Master Class – Palliative Care in the Age of Innovation and Change

Integrating a Palliative Approach to Care in Acute Care

iPAC-AC
Learning Objectives

- To know how to identify those who would benefit from a palliative approach to care.
- To understand the benefits of a palliative approach to care.
- To describe one way to implement a palliative approach to care in acute care.
Faculty/ Presenter Disclosure

Dr. Neil Hilliard, MD, MCFP (PC)
- Program medical director, Palliative Care Program, Fraser Health
- Clinical associate professor, Department of Medicine, UBC

Relationship with commercial interests:
- None to declare in last 2 years
- Grant-in-aid from Hospira Inc. to supply study drug dexmedetomidine for investigator initiated and led pilot RCT, 2012-14.
We need to focus on those being missed

- 3403 patients who die each year are missed!
- 92% are non-cancer patients
- 35% of in hospital deaths
- 42% die in hospital, 42% die in residential care

BC Palliative Population Needs Assessment
For success, we need to know who they are and how they will benefit

Per Cent Nursing Staff in Acute Care who ...

- 50% Identified Patients
- 25% Realized Benefits of iPAC
- 15% Applied iPAC

Integration of a Palliative Approach in Home, Acute Medical, and Residential Care Settings: Findings from a Province-Wide Survey, iPANEL, September 2015
Surprise Question

The Benefits of a Palliative Approach

Applying a palliative approach

Effect of iPAC on 12 week depression

- Depression
- Major Depressive Illness
- Standard Care
- iPAC
Palliative Care is more than just end-of-life care

Palliative Care

Use a palliative approach for life limiting illness

Optimizing QOL

Maximizing community supports

End-of-Life Care

- Weeks to months
- Palliative and medical treatments
- Ongoing supports
- Hospice Care
- Respite and caregiver relief

Early symptom management

Advance care planning

Last Days/Hours Care

- Pain & Symptom Mgt
- Psychosocial & Spiritual supports

BC Palliative Centre for Excellence, June 26th, 2013
Palliative Care is not just at the end of life!

Integrated Approach to Palliative Care

Source: Canadian Hospice Palliative Care Association – A model to guide hospice palliative care 2013
PAIN AND SYMPTOM MANAGEMENT

- REHABILITATION
- SORVIVORSHIP
- Palliative Care
- HOSPICE
- PALLIATIVE CARE UNIT
- END-OF-LIFE-CARE
- BEREAVEMENT

Figure 1: Conceptual model of level of need within the population of patients with a life limiting illness.
Components of a Palliative Approach to Care

Communication: Goals of Care and Advance Care Planning

Symptom Management and Prevention

Support: Unit of care is the patient and family
Applying a Palliative Approach to Care

- Palliative Approach to Care:
  - **Adopt** via upstream identification and orientation to care
  - **Adapt** palliative care knowledge and expertise
  - **Embed** and contextualize within the health care system

- **Focus**
  - Patient and family focus
  - Instead of a disease/problem/task focus
  - Team based (“we can do this”, not “we will refer to PC”)

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Sawatzky et al. BMC Palliative Care (2016) 15:5

BMC Palliative Care

RESEARCH ARTICLE

Conceptual foundations of a palliative approach: a knowledge synthesis

Richard Sawatzky¹, Pat Porterfield², Joyce Lee¹, Duncan Dixon¹, Kathleen Lounsbury¹, Barbara Pesut³, Della Roberts⁴, Carolyn Tayler⁵, James Voth⁶ and Kelli Stajduhar⁷
Embedding a Palliative Approach in Nursing Care Delivery: An Integrated Knowledge Synthesis

Richard Sawatsky, PhD; Pat Porterfield, MSN; Della Roberts, MSN; Joyce Lee, PhD; Linda Long, MSN; Sheryl Reimer-Kirkham, PhD; Barb Pestal, PhD; Tilly Schubawy, MSN; Kelli Stajduhar, PhD; Carolyn Taylor, MA; Jennifer Bauernschub, PhD; Sally Thibon, PhD

A palliative approach involves adopting and integrating principles and values from palliative care into the care of persons who have life-limiting conditions throughout their illness trajectory. The aim of this research was to determine what approaches in nursing care delivery support the integration of a palliative approach in hospital, residential, and home care settings. The findings substantiate the importance of embedding the values and tenets of a palliative approach into nursing care delivery, as the role that nurses have in working with interdisciplinary teams to integrate a palliative approach, and the need for practice supports to facilitate that enablers of collaboration. Key words: Palliative care, health services research, hospital and palliative care nursing, knowledge synthesis, nursing service, palliative approach, person-centered care, practice patterns, nurses.

