iCAN ACP Advance Care Planning | News

November 2018

Message from the Chairs

Welcome to the Fall edition of iCAN-ACP News! We have a lot of news to share in this issue, including conference activities, prize-winning posters and updates from our four project teams.

Members of the iCAN-ACP research team met for a dinner meeting after the Canadian Frailty Network (CFN) Symposium on September 20th in Toronto, which was the mid-point of our 3-year funding period with CFN. The meeting agenda included sector updates, an overview of findings from the patient advisor evaluation, a review of the logic model and an update on knowledge translation activities. It was exciting to hear about each team's activities and the progress that is being made on the project.

In this issue, we are pleased to profile the BC Centre for Palliative Care – one of our iCAN-ACP partners that is doing important work to raise public awareness about advance care planning and work aimed at integrating and improving advance care planning practices in the Canadian health care system.

We are also excited to be adding new knowledge translation activities this month – stay tuned for our first podcast, along with a series of infographics that you can use to promote the study.

We hope you enjoy the newsletter, and as always, we welcome your feedback and suggestions for future issues!

John You & Michelle Howard
Project Co-Leads, iCAN-ACP Study

Have you visited our website recently? Visit icanacp.ca for recent news, resources and upcoming events!

Recent activities

Over the past six months, iCAN-ACP members have been busy sharing knowledge about the project through webinars, conference presentations and posters:

Webinars:
Primary Care Sector: Outcomes of the feasibility pilot of the adapted Serious Illness Conversation Guide Pathway Implementation at Sunridge FM Clinic – September 2018 (Dr. A. Tan).

CFN FRAILTY MATTERS Innovation Showcase:
Projects from the Long-Term Care and Primary Care Teams were chosen by CFN as one of the "Top 30" innovations, new scalable approaches to caring for the elderly living with frailty.

iCAN-ACP Presentations at Recent Conferences:
Hospice Palliative Care Ontario Conference, Apr. 23, 2018, Toronto
Social Work and Sexualities Conference, Aug. 2-10, 2018, Montreal
Toronto Canadian Frailty Network Conference, Sept. 20, 2018, Toronto
International Congress on Palliative Care, Oct. 2-5, 2018, Montreal
Canadian Association on Gerontology 47th Annual Scientific and Educational Meeting, Oct. 18-20, 2018, Vancouver

Visit our website for a full list of posters and presentations.

Congratulation to our award-winning students!

Four of our trainees on the iCAN ACP Project have recently won awards for their research: Christina Ma, Lauren Riehm, Aliza Moledina and Abe Hafid.

Christina Ma and **Lauren Riehm** are medical students at McMaster University who are interested in advance care planning and are working with John You on the Hospital Team. They recently won a joint Medical Student Research Award from McMaster University to fund their research on assessing the quality of goals-of-care conversations during the Serious Illness Conversation Program (SICP) Quality Improvement Initiative at Hamilton General Hospital. Their project involves a retrospective chart review to examine the difference in the quality of goals of care conversations between SICP and non-SICP patients.

The Calgary Hospital Sector Team's poster describing their preliminary findings from implementing the Serious Illness Care Program on the medical ward at Foothills Hospital won first prize in the Quality Improvement category at the October 2018 Canadian Society of Internal Medicine Annual Meeting in Banff, Alberta. The team included medical resident **Aliza Moledina**, along with Seema King, Jocelyn Semenchuk, Fiona Dunne, Irene Ma, and Jessica Simon.

Abe Hafid is a student in the Master of Public Health program at McMaster University who is working in the primary sector. The poster he presented on findings from their work on building capacity for serious illness conversations on interprofessional teams won CFN's Outstanding Poster from a Trainee award at the CFN conference in Toronto on September 20, 2018.

Having 'the talk' with your family doc

The relationship between a family doctor and their patient can run deep. Family physicians often support their patients across their life cycle, and are well acquainted with their specific health conditions and needs. And yet, despite this relationship, many doctors have not had important advance care planning (ACP) discussions with their patients, to help them describe and share their wishes for future medical and personal care. It's an issue that a current research project is hoping to tackle, particularly for older Canadians living with frailty.

Earlier research has found that advance care planning can improve patient satisfaction with care in later life and reduce the use of unwanted treatments. However, we also know from the Improving Advance Care Planning in General Practice (i-GAP) study that there are some barriers to having these conversations in the primary care setting. Just over a quarter (26%) of family (primary care) physicians in the i-GAP study reported feeling comfortable having ACP discussions, with over two-thirds (67%) saying they need more resources and information. And, though half of the surveyed patients reported that they had talked to someone about ACP, only 18% had talked to a health care provider.

The iCAN-ACP Primary Care team's work involves testing advance care planning workbooks, including the national Speak Up tools developed by the Canadian Hospice Palliative Care Association. The team is also using the Serious Illness Conversation Guide in family medicine practices to evaluate whether it can help patients, families and primary care clinicians have these important conversations in a proactive and effective way.

