

Two Steps Forward or Three Steps Back? The COVID-19 Pandemic and its Impact on Palliative Care

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Palliative Care Conference, NOSM 3Feb 2023

Two Steps **Back** and **Three Steps Forward**: The COVID-19 Pandemic and its Impact on Palliative Care

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Learning objectives

At the end of this presentation, participants should be able to:

1. Describe the impact the COVID-19 pandemic has had on the delivery of palliative care across different settings
2. Describe the ways in which the pandemic has set palliative care backwards and others in which the pandemic has created opportunities to advance palliative care

Presenter Disclosure

- Scientific officer at Pallium Canada (non-profit organization)
- No honoraria from industry
- Pallium Canada's COVID-19 pandemic webinars were partly supported by an unconditional grant from Boerigner Ingelheim.
- Canadian Medical Association (CMA) supported Pallium Canada's free online LEAP module offerings April to August 2020

Presentation plan

1

The COVID-19 Experience

2

Unpacking what happened

3

From reflection to action

4

Priorities for a reset

Conclusions, Questions & Discussion

Part 1

1

The COVID-19 experience

Impact in general

- Tragic loss of life and great morbidity
- Burden on patients, families and health care providers, across all sectors
- Major toll on LTC: 80% of COVID-19 related deaths
- Impacted all sectors

Impact in general

- Required considerable re-arranging and reconfiguring
- Many clinicians with limited palliative care skills called to provide palliative and EOL care.
 - Many without the skills & training
 - Added stress and burnout
- Some bizarre decisions as well
 - e.g. ED to support LTC with palliative care in Hamilton region
- Ethics of rationing highlighted

Home and community care

- Care shifted to families who were home
- Rapid transition to virtual care
 - Searching for the right platform, protocols and criteria
 - Trying to find the right balance (in-person vs virtual)
 - Some professions not provided the tools
- PPE shortages
 - Scrambling and fear
- Home care workforce took major hit
 - Restrictions on working across settings and sites
 - Quarantine policies
- **Realization that home care and home deaths is possible!!**

Opinion

COVID-19 rips bandage off the open wound that is our nursing home system



Pandemic has exposed the dismaying inadequacies of Canada's long-term care system for seniors



Dr. Amit Arya

· for CBC News Opinion · Posted: Apr 26, 2020 4:00 AM ET | Last Updated: April 26



LTC: Impact on residents, families & staff

- Visiting restrictions, grief amplified, dying alone, guilt of family
- Lingering effects of forced separation
- Frustration, fear, anxiety and anger
- Families not prepared to engage in ACP & Goals of Care discussions, and now being forced to have them virtually
- Impetus to move residents out of LTC



LTC during the pandemic: The lived experience of clinicians related to palliative and EOL care.

THEMES & SUBTHEMES	
Theme 1: Providing a palliative care approach	
Scaling up	Uncertainty of disease
Preparedness	
Theme 2: Increased demands	
Staffing challenges	Supply and resource shortages
Role changes, added responsibilities and going the extra mile	

LTC during the pandemic: The lived experience of clinicians related to palliative and EOL care.

THEMES & SUBTHEMES	
Theme 3: Communication and Collaboration	
Engage families	Communication & collaboration externally
Communication internally	
Theme 4: Impact of isolation and visitation restrictions	
Resident distress	Impact on staff
Family distress	
Theme 5: Impact on clinicians' personal lives	
Burnout	Moral distress and emotional trauma
Impact on family life	

LTC during the pandemic: The lived experience of clinicians related to palliative and EOL care.

- *“So pre-pandemic we had a good flow, we had lovely processes. During our outbreak, all of those just went by the wayside” [P4]*
- *“ We had actually just had a LEAP course that I had trained 2017-18ish, where all of our frontline staff were brought in there” [P1]*
- *“I had started the work before COVID talking about that every resident coming into long-term care, we should advocate for a palliative approach to care focusing their goals of care on their quality—what it means for their quality of life and what that looks like in terms of medical treatment” [P7]*
- *“The issue was more so that we had had a staffing crisis, which means that the staff that were trained weren't necessarily the ones that we had, including the army” [P1]*
- *“But the PSWs would sit beside them as they were dying. One PSW sang to one of the residents. It was heartbreaking to see them” [P7]*
- *“I think the most memorable is the care that was given by the PSWs and RPNs. The dedication they had to those residents, the love that they showed them when their families weren't around” [P7]*
- *“We became like the proxy family members, and so it did develop some very close relationships with our residents and their care providers” [P4]*

LTC during the pandemic: The lived experience of clinicians related to palliative and EOL care.

- *“And this is the messaging that didn't get there. We hear about everyone that's unhappy about not having essential visitors, and people in, but they really didn't give the staff—nobody has talked about how hard it would be for them to lose 22 people on their unit when they took care of them for three and four years” [P9]*
- *“And so I had people crying, sitting in the corner crying that they could not deliver what they needed to deliver. It was overwhelming” [P9]*
- *“So, yeah, I'm sure many of us have PTSD. So, yeah, I think at some point you just have to recognize that maybe I need to get well myself” [P13]*
- *I think that has been, yeah, that part has become very rewarding now to be able to speak to the families regularly. And just seeing how rewarding that is, how appreciative they are, like that's probably the most rewarding things in long-term care” [P3]*
- *“Residents were dying without their families, and if their families did come in, they had mask, gloves, they had gowns on. There wasn't that physical, that able to physically touch their family member dying.” [P7]*
- *“Well, you know what, I spent a lot of nights lying awake worrying over this nursing home that I lost.. And worrying about getting sick and, you know, worried about what's happening to my practice and my life” [P6]*

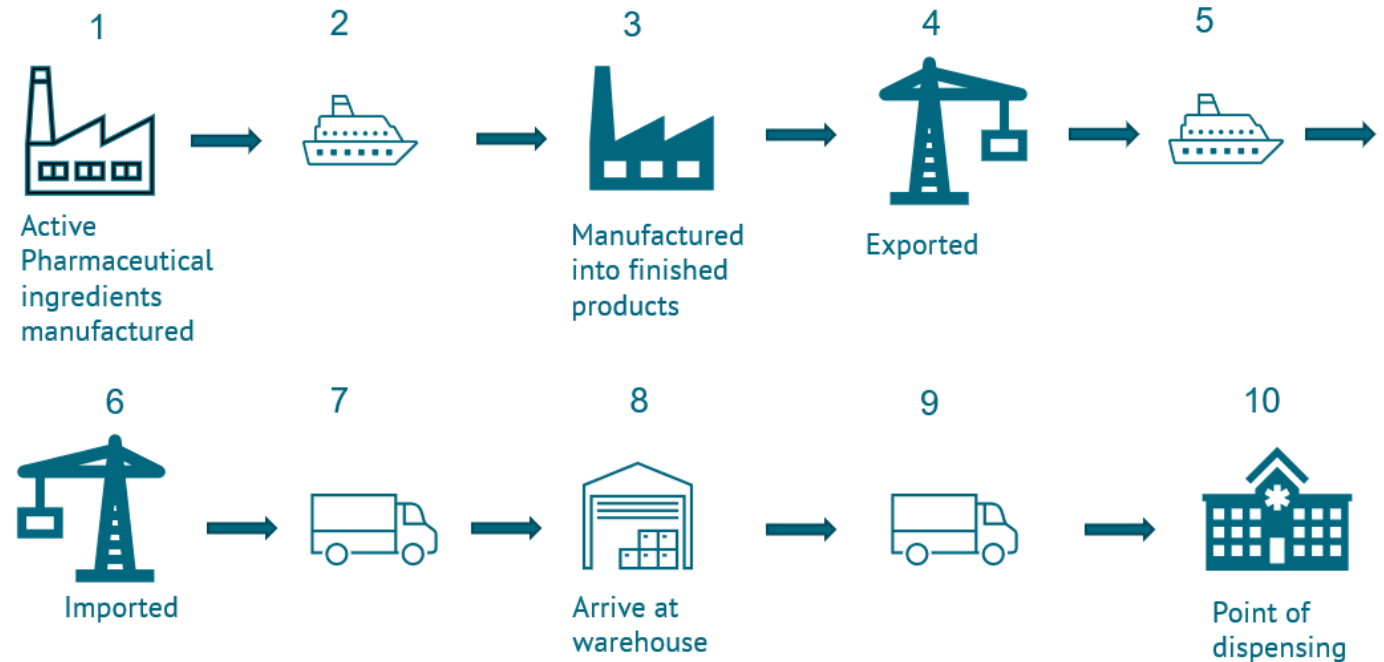
COVID-19: Impact on staff

- Greater workload with reduced resources
- Moral distress
- Public scrutiny
- Communication breakdown
- Lack of appropriate PPE
- Feelings of frustration, fear, anxiety and even anger
- Having to cope with own grief and self care
- Calls for a need for more education and training about a palliative approach to care



Palliative care medication shortages

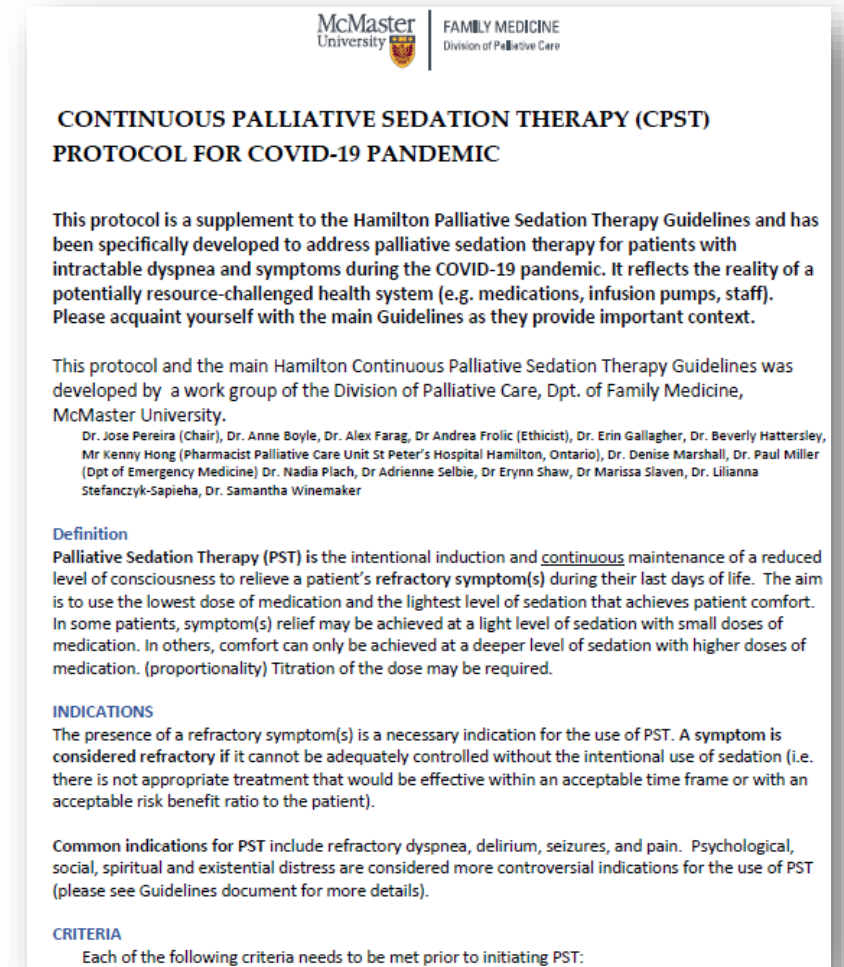
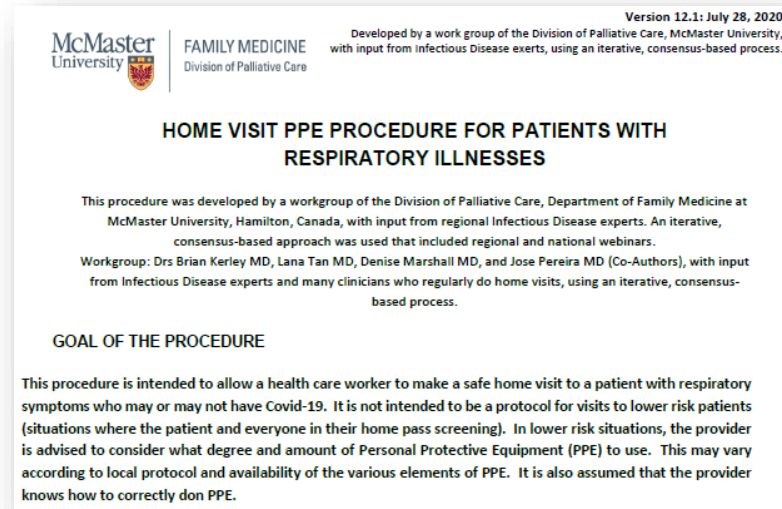
- Need more reliable and predictable palliative medication supplies and supply chains
- Legislation needed to reduce wastage



Pereira J, Arya A, Downar J, Rice P, MacDonald S, Osborne E, Kanji S, Sauls R. Shortages Of Palliative Care Medications In Canada During The Covid-19 Pandemic: Gambling With Suffering. Healthcare Quarterly (in press)

Clinical guidelines and protocols

- Useful
- But.....
- Will need reviewing as we learn more
- May need to unlearn protocols designed for pandemic situation but not optimal ordinarily



The “PPE in the Home” Saga

COVID-19 Personal Protective Equipment in the Home: Navigating the Complexity of Donning and Doffing

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Lana Tan, MD,CCFP(PC)^{2,3}

Denise Marshall, MD, CCFP(PC),
FCFP^{2,4}

Cindy O'Neill, MLT, ART, CIC⁵

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Conflicts of interest: authors report none.

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ABSTRACT

PURPOSE The safety of care professionals and patients is paramount while caring for people with infectious diseases, including those with confirmed or suspected severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and coronavirus disease 2019 (COVID-19). Existing policies and protocols for donning and doffing personal protective equipment (PPE) are primarily for institutional settings such as hospitals, not for home visits for patient care. We describe a protocol for donning and doffing PPE in home settings.

METHODS We used an iterative, rapid-prototyping approach to develop the protocol. A small workgroup created preliminary drafts, drawing on hospital-based protocols and modifying them, while undertaking simulations. Wider input was solicited via 2 webinars; 1 regional (Hamilton, Ontario) with palliative clinicians, and 1 national (Canada) with varying professions. We also consulted a group of infectious disease experts. A “how-to” video accompanies the protocol.

RESULTS Twelve versions of the protocol were produced, with major changes occurring within the first 6 versions. A national webinar mid-development provided further validation and minor modifications. Subsequent versions involved minor changes. The protocol has 4 phases: (1) Preparing, (2) Entering the Home, (3) Leaving the Home, and (4) After the Visit and Reprocessing. In addition to PPE-related equipment, the protocol requires additional materials including 2 pails for transporting supplies, plastic bags, hand sanitizer, disinfectant wipes, and printed easy-to-use checklists.

CONCLUSIONS This protocol addresses gaps in COVID-19-related guidelines, specifically the process of donning and doffing PPE during home visits while supplementing jurisdictional PPE guidelines and protocols.

Ann Fam Med 2021;19:Online. <https://doi.org/10.1370/afm.2667>.

Annals “Online First” article. Accepted for publication in a later issue.

INTRODUCTION

The safety of care professionals and patients is paramount while caring for people with infectious diseases, including those with confirmed or suspected severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and the accompanying coronavirus disease 2019 (COVID-19). Policies and protocols related to donning and doffing personal protective equipment (PPE) are now widely available, but developed primarily for institutional settings such as hospitals, and thus may not prove useful for clinicians doing home visits for patient care.

