT-3[3,a]	SURMOUNT-4[4,b]
Superiority versus	Placebo	Placebo	Placebo	Placebo
Duration (weeks)	72	72	72	88
Mean baseline body weight (kg)	104.8 kg	100.8 kg	101.9 kg	85.2 kg

[a]Data are from baseline; [b]Data are from randomization at week 36 following an open-label period; MTD, Maximum Tolerated Dose

1. Jastreboff AM et al. *N Engl J Med*. 2022;387(3):205-216. 2. Garvey TM et al. *Lancet*. 2023;402(10402):613-626.
3. Wadden TA et al. *Nat Med*. 2023;29:2909-2918. 4. Aronne LJ et al. *JAMA*. 2024;331(1)38-48.

OBESITY: PHARMACOTHERAPY TARGETS

Pharmacotherapy targets of anti-obesity medications



5-HT2c, 5-hydroxytryptamine; D/NE, dopamine/norepinephrine; GABA-R, gamma-aminobutyric acid receptor; GLP-1R, glucagon-like peptide-1 receptor; MOP-R, Mu-Opioid receptor

Patel D. *Metabolism* 2015;64:1376-85

OBESITY: STEPWISE APPROACH

Stepwise approach to obesity treatment

	BMI 25–26.9 kg/m²	BMI 27–29.9 kg/m²	BMI 30–34.9 kg/m²	BMI 35–39.9 kg/m²	BMI ≥40 kg/m²
Surgery 			With type 2 diabetes*	With co-morbidity	+
Pharmacotherapy 		With co-morbidity	+	+	+
Diet, activity & behaviour 	+	+	+	+	+

BMI, body mass index

Yumuk V *et al. Obes Facts* 2015;8:402–24

* Wharton S, Lau DCW, Vallis M *et al. CMAJ* 2020;192:E875-E891 https://doi.org/10.1503/cmaj.191707

Pharmacotherapy for obesity in Canada

	Orlistat	Liraglutide	Naltrexone/Bupropion	Semaglutide
Mode of administration	Oral	Subcutaneous	Oral	Subcutaneous
Dose/frequency	120 mg TID	3.0 mg daily	16/180 mg BID	2.4 mg weekly
Effect on % weight loss at 1 year, placebo subtracted	-2.9%[28]	-5.4%[2]	-4.8%[5]	-12.5%[1]
Effect on weight over longer term, placebo subtracted	-2.8 kg at 4 years[8]	-4.2% at 3 years[3]	Not studied	-12.6% at 2 years
% of patients achieving ≥ 5% weight loss at 1 year	54% (vs. 33% in placebo)[28]	63.2% (vs. 27.1% in placebo)[2]	48% (vs. 16% in placebo)[5]	86.4% (vs. 31.5% in placebo)[1]
% of patients achieving ≥ 10% weight loss at 1 year	26% (vs. 14% in placebo)[28]	33.1% (vs. 10.6% in placebo)[2]	25% (vs. 7% in placebo)[5]	69.1% (vs. 12% in placebo)[1]
% of patients achieving ≥ 15% weight loss at 1 year	Not studied	14.4% (vs. 3.5% with placebo)[3]	13.5% (vs. 2.4% with placebo)[36]	50.5% (vs. 4.9% with placebo)[1]
% of patients achieving ≥ 20% weight loss at 1 year	Not studied	Not studied	Not studied	32% (vs. 1.7% in placebo)[1]
Effect on maintenance of previous lifestyle-induced weight loss	2.4 kg less weight regain vs. placebo over 3 years[7]	-6.0% additional placebo-subtracted weight loss at 1 year[4]	Not studied	Not studied
Cost	$$	$$$$	$$$	Unknown

Pedersen SD, Manjoo P, Wharton S. https://obesitycanada.ca/guidelines/pharmacotherapy

OBESITY: SEMAGLUTIDE EFFECTS

SELECT: Semaglutide effects on cardiovascular outcomes in people with overweight/obesity

Baseline characteristics of trial participants (N=17,604)

Demographics

Male | Female

72.3 | 27.7%

Mean age

61.6 years

Asian|Black|White|Other

8.2 | 3.8 | 84.0 | 3.0%

Participants by CV inclusion criteria

MI only

67.6%

Stroke only

17.8%

PAD only

4.4%

≥2 CV inclusion criteria

8.2%

Number of enrolled participants differs from number reported in baseline publication (17,605) as one participant was randomised twice in error and subsequently removed for the primary analysis.
BMI, body mass index; eGFR, estimated glomerular filtration rate; HbA_{1c}, glycated haemoglobin; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; NYHA, New York Heart Association.

1. Lincoff AM et al. N Engl J Med 2023;DOI:10.1056/NEJMoa2307563; 2. Novo Nordisk. Data on file.

OBESITY: SEMAGLUTIDE EFFECTS

SELECT: Semaglutide effects on cardiovascular outcomes in people with overweight/obesity

Baseline characteristics of trial participants (N=17,604)

Clinical characteristics

Mean HbA_{1c}[1]	Mean BMI[1]	Mean eGFR[2]	Chronic heart failure[1]
5.8%	33.3 kg/m^2	82.5 mL/min/1.73 m^2	24.3%

With prediabetes[1]	Distribution (kg/m^2)[1] <30 | 30–<35 | 35–<40 | 40–<45 | ≥45	Subclass[2] HFpEF| HFrEF | Unknown
66.4%	28.5 | 42.5 | 19.0 | 6.7 | 3.3%	12.9 | 7.7 | 3.8

Number of enrolled participants differs from number reported in baseline publication (17,605) as one participant was randomised twice in error and subsequently removed for the primary analysis.
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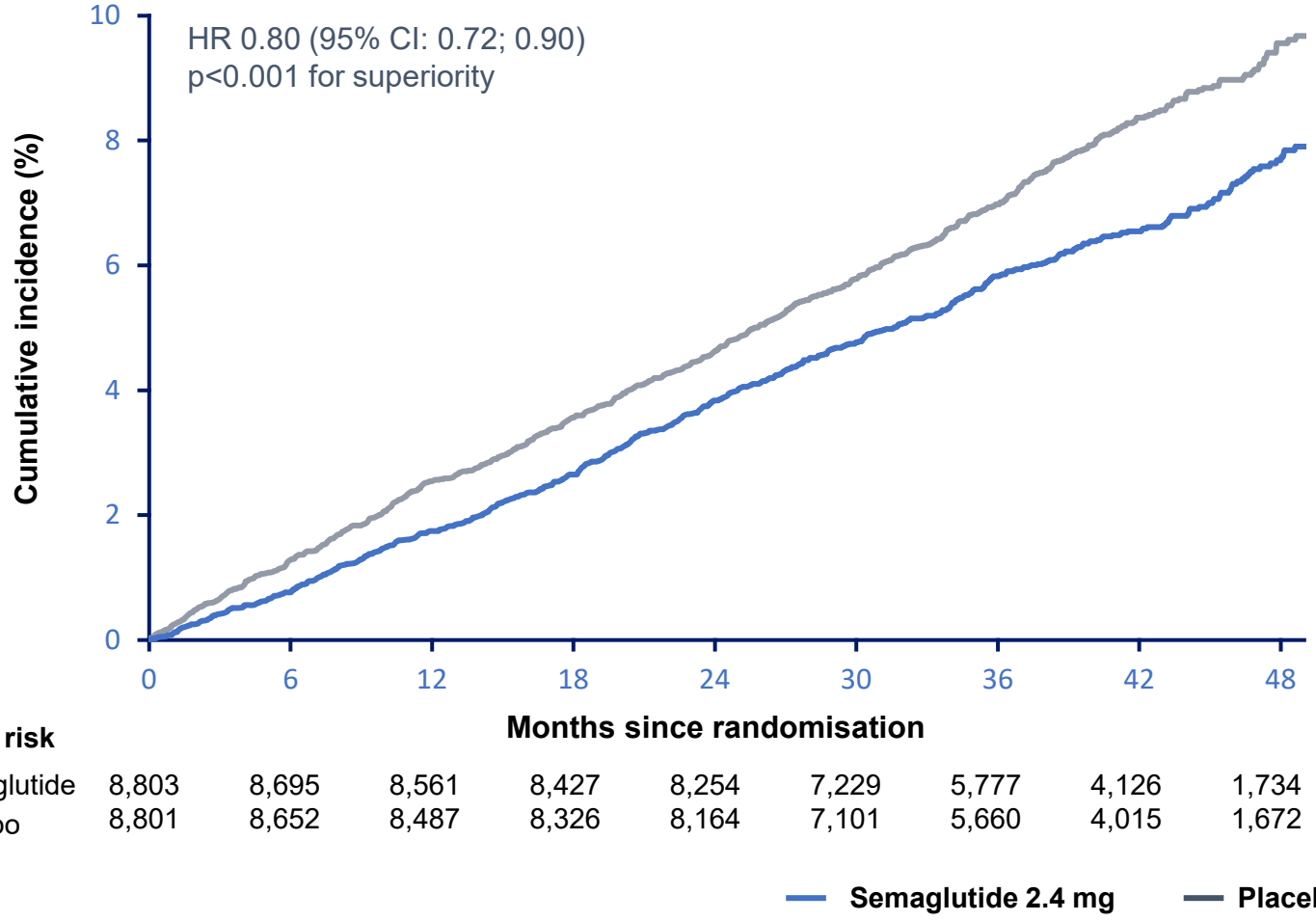
OBESITY: CUMULATIVE INCIDENCE OF MACE

