

# *SELECTED INNOVATIONS*

Let's make change  
*happen.*



**OPEN**

*call for  
innovations in  
PALLIATIVE  
and  
END-OF-LIFE  
CARE*

*A palliative approach to care across the continuum:  
Providing the right care, in the right place, at the right time.*

Let's make  
change **happen.**

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Date: June 5, 2017

Applications were assessed by an external merit review panel. Following this review, CFHI selected 26 Palliative and End-of-Life Care Innovations to be highlighted – 6 panel presentations reflecting 8 projects, plus 18 posterboards – at the 2017 CEO Forum (June 21, 2017) in Toronto, Ontario. Final selection was made to be reflective of innovations happening across Canada – both emerging and demonstrated – that are currently underway, are outperforming current practice or have the potential to outperform current practice and have spread or have the potential to spread.

## EMERGING INNOVATIONS

Emerging innovations are promising practices and emerging ways of improving palliative care that are too new to have results.

This category includes innovations that have been implemented and also evidence-based ideas or conceptual designs for improving palliative care that have not been fully implemented.

## DEMONSTRATED INNOVATIONS

A demonstrated innovation is one that has been implemented and is showing evaluation results. The innovation may have been spread or scaled up to one or more sites beyond the original pilot site.

## About CFHI

The [Canadian Foundation for Healthcare Improvement](#) is a not-for-profit organization funded by Health Canada. CFHI identifies proven innovations and accelerates their spread across Canada by supporting healthcare organizations to adapt, implement and measure improvements in patient care, population health and value for money.

The views expressed herein do not necessarily represent the views of Health Canada.

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# CEO Forum Podium Presentations / 2017 CFHI Palliative and End-of-Life Care Innovation Award Recipients

## CIUSSS du Saguenay—Lac-Saint-Jean (Quebec)

*Front-line care support services for cancer patients*

Primary Contact: Sylvie Massé

### EMERGING INNOVATION

This innovation was brought about in order to reduce stress and the sense of despair in patients and their families when facing a new cancer diagnosis.

The clinical nurse and the front-line care team play a central role in the project by providing care for the patient, based on the patient's needs, in managing their illness. This approach reduces the levels of stress and despair, while fostering a relationship of trust for the full duration of care.

The main goal of this new approach is to improve the quality of life for patients and their families and allowing a relationship of trust to develop between them and their front-line nurse.

## University Health Network/Sinai Health System (Ontario)

*An Automated Tool to Identify Patients for Palliative Interventions*

Primary Contact: James Downar

### EMERGING INNOVATION

This project involves the development of a reliable, automated trigger tool for identifying inpatients who are nearing the end of life.

The tool uses a modified version of a highly-accurate Hospital One-year Mortality Risk (mHOMR) score to identify, in real time, those inpatients who are at elevated risk of mortality in the next 12 months. The tool sends an electronic message to the care team to remind them to address common palliative goals such as symptom management, clarification of goals of care, and medication review.

The tool aims to improve clinical care, but could also be used to advance palliative research and enhance quality improvement initiatives.

# Nova Scotia Health Authority / Health PEI (Nova Scotia, PEI)

## *Paramedics Providing Palliative Care at Home Program in Nova Scotia and Prince Edward Island*

Primary Contact: Alix Carter

### DEMONSTRATED INNOVATION

This project is an inter-provincial implementation of a Clinical Practice Guideline for paramedics responding to and supporting patients receiving palliative and end-of-life care in the community and at home.

The program broadens the scope of emergency medical services (EMS) by educating and empowering paramedics to provide palliative and end-of-life care at home. The creation of the new [Pallium LEAP Paramedic](#) course was a key part of the innovation and enabled the paramedics to expand their role. Paramedics and members of the patient's care team work together to fill existing gaps in home care services, improve the coordination of care, and provide care aligned with the patient's wishes, goals of care and preferred location of care.

This project enhances the coordination and experience of palliative and end-of-life care for patients and their families; improves access to palliative care supports at home; reduces and avoids emergency department visits; and improves paramedics' comfort and confidence in providing palliative care supports for patients and families.

# Alberta Health Services (Alberta)

## *Alberta Health Services Provincial Emergency Medical Services Palliative and End-of-Life Care Assess, Treat and Refer Program (EMS PEOLC ATR)*

Primary Contact: Cheryl Cameron

### DEMONSTRATED INNOVATION

This provincial, system-wide program was developed to support clients receiving palliative and end-of-life care in the community who require urgent symptom management – particularly those who wish to remain at home while nearing end of life.

