

STRENGTHENING OUR LONG TERM CARE TOGETHER:  
EMBEDDING PALLIATIVE APPROACHES TO CARE  
SPREAD COLLABORATIVE

# PROSPECTUS

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# TABLE OF CONTENTS

<b>Executive Summary.....</b>	<b>3</b>
<b>Working Shoulder-to-Shoulder with CFHI.....</b>	<b>6</b>
What is a CFHI Quality Improvement Collaborative?.....	6
<b>Background.....</b>	<b>7</b>
EPAC Overview.....	7
Testing the Innovation.....	8
<b>The EPAC Spread Collaborative.....</b>	<b>9</b>
Objectives of the EPAC Spread Collaborative.....	9
Benefits of Joining the EPAC Spread Collaborative.....	9
How to Apply.....	10
Quality Improvement and Measurement.....	11
Key Dates.....	12
<b>How to Apply to the Collaborative?.....</b>	<b>12</b>
<b>Ethics.....</b>	<b>13</b>
<b>Conflicts of Interest.....</b>	<b>13</b>
<b>Glossary.....</b>	<b>14</b>
<b>References.....</b>	<b>14</b>

*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.*

# EXECUTIVE SUMMARY

The Canadian Foundation for Healthcare Improvement (CFHI) is inviting applications from teams from across Canada to join the Strengthening our Long Term Care Together: EPAC Collaborative taking place between June 2018 and October 2019.

## WHAT IS EPAC?

**EPAC (Embedding a Palliative Approach to Care)** is a successful model of care developed by Vancouver Coastal Health. EPAC improves care at the end-of-life for residents in long term care, their family, surviving residents and the healthcare team. 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.

## WHAT IS A CFHI COLLABORATIVE AND WHAT IS ITS PURPOSE?

CFHI collaboratives are quality improvement initiatives that bring together interprofessional teams to address a common healthcare issue through a team-based quality improvement project and shared learning. CFHI collaboratives support teams to create or strengthen the quality improvement culture within their organization. CFHI supports the implementation of the collaborative by providing seed funding, an evidence-informed quality improvement model, peer-to-peer networking opportunities, measurement and evaluation support and access to a network of expert faculty and coaches.

## WHO SHOULD APPLY?

Groups of long term care homes (LTCHs) that can demonstrate broader system partnerships with other relevant service delivery partners in their region, jurisdiction or system – such as with a regional palliative care program – should apply to the collaborative as a “network.” A network may be (but is not limited to) a health region (e.g. Zones, Local Health Integration Network or sub-LHINs, and/or Regional Health Authorities), a jurisdiction or a group of LTCHs, with or without common ownership, willing to collaborate on this quality improvement project. Networks from Ontario are encouraged to connect with Hospice Palliative Care Ontario when preparing their proposals.

CFHI will provide training and support to a core team of professionals drawn from organizations within the Network (the “Network Team”), who will be responsible for steering processes, training the LTCHs within the network and providing general oversight. The LTCHs within each network will work together to spread EPAC.

## WHY JOIN THE COLLABORATIVE?

Providing a 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 and normalized. In doing so, it can successfully shift the culture of care and improve the end-of-life experience for both the resident and their family, as well as for surviving residents and the healthcare team. CFHI support for the implementation, spread and scale for EPAC includes:

- Seed funding of up to \$30,000 per network
- Support for performance measurement and evaluation
- Access to expert faculty and coaches
- Team coaching for testing change and troubleshooting
- Access to shared online desktop for resources and collaboration
- Peer-to-peer networking and exchanges
- Educational webinars
- In-person workshop

The EPAC Collaborative will advance the shared priority of providing end-of-life care for residents and their families in their homes, including support for all affected by the death of that resident.