Clinical Illness, Palliative Care, and the Problematic Nature of Dying

Kelli I. Stajduhar

Nurses encounter people with life-limiting illness in virtually every sector of the health-care system. In the care of the dying, the role of nurses is central, as the goal typically moves from one of care to one of care (Coluzzi & Khiner, 1996). Nurses spend more time with people who are dying than any other health professional (Baggs, 1993; Fackoury, 1998; Murray Frommelt, 1991) and are, therefore, perfectly positioned to influence the care that dying people and their family members receive. Palliative care nurses pride themselves on adopting a "whole person" approach to care, an approach that promotes quality of life along the illness trajectory, across the lifespan, and with a focus on both the dying person and those who are significant to him or her (Beckstrand & Arcoff, 2005; Coyle, 2006). Key concepts associated with palliative care have been defined. They include dignity, hope, comfort, quality of life, knowing the patient's wishes, understanding of care and caring (Seymour, 2004). Palliative care nursing has emerged as a specialty along with other nursing specialties such as critical care nursing, perioperative nursing, emergency nursing, and gerontological nursing (Canadian Nurses Association, 2011).

(Re)theorizing Integrated Knowledge Translation: A Heuristic for Knowledge-As-Action

Garrett Hartrick Doane, PhD; Sheryl Reimer-Kirkham, PhD; Elisabeth Antifova, MSN; Kelli Stajduhar, PhD

Approaches to knowledge translation (KT) have undergone substantial transformation in an effort to find more effective strategies to ensure the best available knowledge informs nursing practice. However, the fundamental epistemology underlying KT tools has gone largely unquestioned. Of particular concern is the inadequacy of current representational models to depict the complex, social process of KT. To address the limitations of representational models we propose an inquiry heuristic that conceptualizes KT as a knowledge-action process. Developed through a series of KT research projects, the heuristic is intended to guide the KT process and support effective navigation in the complexity of contemporary health care milieus. Key words: heuristics, inquiry, knowledge translation, models, palliative, representational science, translational scholarship

Translational Scholarship and a Palliative Approach

Enlisting the Knowledge-As-Action Framework

Sheryl Reimer-Kirkham, PhD; Garrett Hartrick Doane, PhD; Elisabeth Antifova, MSN; Barbara Pesut, PhD; Pat Porterfield, MSN; Della Roberts, MSN; Kelli Stajduhar, PhD; Nicole Wikijorn, MD

Based on a retheorized epistemology for knowledge translation (KT) that problematizes the "know-do gap" and conceptualizes the knower, knowledge, and action as inseparable, this paper describes the application of the Knowledge-As-Action Framework. When applied as a heuristic device to support an inquiry process, the framework with the metaphor of a kite facilitates a responsiveness to the complexities that characterize KT. Examples from a KT demonstration project on the integration of a palliative approach at 3 clinical sites illustrate the interconnectedness of KT—local context, processes, people, knowledge, and understanding of reality, and values. Key words: evaluation, inquiry, knowledge translation, models, palliative, translational scholarship

Death Is a Social Justice Issue

Perspectives on Equity-Informed Palliative Care

Kelli I. Stajduhar

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Taking an "upstream" approach in the care of dying cancer patients: The case for a palliative approach

Helene Hudson Lecture

Sheryl Reimer-Kirkham, PhD, RN; Kelli Stajduhar, PhD, RN

Bernie Pauly, PhD

Ryan McNeil, PI

All too often, palliative vulnerable, being deficits in the social care. It integrate the preempirical scaffold to illustrate such as key words: absent, poverty, public be

In Canada, as in much of the Western world, palliative care has become associated with serious illness, rather than with its original intent: as a philosophy and approach to care. Instead of an expansion of care, where palliative care begins at the time of diagnosis of cancer (Huston et al., 2011), care has tended to focus on the last months and weeks of life (Stittmann et al., 2014). Instead of palliation, patients are often linger with symptomatic distress (Schofield, 2013). In target settings, when these patients might be seen as a "palliative care" and require the specialized services that have now become associated with palliative care has become challenging. Like other social diseases, it is increasingly recognized that people with cancer are without a defined period of time before an expected death and, as such, must be identified as people who could benefit from the application of the philosophies and principles of palliative care. While there is consensus in the way in which a palliative approach is defined, there is an emerging understanding that...
A palliative approach is different than specialized palliative care. It takes the principles of palliative care and **ADOPTS, ADAPTS, EMBEDS**

