

A Palliative Approach

# Creating a health care system culture shift



Integrating a palliative approach asks health care practitioners, organizations, communities and health systems to think differently about how we care for people who are aging or have chronic and life-limiting diseases. An integrated palliative approach can start anywhere - and everywhere. Everyone has a role to play.



The Canadian Hospice Palliative Care Association and its 37 partners in the Quality End-of-Life Care Coalition of Canada have a collective goal to share The Way Forward, an integrated palliative approach to care that focuses on an individual's quality of life throughout their illness trajectory – not just at the end of life.

## Maximizing Resources

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**In today’s health care settings, expert palliative care teams may vary in each jurisdiction. With a palliative approach in place, the same practitioners providing the person’s care in any setting can initiate and support integrated palliative care in their communities.**

An integrated palliative approach has the potential to:

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Improve health outcomes

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Give people in Canada more say in their care

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Ensure seamless transitions between care settings for people near end of life

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Make better use of skills and resources

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Contribute to the sustainability of our valued publicly funded health care system

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England and Australia have already implemented similar systems and are seeing results. Canada has an opportunity to lead ongoing innovation in transforming palliative care for patient-centred, interdisciplinary models in North America.

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## Instigating Change at the Federal, Provincial and Territorial Levels



Governments at each level can take concrete actions to initiate change:

- Adopt *The Way Forward National Framework* vision, goals, and principles
- Establish policy expectations for all care settings and providers:

All individuals have a care plan

All patients will have access to an integrated palliative approach in the setting where they are receiving care

All care settings will have the capacity to provide high quality hospice palliative services integrated with other care

More health care providers will have the skills to provide an integrated palliative approach to care

Specialized palliative care units and hospice residential beds will be available to individuals with complex symptoms and end-of-life care needs that cannot be managed in other settings

More deaths will occur at home or in other settings where people receive care, such as long-term care homes, and fewer will occur in intensive care units

- Create legislation/regulations, where required, to ensure all settings are accountable for implementing the policy
- Establish guidelines and standards of care that are consistent with the national norms of practice for hospice palliative care and reflect special population needs
- Develop remuneration systems and incentives to support delivery of an integrated palliative approach
- Support communication across settings and seamless care transitions; jurisdictions need tools and processes (protocols, electronic medical records, collaborative care planning meetings)
- Support education of health care providers in all settings; resources developed federally, provincially, or territorially — reduce redundancy in care, promote consistent approach
- Establish indicators and monitoring system



## System - Wide Culture Shift

Ensuring that all people in Canada have access to an integrated palliative approach to care will require significant shifts throughout the health care system:

Promote and support a shift in practice culture

Establish a common language

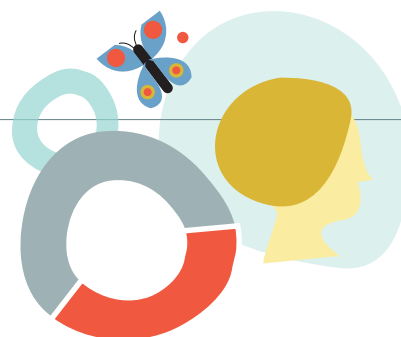
Educate and support providers

Engage Canadians in advance care planning

Create caring communities

Adapt an integrated palliative approach to provide culturally-safe care, including with and for Canada's First Peoples

Develop outcome measures



In 2007, **37%** of Canadians reported a diagnosis with at least **one** chronic condition<sup>1</sup>



**24%** of seniors had **three or more** chronic conditions<sup>2</sup>

British Columbia's Fraser Health Authority recently introduced a Medical Orders for Scope of Treatment (MOST) that provides tools and supports for physicians to give patients prognostic information and to document their advance care planning discussions with patients.