Complex care issues often leave community clinicians and paramedics with no option but to transport clients to hospital during unexpected symptom crisis. In this unique program, paramedics work collaboratively with the client's primary/palliative care team and an online physician to provide support aligned with the client's wishes and goals of care.

Community clinicians and paramedics use resources available on the ambulance (medications and oxygen) to manage the most common palliative and end-of-life symptoms such as pain, nausea and shortness of breath in the home, engaging a palliative physician when specialist advice is needed.

This innovative program aims to enhance patient and family satisfaction, encourage interdisciplinary collaboration, and reduce potentially avoidable transports to hospital.

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## Vancouver Coastal Health (B.C.)

### *The Daisy Project: Embedding a palliative approach in residential settings*

Primary Contact: Jane Webley

#### DEMONSTRATED INNOVATION

This project was initiated to identify and understand the barriers to enabling well planned and coordinated end-of-life care for people in residential facilities in British Columbia.

The approach involves the early identification of residents likely to benefit from a palliative approach to care, focusing on goals of care discussions and effective communication between providers and families. Offering a common, consistent approach to supporting residents who are near the end of life creates opportunities – and provides permission – for death and dying to be openly discussed, normalized and celebrated.

This approach has been shown to be instrumental in successfully shifting the culture and improving the end-of-life experience for both the dying resident and their family, and for the surviving residents and the healthcare team.

## Canadian Virtual Hospice (Manitoba and national)

### *Ask a Professional: Providing responses to Canadians' questions about palliative and end-of-life care*

Primary Contact: Mike Harlos

#### DEMONSTRATED INNOVATION

[Ask a Professional](#) (AAP) is an online resource that provides access to an interdisciplinary clinical team of experts who provide answers to questions on palliative and end-of-life care.

AAP allows people with limited access to specialty palliative care resources to receive answers to their questions in a timely manner. This can include guidance and help in navigating the healthcare system; in making informed decisions and planning for the progression of illness; and in managing grief.

AAP provides a safe place for people to ask questions anonymously and receive evidence-based responses without judgment. AAP is also a resource for healthcare providers who are seeking assistance with decisions, complex cases and navigation of the healthcare system.

# Canadian Virtual Hospice (Manitoba and national)

*MyGrief.ca*

Primary Contact: Shelly Cory

## DEMONSTRATED INNOVATION

[MyGrief.ca](http://MyGrief.ca) is a novel online psycho-educative tool to normalize grief and assist people to grieve in healthy ways.

Evidence-informed content is supplemented with the personal narratives of Canadians sharing diverse experiences and perspectives. This resource brings free grief support into the home regardless of time or geography. The learning modules complement existing grief services and in many communities, may be the only support available.

MyGrief.ca helps people understand the grieving process, manage intense emotions and difficult situations, and identify when they need more help. It gives voice to the bereaved, shows people they aren't alone in what they are experiencing, and provides hope that things will get better. It is also an educational tool for healthcare providers and volunteers.

# Hamilton Health Sciences (Ontario)

*Creating an Inter-professional, Sustainable, Values-based, Whole-person Approach to Medical Assistance in Dying (MAiD) in Acute Care*

Primary Contact: Andrea Frolic

## EMERGING INNOVATION

This project is a comprehensive model of care designed to support patient choice and access to palliative and end-of-life care and high-quality MAiD services, while respecting staff and physicians with diverse moral views on MAiD. The Assisted Dying Resource and Assessment Service model (ADRAS) was developed to provide resources to support patient requests for MAiD, ensuring access to palliative care consultation, symptom management and high-quality evidence-based whole person care for patients and families.

The model includes collaboration and alignment with palliative care resources to help patients make informed choices on a range of end-of-life care options; supports for inter-professional clinical teams to respond to MAiD requests; high-reliability MAiD practices to ensure compliance with legal criteria; peer support and mentorship for MAiD providers; and resources and tools to develop the capacity to provide MAiD across hospital and community settings.

# CEO Forum Storyboard Presentations

## BC Centre for Palliative Care (B.C.)

### *Peer-facilitated Advance Care Planning (ACP) Workshops for the Public*

Primary Contact: Doris Barwich

#### DEMONSTRATED INNOVATION

The main component of this project is a series of advance care planning (ACP) workshops that have a focus on interactive conversations with the public.