Family doctors play a critical role in the advance care planning process and in helping patients identify and share their goals for future medical care. Our aim is to give both family doctors and their patients the right tools to help ensure that these important conversations happen.

Written by Michelle Howard and Amy Tan, funded investigators in the primary care sector.
(published in AVISO, a member publication for the Canadian Hospice Palliative Care Association)

Partner Profile: The BC CENTRE FOR PALLIATIVE CARE

The BC Centre for Palliative Care provides leadership for best practices in research and education in advance care planning and serious illness conversations, the integration of a palliative approach to care, and in building compassionate communities. Established in 2013, The Centre is a provincial hub to support excellence in evidence-informed practice, education, innovation, collaboration and policy development to improve care for those living with serious illness and their families.

The BC Centre for Palliative Care's model to promote public engagement in advance care planning was among the Top 30 selected innovations for the FRAILTY MATTERS Innovation Showcase in Toronto on September 20th, 2018. The 'Peer-facilitated Advance Care Planning Sessions' model was also selected by the Canadian Foundation for Healthcare Improvement in 2016 as an innovative palliative care model.

Partner Profile: The BC CENTRE FOR PALLIATIVE CARE (continued)

The Centre partnered with two community organizations Comox Valley Hospice Society, the Community Engagement Advisory Network (CEAN) and academic researchers to develop and evaluate the model, with a goal to bring ACP conversations where people live and have their wishes known and respected. The model includes:

- online and in-person training curriculum for volunteers to equip them with the knowledge and skills to become peer-facilitators for ACP sessions
- a start-up toolkit that includes resources for community organizations, the facilitators, and public participants
- coaching and mentoring for volunteers

The model has been adopted by 24 community organizations across B.C. through the support of the Centre's seed grants program. So far, over 100 community volunteers have been trained to become peer facilitators for ACP, and evaluation of over 40 public sessions indicates that the model is effective at all levels.

The Centre's Serious Illness Conversation Initiative was launched in November 2016, with a goal to train clinicians to initiate more, earlier and better conversations with individuals diagnosed with a serious illness and their families, to enable person-centered care. The Serious Illness Conversation Guide, created by Ariadne Labs, was used to educate and coach clinicians.

Over 450 clinicians, including nurses, physicians and allied health professionals, were educated in 2017, and a post-workshop survey found that 97% of attendees agreed or strongly agreed that the workshop enhanced their knowledge of serious illness conversations.

Dr. Doris Barwich, the Executive Director of the Centre, and a Principal Investigator with iCAN-ACP's Primary Care Team, notes that the Centre is working to act as a catalyst to stimulate important conversations by developing networks and community partnerships that bring together patients, families, caregivers, clinicians, health administrators, policy makers, researchers and community organizations. "We work with stakeholders at all levels to enable change in the way we live and die in British Columbia," she says. "Our Advance Care Planning and Serious Illness Conversation initiatives are key to our vision of equitable access to compassionate, person-centred care and resources for all British Columbians."

Project Updates:

Primary Care:
The Primary Care team is currently implementing an ACP pathway in three family practices in Alberta, British Columbia, and Ontario. The pathway includes a structured conversation guide (The Serious Illness Conversation Guide) used by clinicians, as well as ACP education and values clarification tools for patients and their substitute decision-makers. The processes are tailored in each province to account for the differences in documentation and laws across provinces. The goal of this phase of the project is to engage 100 older adult patients with a chronic illness in the ACP pathway through their family practice, and evaluate the experience and impacts for patients and their substitute decision-maker using an ACP engagement measure.

Hospital Care:
The adaptation and implementation of the Serious Illness Care Program (SICP) is now in full swing on the medical wards of Hamilton General Hospital, as well as W21C/Foothills Medical Centre in Calgary, and Montreal General Hospital. Preliminary data are showing that patients and families feel more heard and understood after participating in a Serious Illness Conversation and that there is an improvement in their experience with care. The team has also found that patients who have a Serious Illness Conversation and who are re-admitted to hospital may have a shorter length of stay on their subsequent hospital admission.

A full-day Serious Illness Conversation Train-the-Trainer event was held in Hamilton in June 2018, in collaboration with colleagues from the BC Centre for Palliative Care. 42 healthcare practitioners from multiple disciplines participated in sessions designed to build capacity for clinician training in the use of the Serious Illness Conversation Guide. After several months of planning, the Hamilton site will be scaling back funding for the Serious Illness Conversation program, and transitioning to a more sustainable implementation model.

Clinicians in Hamilton are currently being interviewed to explore their experiences with the program, and interviews with clinicians in Calgary and Montreal are being planned for this winter and spring.

Long-term care:
The Long-Term Care team has completed their baseline data collection through an environmental scan of participating sites by collecting staff surveys, conducting focus groups with residents, families and staff, and doing chart audits of deceased residents.