## WHAT WILL BE MEASURED IN THE EPAC SPREAD COLLABORATIVE?

Network teams will be required to collect and report on the following measures:

- Percent and number of residents with documented goals of care discussions
- Percent and number of residents with documented goals of care discussions within 8 weeks of admission
- Time from resident admission to death (length of stay)
- Number of emergency department (ED) transfers in last 3 months of life
- Percent and number of residents dying in acute care
- Resident and family experience

## HOW TO APPLY

[Expressions of Commitment](#) must be submitted by **May 25, 2018** (11:59 Eastern Time).

Review the Strengthening our Long Term Care Together: EPAC Spread Collaborative and [Expression of Commitment](#) for complete details.

Completed Expression of Commitment can be sent to [elan.graves@cfhi-fcass.ca](mailto:elan.graves@cfhi-fcass.ca).

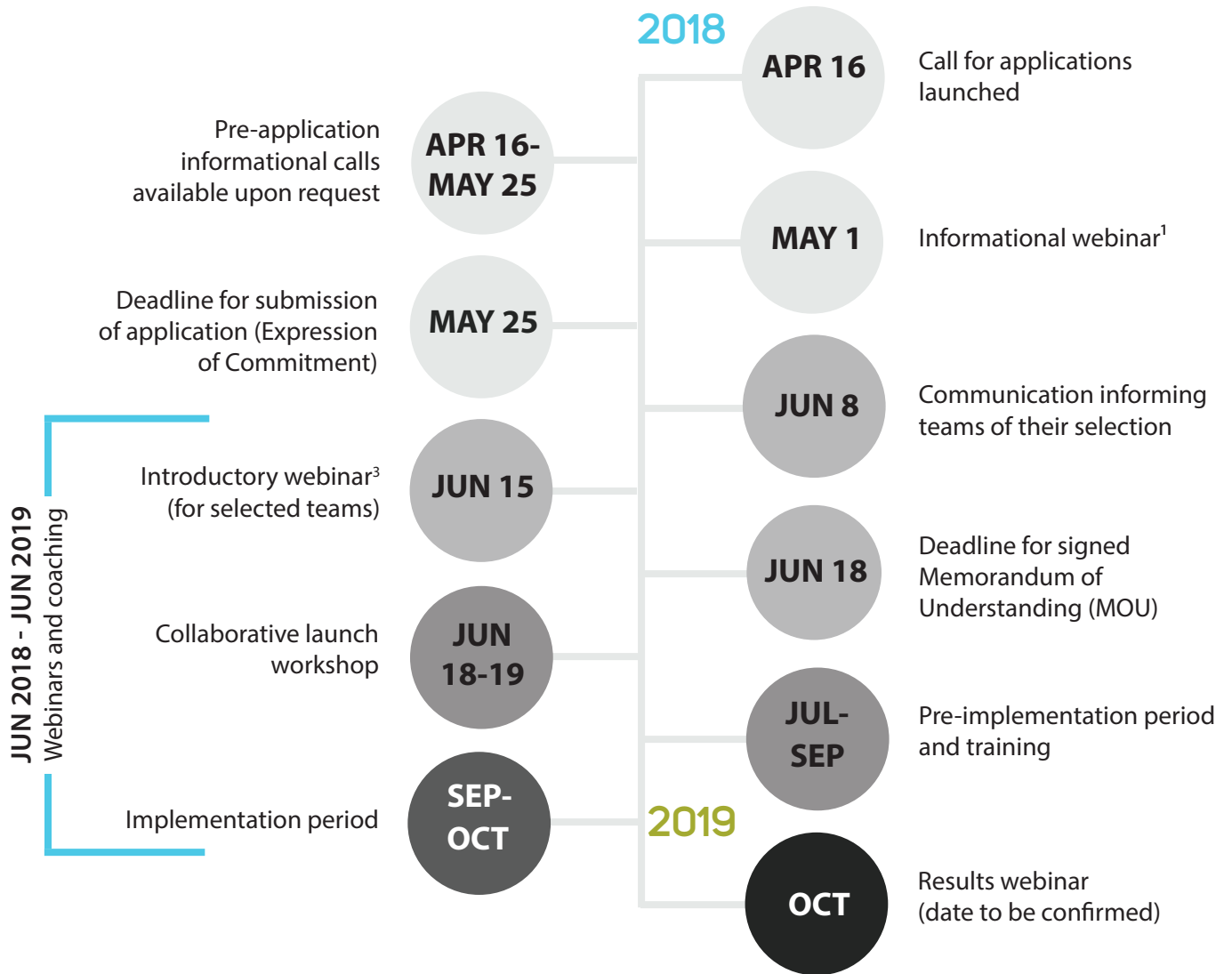
To learn more about the EPAC Spread Collaborative, join CFHI staff for an [informational webinar](#) on **May 1, 2018**.