SELECT: Cumulative incidence of MACE

Primary cardiovascular composite endpoint (N=17,604)



20% reduction in risk of MACE*

Semaglutide 2.4 mg significantly reduced the risk of MACE by 20% compared with placebo in people with obesity and established CVD, without T2D[1,2]

All three components (death from CV causes, non-fatal MI and non-fatal stroke) contributed to MACE risk reduction

Mean follow-up time was 39.8 months

Cumulative incidence (using the Aalen–Johansen method) of the composite MACE primary endpoint. The HR was estimated using a Cox proportional hazards regression model. The proportion of participants with MACE was 6.5% with semaglutide 2.4 mg and 8.0% with placebo. MACE was defined as death from CV causes, non-fatal myocardial infarction, or non-fatal stroke.

CI, confidence interval; HR, hazard ratio; MACE, major adverse cardiovascular events; MI, myocardial infarction.

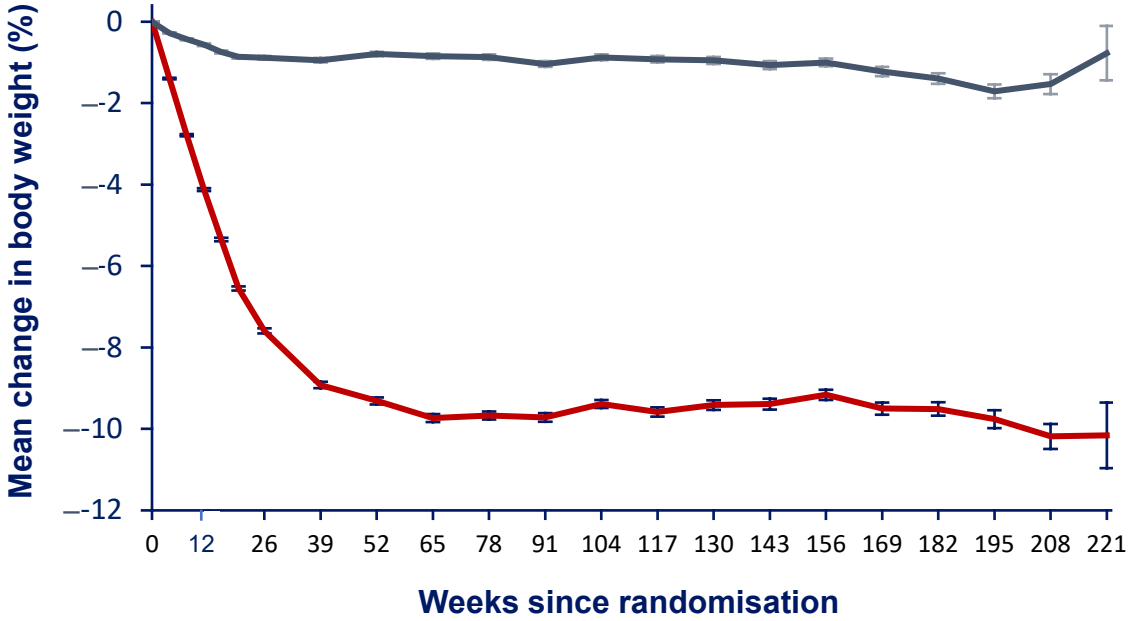
1. Lincoff AM et al. N Engl J Med 2023;DOI:10.1056/NEJMoa2307563; 2. Novo Nordisk A/S. Company announcement, 8 August 2023

OBESITY: CHANGE IN BODY WEIGHT (%)

SELECT: Semaglutide effects on cardiovascular outcomes in people with overweight or obesity

Observed change from baseline over time

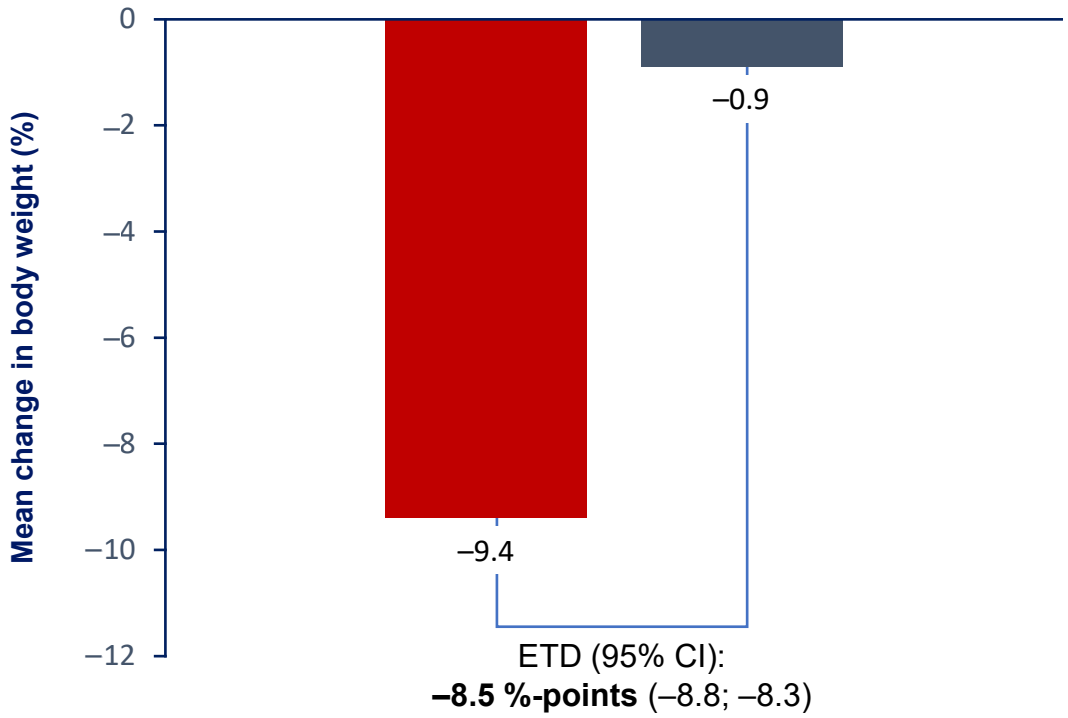
Mean baseline body weight, kg:
Semaglutide 2.4 mg: 96.5 **Placebo: 96.8**



No. of participants

Semaglutide	8,803	7,647	7,493	6,690	7,290	6,447	7,282	6,460	7,474	5,991	5,898	4,686	5,085	3,650	2,954	1,737	921	157
Placebo	8,801	7,715	7,516	6,704	7,269	6,340	7,272	6,392	7,378	5,871	5,879	4,583	5,014	3,560	2,890	1,698	898	152

Estimated change from baseline to week 104*



Semaglutide 2.4 mg Placebo

Error bars in the left-hand figure are 95% CI as calculated by 1.96 times the standard error. *Estimated using an ANCOVA with treatment as factor and the baseline value as covariate, using multiple imputation for missing values under a missing-at-random assumption. CIs have not been adjusted for multiplicity. ANCOVA, analysis of covariance; CI, confidence interval; ETD, estimated treatment difference; SD, standard deviation.