This project will facilitate the training for these workshops in public communities in British Columbia and – given the capacity – further spread throughout Canada. Components of the project include developing a training curriculum for peer facilitators, designing a toolkit, and providing support to organizations.

The overall objective of this project is to help increase the frequency of patients who receive care that aligns with their goals and preferences (using ACP), thereby improving their quality of life and end-of-life experience.

## Calgary Zone, Alberta Health Services (Alberta)

### *Palliative/End of Life Care Program (PEOLC)*

Primary Contact: Beverly Berg

#### DEMONSTRATED INNOVATION

This project provides comprehensive, integrated and tailored palliative care in all urban and rural health sectors in the Calgary Zone of Alberta Health Services.

The PEOLC program is designed to ensure that clinical care flows seamlessly by using established referral criteria and guidelines for all palliative care transitions. Foundational to the sustainability of the project is organizational leadership, along with integrated links to health systems programs such as seniors' health, continuing care and family medicine.

This project's primary objective is to continually support a growing and diverse population of changing palliative needs in keeping with the vision and mission of Alberta Health Services.

# Central West Palliative Care Network (Ontario)

## *Early Palliative Identification Project*

Primary Contact: Margaret Paan

### DEMONSTRATED INNOVATION

This project flags patients with early palliative care needs through stakeholder engagement and education. The primary intervention used in this project is the Early Identification and Prognostic Indicator Guide, which asks providers questions about their patients that help increase knowledge and skills in identifying individuals with palliative needs. A quality improvement approach is used to monitor changes and measure the impact on the patient experience.

The overall objective of this project is to improve the quality of the patient and caregiver experience by identifying patients with palliative care needs earlier to ensure appropriate access and quality of care.

# Nova Scotia Health Authority, Central Zone (Nova Scotia)

## *Palliative and Therapeutic Harmonization (PATH)*

Primary Contact: Paige Moorhouse

### DEMONSTRATED INNOVATION

Palliative and Therapeutic Harmonization (PATH) is a patient-centred program that strives to improve the care experience of frail older adults and their caregivers. By focusing on the “big picture” of health, PATH empowers patients to make evidence based healthcare decisions that are appropriate for their frailty burden.

The PATH model includes clinical tools, evidence informed guidelines and multidisciplinary team training. PATH is a leading practice with Accreditation Canada and has been adopted in care settings (pre-operative, renal, cardiology, orthopedics, rehabilitation and long term care) in BC, Ontario, and Nova Scotia.

PATH has demonstrated a better patient/caregiver experience while achieving significant cost avoidance and cost savings.

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# The Children's Hospital of Eastern Ontario (CHEO) and Roger Neilson House Integrated Palliative Care Program (Ontario)

*A Comprehensive Pediatric Palliative Care Delivery Model*

Primary Contact: Lynn Grandmaison Dumond

## DEMONSTRATED INNOVATION

This project is centered on an integrated and comprehensive model of pediatric palliative care services and supports. These supports are offered by a dedicated inter-professional team as early as possible after the diagnosis of a life-limiting illness.

Delivered in the child and/or family's setting of choice, this model of care provides a seamless, continuous system to provide "added care" along the trajectory of illness and beyond, into bereavement. This model includes regular meetings, home visits, and early referral.

The objectives of this project are to help build relationships of trust, and to make integrated pediatric palliative care available to all children with life-limiting illness and their families.

# Fraser Health, University of Victoria, B.C. (B.C.)

*Integrated Palliative Approach to Care in Acute Care (iPAC)*

Primary Contact: Kelli Stadjuhar

## EMERGING INNOVATION

The Fraser Health Palliative Care Program is engaged in a research-practice partnership, called iPANEL, that aims to discover how specialized palliative care can be adapted and embedded into settings that do not specialize in palliative care.

The various components of the iPANEL innovation help staff in acute care medical units with the uptake, sustainability, and potential spread of a palliative approach to care. Those components include quality of life assessments; goals of care conversations; and aligning care with patients' beliefs, values and goals.

This project's primary goal is to integrate a palliative approach that address patient- and family-centred goals of care in acute care medical units.

## Hospital for Sick Children (Ontario)

*Bridging the Gap: The Paediatric Advanced Care Team (PACT) community outreach nurse practitioner*

**Primary Contact: Adam Rapoport**

### DEMONSTRATED INNOVATION

The PACT community outreach nurse practitioner (NP) provides expert support to community healthcare providers and pediatric palliative care patients and families.