- **ADOPT** principles EARLY (as soon as diagnosis) in the course of a person’s life-limiting condition
- **ADAPTS** strategies to meet patient and family needs, blend principles of palliative care with chronic disease management
- **EMBED** practices into usual care in settings not specialized in palliative care

**Shift your view on when people with life limiting illness could benefit from palliative principles:**

- **Home & community care:** When they are referred to home & community
- **Long term care:** When they move into care
- **Acute care:** When they are admitted to hospital
A palliative approach takes principles of palliative care and **ADOPTS** them **EARLY** in the course of person’s life-limiting condition.

**SHIFT YOUR PRACTICE**

**ADOPT**

**HOW?**

- **A**sk yourself: “Does this person have a life-limiting condition?”
- “Would this person benefit from a palliative approach?”
- **D**evelop an understanding of the illness course and where the person is along their journey.
- **O**pen conversations with people and their families to gauge understanding of their illness, what is most important to them, and their preference for care.
- **P**rioritize care - focus on what is important to people and their families.
- **T**ell people and their families about the illness and what can be expected in the future to inform their goals of care.
A palliative approach takes principles of palliative care and ADAPTS strategies to meet patient and family needs.
A palliative approach takes principles of palliative care and **EMBEDS** practices into usual care in settings that do not specialize in palliative care.

**HOW CAN LEADERS EMBED A PALLIATIVE APPROACH?**

- **Enable** support for early integration in and across settings
- **Mandate** processes for patient and family perspectives to be sought and communicated
- **Build** confidence and competence by interactional education, mentorship and peer support
- **Ensure** access to resources, mentors and specialist palliative care teams
- **Dedicate** time for providers to be involved in creating practical tools and processes for their setting

**Where?**
In all settings, across the continuum of care

**When?**
Early in the course of a chronic life-limiting condition

**Who?**
Everyone working with people with life-limiting conditions
First we aligned key stakeholders

Understand: The need for change
Enlist: A core change team
Envisionage: • Vision • Strategy
Communicate: • Executive support • Local support

First we aligned key stakeholders
Combined Quality Improvement Participatory Action Research Intervention

Baseline Data Collection → Action Cycles → Evaluation Plan
Identification

The Benefits of a Palliative Approach

Applying a palliative approach
Identification

The Surprise Question

- Sensitivity 67.0%, (95% CI 55.7% - 76.7%)
  - Positive likelihood ratio 3.4 (95% CI 2.8-4.1)
  - Negative likelihood ratio 0.41 (95% CI 0.32-0.54)
  - Positive predictive value 37.1% (95% CI 30.2-44.6%)
  - Negative predictive value 93.1% (95% CI 91.0-94.8%)

- The surprise question had worse discrimination in patients with non-cancer illness.

## Identifying patients for iPAC

<table>
<thead>
<tr>
<th><strong>REFERRAL CRITERIA FOR NS PALLIATIVE CARE PROGRAM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>METASTATIC CANCER</strong></td>
</tr>
<tr>
<td><strong>CHF / COPD</strong></td>
</tr>
<tr>
<td><strong>ALS / MOTOR NEURON DISEASE</strong></td>
</tr>
<tr>
<td><strong>CVA</strong></td>
</tr>
<tr>
<td><strong>ENDSTAGE KIDNEY DISEASE</strong></td>
</tr>
<tr>
<td><strong>DEMENTIA / FRAILTY</strong></td>
</tr>
<tr>
<td><strong>PARKINSONS</strong></td>
</tr>
</tbody>
</table>

Dr. Peter Edmonds, Vancouver Coastal
## Look for any clinical indicators of one or more advanced conditions

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Heart/ vascular disease</th>
<th>Kidney disease</th>
<th>Respiratory disease</th>
<th>Liver disease</th>
</tr>
</thead>
</table>
| Functional ability deteriorating due to progressive metastatic cancer. | NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:  
- breathlessness or chest pain at rest or on minimal exertion. | Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health. | Severe, inoperable peripheral vascular disease. | Advanced cirrhosis with one or more complications in past year:  
- diuretic resistant ascites  
- hepatic encephalopathy  
- hepatorenal syndrome  
- bacterial peritonitis  
- recurrent variceal bleeds |
| Too frail for oncology treatment or treatment is for symptom control. | Severe, inoperable peripheral vascular disease. | Kidney failure complicating other life limiting conditions or treatments. | Needs long term oxygen therapy. | Liver transplant is contraindicated. |

### Dementia/ frailty

- Unable to dress, walk or eat without help.
- Eating and drinking less; swallowing difficulties.
- Urinary and faecal incontinence.
- No longer able to communicate using verbal language; little social interaction.
- Fractured femur; multiple falls.
- Recurrent febrile episodes or infections; aspiration pneumonia.