Lincoff AM et al. N Engl J Med 2023;DOI:10.1056/NEJMoa2307563

OBESITY: CONCLUSIONS

Semaglutide 2.4 mg significantly reduced risk of MACE by 20% vs placebo in people with established CVD and overweight or obesity without T2D, with consistent effects across participant subgroups[1,2]

Semaglutide 2.4 mg had consistent beneficial effects across measured CV endpoints[1]

Results suggest a benefit with semaglutide on the risk of CV death, HF composite endpoints and all-cause death (risk reduction for CV-related death did not reach statistical significance and other endpoints were not tested)[1]

Semaglutide 2.4 mg improved multiple modifiable risk factors known to drive CV events, such as body weight, waist circumference, blood pressure, lipids and hsCRP[1]

SELECT safety findings were consistent with previous trials with semaglutide,[1–3] confirming the well-established safety and tolerability profile of semaglutide 2.4 mg

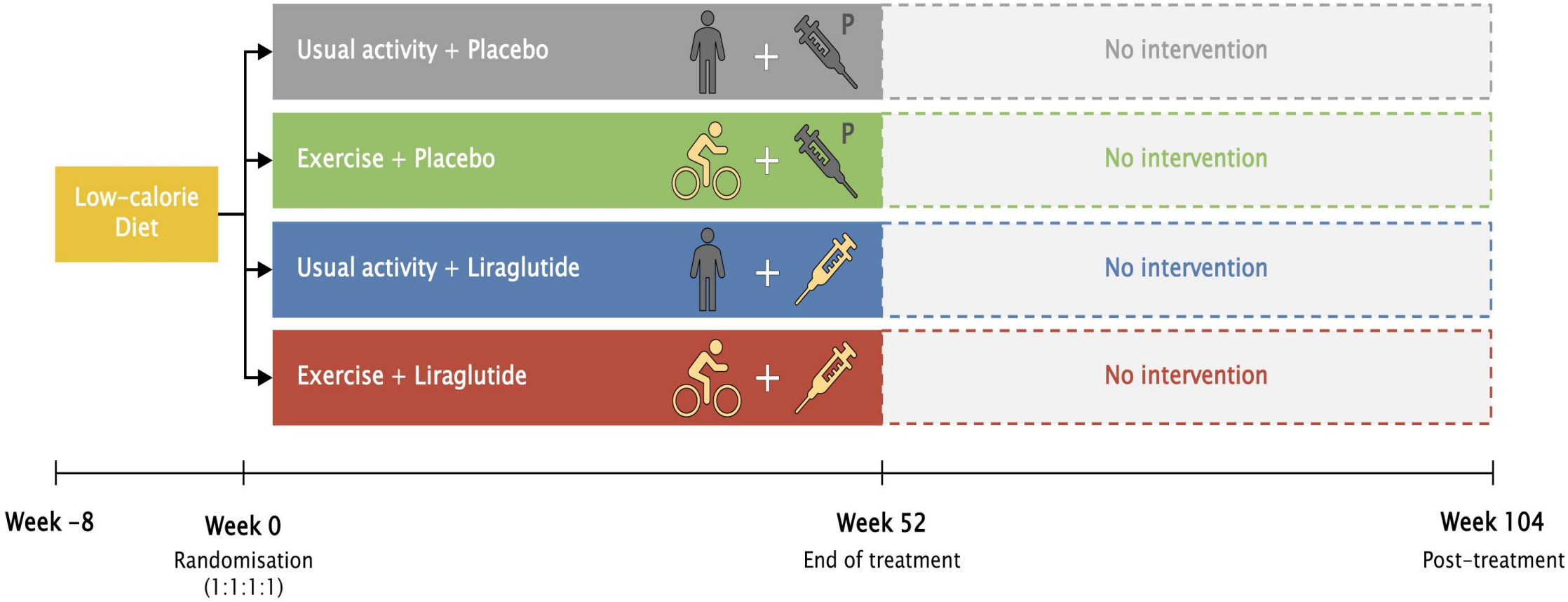
This is the first time a weight management medication has shown a reduction in CV events in people with established CVD and overweight or obesity, without T2D[1]

CV, cardiovascular; CVD, cardiovascular disease; GLP-1RA, glucagon-like peptide-1 receptor agonist; hsCRP, high-sensitivity C-reactive protein; MACE, major adverse cardiovascular events; T2D, type 2 diabetes.

1. Lincoff AM et al. N Engl J Med 2023;DOI:10.1056/NEJMoa2307563; 2. Novo Nordisk A/S. Company announcement, 8 August 2023. Available at: https://www.novonordisk.com/content/nncorp/global/en/news-and-media/news-and-ir-materials/news-details.html?id=166301. Accessed October 2023; 3. Bergman NC et al. Diabetes Obes Metab 2023;25:18–35.

OBESITY: ONE YEAR WITHOUT TREATMENT

Healthy weight loss maintenance with exercise, GLP-1 receptor agonist, or both combined followed by one year without treatment



eClinical Medicine 2024;69 DOI:10.1016/j.eclinm.2024.102475

OBESITY: ONE YEAR WITHOUT TREATMENT

Calgary Zone webinar series: Mental health & hot topics

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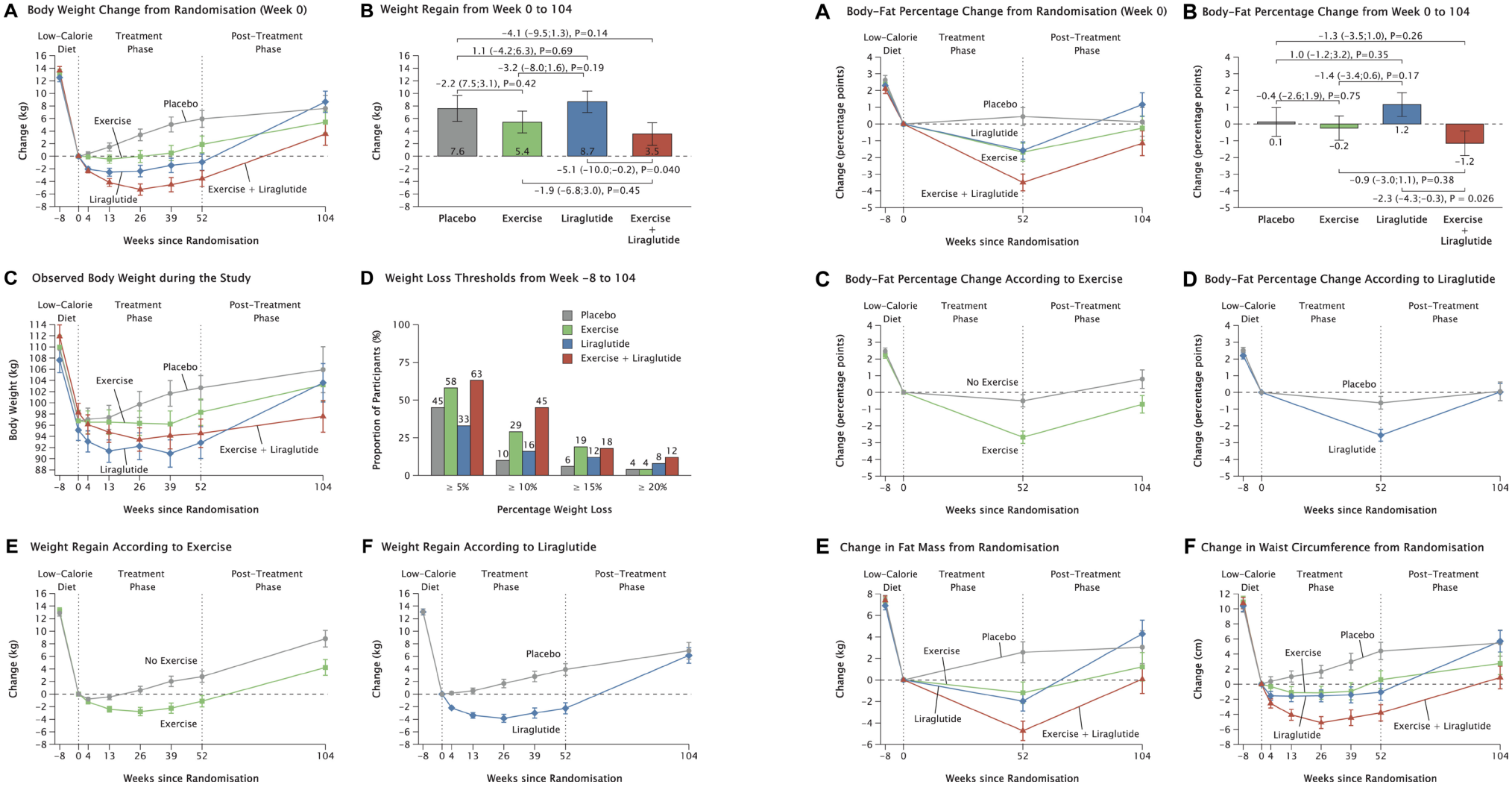