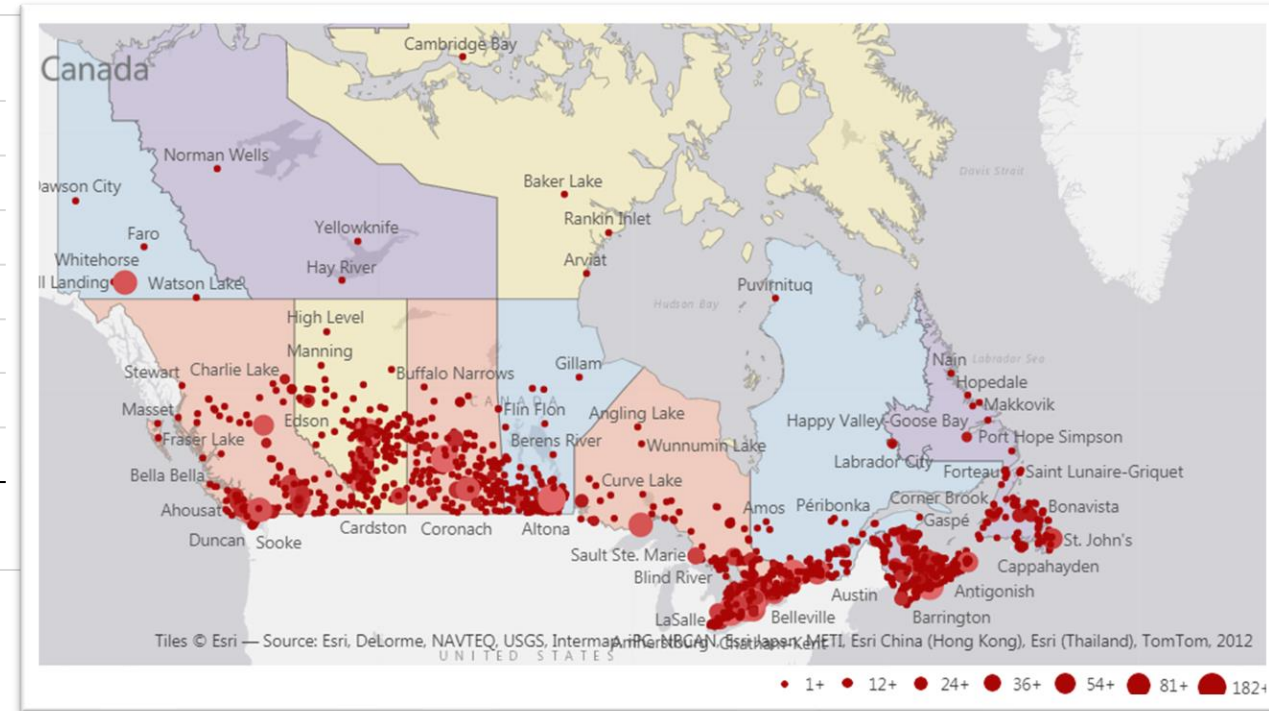
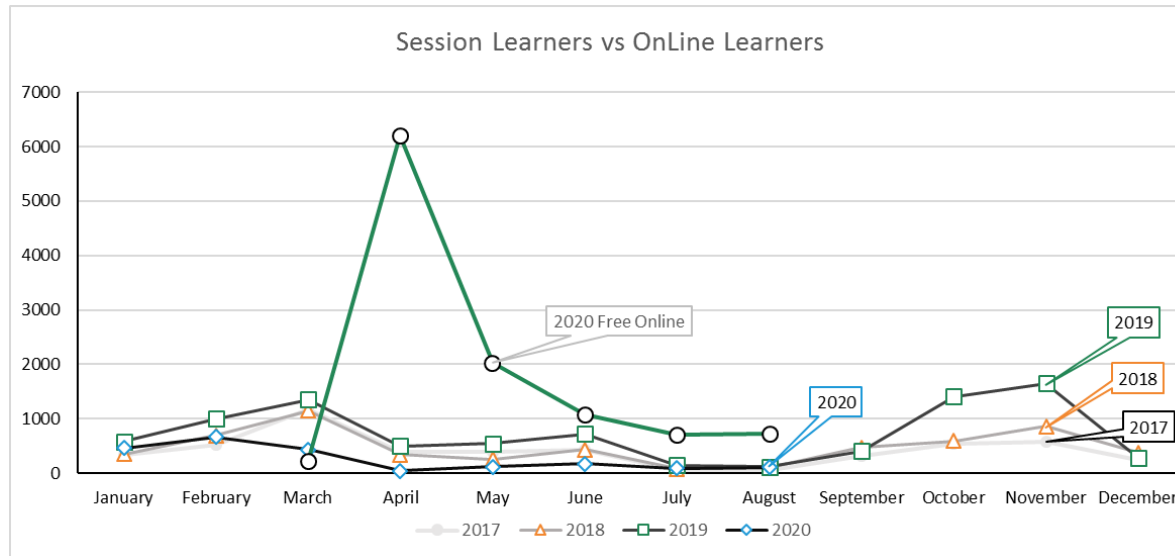
The process of donning and doffing PPE is more complex in a home setting compared with other settings of care such as hospitals. In institutional health care settings, necessary PPE equipment (eg, surgical masks or N95 respirators, gowns) is readily available outside patients' rooms, often accompanied by instructional posters, as part of a coordinated effort by the institution's Infection Prevention and Control (IPAC) team. On completion of a patient encounter, there are bins to discard used PPE. Hospital processes handle the soiled re-usable and non-reusable equipment, which

FAMILY MEDICINE
Division of Palliative Care

Education

- Rapid adoption of virtual learning
 - Learning new technologies and skills (e.g. virtual patients)
- Undergraduate
 - UG: Reduced clinical exposure to palliative care
- Postgraduate
 - PG: Realization of importance of palliative care education
- CPD
 - Many courses and programs cancelled
 - Pivoting to virtual learning

LEAP Online Self-Learning Modules



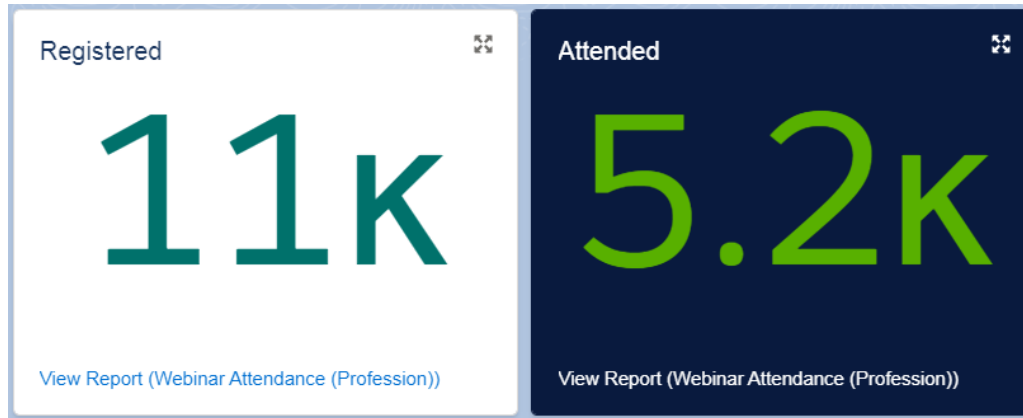
Highest number of monthly LEAP learners(November 2019): **1,649**


Highest number of 'free online' learners(April 2020): **6,190+**

Launched March 31, 2020

What has informed this presentation?

- Pallium COVID-19 webinars
 - Intentionally designed for insights from across the country

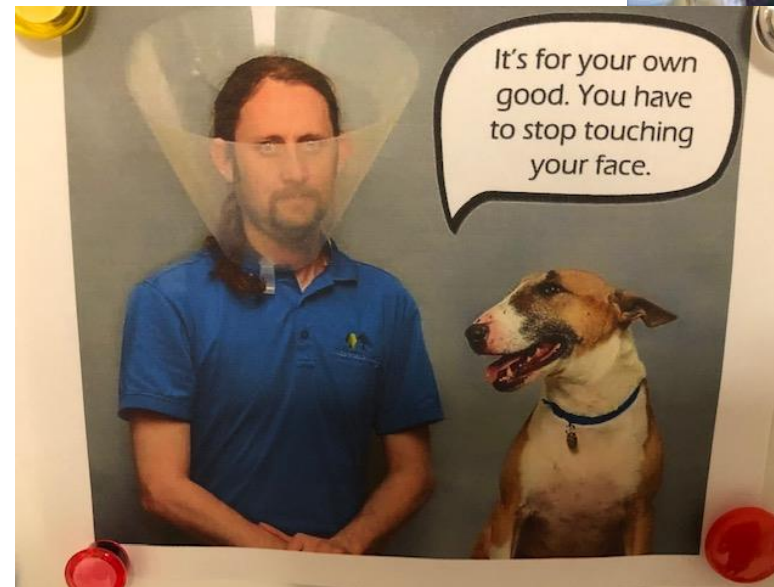
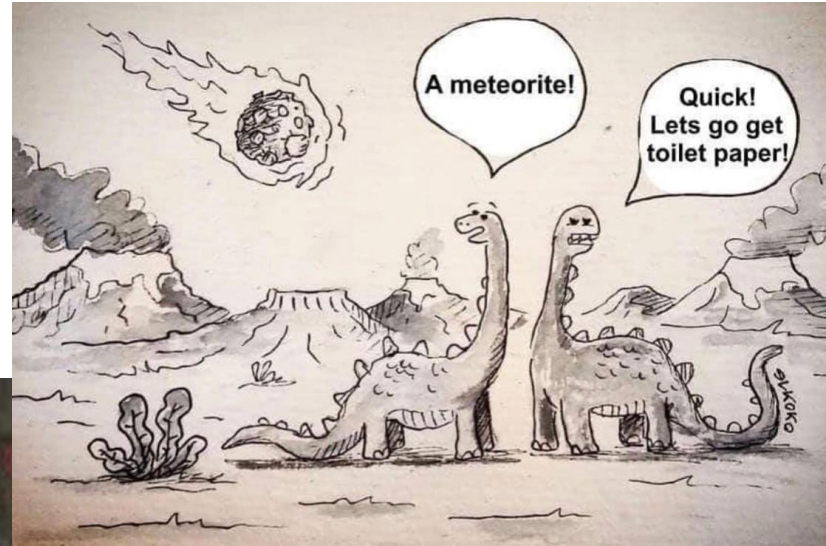


 **YouTube = 15,000+**

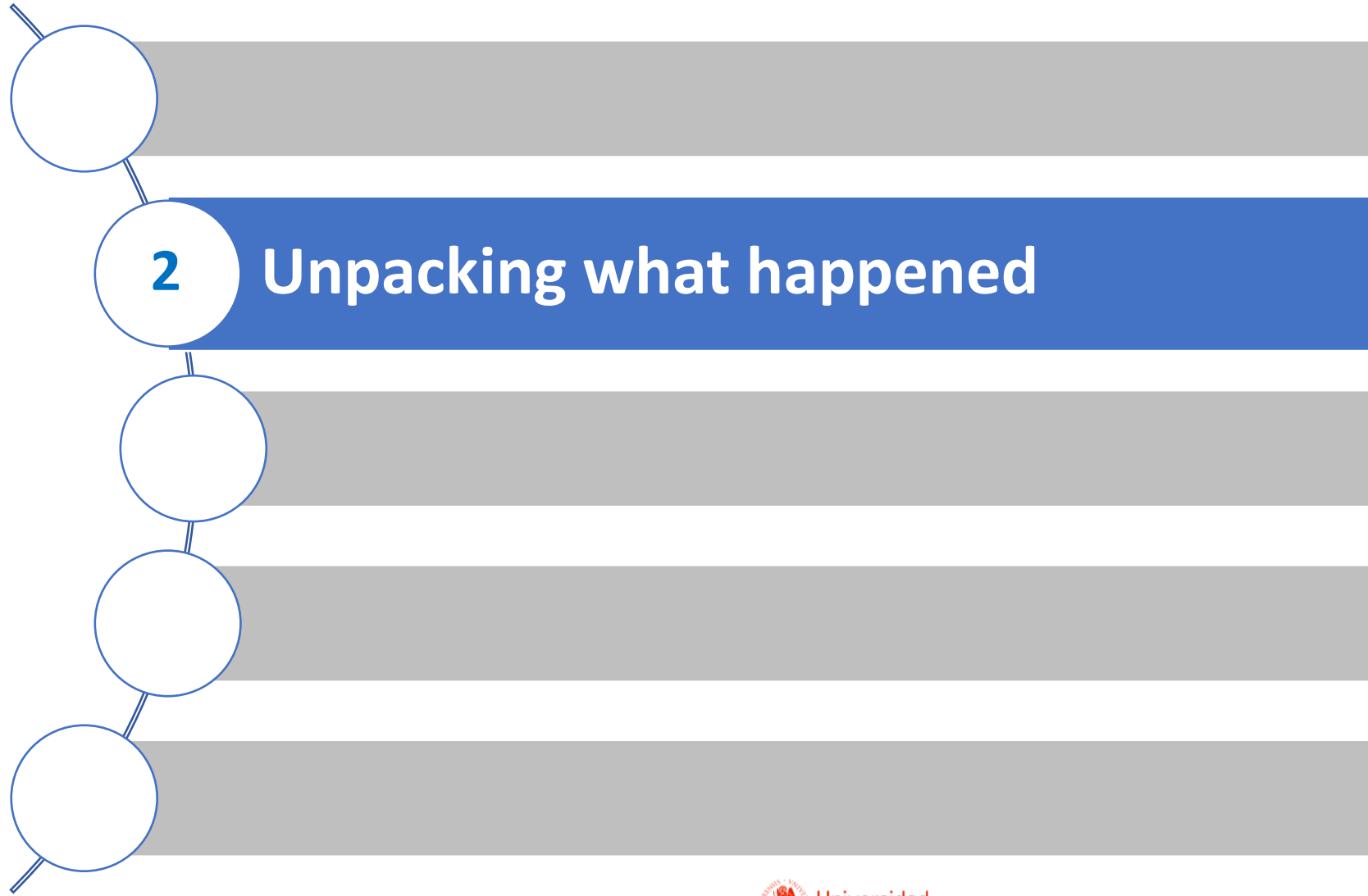
*as of August 31st, 2020

Pallium COVID -19Webinars	Date
PPE in the Home	April 3
End-of-Life Care in the ED for Patients Imminently Dying of a Transmissible Acute Respiratory Infection (such as COVID-19)	April 8
Managing Dyspnea in Patients with COVID-19	April 14
Shortage of Palliative Medications During COVID: Options	April 15
Reorganizing Palliative Care Services during the COVID-19 Pandemic	April 17 – 12pm
Palliative Approach to Care in the Coronavirus Pandemic	April 17 – 5pm
Role of Grief and Bereavement in the Care of Health Care Providers and their Families during COVID-19	April 22
Palliative Approach to Care in Long-Term Care during COVID-19	April 27
Providing Virtual Palliative Care	May 8
Essential Conversations: Utilizing Advance Care Planning & Serious Illness Tools During COVID-19 and Throughout the Patient Journey	May 13
The Psychological Impact of COVID on Health Care Professionals	May 29
Approche palliative et personnes âgées en milieu hospitalier dans le contexte du COVID-19	June 4
The State of Palliative Care in Hospitals: Insights from the COVID Pandemic	June 5
Palliative Care in the Home: Lessons From COVID	June 15
Childcare and Caregiving during COVID: Challenges for Palliative Care Health Care Workers	June 23
Trauma Informed Palliative Care	July 10
Shortage of Palliative Care Medications during COVID-19 – Part 2	July 29
Exploring Trauma Informed Palliative Care for Populations Experiencing Structural Vulnerability	August 14
Clinical Protocols: What Real Cases Have Taught Us	August 27

The lighter side



Part 2



Lessons learned

- The impact of isolation
- The impact of moral distress
- Some service and payment models made it very difficult to mobilize, pivot and restructure
- Not all professions given virtual care tools
- Lack of palliative care skills across workforce, professions and settings
- Virtual teaching, meetings and care can be exhausting
- Clinical gaps caused by virtual care

What we learned (at a societal level)

- ACP and GOC discussions were highlighted
- A home death is possible and can be a good thing.
 - More people at home to care for family.
- Technology (virtual care) can be harnessed
- Privilege of being a care giver and a health care provider
- The importance of communication
- There are strengths and gaps all around us.
 - Opportunities for improvement
 - Stepping stones for the future

Early Palliative Care: An unintended victim?