### Neurological disease

- Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- Speech problems with increasing difficulty communicating and/or progressive swallowing difficulties.
- Recurrent aspiration pneumonia; breathless or respiratory failure.

### Review supportive and palliative care and care planning

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals, and a care plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Record, communicate and coordinate the care plan.
Identification

The Benefits of a Palliative Approach

Applying a palliative approach
Focus Group and Key Informant Findings
Pre-PAR Process (n = 22)

- Understanding the Context of Acute Care
  - Perceived to be over-interventionist
  - Contradictory views among team members and physicians on what is best for the patient
  - Patients (and family members) not routinely consulted on their care
  - Team members uncertain about their roles in integrating palliative approaches and disempowered to advocate for and have sensitive conversations with patients
  - A strong sentiment that it is the physician’s responsibility
June 2016 to September 2016

BASELINE RESULTS
iPAC Demographics
December 2015 to September 2016

Per Cent

Cancer  CHF  COPD  Dementia  Renal Failure  Stroke

Dec  March  June  Sept

0  10  20  30  40  50  60
Symptom Burden

**Patient- and family-reported outcomes: pre-innovation results** (post-innovation results are forthcoming)

Symptom burden (n=40)

| Symptom               | % of patients
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>60%</td>
</tr>
<tr>
<td>Tiredness</td>
<td>70%</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>40%</td>
</tr>
<tr>
<td>Nausea</td>
<td>50%</td>
</tr>
<tr>
<td>Lack of appetite</td>
<td>40%</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>60%</td>
</tr>
<tr>
<td>Depression</td>
<td>30%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>70%</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>60%</td>
</tr>
</tbody>
</table>

**NOTE.** ESAS-R scores range from 0 (none) to 10 (severe)

- **Moderate (ESAS-R score between 4-6)**
- **Severe (ESAS-R score between 7-10)**
Patient and Family Reported Experience

Patient quality of life (n=39)

Patient satisfaction with care (n=36)

Family member quality of life (n=23)

Family member satisfaction with care (n=22)

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## Baker 2 Patient Journey Mapping

### Documentation

<table>
<thead>
<tr>
<th>Item</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Careplan</td>
<td>73.5</td>
</tr>
<tr>
<td>MOST</td>
<td>94.1</td>
</tr>
<tr>
<td>no Most on chart</td>
<td>5.8</td>
</tr>
</tbody>
</table>

### Patient Perception

<table>
<thead>
<tr>
<th>Item</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan of Care</td>
<td>11.8</td>
</tr>
<tr>
<td>Condition</td>
<td>14.7</td>
</tr>
<tr>
<td>Felt heard by Dr</td>
<td>14.7</td>
</tr>
<tr>
<td>Felt heard by others</td>
<td>14.7</td>
</tr>
<tr>
<td>Prognosis</td>
<td>8.8</td>
</tr>
</tbody>
</table>
Integration of a Palliative Approach in Acute Care

Building a Foundation for Integration of a Palliative Approach

- iPANEL data and Pre-PAR data (focus groups; key informant interviews; patient and family reported outcomes) reported at a 1.5 unit retreat
- Creation of a unit “Action Team”

Enlisting Practice Wisdom and Participation

- Developing the ‘intervention’
- Creating a shared sense of ownership
Surprise Question

The Benefits of a Palliative Approach

Applying a palliative approach
Components of iPAC-AC ‘Intervention’

Interventions evolved over the course of the project, identified collaboratively by the research team and action team members. They included:

- **Identification** of patients who could benefit from a palliative approach
- Person-centered (patient and family) **quality of life assessment**: physical, social, spiritual, and emotional
- **Education and mentoring** on disease trajectory/prognosis awareness, serious illness conversations, pain and symptom management
- **Coaching** team members to work to their full scope and prioritize a focus on patients’ beliefs, values and goals and support of family members