eClinical Medicine 2024;69 DOI:10.1016/j.eclinm.2024.102475

OBESITY: DSM-5 DIAGNOSTIC CRITERIA

A

Recurrent episodes of binge eating, including:

- Eating more food than what most people would eat
- Lack of control over the episode

+

B

Episodes are associated with ≥3 of the following:

- Eating more rapidly than normal
- Eating until feeling uncomfortably full
- Eating large amounts of food when not feeling hungry
- Eating alone due to embarrassment
- Feeling disgusted with oneself, depressed or guilty afterward

+

C **Marked distress with regard to binge eating**

+

D Episodes occur, on average, **at least once per week for 3 months**

+

E **No association with recurrent use of inappropriate compensatory behaviours as in bulimia nervosa; does not occur exclusively during the course of bulimia nervosa or anorexia nervosa**

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. 5th ed.* Arlington, VA: American Psychiatric Association; 2013.

OBESITY: THANK YOU!

YOUR HOST: DISCLOSURE/CONFLICTS

Calgary Zone webinar series: Mental health & hot topics

Faculty: Dr. Jilian Arnold
Geriatric Medicine
MAID Medical Lead,
Calgary Zone

Financial sponsors

- I receive a stipend for my role as Medical Lead for MAID in the Calgary Zone

Dr. Jilian Arnold: MAID assessor and provider since 2017: jilian.arnold@ahs.ca

MAID: PRESENTATION OUTLINE

Agenda

- MAID in Canada
- MAID in Alberta
- The patient journey
- MAID eligibility criteria
- The roles a family doctor may take in a patient's MAID request
- Case review
- MAID and Mental Health

Dr. Jilian Arnold: MAID assessor and provider since 2017: jilian.arnold@ahs.ca

MAID: CONTEXT

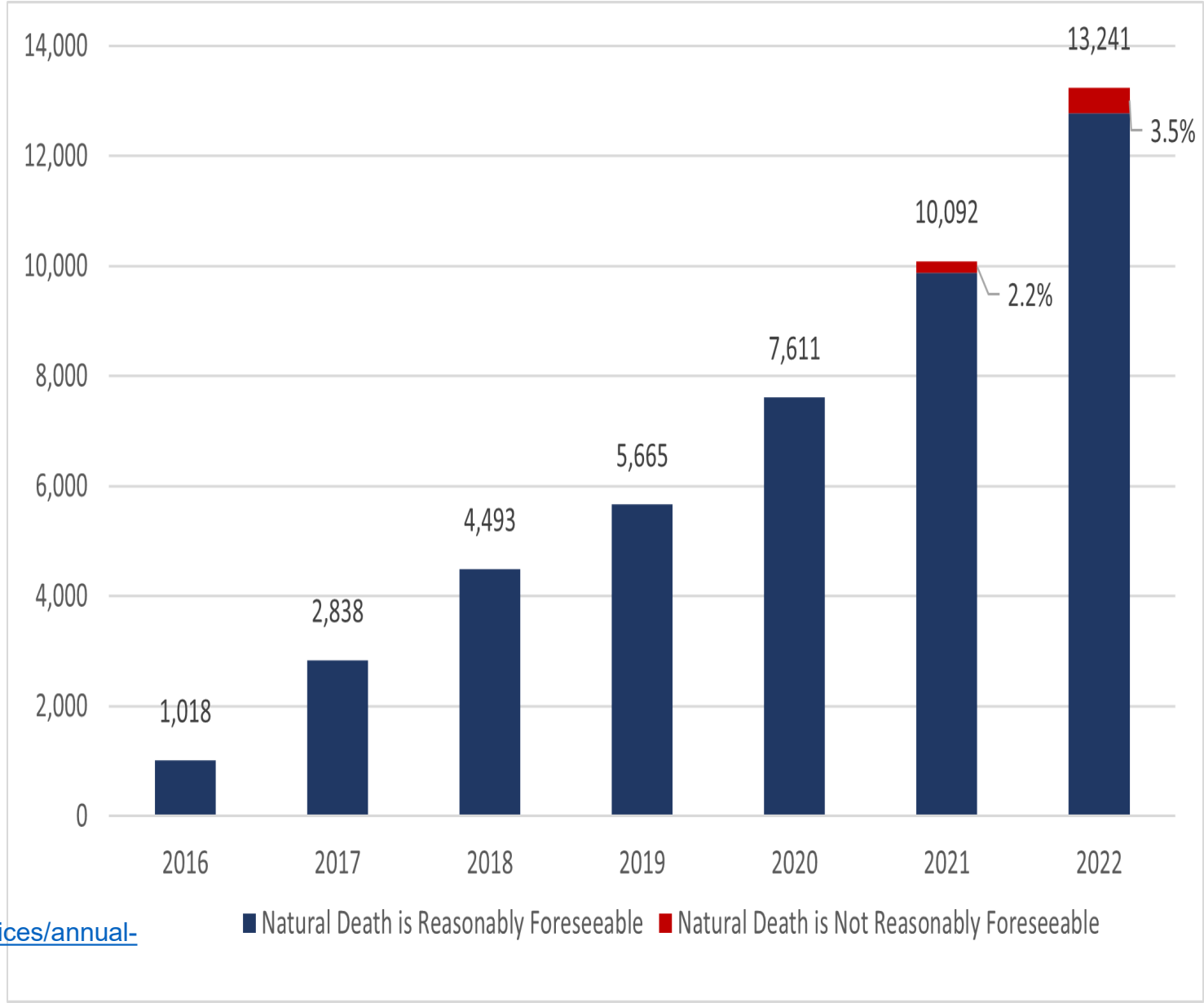
A brief history of MAID in Canada

- **2016:** Bill C-14 Legalization of MAID
- **2021:** Bill C-7
  - Reasonably foreseeable natural death no longer required as an eligibility criteria
  - Waiver of final consent introduced.
- **2023 and 2024:** MAID MDSUMC (mental disorder as the sole underlying medical condition)
  - Temporary exclusion extended to 2027
- Future challenges and controversial topics:
  - Advanced requests – To begin in Quebec in 2025. Unclear how this will roll out
  - MAID for Mature Minors – Unlikely