COVID-19 forces Italian doctors to make life-and-death choices about rationing care



New recommendations advise saving 'scarce resources' for those with the 'greatest chance of survival'

CBC Radio · Posted: Mar 13, 2020 6:15 PM ET | Last Updated: March 13



CBC | MENU ▾

COVID-19 Local updates Watch Live COVID-19 tracker

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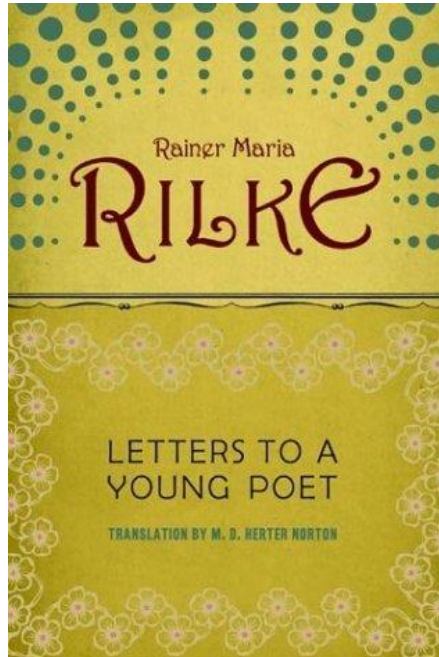
Lessons learned

- We can pivot, we can change and we can innovate when we really need to.
- People and services are able to adapt quickly
- Decisions can be made quickly
- Preparation does help
- The power of teamwork & collaboration
- The power of narrative (good and bad)
- We are only human (burnout, exhaustion)

Lessons learned

- Agility of palliative care services and teams across the country
- Excellent resources emerged
 - BC Centre for Palliative Care
 - Canadian Association of Emergency Physicians (CAEM)
 - McMaster Division of Palliative Care
 - Ontario Palliative Care Network
 - Pallium Canada's Covid webinars
 - Pallium LEAP online

Lessons learned



“Be patient toward all that is unsolved in your heart and to try to love the questions themselves like locked rooms and like books that are written in a very foreign tongue.”

“Speed trumps perfection in a pandemic”

Dr Michael J Ryan, Executive Director, WHO

**Zoom cannot see
everything**



Finding the right balance, using the right tool at the right time



- Imagine, if after all of this, we did nothing!
 - Imagine we don't change or improve what the pandemic has identified as needing fixing.
 - What would those who died and continue to suffer say to us if they found out we did nothing?
-
- There is an opportunity for transformational change.
 - It will take courageous leadership, common visions and everyone helping out

Part 3



Status of palliative care across most Canadian province

- Great progress last decades
 - Across different domains
- Patchwork that is improving but still gaps in many regions
 - Excellence in many regions in one or other area, but gaps in many



2000

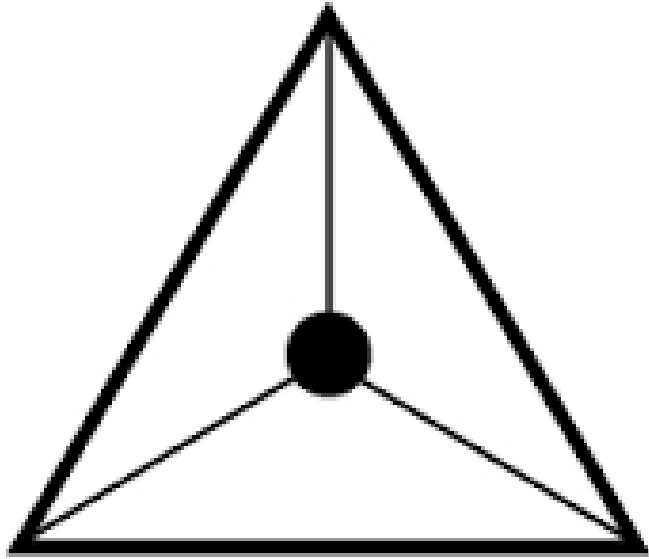


2022

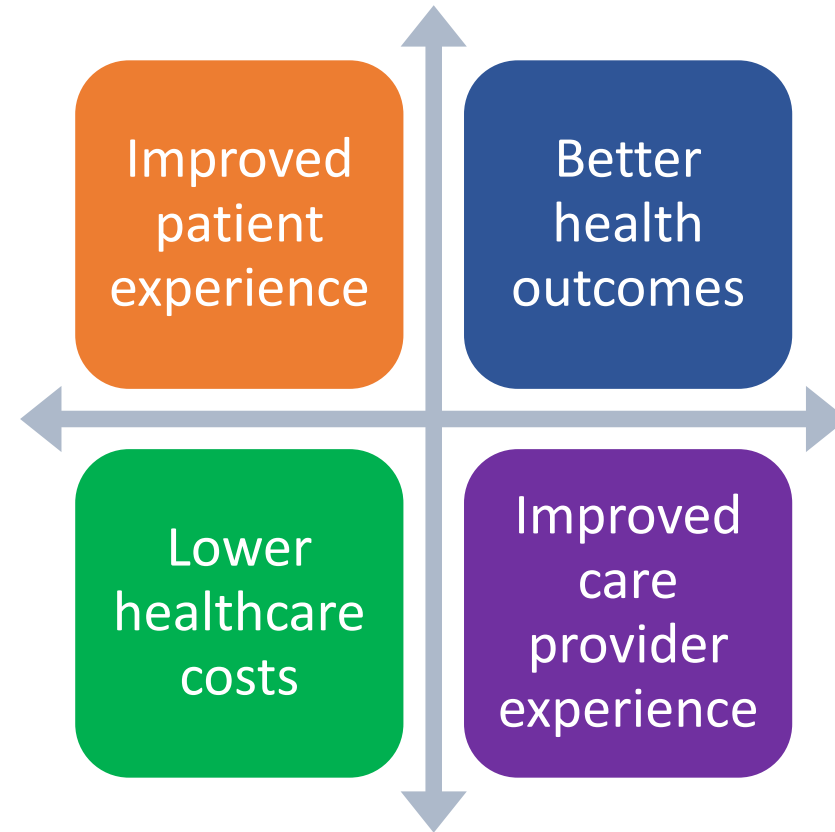


Future?

From the Triple to the Quadruple Aim



IHI *Triple Aim*



Bodenheimer T, Sinsky C. Ann Fam Med 2014; 12(6): 573-576.

Going from Good to Great.

Evolution or Disruption?

Additional fixes or total reorganization?

Halifax Oct 2014: The start of a disruption or evolution?

Paramedics providing palliative care: A multipronged intervention



Halifax
Oct 2014



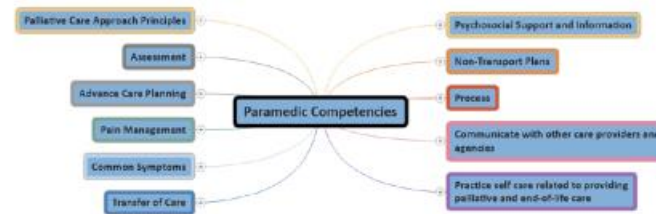
Modified DACUM Workshop

Attendees:

- Michelle Harrison, Project Manager – Paramedics Providing Palliative Care Project
- Shawn Westbury – Senior Operations Paramedic, PEI
- Darcy Clinton – Support Service Manager, PEI
- Mark Walker – Clinical Learning Coordinator, EHS NS
- Marianne Arab – Project Co-Lead & Manager Supportive Care, CCNS
- Katherine Houde – ACP Paramedic, Nova Scotia
- Sandee Crooks – ACP Paramedic, Nova Scotia
- Dr. Kathryn Downer – National Director, Ottawa
- Dr. Jose Pereira – Scientific Officer, Ottawa
- Dr. Erin O'Connor – ED and PC Physician, Ottawa
- Dr. Lisa Fischer – ED and PC Physician, Ottawa
- Nathalie Ray – Pallium Canada Program Manager, Ottawa

Regrets: Dr. Alix Carter, University of Dalhousie

Competency Map: To Identify EMS Competencies in delivering Palliative Care at Home
Table 1:



Process for developing EMS palliative care competencies

- | | |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Step 1: | Brainstorm:
Identify all the competencies you think you need to provide <u>effective palliative & end of life care</u> (write these on stickies & put on wall) <ul style="list-style-type: none">• Start by looking at what you already have identified• Continue adding (will be broad and specific competencies) |
| Step 2: | Organize into domains
Organize stickies into domains; name these domains <ul style="list-style-type: none">• Use Family Medicine domains as a rough guide only• Are there any missing domains? |
| Step 3: | Separate “Broad” from “Specific” competencies (within domains) |
| Step 4: | Identify the Broad Competencies for each domain <ul style="list-style-type: none">• Use existing Broad competencies• Are there any missing broad competencies? |
| Step 4: | Identify Specific Competencies for each Broad Competency <ul style="list-style-type: none">• Use existing stickies with specific competencies• Are there any missing specific competencies? |
| Step 5: | Further validation & fine-tuning of competencies with colleagues |

Redesigning the system

Paramedics providing palliative care

Paramedics providing palliative care at home: A mixed-methods exploration of patient and family satisfaction and paramedic comfort and confidence

Alix J. E. Carter, MD, MPH^{*†}; Marianne Arab, MSW/RSW[‡]; Michelle Harrison, BSc, AHN, MA^{†‡}; Judah Goldstein, PCP, MSc, PhD^{*†}; Barbara Stewart, RN[‡]; Mireille Lecours, MD[§]; James Sullivan, BScN, RN[§]; Carolyn Villard, BSc[§]; Wilma Crowell, RN^{*}; Katherine Houde, ACP^{*}; Jan L. Jensen, ACP, MAHSR^{*†}; Kathryn Downer, MSc, EdD[¶]; Jose Pereira, MBChB, MSc[¶]

CLINICIAN'S CAPSULE

What is known about the topic?

A novel program was implemented to enhance the care provided by paramedics to patients with palliative goals of care.

What did this study ask?

This study asked about patient experience with the program and the comfort and confidence of paramedics to deliver this care.

What did this study find?

Patients praised the compassion of paramedics and staying home, and paramedics strongly agreed palliative care should be in their practice.

Why does this study matter to clinicians?

Knowledge of this program will support similar initiatives and increase access to care and death outside of the hospital setting.

Likert scale, reported as the median (interquartile range [IQR]); analysis with Wilcoxon ranked sum/thematic analysis of free text.

Results: In Part A, 67/255 (30%) enrolment surveys were returned. Three themes emerged: fulfilling wishes, peace of mind, and feeling prepared for emergencies. In 18 post-encounter interviews, four themes emerged: 24/7 availability, paramedic professionalism and compassion, symptom relief, and a plea for program continuation. Thematic saturation was reached with little divergence. In Part B, 235/1255 (18.9%) pre- and 267 (21.3%) post-surveys were completed. Comfort with providing palliative care without transport improved post launch ($p < 0.001$) as did confidence in palliative care without transport ($p < 0.001$). Respondents strongly agreed that all paramedics should be able to provide basic palliative care.

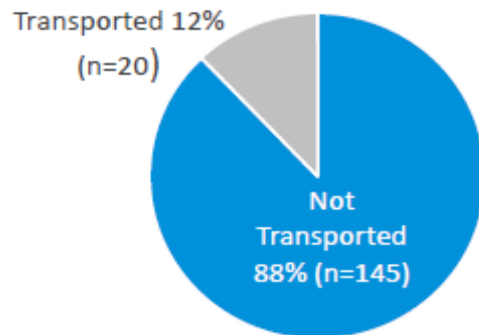
Conclusions: After implementation of the multifaceted Paramedics Providing Palliative Care at Home Program, paramedics describe palliative care as important and rewarding. The program resulted in high patient/family satisfaction; simply registering provides peace of mind. After an encounter, families particularly noted the compassion and professionalism of the paramedics.

LEAP Paramedics: Evidence of Impact at Level 4 in Alberta

Alberta

Most Treated At Home

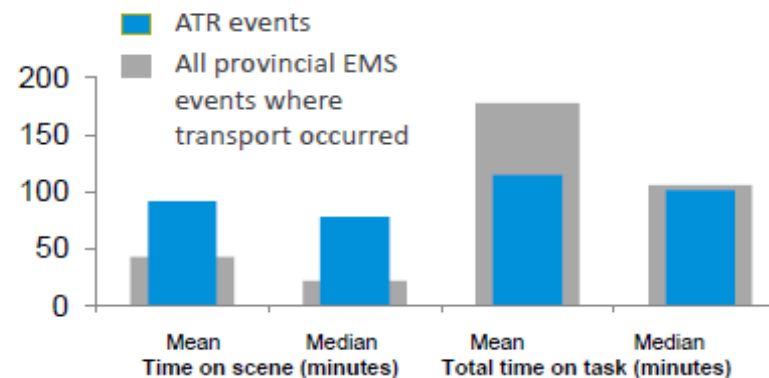
- **88% of patients were successfully treated in place** and not transported to the hospital



(n=165 Phase I one – March 2015 through September 2016)

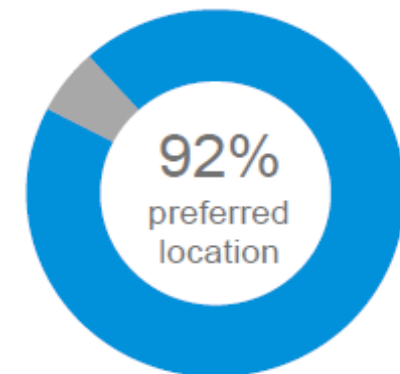
EMS Time Savings

- Despite longer time on scene, **the overall time on task for EMS staff was lower** when compared to all EMS transport events

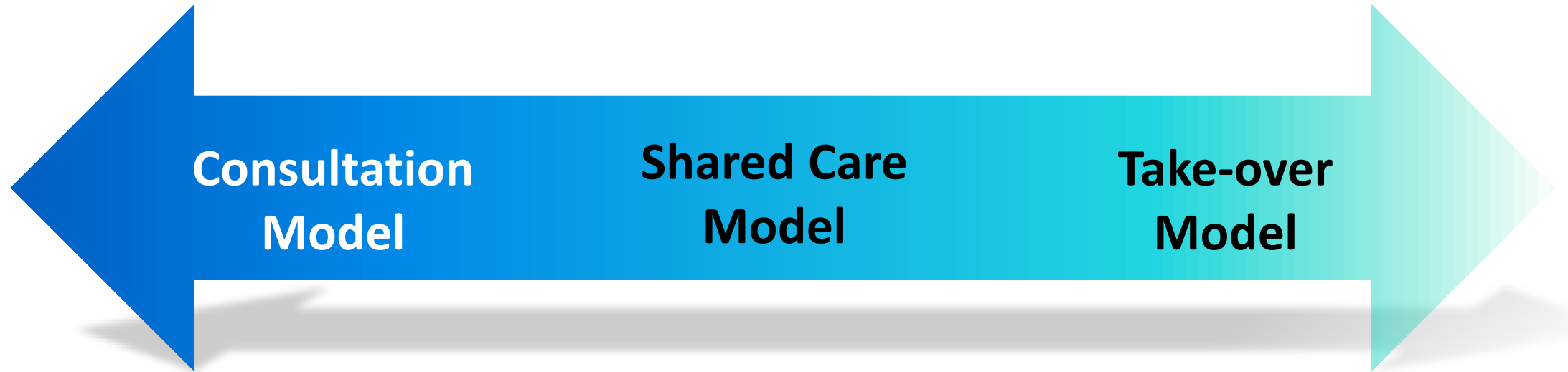


Preferred Location of Care

- The majority of family members surveyed said that **the patient received treatment in their preferred location of care**








Models of Practice: A Conceptual Framework for specialist palliative care teams



Pereira J et al. EAPC 2014

Original Article

Palliative care physicians' motivations for models of practicing in the community: A qualitative descriptive study

Abby Maybee^{1,2} , Samantha Winemaker^{1,2}, Michelle Howard¹ , Hsien Seow³ , Alexandra Farag^{1,2}, Hun-Je Park^{1,2}, Denise Marshall^{1,2}  and Jose Pereira^{1,2} 

Maybee A, Winemaker S, Howard M, Seow H, Farag A, Park HJ, Marshall D, Pereira J. Palliative care physicians' motivations for models of practicing in the community: A qualitative descriptive study. Palliat Med. 2022 Jan;36(1):181-188.