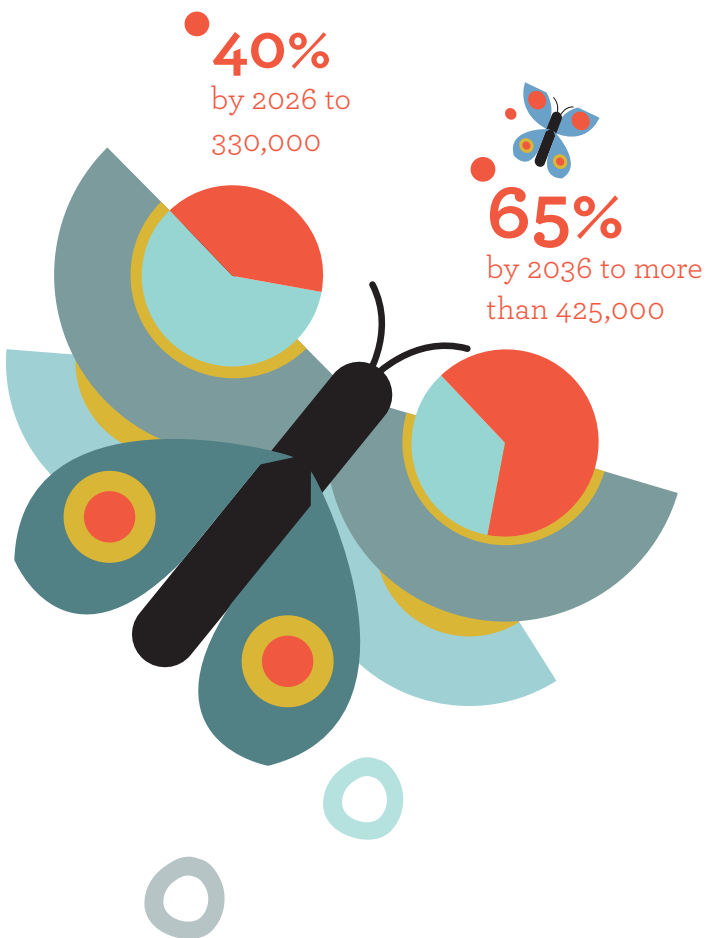
1 10th Annual Health Care in Canada Survey: A national survey of health care providers, managers and the public, 2007, <http://www.hcicsssc.ca>

2 "Health Care in Canada, 2011: A focus on seniors and aging," Canadian Institute for Health Information, last modified December 1, 2011, [https://secure.cihi.ca/free\\_products/HCIC\\_2011\\_seniors\\_report\\_en.pdf](https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf).

## System - Wide Actions



With an aging population, the number of Canadians dying each year will increase<sup>3</sup>



### Instigate Change

To integrate a palliative approach into routine care for people who are aging or have chronic illnesses, we must shift attitudes – in the health care system and within society at large. We must start the conversation about how loss, dying and death are part of life. To shift attitudes within the health care system, we must educate and support health care providers to help them overcome their own fear of loss, dying and death. An integrated palliative approach to care should be part of all health care providers' education.

#### *Actions:*

Review and revise systems, policies, guidelines, protocols, and front-line service models to support a palliative approach.

- a. Adopt and adapt the National Framework of The Way Forward
- b. Establish policy expectations
- c. Legislate/regulate
- d. Establish national guidelines for a palliative approach

<sup>3</sup> Canada. Statistics Canada. "Population Projections for Canada, Provinces and Territories: 2000 – 2026. Catalogue #91-520" (March 2001) P 124.1, <http://publications.gc.ca/Collection-R/Statcan/91-520-XIB/91-520-XIB-e.html>.

## Engage and Educate

### Individuals and Families

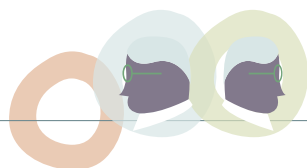
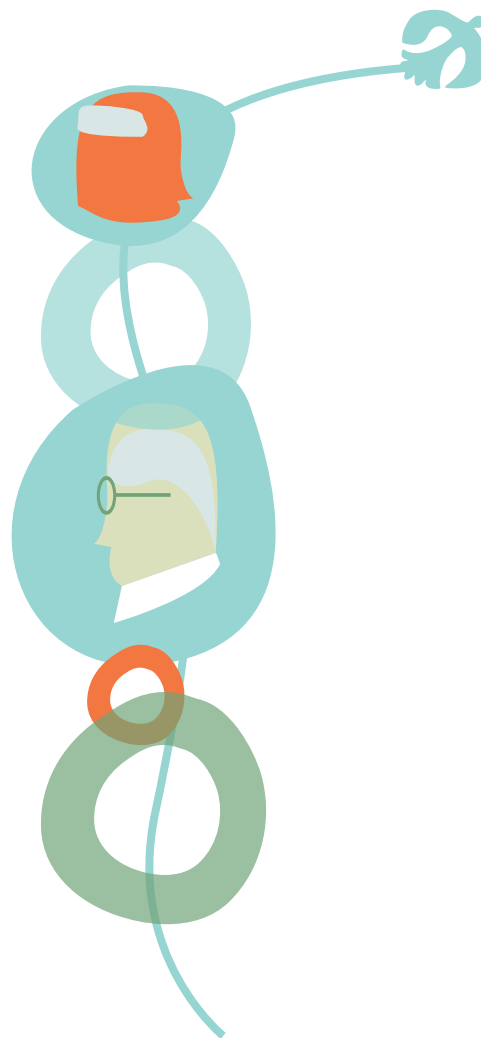
Advance care planning should begin when people are well, and then continue throughout their lives. It should be grounded in a person-centred, holistic approach and empower people. By talking openly and often about their health and treatment options with their families and care providers, people become more involved in their care and better able to make informed decisions.