TOPIC: CONTEXT

Calgary Zone webinar series: Mental health & hot topics

MAID deaths in Canada



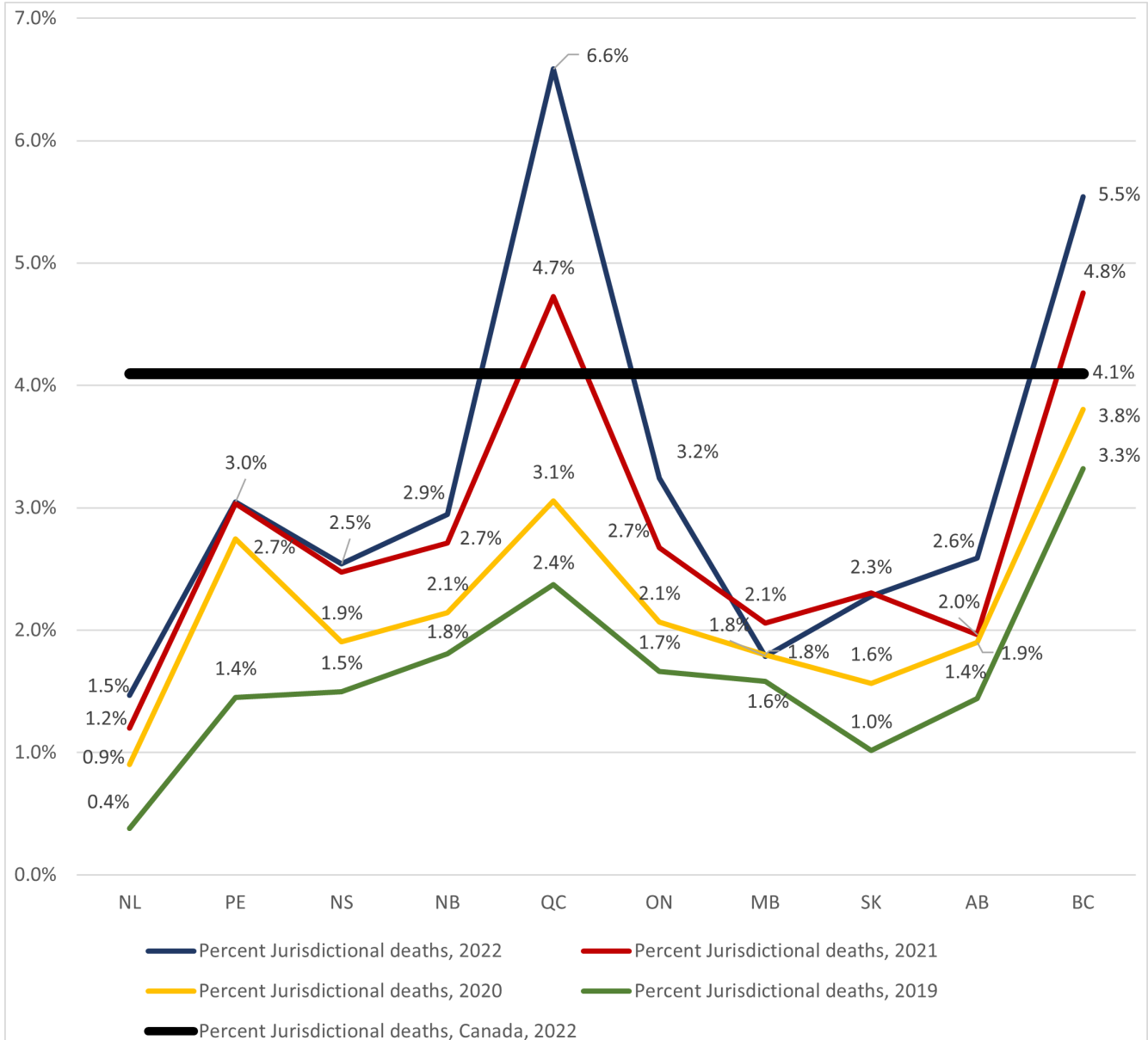
www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html#a3

TOPIC: PRIMARY CARE HOT TOPICS

Calgary Zone webinar series: Mental health & hot topics

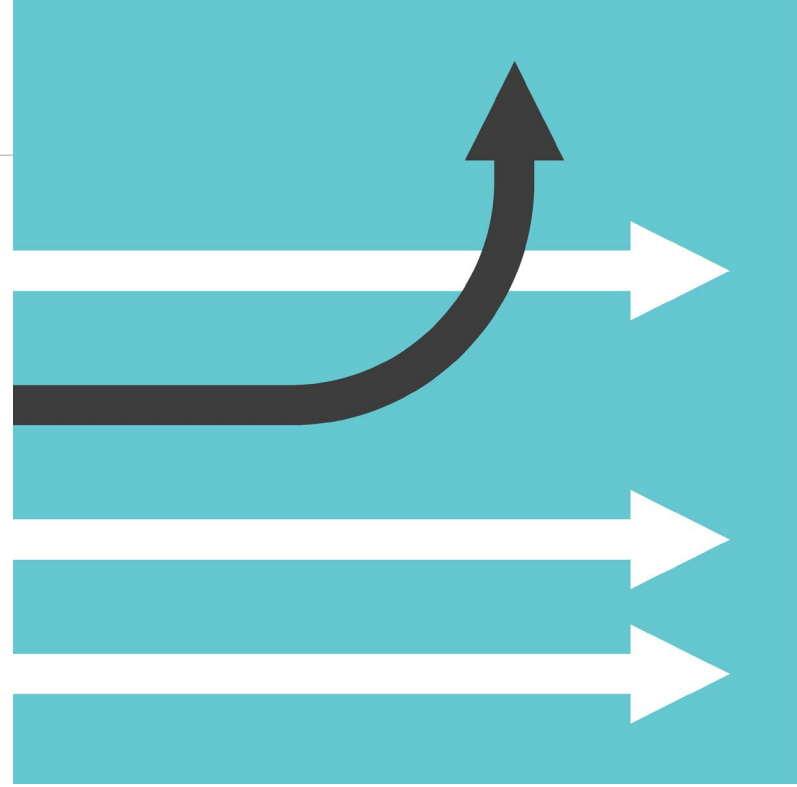
Percentage of total deaths attributed to MAID

- By jurisdiction: 2019-2022



www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html#a3

MAID: HOW IT WORKS



Patient journey

- Contact care coordination service at any time for questions or information (811, www.ahs.ca/maid, maid.careteam@ahs.ca)

- **Submit Record of Request – application officially begins here.**

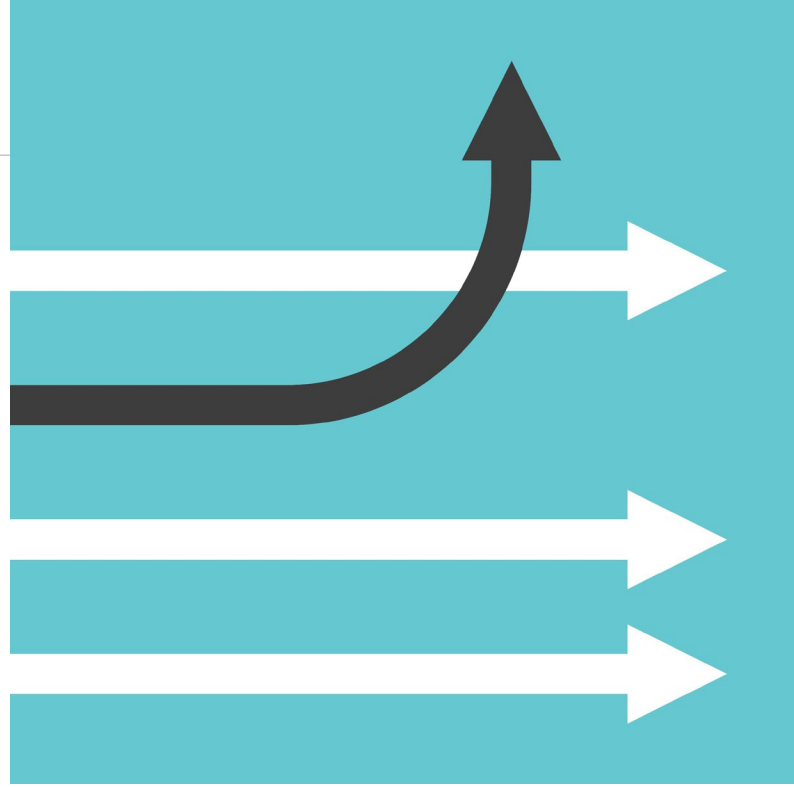
  Please don't do an assessment before this step is completed!