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*If you have any questions about the application process, or to arrange a pre-application coaching call, please contact Elan Graves, Senior Improvement Lead, at [elan.graves@cfhi-fcass.ca](mailto:elan.graves@cfhi-fcass.ca) or 613-728-2238 (x268).*

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# KEY DATES



<sup>1</sup> This will be recorded and available for viewing on the CFHI website

# WORKING SHOULDER-TO-SHOULDER WITH CFHI

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. We work shoulder-to-shoulder with you to improve health for all Canadians.

*"... pockets of extraordinary creativity and innovation dot the Canadian healthcare landscape. Local, regional and even provincial programs worthy of emulation have simply not been scaled up across the nation... CFHI punches above its weight in scaling up innovation..."*

- Federal Advisory Panel on Healthcare Innovation (2015)

CFHI focuses on:

- **Building leadership and skill capacity:** We enhance organizational capacity to champion and lead improvement.
- **Enabling patient, family and community engagement:** We catalyze healthcare innovation by involving those who experience and need care as experts in improvement and co-design.
- **Applying improvement methodology:** We use improvement tools and methods to drive measurable results towards better patient care, better health and better value.
- **Creating collaboratives to spread evidence-informed improvement:** We bring together 'coalitions of the willing' and support these networks of change agents to implement improvement across Canada.

## WHAT IS A CFHI QUALITY IMPROVEMENT COLLABORATIVE?

CFHI collaboratives are quality improvement initiatives that bring together interprofessional teams of healthcare providers, non-healthcare staff, as well as patients or residents and their families from across Canada to address a common healthcare issue through a team-based quality improvement project and shared learning. In addition to spreading innovations across Canada, CFHI collaboratives support teams to create or strengthen the quality improvement culture within their organization.

CFHI supports the implementation of the collaborative by providing seed funding, an evidence-informed quality improvement model, and coaching and advisory services. The collaborative provides a common framework for addressing a healthcare issue that is tailored by each team based on the context and needs of their organization. This includes an evaluation component where teams learn how to assess the impact of the innovation on their organization using performance measurement.

CFHI supports the implementation of collaboratives through activities that provide a balance of theory, tools and practical techniques to build capacity in the following core competencies:

- **Identify and interpret evidence for improvement:** Teams will gain proficiency through setting goals and targets, implementation and spread goals, and designing person-centred care approaches.
- **Work collaboratively towards improvement with residents, families, caregivers, communities and interprofessional teams:** Teams will gain proficiency by collaborating in multidisciplinary teams to design and implement person-centred care practices and data-driven improvements.
- **Design and implement improvement:** Teams will understand and apply quality improvement methodology for developing and sustaining evidence-informed improvements.

- **Lead change in complex organizations/environments:** Teams will understand and develop proficiency in applying principles of change management across the organization.
- **Measure, monitor and report improvement:** Teams will gain proficiency in using data to set targets, monitor progress, inform care planning, and develop open channels of communication to share information about progress and key results.
- **Plan for spread and sustain the gains:** Teams will gain proficiency in assessing the sustainability and spread of their improvement efforts.