### Support Providers

Practitioners in all care settings must have the skills and competencies to integrate a palliative approach into routine care. They must be able to talk easily about death and dying. They must also be able to recognize when a singular focus on treating or curing patients is no longer the best thing for their health and well-being; when they can provide integrated palliative care themselves; and when to consult with expert hospice palliative care teams or refer patients and families to more specialized services.

### **Actions:**

- Using all types of communication channels, from social media to public forums, we must reinforce that advance care planning is an ongoing process – not a one-time discussion.
- We must make innovative use of different tools to reach providers, including social media and story-telling videos. The skills and competencies to provide an integrated palliative approach to care should become a requirement for registration and accreditation.



## Provide Training and Tools

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To support integration, access to education and training is needed for all members of the care team, in all care settings.

### **Actions:**

- Develop training resources and best practices; list pre-existing resources.
- Create easy to use tools and algorithms to help them deliver integrated palliative care, such as tools to assist in advance care planning, communication cues, descriptions of both the benefits and risks of different treatments for life-limiting conditions, and criteria and reminder systems that trigger teams to revisit care plans.

## Create Caring Communities

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With an integrated palliative approach to care, most people in Canada will receive the palliative services they need – such as open and sensitive communication about their prognosis, advance care planning, psychosocial and spiritual support, and pain or symptom management – from their current providers in the settings where they receive care. Only the small proportion of people with complex medical needs will require expert hospice palliative care services, and providers in other settings can link with specialist care as required. Most communities are ready, willing and able to take on this role, but some may need some help and support. It will be up to local health care organizations to identify families, populations and/or communities that may struggle to fulfill this role.

### **Actions:**

- Provide culturally-safe and appropriate integrated palliative care for people of different cultures, including Aboriginal Canadians.
- Communication, education and tools provided across settings.

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In 2008, the Department of Health in the United Kingdom launched the National Strategy for **End-of-Life Care**.<sup>4</sup> The strategy focuses on providing **high quality care in the final years of life** by health and social services. In response, the Department of Health published a report on quality markers that align with the national strategy and Gold Standards Framework.<sup>5</sup>

4 "End-of-Life Care in Primary Care: 2009 National Snapshot Omega," The National Association for End-of-Life Care, accessed November 13, 2014, <http://www.omega.uk.net/primary-care-snapshot-p-126.htm>.

5 "End-of-Life Care Strategy: Quality Markers and Measures for End-of-Life Care," Department of Health, last modified June 2009, <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/DH-EOLC-strategy.pdf>.

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## Measure Outcomes

To determine whether we are successful, we need specific measurable goals to drive the system-wide shift in practice, as well as ways to monitor changes and identify barriers to change.

### ***Actions:***

- Are people who are elderly or have a chronic condition more satisfied with their care?
- Do they have a plan of care?
- Do they have a greater sense of control and more support in making their care decisions?
- Are they enjoying better quality of life?
- Are providers more satisfied with the care they provide?
- Did they have ongoing conversations with people about their prognosis and their choices?
- Do providers find it easier to communicate with patients or clients?
- Are people able to receive care in the setting of their choice?
- Is the system seeing less use of hospital and emergency services in the last weeks or months of life?
- Are people receiving fewer unnecessary interventions near end of life?

### **Please visit these sites to learn more:**

The Way Forward and a palliative approach:  
[www.hpcintegration.ca](http://www.hpcintegration.ca)

Palliative care education and resources:  
[www.pallium.ca](http://www.pallium.ca)

Advance Care Planning:  
[www.advancecareplanning.ca](http://www.advancecareplanning.ca)  
(including workbooks and tools by province)

Hospice palliative care:  
[www.chpca.net](http://www.chpca.net)

Production of this document has been made possible through a financial contribution from the Government of Canada. The views expressed herein do not necessarily represent the views of the Government of Canada.