



HIGH IMPACT PRACTICES

Evidence-informed practices in home and community care that result in better care, better outcomes and better value.

Implementing a palliative approach to care by having conversations early (IPACE)

Empowering frontline staff to incorporate early conversations with patients about their goals for care

Having early conversations with patients about their goals for care is associated with better quality of life, reduced use of non-beneficial care near death, and positive family outcomes. However, these conversations do not routinely occur, or they occur too late in patients' illnesses to impact their care in a meaningful way. **This High Impact Practice showcases an innovative approach developed at Vancouver Coastal Health (VCH) to provide training and education to frontline staff (physicians, nurses, allied providers) across disciplines and care settings to help them incorporate these conversations into their work.**

BACKGROUND

Identifying individuals who could benefit from a palliative approach to care is often challenging. Many patients' illnesses have unpredictable trajectories, making it difficult to recognize the terminal phase. When this situation occurs, patients who would benefit from a palliative approach to care may not access the appropriate palliative services that could enhance their quality of life. To facilitate early identification and access to necessary services, practice changes are needed to support clinicians, patients and their families to shift their understanding that palliative care is not for short-term end-of-life, but rather it is an essential part of a comprehensive approach to care for individuals with chronic illness and seniors living with frailty.

Advance Care Planning (ACP) is one of the ways to facilitate the shift toward a person-centred and holistic palliative approach to care. It is a process of reflection and communication when a person reflects on their values and wishes and discusses the kind of health and personal care they would want in the future if they were unable to speak for themselves. Effective, ongoing communication among the patient, family caregivers and health care team members is essential to effective ACP. Although effective ACP should begin well in advance of serious illness, these conversations do not routinely occur. In the absence of culturally sensitive and respectful conversations about serious illness and care planning, many Canadians will not receive the benefits associated with palliative care.

The research shows that conversations about patients' wishes are conducted inconsistently, largely due to health care providers' lack of competency and comfort. This

situation is exacerbated by inconsistent documentation of goals of care due to the use of multiple reporting systems and the lack of interoperability between them. Patients with serious illnesses routinely interact with multiple health care providers and different parts of the health care system. This complexity makes it difficult to ensure that patients' wishes are communicated and shared with all members of their health care team.

A palliative approach to care applies the principles of palliative care, including enhancing quality of life and providing excellent symptom control, to the care of anyone with a life-limiting illness, regardless of the stage of the illness.

Need for Change

In response to feedback from clients and families, the Vancouver Coastal Health began work to determine how patients' beliefs, values and wishes could be better respected throughout their health care journey. Research in this area clearly showed that not having conversations early in a patient's care journey, in addition to a lack of consistency and competency in conducting these conversations, has far-reaching ramifications. The following illustrates how client care, client and family experiences and both health care providers and the system are impacted.



Client Care

- Care providers and family caregivers are less able to actively support client's care.
- Care is often not in line with client's wishes.
- Referrals to palliative care programs and services are missed or done too late.

Client and Family Experiences

- Clients and families scramble during a crisis to understand their options.
- Families unable to advocate for patients as wishes were not assessed earlier.
- Lack of satisfaction if care does not align with goals of care.

Health Care Providers and System

- Patients experience unnecessary and unwanted interventions and/or hospitalization.
- Health care providers may lack confidence and validation in providing the care the patient wants.
- Costly interventions may be used that do not meet the patient's wishes.

DEVELOPMENT

Through a generous donation, the Vancouver Coastal Health developed and implemented a unique three-year initiative to help shift both culture and practice toward embedding a palliative approach to care into all aspects of patient care (physical, emotional and spiritual needs). Implementing a Palliative Approach to Care by having Conversations Early (IPACE) changes how health care team members identify, monitor and support patients with a serious illness. The initiative includes tools and resources in addition to staff education. The program is delivered by specialized palliative care community leads (agents of change) who educate colleagues in urban and rural areas of Vancouver, Richmond and the Coastal regions.

Strategic Goals and Objectives

The strategic goals of the IPACE initiative are to increase clinical capacity and competency and ensure sustainability of the project following the initial pilot funding. The objectives for the pilot phase were as follows:

- Identify clients who could benefit from a palliative approach to care.
- Have regular and consistent goals of care conversations with clients and families that were documented and respected.
- Provide timely, coordinated quality of care for patients receiving end-of-life care at home or in hospice.
- Facilitate appropriate referrals to community-based services.
- Decrease inappropriate emergency and hospital-based care for end-of-life patients.