## BACKGROUND

### EPAC OVERVIEW

Caring for residents at the end of their lives has become an important part of long term care. Providing quality palliative care not only supports the needs of residents, it empowers staff to care for dying residents and grieving families and it allows homes to meet the expectations of families and the public that quality palliative care is an embedded component of the care available to residents.

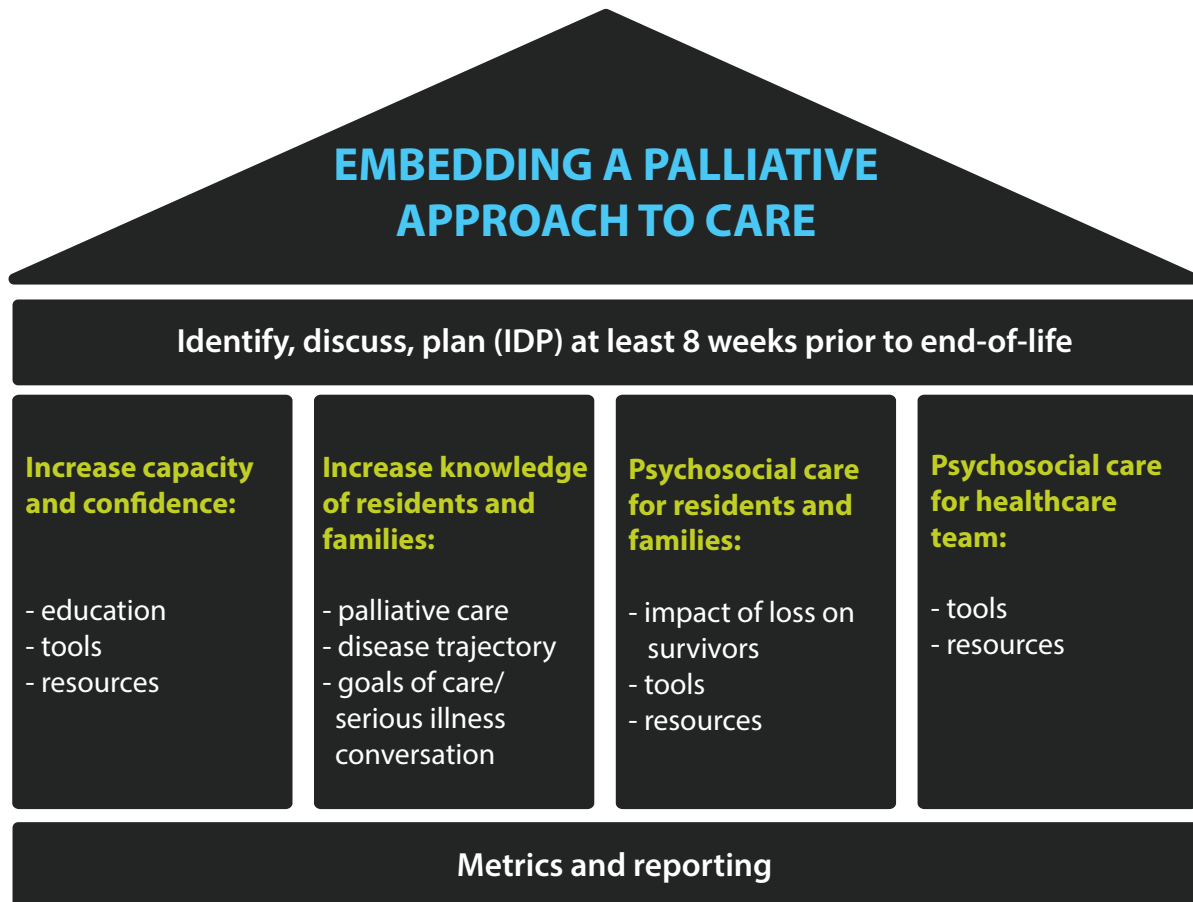
Jane Webley, Regional Leader, End of Life, at Vancouver Coastal Health, initiated **EPAC** (Embedding a Palliative Approach to Care) at Vancouver Coastal Health in British Columbia to understand the barriers to enabling well-planned and coordinated end-of-life care for people in long term care homes. 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 and normalized. This approach has been shown to be instrumental in successfully shifting the culture and improving the end-of-life experience for both the resident and their family, and for the surviving residents and the healthcare team.