A key focus: Embedding into usual care processes
# Integration Strategies

## Intensive 6-month Engagement with Action Team Members

<table>
<thead>
<tr>
<th>Weekly Action Team Meetings with CNS facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bi-Monthly Participatory Research Facilitation Meetings to coach and mentor CNS facilitators</td>
</tr>
<tr>
<td>Diffusing Knowledge Related to a Palliative Approach to Care including print materials, educational workshops</td>
</tr>
<tr>
<td>Policy Review of relevant organizational documents</td>
</tr>
<tr>
<td>Incorporation of Identification Processes into Usual Care – complex care rounds, flagging in Meditech system</td>
</tr>
<tr>
<td>Huddles 2-3 times/week included ‘on the spot’ education about a palliative approach and incorporated identification processes</td>
</tr>
<tr>
<td>Leadership, Communication, Mentorship and Role Modelling</td>
</tr>
<tr>
<td>Suggestion/Question Box</td>
</tr>
</tbody>
</table>
October 2016 to September 2017

ACTION CYCLE RESULTS
Pre- and post-innovation comparisons of chart audit data (n = 128 pre- and 221 post-innovation) Increased % of patients identified as ones who could benefit from a palliative approach

% medical unit patients identified as benefiting from iPAC

- Monthly median
- Baseline median (months 1-4)

iPAC innovation

iPOC

Month
### Hospital days saved through early iPAC identification per patient (N=653)

<table>
<thead>
<tr>
<th>iPAC patients</th>
<th>Days saved</th>
<th>End of action cycles</th>
<th>Following five months</th>
<th>Sustained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>Average</td>
<td>4.5</td>
<td>4.4</td>
<td>Sustained</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>2.2</td>
<td>1.2</td>
<td>Partially</td>
</tr>
</tbody>
</table>

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# Medial Length of Stay (MLOS) iPAC patients (N=653)

<table>
<thead>
<tr>
<th>iPAC patients</th>
<th>MLOS pre PAR</th>
<th>MLOS PAR</th>
<th>MLOS post PAR</th>
<th>Days saved</th>
<th>Sustained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>Average</td>
<td>10.6</td>
<td>8.4</td>
<td>9.5</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>9.4</td>
<td>8.6</td>
<td>9.5</td>
<td>0.8</td>
</tr>
</tbody>
</table>
**ER and acute care utilization of iPAC patients (N=653)**

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Pre PAR (Jun-Sept)</th>
<th>PAR (Oct-Mar)</th>
<th>Post PAR (Apr-Jul)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td># ER visits/mo. for readmission</td>
<td>5.5</td>
<td>6.9</td>
<td>8.5</td>
<td>Increased</td>
</tr>
<tr>
<td>30 day readmission rate (%)</td>
<td>28</td>
<td>34</td>
<td>31</td>
<td>No significant difference</td>
</tr>
<tr>
<td># days in acute care 6 months preceding death</td>
<td>22</td>
<td>44</td>
<td>38</td>
<td>Increased</td>
</tr>
</tbody>
</table>
HBA QI Reports
(N = 653)

Days to iPAC ID (days):
- Pre PAR: 7.5
- PAR: 3.7
- Post PAR: 3.7

Deaths overall (%):
- Pre PAR: 6
- PAR: 4
- Post PAR: 4

Deaths iPAC (%):
- Pre PAR: 10
- PAR: 7
- Post PAR: 8

Colors:
- Pre PAR: Green
- PAR: Blue
- Post PAR: Purple
HBA QI Reports
(N = 653)

Referrals PC prg (patients)  | CSAE (events/100 patients)  | Labs/10 per patient  | Deaths in hospice (avg. %)
--- | --- | --- | ---
Pre PAR  | PAR  | Post PAR

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Chart audits (N=40)
First 20 deaths all patients on ARH Baker 2

<table>
<thead>
<tr>
<th>ICU Utilization (%)</th>
<th>ALOS (days)</th>
<th>PC Referrals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre PAR</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td>Post PAR</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

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Facilitators to iPAC-AC

- Leadership motivated by excellence in care
- Skilled Mentorship and Capacity Building by Action Team Facilitators
- Receptivity to a Palliative Approach to Care
- Embedding Practice Support Tools into Usual Care Processes
- Engaged Partnerships between Practice Leaders and Researchers
Challenges to iPAC-AC

- Promoting active engagement of action team members
- Physician engagement
- Getting the team “on the same page”
- Busyness of the acute care environment
- Multiple competing priorities and silo(ing) of care systems
Qualitative Outcomes