The IPACE approach was adapted from the Serious Illness Care Program developed by Ariadne Labs [www.ariadnelabs.org/areas-of-work/serious-illness-care/], an evidence-based program that provides clinicians with the language to ask patients about their goals, values and wishes using a Serious Illness Conversation Guide (SICG). Using the guide as the core of the IPACE approach, a multi-component program was designed to create system-level support for clinicians to facilitate patient conversations.

A steering committee was established to set the direction for the overall project, allocate resources, provide oversight and to resolve project issues at a senior management level. The steering committee also played a key role in communicating the status of the project to executive sponsors and supporters. The project leadership team consisted of a project director/manager, end-of-life clinical leads, palliative care leads, regional leaders and other experts, such as evaluators, human resources, information management/information technology services, and operations managers. The project director/manager provided updates to monthly meetings of the existing Regional End-of-Life Program.

To meet the needs of the diverse population in the Vancouver Coastal Region, the IPACE initiative translated the SICG into 11 different languages. The project team worked with clinicians, translators and interpreters to ensure that the translation of the tool was both culturally sensitive and clinically accurate. The focus was on maintaining the meaning and intention of questions rather than simply translating specific words. The inclusion of interpreters in this process was a unique and innovative approach to support the culturally sensitive goals of care ACP discussions.

The process included the following steps:

- Translate source tool and then health care providers who speak and read the language review it.
- Edit based on feedback from frontline clinical staff.
- Prepare "back" translation with input from interpreters (i.e., the previously translated document is translated back to the original language).
- Compare "back" translation with source document.
- Pilot draft versions with a small group of clinicians and interpreters.
- Finalize conversation guides (interpreters use translated guides and clinicians use English version).
- Supplement conversation guides with classroom training for interpreters and an online course.

A detailed project charter and framework were developed to provide the road map for the project, including key project milestones and measures. The project began in March 2017, with the final evaluation planned for March 2020. Key deliverables for the project included:

- Hiring of clinical practice leads
- Development of project charter and plan
- Creation of an evaluation framework (metrics for quality improvement, outcomes and training)
- Community engagement (public awareness of palliative approach to care, client and family satisfaction, and engagement sessions data)

"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want —is this okay?"

—Serious Illness Conversation Guide

Implementing a palliative approach to care

Championing virtual care to empower patients and build system capacity

- Capacity building and training plans – development of resources and training delivery
 - Identification workshops
 - Goals of care workshops
 - Site champions
 - On-site coaching and mentoring
- Completion of training
- Project evaluation

One of the critical steps to improving client care is to identify those clients who would benefit from a palliative approach to care. Participating Community of Care centres were provided with existing validated tools to choose for the project, including:

- Supportive and Palliative Care Indicators Tool – Gold Standard Framework (SPICT-GSF)
- Palliative Approach Assessment Tool (IPAL)
- Clinical Frailty Scale
- Surprise Question (Would I be surprised if this patient died in the next 12 months?)

IPACE Training Approach

Training aimed at all disciplines (nursing, case managers, social work, rehab, dietitians, recreational workers, psychologists)

Palliative Approach to Care

→ Helps staff learn to identify clients in their caseloads who can benefit from a palliative approach to care

Serious Illness Conversation Guide Workshop

→ Focuses on finding out what is important to a person
→ Questions do not focus on death or dying
→ Priority is learning about the clients' goals, values and wishes as they live with a serious illness

Champion Training (Train the Trainer)

→ Taught how to problem solve difficulties faced when using the SICG in practice; advocate use of SICG
→ Strategies to overcome staff resistance
→ Update staff on new developments/change in practice.
→ Part of a community of practice (COP)



“If you become sicker, how much are you willing to go through for the possibility of gaining more time?”

“How much does your family know about your priorities and wishes?”