Based on a careful root cause analysis, the project team, which included residents and families, identified four goals:

1. Every resident will have a documented goals of care discussion early before their death
2. All stakeholders will be supported at the time of a resident's death
3. All stakeholders will have access to honest, relevant information and education
4. Goals of care will be respected across the healthcare continuum

The pillars of the EPAC model are flexible, enabling individual homes to adopt and adapt them to their unique local needs and strengths (see Figure 1).

Figure 1:



## TESTING THE INNOVATION

From 2012-2017, EPAC (previously known as DAISY) was implemented in 48 long term care homes, including urban and rural sites and homes caring for specialized populations such as acquired brain injury (ABI), Amyotrophic Lateral Sclerosis (ALS) and marginalized persons across Vancouver Coastal Health. The initiative demonstrated success in enabling residents to receive improved end-of-life care at home, avoiding unnecessary hospital transfers and supporting all stakeholders through the experience.

The project team has trained leaders and site champions, increasing capacity and capability in the delivery of a palliative approach to care, increasing confidence to discuss goals of care with the resident or substitute decision maker, and contributing to cross-sector benefits for both acute and long term care. The initiative achieved a 60% decrease (n=75<sup>2</sup>) in ED transfer rates without admission, and a 27% (n=276<sup>3</sup>) reduction in number of days residents spent in acute care.

<sup>2</sup> Number of transfers decreased

<sup>3</sup> Number of days decreased



Family members expressed their confidence in the care both they and the resident receive:

*“The staff supported our family completely. They helped us prepare and make arrangements in advance. We appreciated staff coming to say goodbye.”*

*“The palliative approach was comforting knowing that my Mum would die in a place that she felt cared for and we felt at home here.”*

## THE EPAC SPREAD COLLABORATIVE

### OBJECTIVES OF THE EPAC SPREAD COLLABORATIVE

The EPAC collaborative will help healthcare organizations across Canada to identify and reach all residents in long term care within their jurisdiction who stand to benefit, as well as to ensure that all providers who could deliver a palliative approach to care have the capacity and skills required to do so. Spreading EPAC will create more equitable access to improved quality of life for residents living with life threatening or life limiting conditions, and their family members.

The objectives of the collaborative are:

- Improving long term care teams' ability to have effective, timely goals of care discussions with residents and their substitute decision makers
- Improving the experience of end-of-life care for residents, families and staff in long term care
- Reducing unnecessary transfers to acute care
- Improving capacity to provide end-of-life care in the location of the resident's choice
- Building quality improvement capacity in long term care

CFHI is focusing on shifting care from acute to community-based settings. The collaborative will support this shared federal/provincial/territorial priority by reducing the number of patients in hospital who could be better cared for at home in their own community.

### BENEFITS OF JOINING THE EPAC SPREAD COLLABORATIVE

The EPAC Spread Collaborative will use a train-the-trainer approach for building capacity at the network level to implement and spread the model of care using quality improvement methodology. The Collaborative will also help build capacity for network members to implement future quality improvement strategies.

Network teams will also have access to a range of valuable resources to help participating organizations spread and embed this innovative approach to care in their homes. These resources include:

- Seed funding of up to \$30,000 per network
- Collaborative support for the implementation, spread and scale up
- Support for performance measurement and evaluation
- Access to a network of expert faculty and coaches

- Peer-to-peer networking and exchanges
- Access to shared online desktop for resources and collaboration
- Educational webinars
- In-person workshop to foster cross-team learning

## HOW TO APPLY

Teams apply as a network. A network may be a health region, a jurisdiction or a group of long term care homes, with or without common ownership, willing to collaborate on this quality improvement project. Networks from Ontario are encouraged to connect with Hospice Palliative Care Ontario when preparing their proposals.