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2022, Vol. 36(1) 181–188
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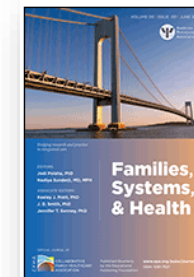
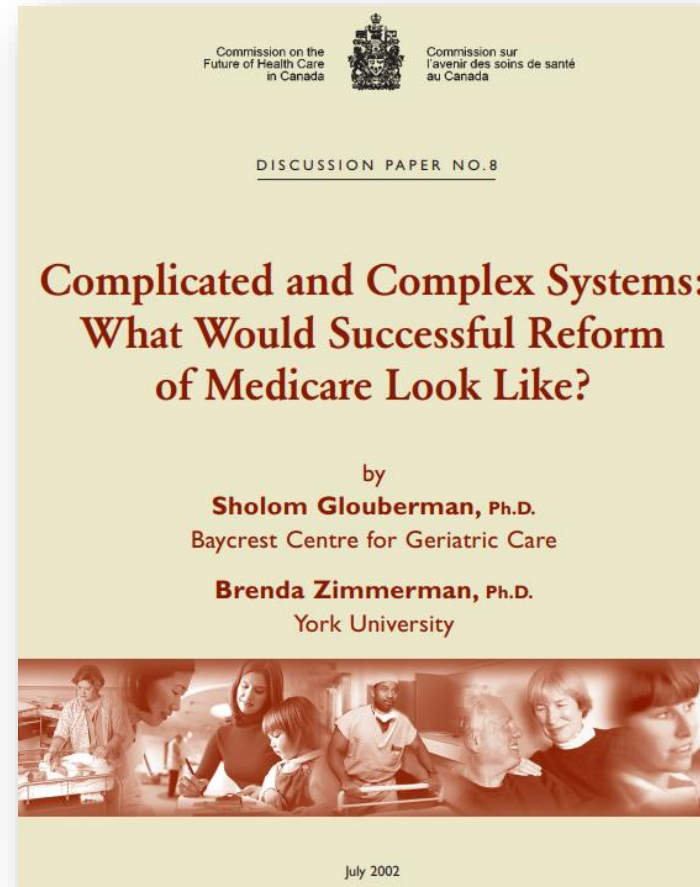
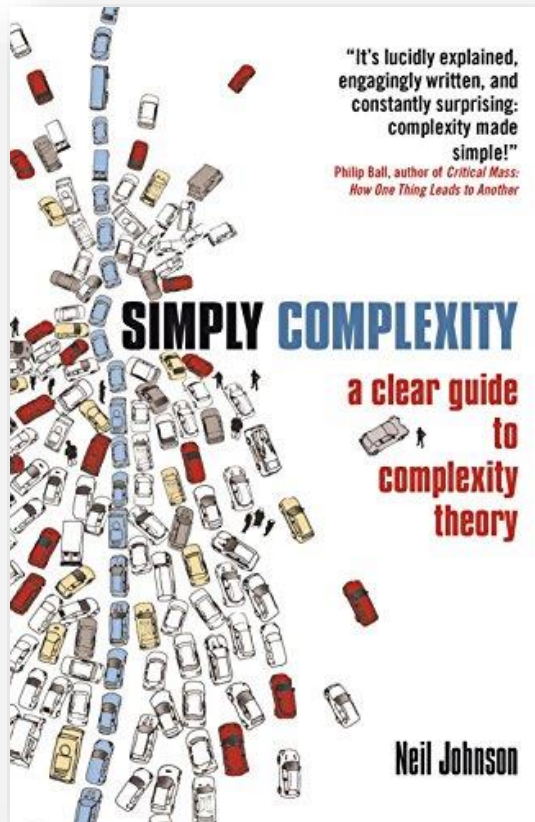

- N = 14 participants
 - 4 worked in a consultation model
 - 8 in a takeover model
 - 2 transitioning to a consultation model.
- Different motivators found for the two practice models.
 - Takeover model: palliative care physicians primarily motivated by their relationships with patients.
 - In the consultation model, primarily motivated by their relationships with primary care.
- These differing motivations corresponded to differences in the day-to-day processes and outcomes of care.
- The physician's personal or internal motivators were drivers

Systems thinking, complexity & a long term vision



de Savigny D, Adam T. 2009. Systems Thinking for Health Systems Strengthening. Alliance for Health Policy and Systems Research, World Health Organization

Systems thinking, complexity & a long term vision



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Healthcare's wicked questions: A complexity approach.

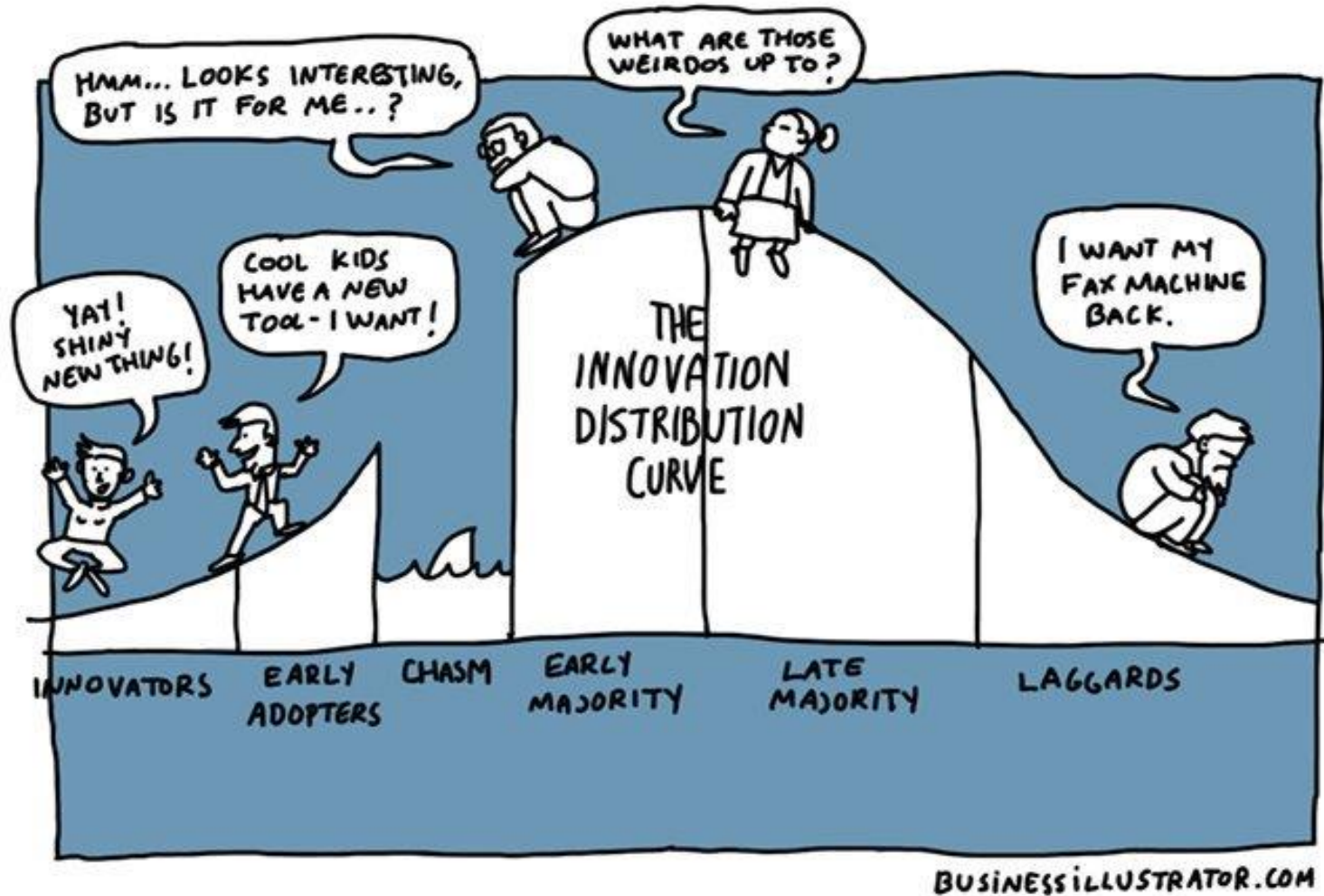
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Valeras, A. S. (2019). Healthcare's wicked questions: A complexity approach. *Families, Systems, & Health*, 37(2), 187–189. <https://doi.org/10.1037/fsh0000425>

The previous President's Column explored Glouberman and Zimmerman's (2002) differentiation of complex problems versus those that fall under the domains of *simple* or *complicated*, concluding with an invitation to enter the fray for health care's future state (Valeras, 2019). In this second column on the subject of complexity, the author invites us to continue to explore the topic of complexity and embrace it within health care, rather than shy away from it, in order influence the future state. One tactic, when engaging with a complex adaptive system, is to ask Wicked Questions. Williamson (2015) defines Wicked Questions as what is used to to expose the assumptions which shape our actions and choices. Some of the Wicked Questions that can be asked regarding the U.S. health care system are discussed. Exploring complexity and complex adaptive systems may provide the way forward for the challenges we face in health care. (APA PsycInfo Database Record (c) 2019 APA, all rights reserved)



Reaching the Tipping Point and Overcoming the Chasm



Everett Rogers.
Diffusion of
Innovation.



GETTING TO MAYBE: THIS BOOK IS FOR THOSE WHO ARE NOT HAPPY WITH THE WAY THINGS ARE AND WOULD LIKE TO MAKE A DIFFERENCE. THIS BOOK IS FOR ORDINARY PEOPLE WHO WANT TO MAKE CONNECTIONS THAT WILL CREATE EXTRAORDINARY OUTCOMES. THIS IS A BOOK ABOUT MAKING THE IMPOSSIBLE HAPPEN
HOW THE WORLD IS CHANGED.

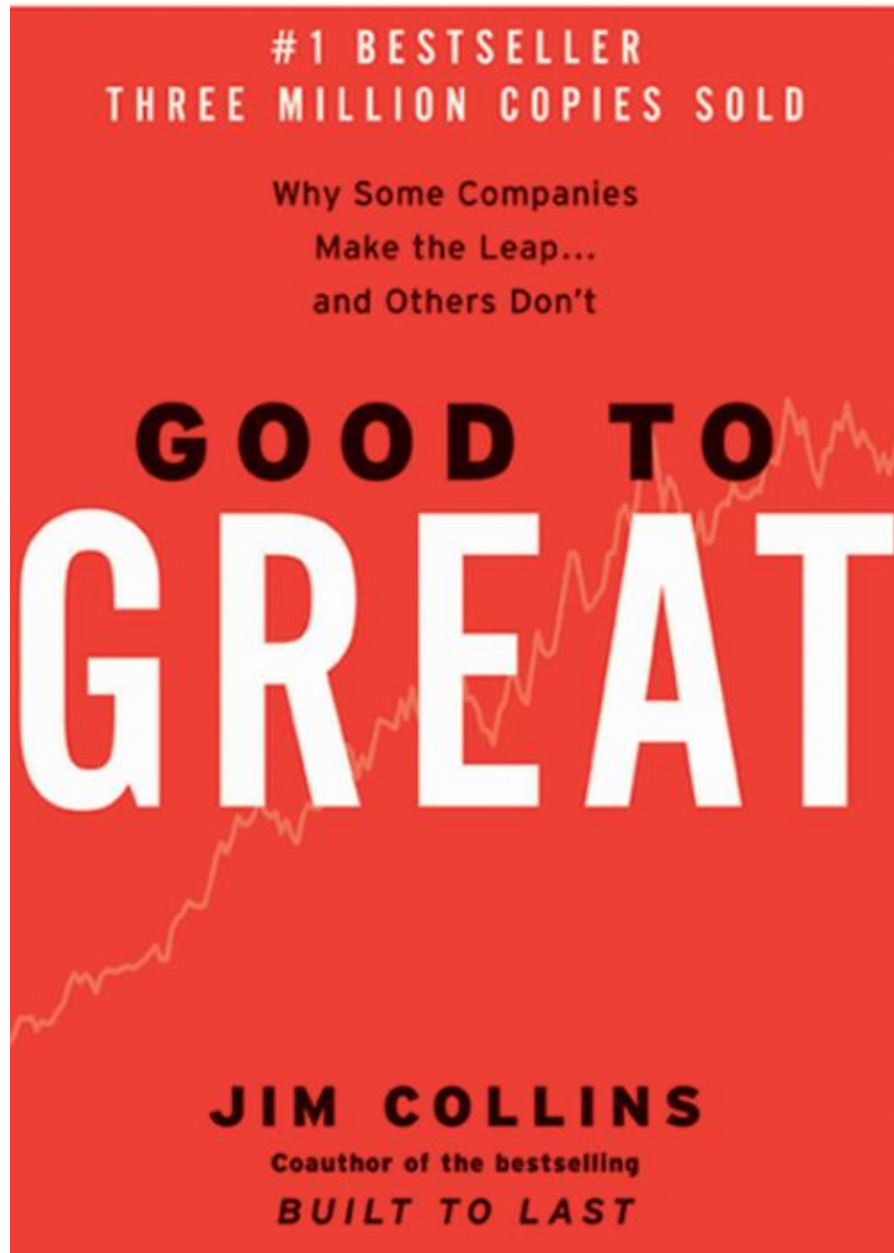
“This book is not for heroes or saints or perfectionists.