- Patient is contact by the Care Coordination Service to discuss MAID and discuss next steps

MAID: HOW IT WORKS

Patient journey

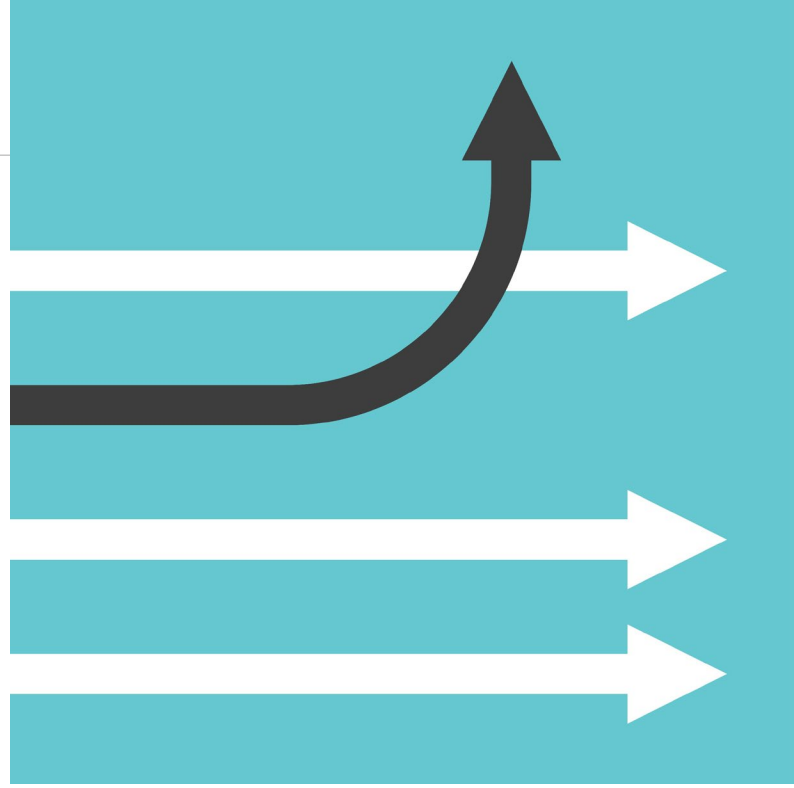
- 2 independent assessments
  - Coordinated by the Maid CCS
  - They may ask the family doctor or specialist to complete one assessment
- +/- further consultations
- Care Coordination Service reviews all assessments and contacts patient about eligibility status



MAID: HOW IT WORKS

Patient journey (if eligible)

- Provision planning: Up to the patient to contact the CCS
  - Patients often have questions about funeral plans, organ and tissue donation, death certificates, how many people can attend, etc.
- MAID provision
  - MD/NP and an RN will attend
  - IV medications preferred
  - Location:
    - Home, hospice, long term care, in hospital only if they are already admitted
    - Community bed available at no cost
  - Consent obtained prior to giving the medication (unless using waiver of consent)



MAID: HOW IT WORKS

Eligibility criteria

- At least 18 years old
- Eligible for publicly funded health care services in Canada
- Make a voluntary request that is not the result of external pressure

MAID: HOW IT WORKS

Eligibility criteria

- Capacity to make decisions with respect to their health
  - If PD enacted, the agent cannot apply for MAID on patient's behalf
  - Patients with dementia who retain capacity can apply
  - Formal capacity assessments may be requested by the MAID assessors

MAID: HOW IT WORKS

Eligibility criteria

- Did the patient give informed consent to receive MAID after having been informed of the means that were available to relieve their suffering, including palliative care?
  - May require consultation with family doctor, referrals to specialists, follow-ups, etc.
  - Includes medical interventions, allied health supports such as social work referral, review of home-care resources, review of assisted living options, discussion of financial or housing supports

MAID: HOW IT WORKS

Eligibility criteria

- Has a **grievous and irremediable** medical condition:
  - Serious and incurable illness, disease or disability;
  - Advanced state of irreversible decline in capabilities; and
  - Enduring physical or psychological suffering, caused by either the illness, disease or disability, or by the advanced state of decline in capabilities, that is intolerable to the person and cannot be relieved under conditions that they consider acceptable

MAID: HOW IT WORKS

Eligibility criteria

- Reasonably foreseeable natural death is no longer an eligibility criteria…. but is still considered at the assessment
  - What does “Reasonably foreseeable” mean?
  - Trajectory toward death is predictable taking all aspects of their health into account
  - Prognosis not required
  - Goals of care can be considered
  - Reasonably predictable

- The Clinical Interpretation of “Reasonably Foreseeable”, Clinical Practice Guideline, CAMAP, June 2017

MAID: HOW IT WORKS

Documentation

- MAID assessments are not routinely shared with other healthcare providers
  - Important ethical arguments and considerations on both sides of this
  - Likely to be reviewed over the coming year as MAID transitions to CC
- All cases reported to Health Canada
- MAID assessment can be shared with patient permission

MAID: HOW IT WORKS

Anecdotal experiences

- Patients often express gratitude about the care they've received. This happens whether their family doctor supports their MAID process or not
- Patients often tell me that they understand if/why their family doctor doesn't want to be part of their MAID process. Some are worried it will affect their relationship, some are not
- Patients are often nervous about telling their family doctor or specialist about applying for MAID
- Some want the MAID information shared with their family doctor and some do not

MAID: HOW IT WORKS

Family physician involvement

- Objector
- Goals of care discussions
  - Should we bring up MAID?
- Facilitator/supporter
- Consultant
- Assessor
- Provider

Please **avoid informal assessments**! If you're not sure…ask, or have patient contact the care coordination service

MAID: HOW IT WORKS

Objector

College of Physicians and Surgeons of Alberta:
*"A regulated member who receives an inquiry from a patient with respect to medical assistance in dying **must** ensure that contact information for the Alberta Health Services medical assistance in dying care coordination service is provided to the patient, or to another person identified by the patient, without delay"*

- CPSA, Standards of Practice
Conscientious Objection, June 2016

Call 811, visit ahs.ca/maid, email maid.careteam@ahs.ca

MAID: HOW IT WORKS

Bringing up MAID

- Does it align with the patients' values?
- Consider appropriate timing: *"..it would be clinically inappropriate to initiate such a discussion immediately upon delivery of a diagnosis…"*
- *"…not a coercive recommendation to a vulnerable patient"*
- *"…If,… a patient would not meet the legal eligibility criteria, MAID should not be offered as a treatment option."*

- Bringing up Medical Assistance In Dying (MAID) as a clinical care option, Canadian Association of MAID assessors and providers

MAID: HOW IT WORKS

Facilitator/supporter

- ahs.ca/MAID
- RECORD OF REQUEST – a healthcare provider **can witness** this form
- If you witness the form you **cannot assess or provide**

Medical Assistance in Dying

We know that end-of-life care and medical assistance in dying (MAID) are important, sensitive, and emotional issues for Albertans and Canada.

If you are looking for information on all end-of-life options please visit: MyHealth.Alberta.ca - Palliative Care

AHS wants to ensure patients can access compassionate high quality care, while ensuring staff and physicians can provide services within the law.

How Can We Help You?