For the Collaborative, networks must:

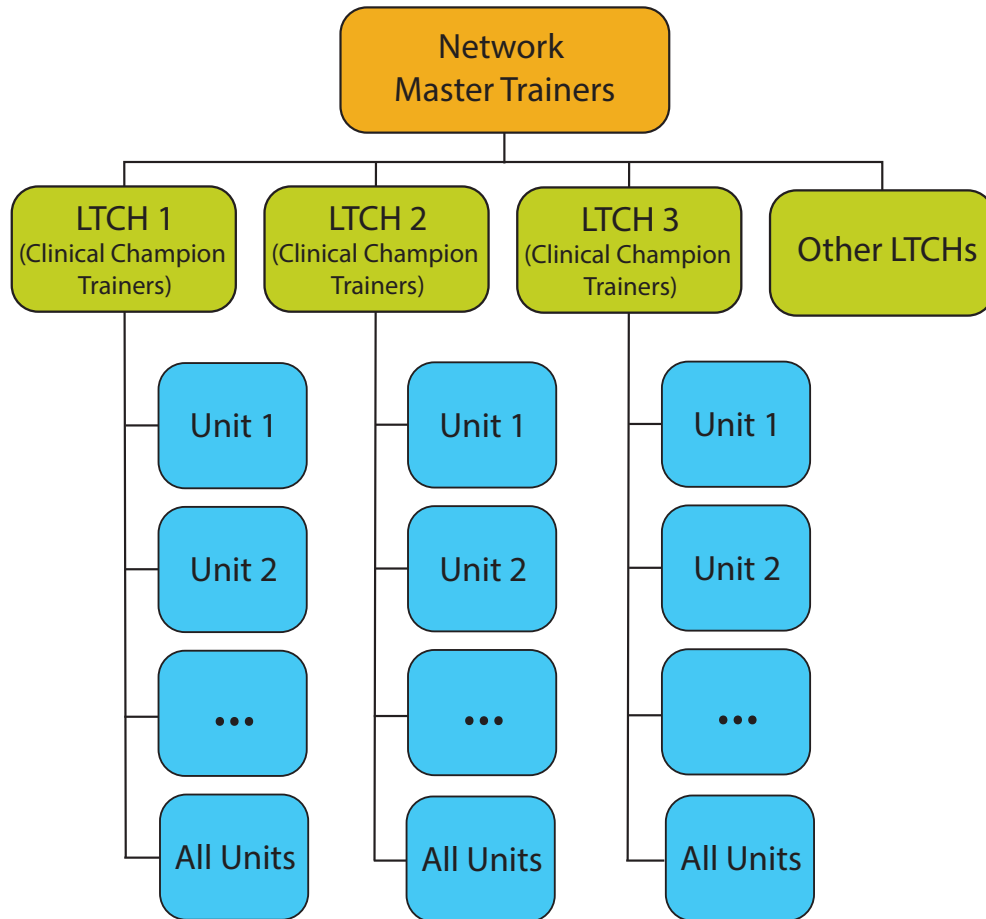
- Demonstrate local project oversight that enhances and accelerates any prior or current quality improvement initiatives focused on palliative and end-of-life care
- Where feasible, include the voice of residents and their families
- Designate regional/network “master trainers” including a plan for sustaining this function should staff turnover occur
- Demonstrate how they will collaborate to spread the EPAC model as widely as possible within their network. Urban networks should consider how they can support neighboring rural regions
- Have executive endorsement and support from each participating organization
- Demonstrate how they will collaborate with local/regional palliative and end-of-life care services and other community supports that may be appropriate.
- Provide a regional strategy to evaluate project impact