This book is for flawed people (and we are all flawed in one way or another) who are not happy with the way things are and would like to make a difference”

Frances Westley

Brenda Zimmerman

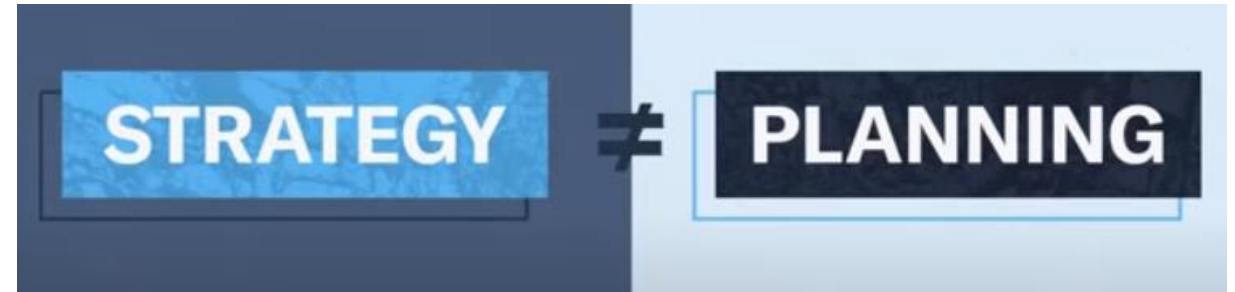
Michael Quinn Patton



Key ideas

- 1 Finding your “hedgehog concept” will give you a clear path to follow.
- 2 Success comes from many tiny, incremental pushes in the right direction.
- 3 New technology should be viewed as an accelerator toward a goal – not as a goal itself.
- 4 Level 5 leaders drive success transformations from good to great.
- 5 The right people in the right place are the foundation of greatness.
- 6 Success requires confronting reality – and never losing faith.
- 7 Leaders must create an environment where harsh facts can be aired without hesitation.

“A Plan is Not a Strategy”



Not knowing for sure
isn't bad management.
It's great leadership.

A video frame showing Roger Martin, a man with glasses and a blue blazer, speaking and gesturing with his hands. The background is a solid green color.

Strategy

- Actual customers are the customers.
- You don't control them.
- You don't control revenues. 😞

Planning

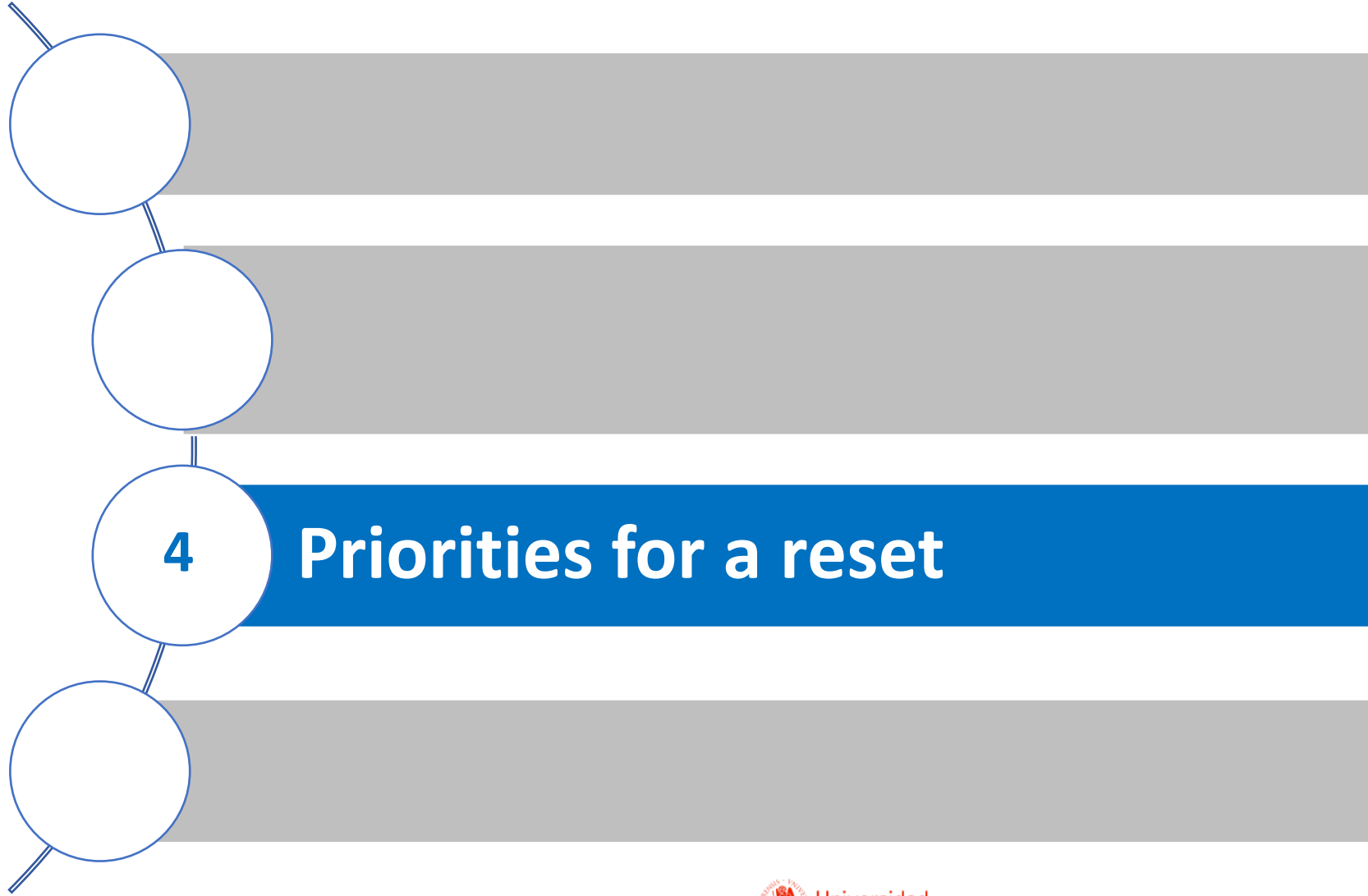
- You control costs.
- You are the customer.
- It's comfortable. 😊

Roger Martin

Professor Emeritus,

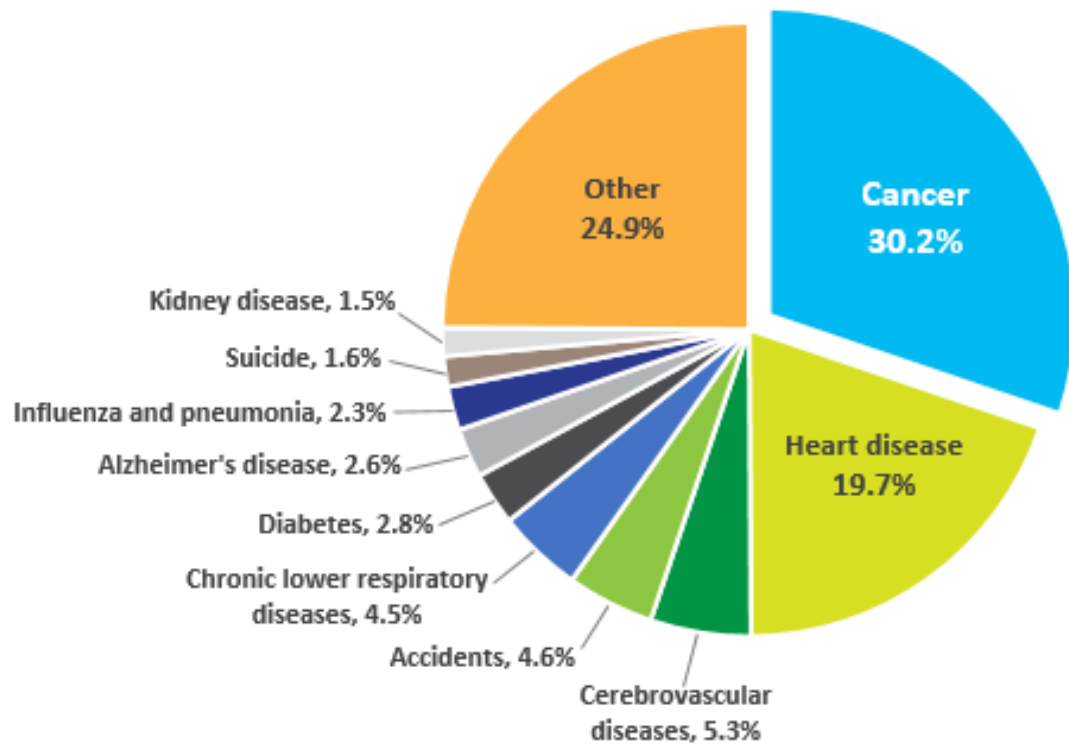
Rotman School of Management, University of Toronto.

Part 4



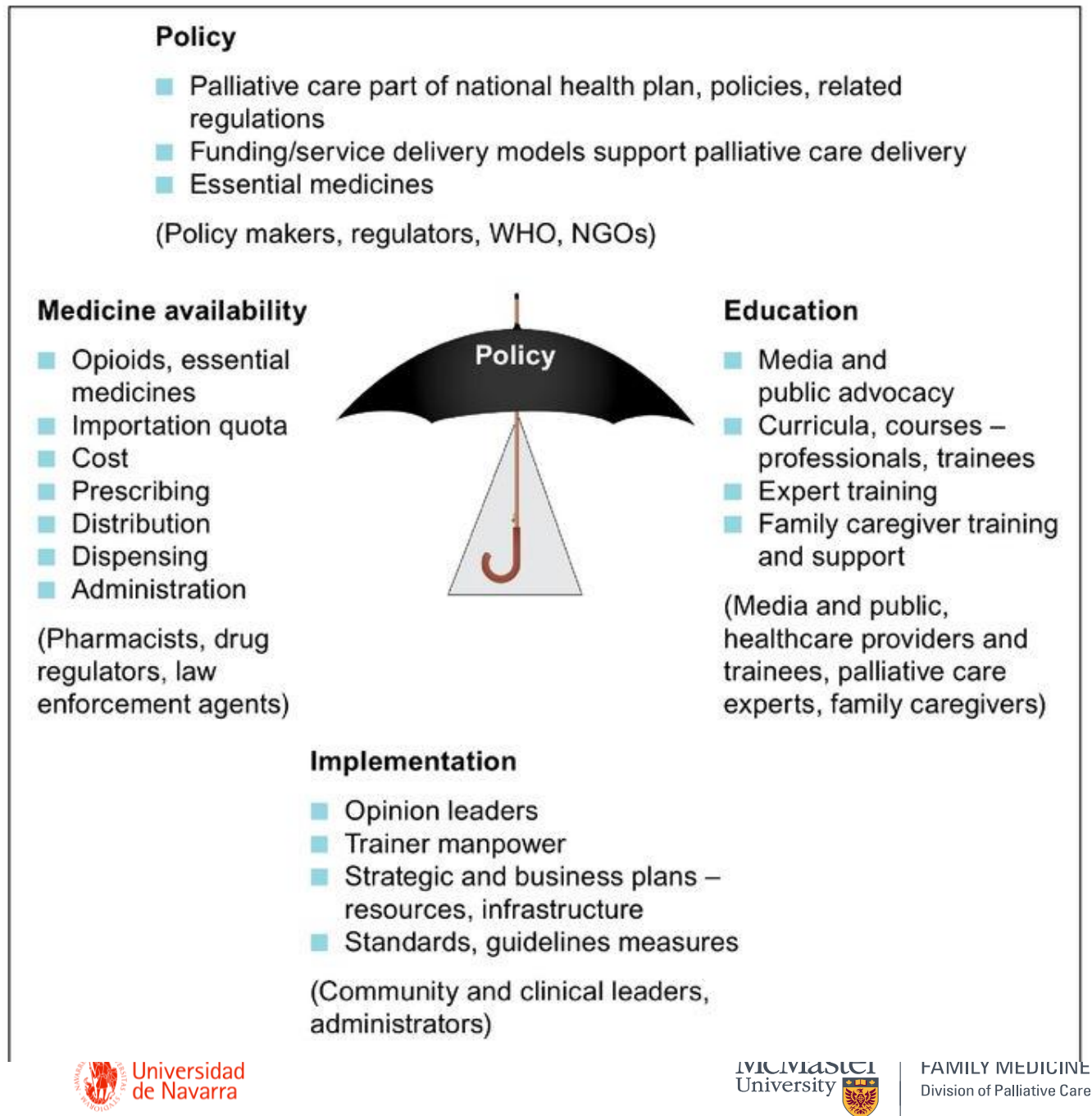
Palliative care early and across cancer and non-cancer illnesses

Proportion of deaths due to cancer and other causes, Canada, 2012

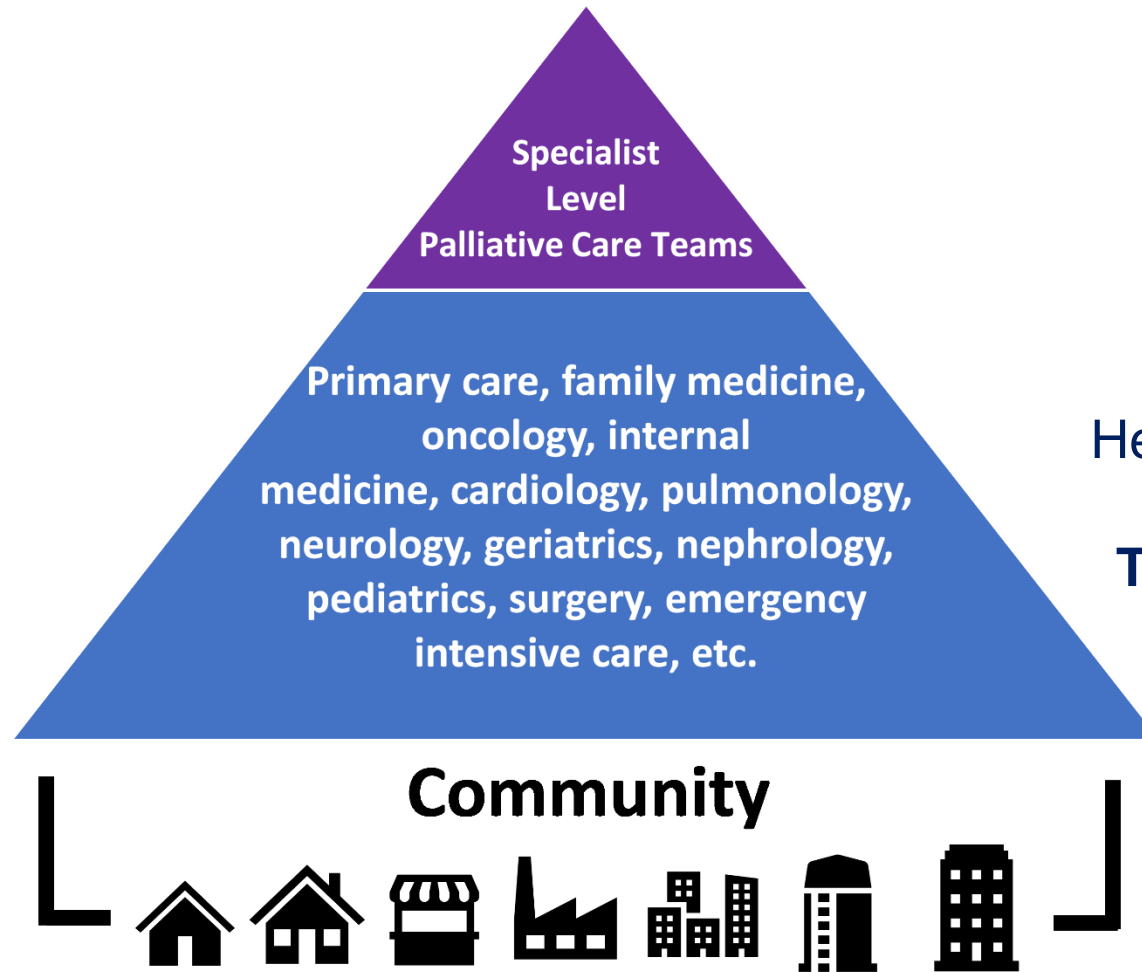


A public health approach & public health model

Stjernsward J, Foley K, Ferris F. The Public Health Strategy for Palliative Care. J Pain Sympt Manage 2007;33(5):486-493



Need specialist- and primary-level palliative care



Primary palliative care
Healthcare professionals with core
palliative care skills.....
The Palliative Care Approach.