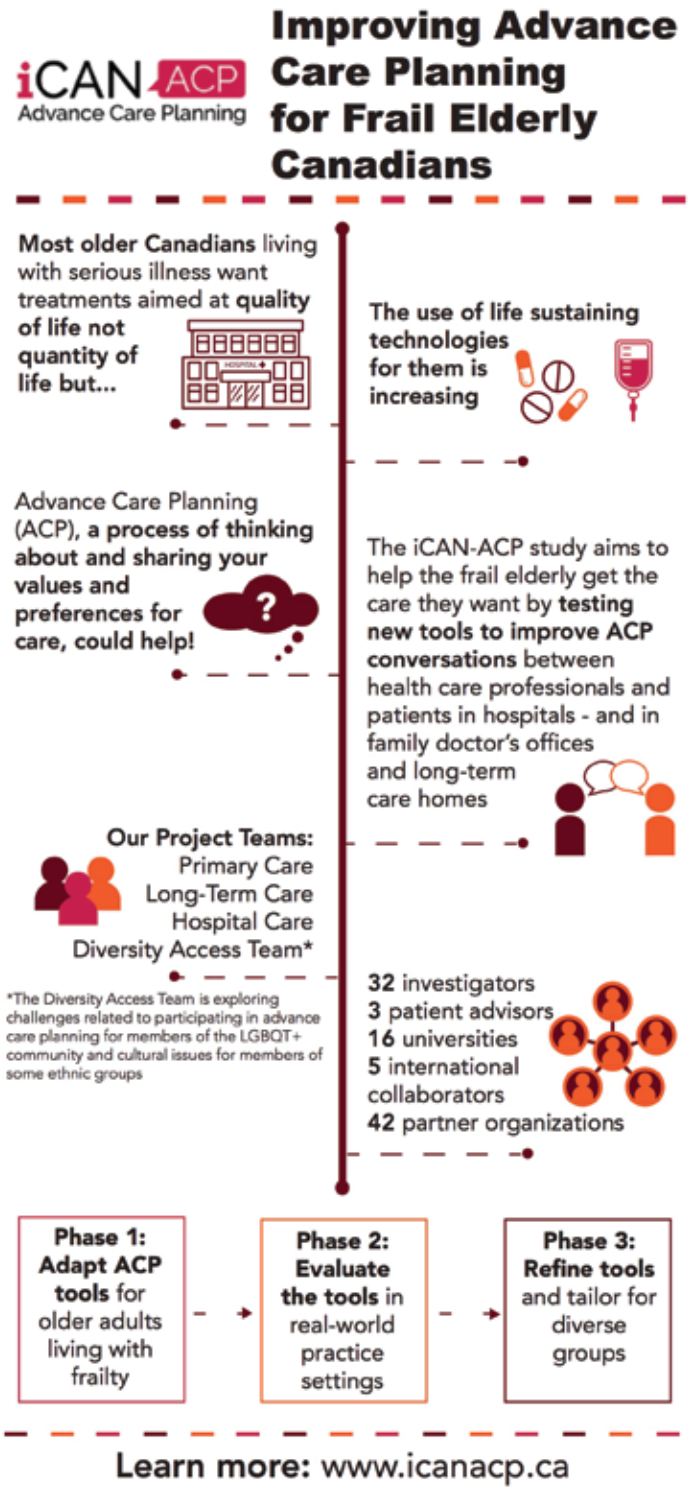
Staff education sessions were held at all participating sites with 68 staff from various disciplines. Led by education consultant Jane Webley, these sessions provided training on starting end-of-life conversations with residents and families.

The team is currently implementing the Conversation Starter Kit with residents and families to better understand the usefulness of the toolkit, advance care planning engagement, and family decision-making. To date, 40 residents and family members have been enrolled across participating sites to complete the Conversation Starter Kit and provide feedback. Data are being collected through surveys and qualitative interviews.

Diversity Access Team:
The Diversity Access team has been making progress in all three sectors of care. In the Long-Term Care sector, they have held focus groups with residents, families and three levels of staff in exclusively Chinese and in multi-ethnic care homes. Recruitment is underway for a face-to-face focus group with persons who have a loved one from the LGBT community who is living in a long-term care home in British Columbia.

The Diversity Access Team's work in the primary care sector includes a qualitative sub-study in Montreal with community-dwelling gay men aging with HIV/AIDS, and sub-studies in British Columbia with LGBT older adults in six non-metropolitan communities, as well as with bilingual ethnic Chinese seniors. The objectives of these sub-studies are to explore study participants' basic understanding of ACP and to obtain their feedback on the cultural sensitivity of the ACP tools being tested in the primary care sector.

Work in the hospital sector includes developing an LGBT-Aging expert panel, and conducting interviews with hospital staff regarding the cultural sensitivity of the Serious Illness Conversation Guide and the Best Worst Case Scenario Tool.



Canadian Frailty Network | Réseau canadien des soins aux personnes fragilisées

This research is funded by Canadian Frailty Network (known previously as Technology Evaluation in the Elderly Network, TVN), supported by Government of Canada through Networks of Centres of Excellence (NCE) Program.