—Series Illness Conversation Guide

IMPLEMENTATION

The project was launched in September 2017. Education and training for staff across disciplines was the foundation for the project. The team developed the training and conducted workshops to help build competency. As illustrated in the chart, there were 3 levels of training based on the role of the participant. Resources used to develop the education component included:

- Serious Illness Conversation Guide
- Embedding a Palliative Approach to Care in Residential Settings (EMPAIRS 4 Questions)
- Palliative Approach Assessment Tool (IPAL)

The education and training was carried out by the community leaders who were hired for each Community of Care Centre (COC). In community health, two workshops were conducted to train clinicians in the areas of home health, mental health, primary care, and assisted living. The training was done in stages, starting with home health and then moving to the other settings within ten to twelve months. The purpose of this training was to:

- Identify those patients who could benefit from a palliative approach to care using identification tools (clinicians brought their caseload files to analyze)
- Learn how to use the SICG
- Document using existing IT systems

Consistent processes for documentation are critical to ensure that patients' beliefs, values and wishes are better respected throughout their health care journey. As part of the implementation, the team coordinated processes for the handling of the following documents and systems:

- Green Sleeves (plastic pocket that holds ACP forms)
- Medical Orders for Scope of Treatment (MOST)
- Advance Care Planning (ACP)
- Do Not Resuscitate form (DNR)

Audits and evaluation were key to the project design. Solid metrics were developed to measure outcomes and achievement of goals and objectives. While donor support was the catalyst for the pilot, the development team were committed to ensuring the long-term sustainability of the operational changes. In addition to data collection, the team ensured that ongoing training was maintained to sustain the culture change.

OUTCOMES

Over 40 nurse practitioners and over 50 family physicians received training on palliative approach basics and the SICG. In addition, 50 interpreters from the provincial language training services were trained, and this will be extended to other interpreters through a specialized online module.

In addition to the workshops, community leaders provided on-site support through joint home visits with those clinicians who wanted coaching and mentoring. Staff were invited to be “champions” at each site and were provided with additional training to provide support and to advocate for early conversations in their area. Ongoing meetings with the project leadership team were held to share results and strategies to address any challenges that developed during implementation.

While audits and evaluation of the project are still underway, some early metrics show that the program is meeting its objectives. The results of the training have been very positive, indicating a strong increase in staff confidence and competence in the identification of patients who could benefit from a palliative care approach and in holding serious illness conversations. Since the introduction of the training, there has been a 33% increase in documented Goals of Care plans. With the introduction of Serious Illness Conversations, records show patients are more likely to die at home or in a hospice. Once the evaluation is complete, additional qualitative and quantitative outcome measures will be available.

ELEMENTS FOR SUCCESS

Factors that contributed to the successful implementation of this program included:

- Donor support
- Staff support at all levels

- Designated funding for project deliverables
- Clinicians who recognize the value of the work
- Validated tools for the education sessions
- Support from interpreters
- Collaboration with a broad range of stakeholders (e.g., hospitals, mental health, community health, primary care, assisted living, Alzheimer’s Society, Parkinson’s Society, seniors groups, Cardiac Forum, BC Care Providers Association, Ariadne Labs, community partners)

FUTURE OPPORTUNITIES

Designated funding is currently being considered to continue the work done by the community leads. Practice sessions using the SICG are continuing, and the project leadership team has developed online modules based on the in-person workshops. Champions have been identified and trained to support their own disciplines at each of the home-based teams. Through a Community of Practice, these champions will become agents of change and help advance integration of palliative care practice among all disciplines through the use of identification tools and the SICG. To help sustain the practice, process workflows and documentation processes have been implemented. Vancouver Coastal and Ariadne Labs have formed a partnership to support the Community of Practice with access to current research and evidence on the SICG.

To help spread this unique program, efforts will focus on enhancing the 11 translations of the SICG and testing through Ariadne’s Community of Practice. The online courses will also help other organizations implement this practice. In particular, the interpreters’ online course could be implemented in other regions and countries.

SOURCES

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- Speak-Up, <https://www.advancecareplanning.ca/what-is-advance-care-planning/>

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Vancouver Coastal Health provides health care services through a network of hospitals, primary care clinics, community health centres and residential care homes. Search our health care services in Vancouver, Richmond, North and West Vancouver and along the Sea-to-Sky Highway, Sunshine Coast and BC’s Central Coast. We deliver services to more than 1.25 million BC residents (nearly 25% of British Columbia’s population) living in our communities.



The Canadian Home Care Association (CHCA) is dedicated to ensuring the availability of accessible, responsive home care to enable people to safely stay in their homes with dignity, independence and quality of life. Our vision is an integrated health and social care system that provides seamless patient- and family-centred care that is accessible, accountable, evidence-informed, integrated and sustainable.

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