**Palliative Care is
everyone's business!**



Compassionate Communities, Kingston: Talking About Death Never Killed Anyone

Learn how one engaged community member spearheaded community-wide change using the Compassionate Community Startup Toolkit.

[Read this story >](#)

Palliative care needed across all specialty areas:

Impact of palliative care on healthcare use across disease groups

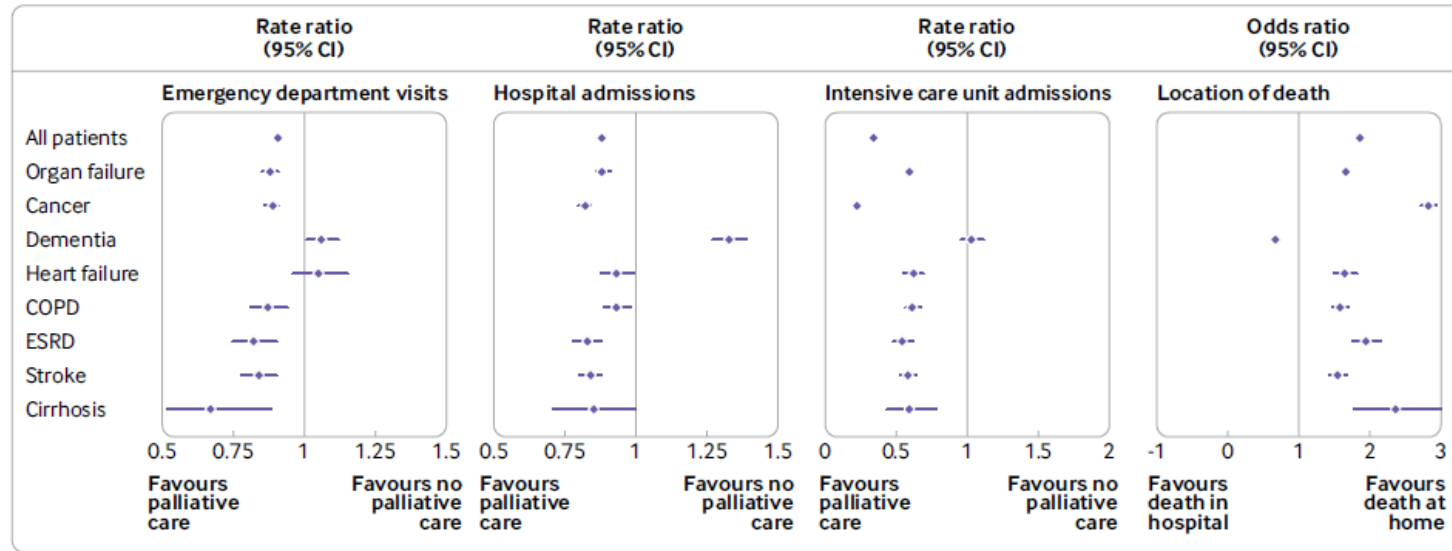


Fig 2 | Association between palliative care and healthcare use. Association between newly initiated palliative care and rates of emergency department visits not resulting in admission to hospital, hospital admissions, and intensive care unit admissions, or location of death among adults in the last six months of life dying from cancer and non-cancer illness in Ontario between 2010 and 2015. Locations of death were home (including nursing home), acute care (including hospital and intensive care unit), and other. Models were adjusted for age, sex, comorbidities, rural location of

The authors concluded:

“Increasing access to palliative care through **sustained investment in physician [and other professions] training** and current **models of collaborative palliative care** could improve end-of-life care, which might have important implications for health policy.”



From Over-Burdened And Under-Resourced To Many Knowledgeable Hands On Deck

Read how the Bruyère Academic Family Health Team trained all staff on LEAP to ensure that patients and families were surrounded by health care professionals trained together.

[Read this story >](#)



Palliative Care as a Team Sport: Training Builds Alliances in Rural Ontario

Read how training on LEAP helped the Petawawa Centennial Family Health Centre with their comfort and skill in providing a palliative care approach to patients and families.

[Read this story >](#)

STORIES FROM ORGANIZATIONS



How Family Doctors Can Support Patients In Having A Good Death

Read one family doctor's desire to continue treating patients who could benefit from a palliative care approach.

[Read this story >](#)

STORIES FROM PROFESSIONALS



Nova Scotia Takes A Strong and Coordinated Approach to Training Primary Health Care Providers

Learn how the Nova Scotia Health Authority used LEAP to bring a coordinated approach to better palliative care services across the province.

[Read this story >](#)

STORIES FROM ORGANIZATIONS

It is possible

Program Description

Print short, Web long*

Enhancing family physician capacity to deliver quality palliative home care

An end-of-life, shared-care model

Denise Marshall MD FCFP Doris Howell PhD RN Kevin Brazil PhD Michelle Howard MSc PhD Alan Taniguchi MD FCFP

ABSTRACT

PROBLEM BEING ADDRESSED Family physicians face innumerable challenges to delivering quality palliative home care to meet the complex needs of end-of-life patients and their families.

OBJECTIVE OF PROGRAM To implement a model of shared care to enhance family physicians' ability to deliver quality palliative home care, particularly in a community-based setting.

PROGRAM DESCRIPTION Family physicians in 3 group practices (N=21) in Ontario's Niagara West region collaborated with an interprofessional palliative care team (including a palliative care advanced practice nurse, a palliative medicine physician, a bereavement counselor, a psychosocial-spiritual advisor, and a case manager) in a shared-care partnership to provide comprehensive palliative home care. Key features of the program included systematic and timely identification of end-of-life patients, needs assessments, symptom and psychosocial support interventions, regular communication between team members, and coordinated care guided by outcome-based assessment in the home. In addition, educational initiatives were provided to enhance family physicians' knowledge and skills.

CONCLUSION Because of the program, participants reported improved communication, effective interprofessional collaboration, and the capacity to deliver palliative home care, 24 hours a day, 7 days a week, to end-of-life patients in the community.

MEMBERS' STORIES

Manitoulin Central FHT Physician Awarded Associated Medical Services (AMS) Phoenix Fellowship

OCTOBER 25, 2017

SHARE:



Association of
Family Health
Teams of Ontario
AFHTO

[The Manitoulin Expositor article published October 20, 2017.](#) Article in full pasted below. Expositor Staff, *The Manitoulin Expositor* MINDEMOYA—A Northern Ontario School of Medicine (NOSM) faculty member who works at the [Manitoulin Central Family Health Team](#) and Manitoulin Health Centre in Mindemoya, Dr. Frances Kilbertus, is among six distinguished educators to receive a 2017 Associated Medical Services (AMS) Phoenix Fellowship. Dr. Kilbertus, NOSM associate professor, and Dr. James Goertzen, NOSM assistant dean, continuing education and professional development, are among six distinguished educators to receive the award. Dr. Kilbertus is focusing her Fellowship on projects that explore how the community, the workplace, health professionals and learners are interwoven in a process of learning and practicing palliative care in the culturally diverse rural community on Manitoulin Island. "The focus for the first year of the fellowship will be exploring community involvement, creating opportunities for engagement and dialogue around death and dying, and developing learning tools for palliative care that are inclusive of an Indigenous perspective," Dr. Kilbertus says. "The second year will focus on the rural clinical workplace; how learners and practitioners understand and appreciate palliative care and how compassionate learning environments are created and sustained." The Fellowship from AMS Healthcare is awarded each year and specifically targets individuals with strong leadership abilities who are committed to nurturing and sustaining the learning and practice of compassionate care. The intent of the Fellowship is to provide support (the equivalent of \$50,000) to individuals to allow them to devote time to engage in leadership activities, building capacity in their home institution and across Ontario. "The Northern Ontario School of Medicine was founded on a strong social accountability mandate," says Roger Strasser, NOSM Dean and CEO. "These fellowships, which advance compassionate care within the health-care community and sustain compassion in the environments on which health professionals learn and work, fit perfectly with the Schools' distributed, community-engaged, learning-centred model of education and research." [Click here to access The Manitoulin Expositor article.](#)

Do family health clinics provide primary-level palliative care in Ontario and the eastern regions of Quebec?

Bruno Gagnon, Sandy Buchman, Anum Irfan Khan, Mamie MacKinnon, Sara Urowitz, Tara Walton, Marie Immacula Fabienne Cléophat-Jolicoeur and José Pereira

Canadian Family Physician February 2019, 65 (2) 118-124;

Table 1. Number of responding primary care clinics and response rates

PROVINCE	TYPE OF PRIMARY CARE PRACTICE	CLINICS IN JURISDICTION, N	COMPLETED SURVEYS,* N	RESPONSE RATE, %
Ontario	Family health team	185	54	29
	Community health centre	108	23	21
	Nurse practitioner-led clinic	25	20	80
	Aboriginal health access centre	10	5	50
	Total	328	102*	31
Eastern Quebec	Local community health service centre (centre local de services communautaires)	50	13	26
	Family medicine group (groupe de médecine familiale)	55	15	27
	Family medicine unit (unité de médecine familiale)	12	11	92
	Total	117	39	33

*Partially completed surveys were excluded.

Do family health clinics provide primary-level palliative care in Ontario and the eastern regions of Quebec?

Bruno Gagnon, Sandy Buchman, Anum Irfan Khan, Marnie MacKinnon, Sara Urowitz, Tara Walton, Marie Immacula Fabienne Cléophat-Jolicoeur and José Pereira

Canadian Family Physician February 2019, 65 (2) 118-124;

search 

[Advanced Search](#)

- Response rate of clinics: 32%.
- Clinics in both provinces reported providing palliative care to ambulatory patients (83% of Ontario clinics and 74% of Quebec clinics).
- Only 29 of 102 (28%) Ontario clinics provided on-call services themselves, compared with 31 of 34 (91%) Quebec clinics,
- Access to palliative care specialist teams for support was higher in Ontario than in Quebec (67% vs 41%, respectively).
- In Ontario, 56% of practices indicated that they had access to palliative care physicians who could take over the care of their patients with palliative care needs, but a lower number (44%) actually handed over care to these physicians.
- A relatively small group of clinics in Ontario (28%) and most clinics in Quebec (91%) provided on-call palliative care services themselves.

Research

Impact of community based, specialist palliative care teams on hospitalisations and emergency department visits late in life and hospital deaths: a pooled analysis

BMJ 2014 ; 348 doi: <https://doi.org/10.1136/bmj.g3496> (Published 06 June 2014)

Cite this as: BMJ 2014;348:g3496

Article

Related content

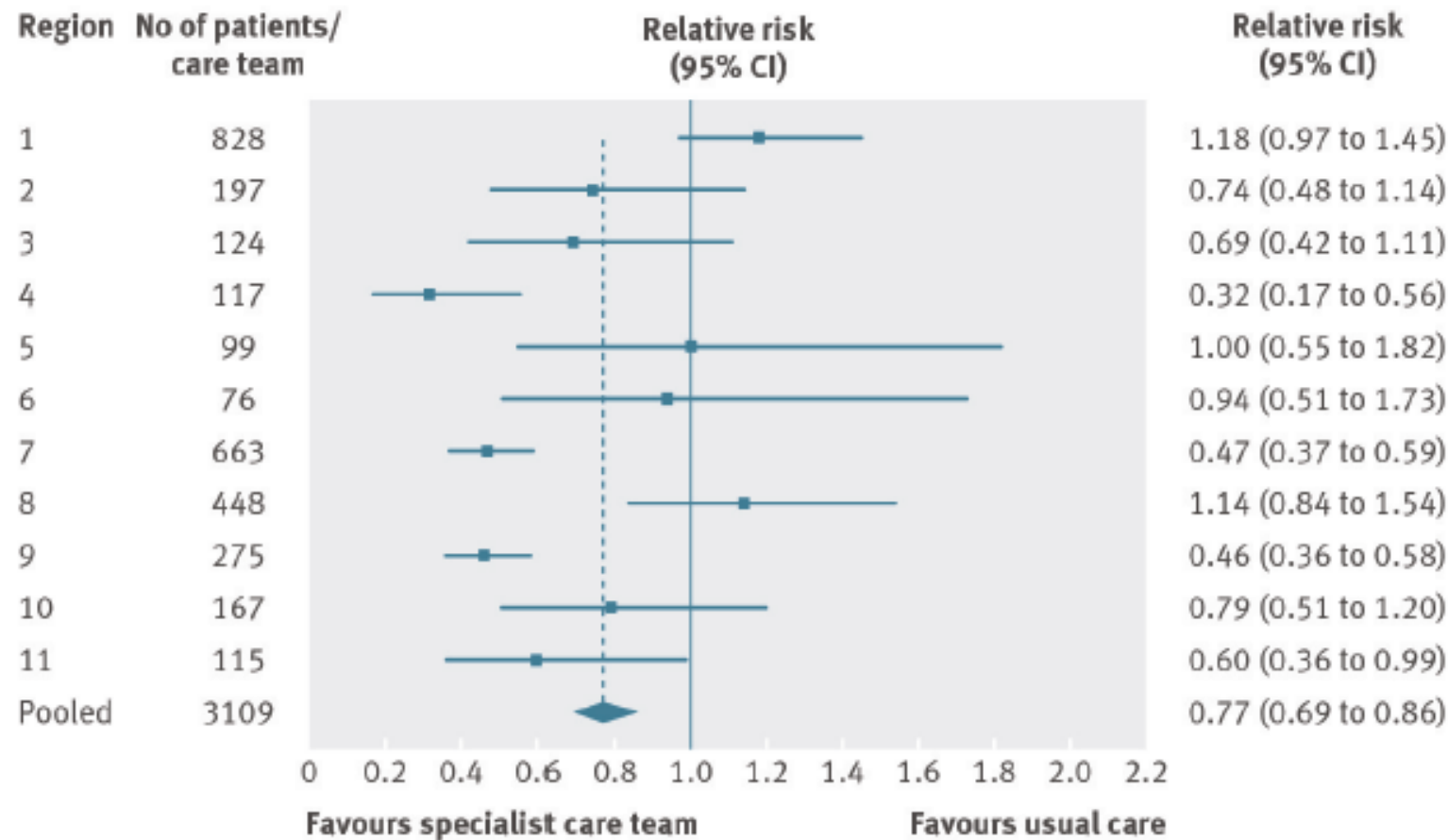
Metrics

Responses

Peer review

Hsien Seow, associate professor¹, Kevin Brazil, professor of palliative care², Jonathan Sussman, associate professor¹, José Pereira, head of division of palliative medicine³, Denise Marshall, associate professor⁴, Peter C Austin, professor⁵, Amna Husain, associate professor⁶, Jagadish Rangrej, senior biostatistician⁷, Lisa Barbera, associate professor⁸