In their commitment to the project, each participating home must:

- Develop a plan for engaging residents and families
- Identify a champion team that reflects the interdisciplinary nature of palliative and end-of-life care and include, at minimum, a registered nurse and a personal support worker/care aide
- Provide a plan for staff training
- Develop a quality improvement plan to implement EPAC in their unique home context
- Be willing to collect and report evaluation metrics (e.g. locations of resident death, family experience, documentation of goals of care) for, at minimum, the duration of the collaborative

For this collaborative, CFHI will use a train-the-trainer approach to education. Specifically, CFHI subject matter experts (clinical and quality improvement) will train network master trainers and then actively and directly mentor those individuals to train clinical champion trainers/teams champion teams from participating homes. Clinical mentorship and leadership skills development and mentoring will be an integral component of this training model (see Figure 2).

Figure 2:



## QUALITY IMPROVEMENT AND MEASUREMENT

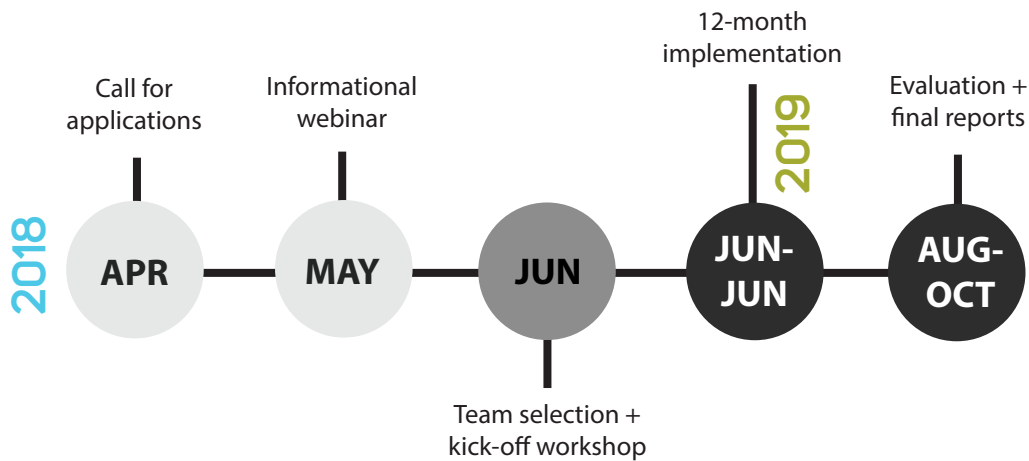
Network teams will be required to regularly collect and report on identified improvement measures.

As part of CFHI's commitment to capacity development, we will support LTCHs to track a range of metrics through quantitative and quality analysis including:

- Percent and number of residents with documented goals of care discussions
- Percent and number of residents with documented goals of care discussions within 8 weeks of admission
- Time from resident admission to death (length of stay)
- Number of ED transfers in last 3 months of life
- Percent and number of residents dying in acute care
- Specific resident and family experience
- Clinician confidence and the experience of delivering the EPAC model
- Cultural change factors (e.g. staff comfort levels)
- Sustainability of innovative practices in teams participating in the collaborative

Aggregated results will be shared with the network teams for continuous quality improvement. An Evaluation Working Group will be formed to support this Collaborative. The evaluation approach for EPAC will include a collaborative approach where the evaluators work with members of the program community (stakeholders) to both implement the evaluation and produce information and results about the project.

## KEY DATES



## HOW TO APPLY TO THE COLLABORATIVE?

### CALL FOR APPLICATIONS

- EPAC Spread Collaborative call for applications is open from April 16 to May 25, 2018.
- Pre-application teleconference calls can be arranged throughout the application period by emailing [elan.graves@cfhi-fcass.ca](mailto:elan.graves@cfhi-fcass.ca).