Patients or Family Members

Health Professionals or Volunteers

MAID: HOW IT WORKS

Consultant

- An assessor may contact the family doctor for various reasons such as:
  - Medical records not available on CC/Netcare
  - Further information about the history of a condition (such as chronic pain or mental health concerns)
  - Expert opinion on symptom management
- You do not need to provide an opinion on their MAID eligibility

MAID: HOW IT WORKS

Family physician involvement

- Objector
- Goals of care discussions
  - Should we bring up MAID?
- Facilitator/supporter
- Consultant
- Assessor
- Provider

Please **avoid informal assessments**! If you're not sure…ask, or have patient contact the care coordination service

MAID: CASE DISCUSSIONS

Case #1: AB

- 68M with new diagnosis of SCLC with mets to brain. Diagnosed following a pneumonia. Has SOB on minimal exertion and chest wall discomfort. Lives at home with spouse Struggling to walk to bathroom and with self-care. PPS 40%
- Saw med onc: Stage 4, pall. Chemo not recommended. Has seen palliative care and home care initiated. Supportive family. Considering hospice when care needs increase

  PMH HTN, DL, Ex smoker.

MAID: CASE DISCUSSIONS

Case #1: Eligibility criteria

- Capacity to make decisions with respect to their health
- Informed consent to receive MAID … informed of the means that were available to relieve their suffering, including palliative care
- Has a **grievous and irremediable** medical condition:
  - Serious and incurable illness, disease or disability;
  - Advanced state of irreversible decline in capabilities; and
  - Enduring physical or psychological suffering, caused by either the illness, disease or disability, or by the advanced state of decline in capabilities, that is intolerable to the person and cannot be relieved under conditions that they consider acceptable
  - Reasonably foreseeable natural death? *Remember: you don't need an "official prognosis"*

MAID: CASE DISCUSSIONS

Case #2: CD

- 68M with new diagnosis of NSCLC with mediastinal spread.
  - Diagnosed following a pneumonia. Prior to pneumonia was walking 2-4km/day. SOBOE and mild chest wall discomfort. Lives at home with spouse. Independent with IADL and ADL but becomes fatigued more easily
  - Saw med onc: stage 4. Palliative chemo was discussed. Awaiting biopsy results to see if candidate for immune therapy. Has seen pall care for symptom management. No home care needed yet. Supportive family

PMH HTN, DL, Ex smoker.

Case #2: Eligibility criteria

- Capacity to make decisions with respect to their health
- Informed consent to receive MAID … informed of the means that were available to relieve their suffering, including palliative care
- Has a **grievous and irremediable** medical condition:
  - Serious and incurable illness, disease or disability;
  - Advanced state of irreversible decline in capabilities; and
  - Enduring physical or psychological suffering, caused by either the illness, disease or disability, or by the advanced state of decline in capabilities, that is intolerable to the person and cannot be relieved under conditions that they consider acceptable
  - Reasonably foreseeable natural death?

MAID: CASE DISCUSSIONS

Case #3: DE

- 73F with Parkinson's disease diagnosed 10 years ago. Followed by movement disorders (neurology). Initially had predominantly motor symptoms but now suffering with many non-motor symptoms including anxiety, orthostatic hypotension, constipation. Mild dementia (still has capacity).

- Lives with supportive husband, home care 3 days per week.

Case #3: Eligibility criteria

- Capacity to make decisions with respect to their health
- Informed consent to receive MAID … informed of the means that were available to relieve their suffering, including palliative care
- Has a **grievous and irremediable** medical condition:
  - Serious and incurable illness, disease or disability
  - Advanced state of irreversible decline in capabilities; and
  - Enduring physical or psychological suffering, caused by either the illness, disease or disability, or by the advanced state of decline in capabilities, that is intolerable to the person and cannot be relieved under conditions that they consider acceptable
- Reasonably foreseeable natural death?
  - One assessment must be done by someone with expertise in the area causing the patient's suffering OR an expert was consulted.
  - Minimum 90-day assessment period

MAID: Mental disorder as the sole underlying condition

- Mental Disorder as the Sole Underlying Medical Condition

- Temporary exclusion until 2027

- Data from Benelux countries

MAID: HOW IT WORKS

Resources for patients/families

- Bridge C-14:
  www.bridgec14.org

- MAID family support services
  www.maidfamilysupport.ca

- Dying with Dignity
  www.dyingwithdignity.ca

- Book: *The Many Faces of MAID – What to expect when someone you know chooses MAID* – Cyntia Clark
  - Available on Amazon and proceeds go to MAID family support services

primary care

HOT TOPICS

HEALTH CARE

with Dr. Christine Luelo

SPEAKER: DISCLOSURE/CONFLICTS

Dr. Christine Luelo
Family Physician

Financial sponsors

- Fee for service for clinical work
- Contract for Calgary area PCNs

Potential for conflict(s) of interest:

- None

TOPIC: PRIMARY CARE HOT TOPICS

Palliative care referral guidelines

- Home care referral goes live on Connect Care May 4
- Two main referral touch points for palliative care services
  - Palliative home care (in rural this is through integrated home care service)
  - Palliative consult service
- Specialist Link access pathway/tele-advice line
- Key components for smooth transition:
  - Patient agrees with referral, goals for care aligned
  - Patient has symptoms related to progressive life-limiting illness, initial symptom management strategies implemented AND case management required (if support needed, consider consult service)
  - Home care reviews referrals with R goal of care designation
  - Patients are eligible for Cdn health services or have refugee status

TOPIC: PRIMARY CARE HOT TOPICS

Palliative care referral (continued)

- Ways you can help:
  - Ensure med rec, ambulatory orders in Connect Care
  - Not on Connect Care - excellent up to date referral letter!
  - Use tracking record for goals of care designation conversations (PPIP idea!)
  - Prepare patients, families

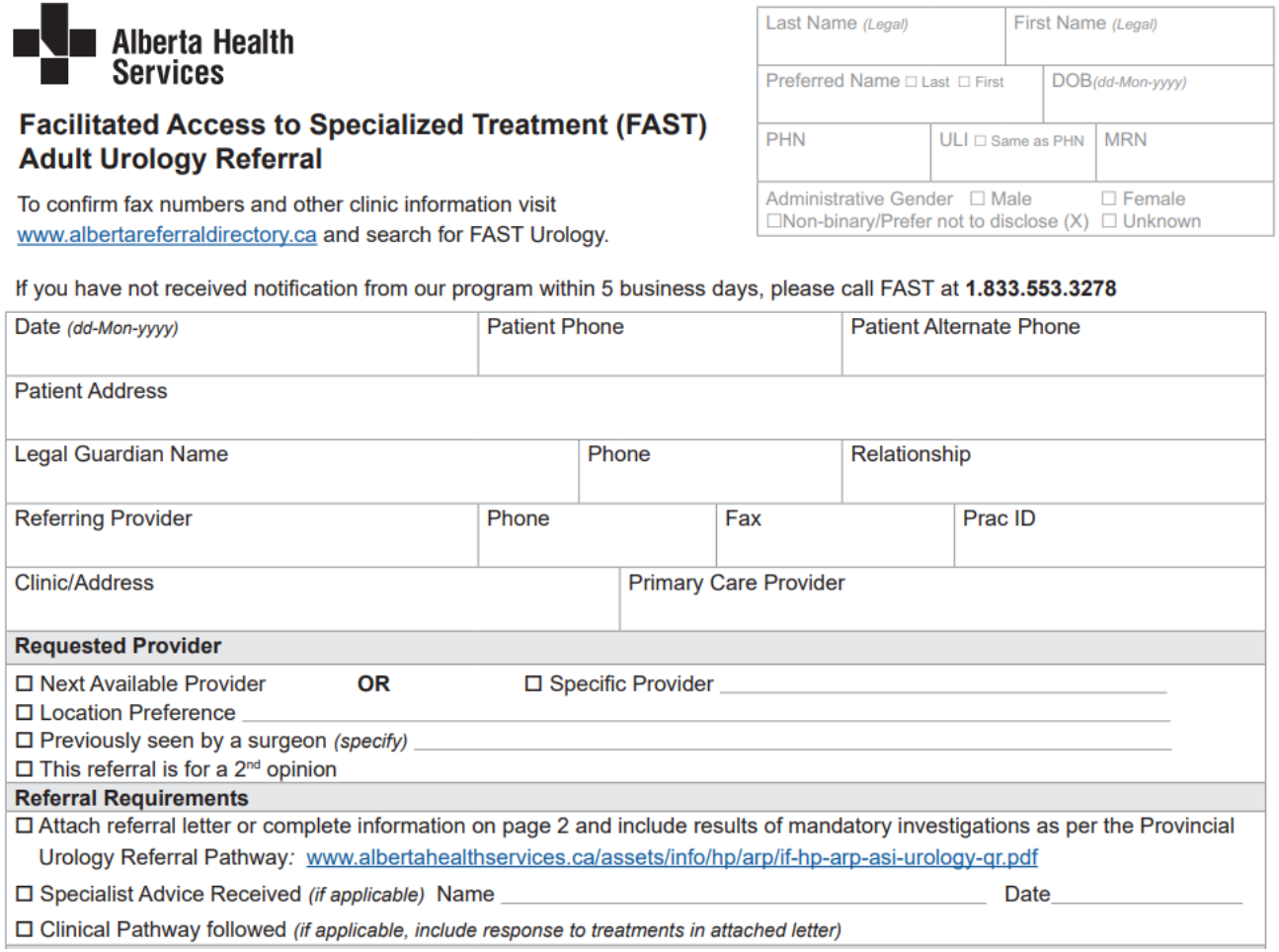
- And did you know?
  - The palliative care consult service can assist with difficult goals of care conversations
  - PEOLC consults are available concurrently with MAID contemplations/requests
  - A Specialist Link call could be appropriate for patients with non-life-threatening illness to consider a consult to address suffering