The PACT NP facilitates smooth transitions from hospital to home or hospice for end-of-life care. After establishing a relationship with the family in hospital, the PACT NP participates in the first home visit, where the clinical situation is reviewed with the community team and anticipated challenges are discussed. The NP remains available to the community team by phone, e-mail or in person to help address challenges as they develop.

The goal is to help bridge the gaps that currently exist between the tertiary pediatric institution and the community, and to help families feel more comfortable and supported.

## CISSS de la Montérégie-Ouest (Quebec)

*Developing a program to support end-of-life care at home*

**Primary Contact: Mélanie Dubé**

### EMERGING INNOVATION

This innovation offers the person in end-of-life care the option to fulfill their wish to die at home.

The project's implementation is guided by four set indicators: an increase in home death rates for people receiving end-of-life care at home who have expressed a desire to die at home; a reduced need for these patients to resort to hospitalization in healthcare facilities; reduced emotional stress and sense of despair for caregivers; and an improved sense of efficacy for caregivers.

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## McMaster University (Ontario)

### *Building CAPACITI: Community Access to a Palliative Approach to Care via Inter-professional primary care Teams Intervention*

**Primary Contact: Hsien Seow**

#### EMERGING INNOVATION

CAPACITI is an intervention that provides education, tools, coaching, measurement support, facilitation and local adaptation to help teams of primary care providers deliver home-based palliative care.

CAPACITI combines three evidence-based interventions and adapts them to a Canadian and local context:

- Standardized education
- UK's Gold Standards Framework
- Kelley's Community Capacity-Building Model

This project's primary goal is to build the capacity of primary care provider teams to deliver a palliative approach to care so that patients can get earlier and increased access to home-based palliative care. Its innovation is that it guides providers in the foundational steps to deliver home-based palliative care, while allowing flexibility to develop a local model.

## Nova Scotia Health Authority (Nova Scotia)

### *Integrating the Palliative Approach in the Primary Health Care Setting: An operational framework to support early access to palliative care*

**Primary Contact: Cheryl Tschupruk**

#### EMERGING INNOVATION

This project involves using an operational framework to support effective integration of the palliative approach in the primary healthcare setting.

The framework guides providers and leaders through the process of practice change using strategies such as a readiness assessment; value stream mapping; capacity building; toolkits; and patient, provider and family engagement. Integrating the various components of the framework can help strengthen community, build relationships, enhance knowledge and skills, and deliver quality palliative care.

The goal of this framework is to support earlier access so that all patients with a life-limiting illness can benefit from the key elements of quality palliative care that improve the patient and family experience.

# Riverview Manor Long Term Care Home (Ontario)

## *Riverview Manor Palliative Care Program*

**Primary Contact: Patsy Morrow**

### EMERGING INNOVATION

The Riverview Manor Palliative Care Program is a comprehensive approach to ensuring that end-of-life care is offered to residents and their families in a coordinated and collaborative way.

This project incorporates several best practices, including developing an end-of-life plan upon admission; designing care plans that reflect palliative scores and appropriate actions updated quarterly; and engaging an informed inter-professional care team to support residents and their families.

The primary goal of this project is to ensure that every long term care resident at Riverview Manor has a positive, seamless and dignified end-of-life experience where their wishes are carried out and their families are supported.

# Division of Palliative Care, University of Toronto (Ontario)

## *Getting ACP Right: Advance Care Planning conversations*

**Primary Contact: Jeff Myers**

### EMERGING INNOVATION

This project will use a standardized set of Advance Care Planning (ACP) questions and educational materials packaged into a clinical tool to guide and inform clinicians, individuals and their substitute decision-makers.

This project will implement this "ACP Conversation Guide" in acute and ambulatory care settings to enable values-based conversations and increase the frequency of documented ACP conversations among patients, substitute decision-makers and direct care providers.

The goal of this project is to empower an individual and their substitute decision-makers through person-centred ACP guidance and education, and to inform and educate direct care providers on how to facilitate values-based ACP conversations.

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## Toronto Central Local Health Integration Network (Ontario)

*A Palliative Care Resource Matching and Referral Program: A strategy to improve access, availability, integration and patient transitions to inpatient palliative care units*

Primary Contact: Rose Cook

### DEMONSTRATED INNOVATION

The Palliative Care Resource Matching and Referral program (PC RM&R) is a new pathway built into an existing Local Health Integration Network (LHIN)-wide program.