- Shifts from Task Orientation Toward a Palliative Approach to Care
- Reclaiming Agency and Power to Make a Difference
- Fostering Confidence to Prioritize Patient Goals and Preferences
- Building a Cohesive Team that Exhibits Pride and Integrity in their Work
Patient Journey Mapping

Comparison of Cohort 1 (N=34) and Cohort 2 (N=20)

- Patient: Cohort 1 100%, Cohort 2 80%
- Family: Cohort 1 12%, Cohort 2 12%
- Plan of Care: Cohort 1 50%, Cohort 2 15%
- Condition: Cohort 1 15%, Cohort 2 15%
- Patient felt heard Dr.: Cohort 1 15%, Cohort 2 15%
- Patient felt heard others: Cohort 1 9%, Cohort 2 60%
- Prognosis awareness: Cohort 1 74%, Cohort 2 70%
- Care Plan: Cohort 1 70%, Cohort 2 100%
- MOST: Cohort 1 3%, Cohort 2 5%
- ACP: Cohort 1 0%, Cohort 2 0%
- Data input within 48 hours: Cohort 1 0%, Cohort 2 3%
Pending Results

- Post PAR PROMs and PREMs and comparison
- CIHI data for period April-August 2017
CULTURE AND CARE EXPERIENCE

IPAC-AC HAS RESULTED IN

- Increased interdisciplinary collaboration
- Implementation of iPAC-AC rounds twice/week
- Identification flags incorporated into workflow
- Increased staff confidence in initiating goals of care conversations and ACP
- Increased nurse confidence in talking with physicians about patient status
- Re-focused care on what is meaningful for patients and families

“During everyday conversations I ask patients ...
what brings you joy and meaning in your life” (Staff Nurse)
Accomplishments

- Culture change to a person focused and team based palliative approach to care
  - Goals of care discussions
  - Intolerance for inadequately managed pain and other symptoms
  - Supports for patients and families
Partners

Health Authority
- Palliative Care Program
- Medicine Program
- Abbotsford Regional Hospital

Academic
- University of Victoria
- Trinity Western University

Industry
- Intogrey Research and Development Inc.
iPAC-AC Innovation Community

**Principal Investigators**
- Neil Hilliard
- Richard Sawatzky
- Kelli Stajduhar (project leader)

**Co-investigators**
- Gweneth Doane
- Lesli Matheson Jennings
- Claudia Meyerman
- Sheryl Reimer-Kirkhan
- Della Roberts

**HQPs/Group Facilitators**
- Nicole Wikjord
- Patty Roy

**Steering committee**
- Doris Barwich, Kim Crooks, Carren Dujela, Jerry Gosling, Neil Hilliard, Cari Hoffmann, Jay Lambert, Joyce Lee, Lesli Matheson Jennings, Claudia Meyerman, Della Roberts, Patty Roy, Skanthan Sithamparanthan, Rick Sawatzky, Kelli Stajduhar, Annie Smith, Nicole Wikjord, Connie Wong

**Operations committee**
- Trena Canning, Neil Hilliard, Leslie Matheson Jennings, Nicole Wikjord, Patty Roy, Cornelia Vera

**Strategic Transformation Team**
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- Annie Smith

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- Trena Canning, Iona Wray, Margaret Chafe, Crystal Andrew, Sukhwinder Brar
- Karen Griffiths-Hawrylko, Cornelia Vera, Roselyn Beukens, Circe Codio, Maryna Koechlin, Sandra Nechwediuk, Jocelyn Klemes

**Patient Journey Mapping**
- Kevin Hare, Kathrin Eibl, Karen Symmes, Hamze Jomaa

**Data Collection**
- Dawson McCann, Nicole Wikjord, Patty Roy

**Key informant interviews**
- Melissa Giesbrecht

**Health Business Analytics**
- Yurik Sandino Alarcon
- Chong Chen

**Health Informatics**
- Noel Francisco

**Individual Level Data Analysis**
- Erin Krieter
- Melissa Giesbrecht

**Industry Partner**
- James Voth, CEO, Intogrey

**Admin Support**
- Carren Dujela
Acknowledgements

• Kelli Stajduhar, RN, PhD, Professor School of Nursing and Centre on Aging, University of Victoria

• Richard (Rick) Sawatzky PhD, Canada Research Chair in Person-Centred Outcomes, Professor School of Nursing, Trinity Western University

• BC Center for Palliative Care

• Intogrey Research and Development Inc.