TOPIC: PRIMARY CARE HOT TOPICS

Calgary Zone webinar series: Mental health & hot topics

Facilitated Access to Specialized Treatment (FAST)

- Referral pathways (includes forms) for ortho, urology, vascular surgery, general surgery available via Specialist Link (gynecology coming soon)
- Only 27% using referral forms
- Reminder of fax #: 1-833-627-7023
- Referrals can also go via eReferral, Connect Care



Alberta Health Services

Facilitated Access to Specialized Treatment (FAST)
Adult Urology Referral

To confirm fax numbers and other clinic information visit www.albertareferraldirectory.ca and search for FAST Urology.

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown		

If you have not received notification from our program within 5 business days, please call FAST at **1.833.553.3278**

Date *(dd-Mon-yyyy)*	Patient Phone	Patient Alternate Phone	
Patient Address			
Legal Guardian Name	Phone	Relationship	
Referring Provider	Phone	Fax	Prac ID
Clinic/Address	Primary Care Provider		

Requested Provider

☐ Next Available Provider **OR** ☐ Specific Provider _____
☐ Location Preference _____
☐ Previously seen by a surgeon *(specify)* _____
☐ This referral is for a 2nd opinion

Referral Requirements

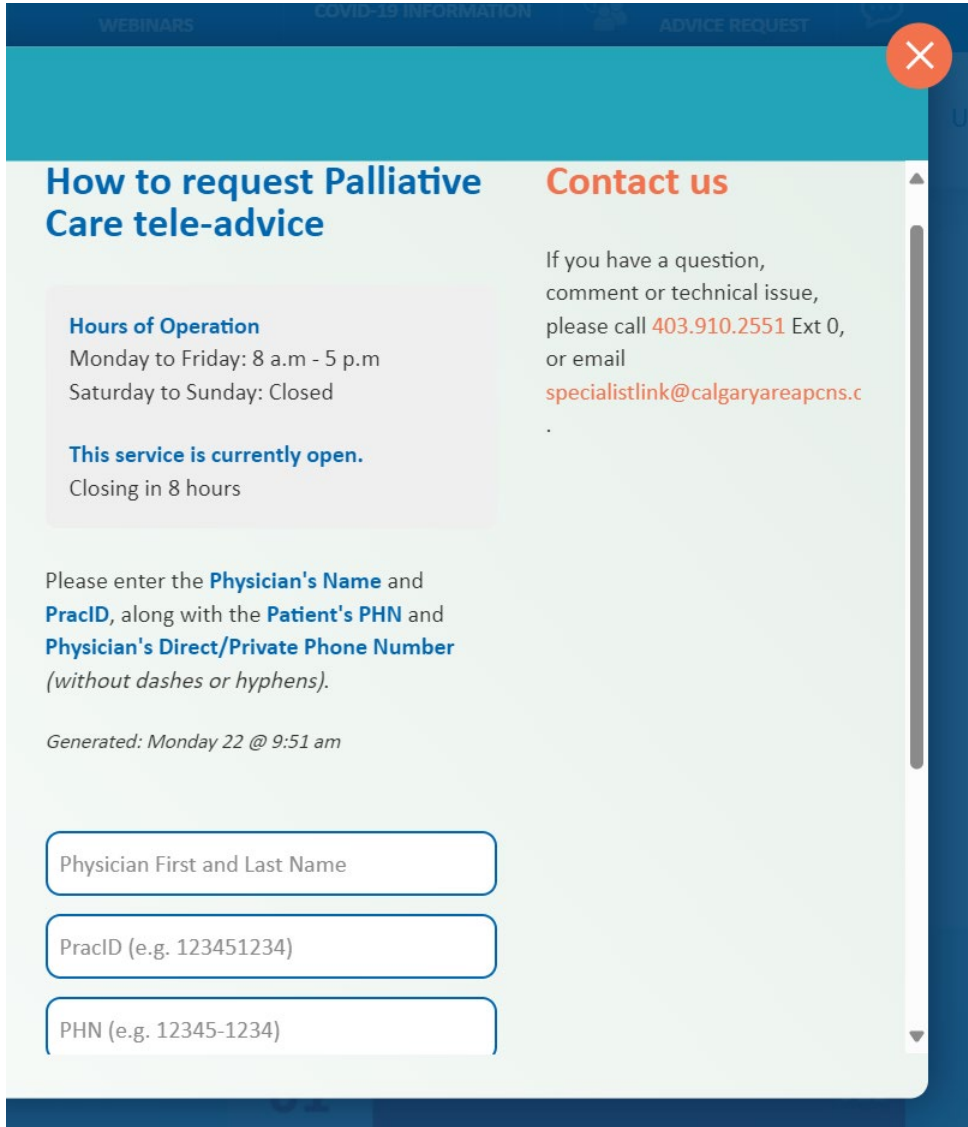
☐ Attach referral letter or complete information on page 2 and include results of mandatory investigations as per the Provincial Urology Referral Pathway: www.albertahealthservices.ca/assets/info/hp/arp/if-hp-arp-asi-urology-qr.pdf
☐ Specialist Advice Received *(if applicable)* Name _____ Date _____
☐ Clinical Pathway followed *(if applicable, include response to treatments in attached letter)*

TOPIC: PRIMARY CARE HOT TOPICS

Calgary Zone webinar series: Mental health & hot topics

Specialist Link

- Specialist's name who will be calling back and their Prac ID now visible after making request online
- 03.01lg referring physician, daytime
- Some exceptions…



TOPIC: PRIMARY CARE HOT TOPICS

Calgary Zone webinar series: Mental health & hot topics

Neurology access

- Access pathway and headache clinical pathway update in progress
- In meantime … for non-urgent migraine you can also refer to authorized family practice migraine special interest clinics (Specialist Link) if patient has failed 2-3 preventative meds (botox and monoclonals available)

Refugee support

- Greater need for support of population in community
- Tele-advice available via Specialist Link
- See also website for excellent resources
- Most billing through Alberta Health Care, occasionally Blue Cross Medavie (federal), rarely no coverage

Refugee Health YYC

Q&A

Calgary Zone webinar series: Mental health & hot topics

WEBINAR SERIES: TILL NEXT TIME

Calgary Zone webinar series: Mental health & hot topics

Thank you for attending!

Survey for Mainpro+ credits: https://survey.alchemer-ca.com/s3/50256978/Calgary-Zone-Primary-Care-Webinar

Feedback, issues, support or complaints: info@calgaryareapcns.ca

Next webinar:
Monday, June 24, 2024
(fibromyalgia is the planned topic)
https://www.eventbrite.ca/e/fibromyalgia-webinar-tic
887829400637?aff=oddtdtcreator