The PC RM&R system accelerates patient transitions by improving referrals through standardization, automation, and efficient and appropriate matching of patients to care based on their clinical needs. It also tracks, monitors, and provides standardization of the application process and metrics for performance measurement.

The goal of the program is to enhance capacity and collaboration across the system, and to improve patient experience, access, equity and safety by optimizing transitions across sectors.

## University Health Network (Ontario)

*Symptom Screening with Targeted Early Care (STEP) for Patients with Advanced Cancer*

Primary Contact: Ashley Pope

### EMERGING INNOVATION

The project uses the Symptom screening with Targeted Early Care (STEP) assessment method to indicate whether patients' symptoms require a referral to the outpatient oncology palliative care clinic (OPCC).

When patients are in the waiting room during regular oncology clinic visits, each patient routinely completes an online assessment of various symptom severity ratings. For consenting study participants, moderate to high symptom scores are automatically sent to the study triage nurse via e-mail. The triage nurse then notifies the oncology team, calls the patient for further assessment, and offers an appointment in the OPCC.

The goal of this project is to improve access to appropriate care by identifying patients with the greatest need for triage and targeted referral to the OPCC.

# University Health Network / Sinai Health System (Ontario)

## *A Medication Rationalization (MERA) Intervention for Patients with Advanced Illness and a Palliative Treatment Philosophy*

Primary Contact: James Downar

### DEMONSTRATED INNOVATION

This project involves using a Medication Rationalization (MERA) algorithm to rationalize medications prescribed for patients with advanced illness and a limited life expectancy.

An inter-professional team reviews a patient's current medications; makes recommendations for stopping or changing medications based on accepted guidelines (for example, Beers' criteria, STOPP/START, Choosing Wisely); and suggests simple medications to address any uncontrolled symptoms.

The goal of this project is to ensure that medications are aligned with the needs of a patient who is nearing the end of life.

# University of Alberta (Alberta)

## *Patient-centred ILD Collaborative for Early Integrated Palliative Care*

Primary Contact: Janice Richman-Eisenstat

### EMERGING INNOVATION

This project consists of an innovative collaborative network of healthcare teams that provides patient-centred care in the community for those with Interstitial Lung Disease (ILD) across the disease continuum from diagnosis to death.

The network includes a multidisciplinary ILD specialty clinic, an ILD-specific pulmonary rehabilitation program, primary care practitioners, allied health home care staff, and a patient support group.

A proactive approach to symptom recognition and management, along with ongoing advance care planning, is implemented through close collaboration within the network.

The primary objective is to provide personalized, self-directed, early and prompt symptom management to maximize quality of life in the patients' preferred location of care, and good quality of death and dying in the patients' preferred place of death.

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## University of British Columbia, Okanagan (B.C.)

*N-CARE: Volunteer navigation partnerships to support a compassionate community approach to early palliative care*

Primary Contact: Barb Pesut

### EMERGING INNOVATION

N-CARE (Navigation: Connecting, Accessing, Resourcing, Engaging) is an evidence-informed, community-based intervention in which hospice volunteers, trained in navigation, provide supportive services to adults living with advanced chronic illness in the home.

This project will develop a new role for hospice volunteers to meet the unique needs of the early palliative population and encourage partnerships that characterize a compassionate community approach to care. N-CARE includes an implementation toolkit for experienced hospice volunteers that provides step-by-step guidance for implementing, developing, and evaluating the N-CARE service.

The goal of this project is to improve the quality of life of adults living at home with an early palliative diagnosis.

## University of Saskatchewan (Saskatchewan)

*Keeping Hope Possible: A supportive toolkit for use with parents in pediatric palliative care*

Primary Contact: Jill Bally

### EMERGING INNOVATION

The Keeping Hope Possible (KHP) intervention is a toolkit designed to support families when caring for a child with a life-limiting or life-threatening illness.

The KHP Intervention involves self-administered, focused activities and writing that explore hope and caregiving experiences. The toolkit is made up of four interrelated sections that can be made adaptable to personal experience. The activities encourage parents or other family caregivers to reflect, express their emotions, and find personal and creative ways to keep hope possible in the unique journey through their child's illness.

This project aims to support parents in keeping hope possible while navigating their child's life-limiting illness or life-threatening illness.