### INFORMATIONAL WEBINAR

- To learn more about the EPAC Spread Collaborative, please join faculty and CFHI staff on an [informational webinar](#) on May 1, 2018. Please register online.
- The webinar recording will be available On Demand following the live presentation.

### EXPRESSION OF COMMITMENT

- Applicants must complete an [Expression of Commitment](#) form by May 25, 2018.
- The completed Expression of Commitment and any declaration of conflicts of interest may be submitted in English or French via email to [elan.graves@cfhi-fcass.ca](mailto:elan.graves@cfhi-fcass.ca).

## MERIT REVIEW PROCESS

- All applications will be screened by CFHI staff to ensure that essential program requirements have been met.
- An expert panel will review the applications and confirm the selection of teams to participate in the Collaborative based on established criteria, and provide feedback as needed.

## MEMORANDUM OF UNDERSTANDING

Teams will be asked to sign a Memorandum of Understanding (MOU) with CFHI that reflects CFHI's support and the commitment of the organization and team members. Applicants are encouraged to review the MOU template before submitting their application. The deadline to submit the signed MOU is June 18, 2018.

If you would like to arrange a call with CFHI to discuss your application, please contact [Elan Graves](#).

## ETHICS

It is the responsibility of each organization applying to participate in the EPAC Spread Collaborative to determine if ethics approval from a research ethics board is required. Organizations should identify at the application stage if the nature of the improvement project will require ethics board approval. If applicable, plans to attain ethics approval must be described and factored into the timeline of the proposed improvement project.

Tri-Council Policy Statement (TCPS2) governs requirements pertaining to research ethics in Canada, distinguishes quality improvement and research, and advises when seeking ethics approval is required.

[Article 2.5](#): "Quality assurance and quality improvement studies, program evaluation activities, and performance reviews, or testing within normal educational requirements when used exclusively for assessment, management or improvement purposes, do not constitute research for the purposes of this Policy, and do not fall within the scope of [research ethics board] review."

For more information, please consult the [Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans \(2014\)](#), the [Tri-Agency Framework: Responsible Conduct of Research \(2016\)](#), [TCPS: Section 6: Research Involving Aboriginal Peoples and First Nations Principles of OCAP™](#) (ownership, control, access, and possession).

## CONFLICTS OF INTEREST

By completing the Expression of Commitment, the Lead Organization and Network Team members confirm that they have reviewed and understood [CFHI's Conflict of Interest Policy](#), including the rules regarding the eligibility of CFHI employees, directors, registrants and agents. Organizations from which any members of CFHI's Board of Directors, or Foundation agents or employees, receive remuneration are eligible to apply to this competition. Applicants must fully disclose any relationship with current members of CFHI's Board of Directors.

# GLOSSARY

- **Network:** A network may be (but is not limited to) a health region (e.g. Zones, Local Health Integration Networks or sub-LHINs, and/or Regional Health Authorities), a jurisdiction or a group of LTCHs, with or without common ownership, willing to collaborate on a quality improvement project.
- **Spread:** The transfer of a best practice from one site to another (from best to common practice). Spread goes beyond diffusion to actual implementation.
- **Scale:** Expanding the reach to all who stand to benefit (i.e. patients, providers) in a defined jurisdiction. Some might say we spread our way to scale. Doing so requires creating an enabling environment beyond delivery to policy and system attributes that support optimizing reach.
- **Sustain:** Holding the gains or cementing the improvements. It is not about the same things, it is about building upon existing improvements to continue to realize gains in health, care and value for money – well into the future.

# REFERENCES

- For the purpose of this document ‘palliative care’ refers to hospice, hospice palliative care and the care required by all patients with life-limiting illness from the point of diagnosis until bereavement.
- Canadian Hospice Palliative Care Association The Palliative Approach: Improving care for Canadians with life-limiting illnesses. Prepared by Bacon J (2012). <http://www.hpcintegration.ca/media/38753/TWF-palliative-approach-report-English-final2.pdf>
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