Reduced relative risk of an emergency department visit in the last two weeks of life (exposed vs unexposed patients) for patients cared by community palliative care teams



The INTEGRATE Project:

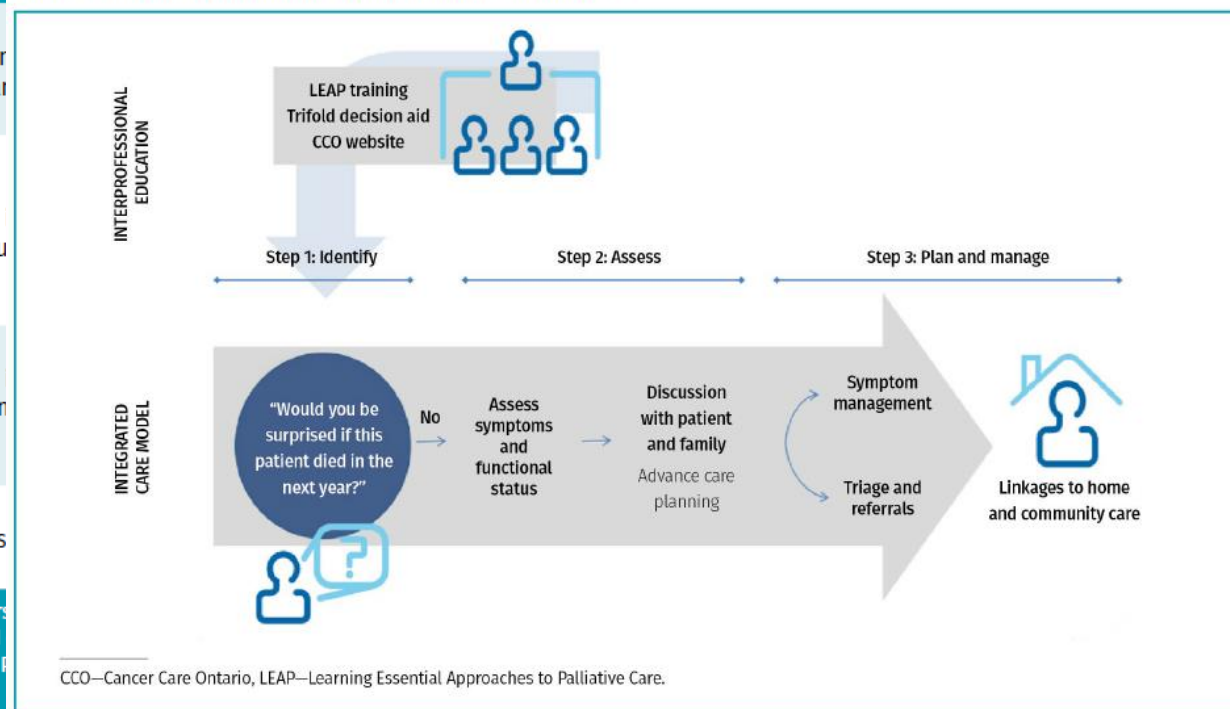
4 FHTs & 4 Cancer Centres in Ontario, 1 GMF & 1 Cancer Centre in Quebec

Table 1. Primary care practices that participated in the INTEGRATE Project

PRACTICE NAME AND MODEL*	REGION OF ONTARIO	PRACTICE CHARACTERISTICS
Petawawa Centennial Family Health Team	Champlain	<ul style="list-style-type: none"> Rural 8 family physicians and various other professionals, including nurses, a pharmacist, a social worker, and a dietitian Roster of about 6300 patients
Sunnybrook Academic Family Health Team	Toronto Central North	<ul style="list-style-type: none"> Urban Academic 13 family physicians and various other professionals, including nurses, dietitians, diabetes nurse educators, an occupational therapist, a pharmacist, and a nurse navigator Roster of about 9300 patients
Forest Hill Family Health Group	Toronto Central South	<ul style="list-style-type: none"> Urban 10 family physicians and various other professionals, including nurses, a child psychologist, a speech pathologist, a neurologist, an endocrinologist, physiotherapists, and chiropractors Roster of about 10 000 patients
Barrie and Community Family Health Team	North Simcoe Muskoka	<ul style="list-style-type: none"> Rural 84 family physicians in teams of 2 to 4 across 35 sites Roster of about 131 000 patients

*A family health team is an interprofessional team of health care providers—family physicians, nutritionists, social workers, nurses, and other professionals—who provide comprehensive care to patients enrolled within the family health team. Physicians are paid through blended fee-for-service. A family health group is a group of 3 or more family physicians who work together but not necessarily in the same office. Physicians are paid through fee for service.

Figure 1. INTEGRATE model of care for primary care practices



INTEGRATE PROJECT

- Improvement in provider confidence to deliver palliative care and self-reported use of palliative care tools and services.
- Substantial variation across practices:
 - % of patients identified using the surprise question (0.2% to 1.5%),
 - The number of advance care planning conversations initiated (50% to 90%)
 - Mean time to conversation (13 to 76 days).
- Variation attributable, in part, to contextual differences across practices.

Table 5. Comparison of provider survey responses before and after implementation of the INTEGRATE Project

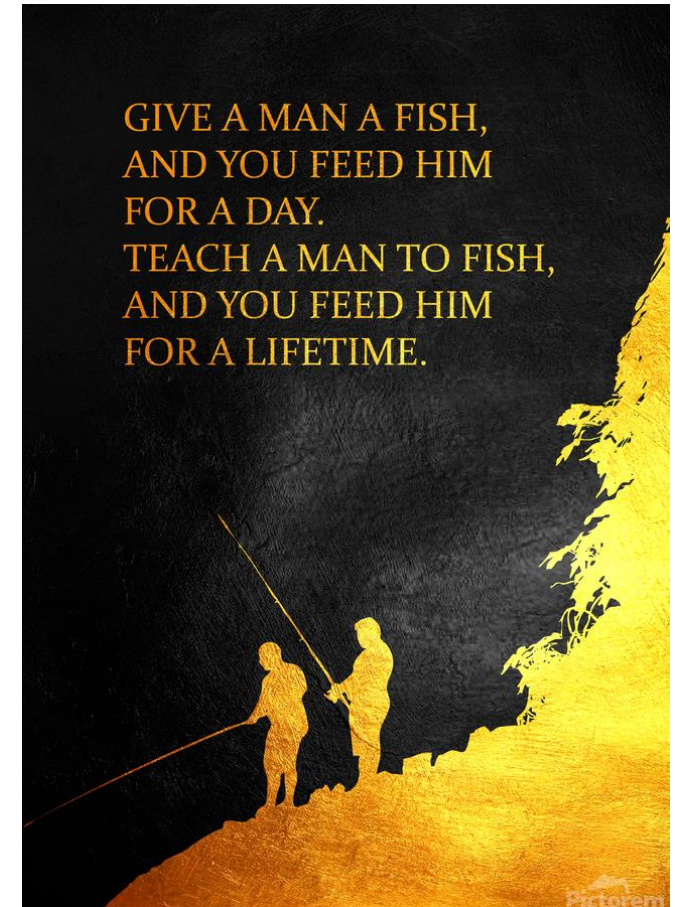
RESPONSE	BEFORE IMPLEMENTATION, % (N = 71)	AFTER IMPLEMENTATION, % (N = 49)
Attitudes and education*		
• Belief that “palliative care should be considered for patients who have a progressive, life-limiting illness (even if they still have many months to live)”	92	96 [†]
• Belief that I have sufficient education or training to provide palliative care	21	64 [†]
Confidence*		
• Confidence to discuss patients’ progressive noncurable illness	27	60 [†]
• Confidence to initiate ACP discussion	25	62 [†]
• Confidence to discuss different options for care settings	24	53 [†]
• Confidence to inform patients and families of support services available	17	36 [†]
Use of palliative care tools[†]		
• Surprise question	54	91 [†]
• Palliative Performance Scale	44	67 [†]
• CCO Psychosocial Oncology Program and palliative care tools	3	16 [†]
• Edmonton Symptom Assessment Scale	28	62 [†]
• CCO symptom management guides	37	56 [†]
Delivery of palliative care[†]		
• Held ACP or GoC discussions with patients	21	64 [†]
• Provided home visits for palliative care	48	71 [†]
• Linked patients to community palliative care services	59	84 [†]
Barriers to palliative care delivery[†]		
• Lack of time to have ACP or GoC conversation	82	76 [†]
• Lack of comfort initiating ACP or GoC conversation	59	33 [†]
• Lack of knowledge, training, or skills to provide palliative care	85	49 [†]

People Who Say It Cannot Be Done Should Not Interrupt Those Who Are Doing It



Opportunity for Total Reorganization

- Supporting and engaging primary care & other specialties
- Ownership of primary-level palliative care (the palliative care approach)
 - Across settings
 - Across specialty areas
 - Across professions (especially physicians)



Areas where disruptions (total reorganization) may be needed

- Funding of palliative care physicians
 - The story of the APP and AFP in Ontario, and the emergence of the Fee-for-Service model
 - The Billing Codes and the story of the G512
- Consolidation perhaps needed?
 - Palliative Care NPs, PPSMC Teams & Community Palliative Care Physicians
- Palliative home care, in the midst of workforce shortages & burnout

RESEARCH ARTICLE

Open Access



Implementing the first regional hospice palliative care program in Ontario: the Champlain region as a case study

José Pereira^{1,2,3*} , Jocelyne Contant¹, Gwen Barton¹ and Christopher Klinger^{1,2}

Abstract

Background: Regionalization promotes planning and coordination of services across settings and providers to meet population needs. Despite the potential advantages of regionalization, no regional hospice palliative care program existed in Ontario, Canada, as of 2010. This paper describes the process and early results of the development of the first regional hospice palliative care program in Ontario. The various activities and processes undertaken and the formal agreements, policies and documents are described.

Methods: A participative approach, started in April 2009, was used. It brought together over 26 health service providers, including residential hospices, a palliative care unit, community and hospital specialist consultation teams, hospitals, community health and social service agencies (including nursing), individual health professionals, volunteers, patients and families. An extensive stakeholder and community vetting process was undertaken that included work groups (to explore key areas such as home care, the hospital sector, hospice and palliative care unit beds, provision of care in rural settings, e-health and education), a steering committee and input from over 320 individuals via e-mail and town-halls. A Transitional Leadership Group was elected to steer the implementation of the Regional Program over the summer of 2010. This group established the by-laws and details regarding the governance structure of the Regional Program, including its role, responsibilities, reporting structures and initial performance indicators that the Local Health Integration Network (LHIN) approved.

Results: The Regional Program was formally established in November 2010 with a competency-based Board of 14 elected members to oversee the program. Early work involved establishing standards and performance indicators for the different sectors and settings in the region, and identifying key clinical needs such as the establishment of more residential hospice capacity in Ottawa and a rural framework to ensure access for citizens in rural and remote regions. Challenges encountered are explored as are the process enablers and facilitators. The paper views the development and implementation process from the perspectives of several frameworks and models related to change management.

Conclusions: Following on several initial achievements, the long term success of the Regional Program will depend on consolidating the early gains and demonstrating changes based on key measurable outcomes.

Keywords: Regional, Palliative care, Change management, System

Table 2 Guiding principles and foundational recommendations in the business plan for the Champlain Hospice Palliative Care Program

Guiding Principles and Elements

- A common region-wide vision and mission
- A single common governance body that still allows for independence of the various service providers
- An adequately resourced program and system
- Evidence-guided care and diffusion of best practices through education and knowledge transfer
- An accountability system of reporting and system-wide (macro) and institutional (micro) performance indicators
- The establishment of standards for the region
- Improve the capacity of primary care to provide primary-level palliative care (palliative care approach), with adequate resources to provide support to primary care clinicians
- Ongoing role for the local End-of-Life Networks to enhance the role of the Regional Program

Foundational Recommendations^a

- Establish a Regional Hospice Palliative Care (HPC) Program
- Establish a Program Council of Directors (later renamed "Board of Directors") to oversee the Program, supported by an executive office
- Establish formal agreements between the Regional HPC Program and the LHIN, and between the LHIN and service providers to:
 - Support the objectives of the program
 - Report on key performance indicators

^aThere were also several supporting recommendations covering various priority areas

Table 4 Facilitators and Enablers of Success in Developing a Regional Hospice Palliative Care Program

- A history in the region of attempts at initiating a regional program;
 - A funded full-time coordinator;
 - Support from the Local Health Integration Network's (LHIN's) CEO and Board of Governors;
 - Starting the process using an Appreciative Inquiry approach;
 - Early commitment by most stakeholders;
 - Maintaining and sustaining momentum throughout the process;
 - Co-chairing of the process by two co-chairs ;
 - Significant community and stakeholder engagement;
 - Exemplars in the region of other regional programs, specifically Stroke and Geriatrics-Care of the Elderly;
 - Use of a "Change Management" approach;
 - Creation of a common vision early in the process;
 - Flexibility to adapt and modify the emerging plan and process; and
 - Establishment of a competency-based Board, instead of one that represents specific service providers, settings and sites of care.
-

Pereira J, Contant J, Barton G, Klinger C. Implementing the first regional hospice palliative care program in Ontario: the Champlain region as a case study. BMC Palliat Care. 2016 Jul 26;15:65.

Learn from others, adopt and adapt



ORIGINAL RESEARCH

Developing rural palliative care: validating a conceptual model

ML Kelley¹, A Williams², L DeMiglio², H Mettam³

¹Lakehead University, Thunder Bay, Ontario, Canada

²McMaster University, Hamilton, Ontario, Canada

³Ministry of Citizenship & Immigration, Ontario, Canada

Submitted: 2 February 2011; Revised: 15 March 2011; Published: 19 May 2011

Kelley ML, Williams A, DeMiglio L, Mettam H

Developing rural palliative care: validating a conceptual model

Rural and Remote Health 11: 1717. (Online) 2011

Available: <http://www.rrh.org.au>

ABSTRACT

Rural and Remote Health

The International Electronic Journal of Rural and Remote Health Research, Education Practice and Policy

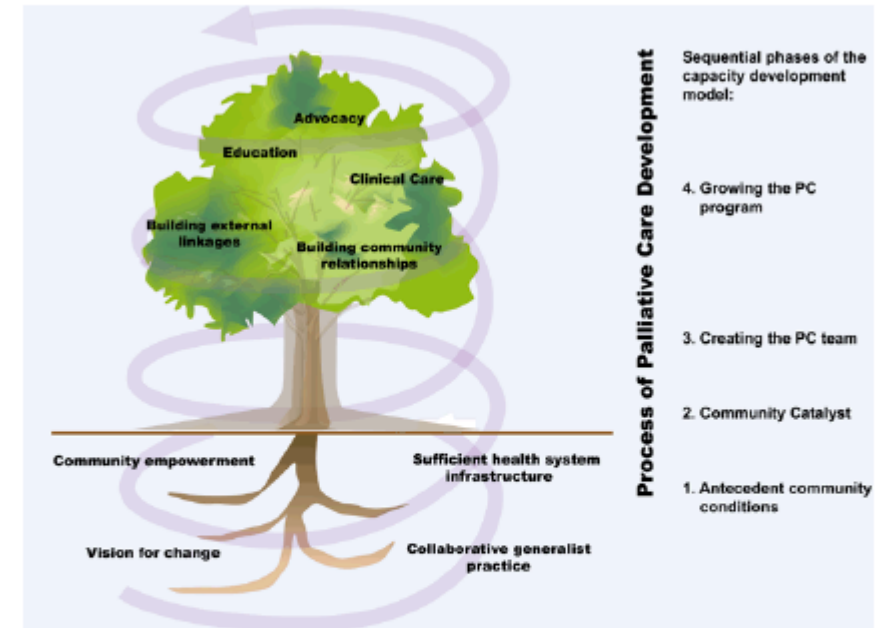


Figure 1: Developing a rural palliative care model adapted with new antecedent condition.

Table 1: Overview of the four-phase

Model phase	Description
1. Having antecedent community conditions	Sufficient local health infrastructure, having collaborative generalist practice and sharing a vision of change. Keys to success are: working in a small community, working together, and being community focused.
2. Experiencing a catalyst for change	A person or event disrupts the community's status quo, for example a local champion, a new policy or education.
3. Creating the Local Team	Requires having dedicated providers and getting the right people involved. Keys to success include working together, dedication, and physicians' support.
4. Growing the program	Involves strengthening the team, engaging the community and sustaining palliative care. Keys to success are remaining community focused, educating community providers, using teamwork, having local leadership and feeling pride in accomplishments.

Quality Palliative Care in Long Term Care

Tools & Resources for Organizational Change

[The Project \(2008–2013\)](#)

[The Alliance](#)

[Project Knowledge Exchange](#)

[QPC–LTC Toolkit](#)

[Links](#)

Key Partners



A- A+



A Pathway to Achieve Sustainable Palliative Care in Long Term Care

The Project

Improving Quality of Life for People Dying in Long Term Care Homes was a five-year comparative case study research (2008–2013) involving four long term care homes in Ontario. It was funded by the Social Science and Humanities Research Council and conducted by the Quality Palliative Care in Long Term Care Alliance that consisted of researchers, long term care homes and community health and social service organizations.

The primary goal of the research was to improve the quality of life of people dying in long term care homes by developing palliative care programs specific to the needs of residents and homes. Other goals included promoting the role of the personal support worker in palliative care, creating partnerships between long term care homes, community

Palliative Care Models in Long-Term Care: A Scoping Review

Kaasalainen S, Sussman T, McCleary L, Thompson G, Hunter PV, Wickson-Griffiths A, Cook R, Bello-Haas VD, Venturato L, Papaioannou A, You J, Parker D. Palliative Care Models in Long-Term Care: A Scoping Review. Nurs Leadersh (Tor Ont). 2019 Sep;32(3):8-26.

Models

- **Model 1:** External specialist EOL model
- **Model 2:** In-house EOL care
- **Model 3:** In-house capacity building within a palliative care approach
- **Model 4:** In-house capacity building with external support from palliative care specialists

Palliative Care Models in Long-Term Care: A Scoping Review

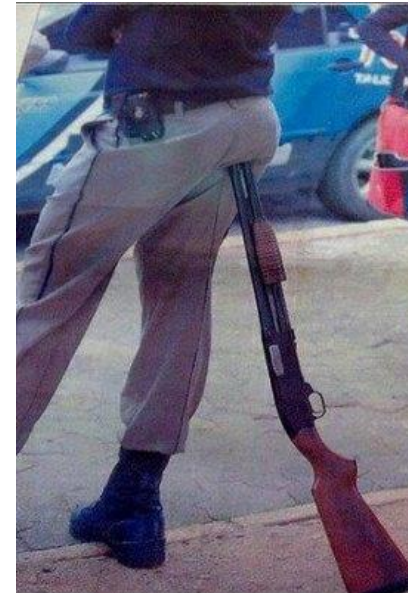
Kaasalainen S, Sussman T, McCleary L, Thompson G, Hunter PV, Wickson-Griffiths A, Cook R, Bello-Haas VD, Venturato L, Papaioannou A, You J, Parker D. Palliative Care Models in Long-Term Care: A Scoping Review. Nurs Leadersh (Tor Ont). 2019 Sep;32(3):8-26.

Key components

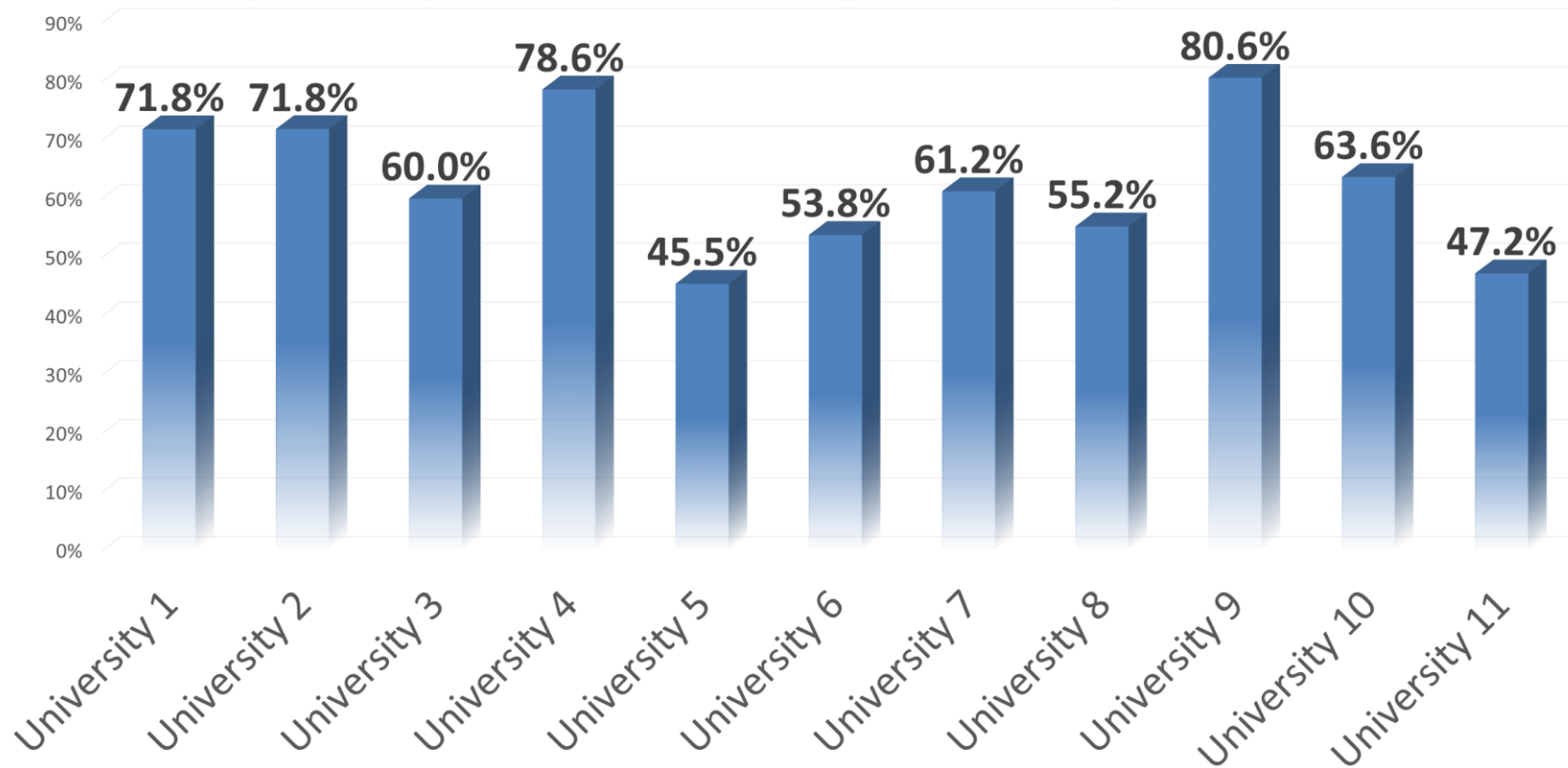
- Training and capacity-building strategies for LTC staff
 - Internal training and capacity-building activities have been recommended to “skill-up” LTC staff to provide quality care.
- Internal palliative champion or champion team
- External supports: palliative care nurse practitioners or physicians.
 - Community outreach palliative care nurses conduct regular visits to the LTC home
- Resident, family and staff support
 - Regular debriefing and case-conferencing.
- Advance care planning and goals of care discussions early and ongoing
- Institutional policies to support palliative and EOL care.

The role of virtual learning and teaching vs traditional classroom learning

- Virtual learning is not a panacea
- Harnessing its strengths, mitigating its limitations and avoiding its pitfalls
- Need to find the right tool for the job



Family Medicine trainees' intention (somewhat/highly likely) to provide palliative care after graduation by medical school*



* Results of 11 out of Canada's 17 medical schools shown; response rates were too low for 4 medical schools and 2 other schools do not provide Triple-C data.

Collaborate rather than duplicate

“A great deal of human effort is being spent to develop palliative care educational material that essentially duplicates or at best is a minimal improvement over existing resources....

However, the knowledge base of palliative care evolves slowly and does not justify the routine development of new material from scratch...

A more efficient system would be to have one or two standardized curricula. This would allow efforts toward broad dissemination rather than duplication, much as is done for advanced cardiac life support training.

Downar J. J Pall Med. 2018;21(S1)

Quality Improvement Condensed (QUIC)

Identify patients with palliative care needs and develop a practice palliative care register

pallium.ca

How to use this toolkit

AIM OF TOOLKIT

To help you identify patients who could benefit from a palliative care approach and develop a palliative care register (list) for your practice.

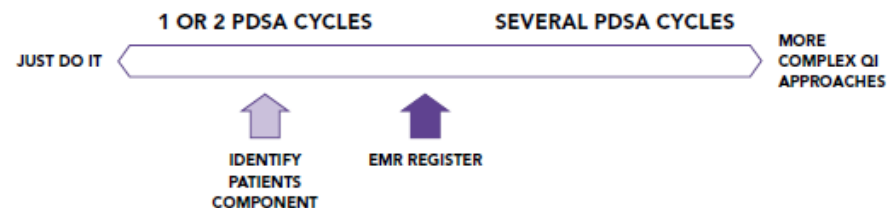
- The toolkit is a condensed step-by-step approach to undertaking quality improvement (QI) in your practice as it relates to palliative care. It draws on, and provides links to excellent existing resources.
- This QUIC goes hand-in-hand with QUIC Activating a palliative care approach (forthcoming).
- First, review the entire document to understand the big picture. Then follow the steps and refer to the Resources section and useful links at the end of the toolkit as you go along.

- QI is a team activity, so involve all those who will be affected or involved. Consider including a patient or family member in your team.
- This toolkit uses the Model for Improvement (MFI) of the Institute for Healthcare Improvement (IHI). It consists of three key questions and Plan-Do-Study-Act (PDSA) cycles. You may use other approaches that you may feel more acquainted with or feel would be more appropriate.
- Don't forget to celebrate successes! If there are shortfalls or failures, try a different approach. That is the advantage of using a QI approach — small ongoing steps.

EASE OF IMPLEMENTATION SCALE (VARIABLE)

Some QI efforts are straightforward and quite easy. We call these “just do it’s.” Others require several cycles (PDSA cycles), each one making small adjustments and improvements. A few require complex approaches.

This QUIC, especially the ‘identifying patients’ part of it, falls toward the “just do it” spectrum, as showcased in this diagram. Developing a registry for your practice may require some PDSA cycles, especially if you need to embed it in your electronic medical record (EMR)—but it is worth it!



QUIC Steps

STEP 1: GET STARTED

Ask: Is this for my patients or for the whole clinic?

- Sometimes you may need to start first with your own patients and then use your example to convince your colleagues.

Ask: Who can help me with this?

- This may be one or two colleagues. Can be from different professions and/or administrative team.

Get one or two colleagues and staff on board.

- Get them to view the short Pallium video **Better Early Than Late** and discuss. Think of a specific patient in your practice where earlier palliative care could have helped them.

Coffee chat (in-person or virtual)

- Explore this QUIC together to start thinking about how to implement this improvement in your practice.
- Reflect briefly on the following questions:
 - Does this make sense for our practice?
 - What are we trying to accomplish?
 - How will we know that a change is an improvement?
 - What change(s) can we make to accomplish this improvement?

STEP 2: DOES THIS APPLY TO US?

Consider one or two of the following:

- Rapid chart audit (See Resources 4 & 5)
- A check sheet (See Resource 5)
- Case reflections (See Resource 5)

- If this confirms an improvement opportunity, use this information and the "Make the Case" slide deck to engage the whole team (Currently in development).

STEP 3: A DEEPER DIVE

The following questions can help to understand the opportunity better:

1. What are the root causes of the problem in our practice? (See Resource 6)
2. Are we ready for the change?
3. What should we do to prepare for the change?
4. What would make most sense in our practice?
5. What can help us get there?
6. What could block us?
7. Who need to be involved?
8. Who do we need to speak to (folks who could help or could have other important views)?
9. What resources or tools will help us?

STEP 4: PREPARE FOR THE CHANGE



What are we trying to accomplish?

Summarise your problem

- In my/our practice, we activate a palliative care approach too late in the illness journey, often only in the last days or weeks of life. We also don't have a good idea of who the patients are in our practice who would benefit from a palliative care approach. This makes it difficult to be pro-active in organizing their care.

Develop an AIM STATEMENT

- **Example:** Within [x] months [or by date], [select doable % e.g. 80%] of all patients in my/our practice with advanced [name disease] that meet the "Surprise Question" and SPICIT criteria, will be flagged in their charts as requiring a palliative care approach and included in a practice Palliative Care Register
- **Note:** The register can be done simultaneously with early clinical identification (preferred) or can follow work on first making clinical identification part of everyday practice.
- **Note:** Creating a register would require incorporating a unique flag or code in your electronic medical record (EMR) to help with searches or an indicator in your paper records that identifies patients with palliative care needs. You may need help from your EMR support team.
- The Surprise Question (See Resource 2)
- The SPICIT Tool (See Resource 3)

TIPS

- There are many cancer and non-cancer diseases. You may consider, as a test/pilot, starting with one disease group. Learn from that, fine-tune, celebrate success, and then extend to other diseases.
- Seek input from all team/clinic members that will be involved in this change. Engage them in co-developing the AIM statements, measures and changes being implemented.

STEP 5: PLAN (P)

- This will depend on the scope of your intended improvement idea (e.g., clinical identification only or clinical identification alongside register).
- Engage the whole team and involve them in the work.
- See tables on P. 6 and 7 for planning considerations.

Clinical Identification

(See Resources 2 and 3)

Questions to answer	Possible "answers" (modify to your practice)
What? (what will be done?)	<ul style="list-style-type: none">• Use the Surprise Question• If a register has been developed, use practice charts to track appointments to see the patients on the register
Who?	Clinic doc(s), nurses, for each task above.
When?	Practice co-decides timing.
Where?	Practice decides: One or whole practice.
What should we anticipate?	Pushback from colleagues to mitigate (e.g. palliative care or LEAP Online model).
Enablers & barriers?	Who and what? Team or mitigate.

Conclusion





- Courageous leadership, focus on what really matters (whose interests?), and teamwork will be needed.

**“If you want to travel fast,
travel alone.
If you want to travel far,
travel together.”**

(N’gambai African Proverb)

*Thank
you*

