

Updates and Innovations Series

Hearing What Matters: Early learnings about GOC conversations with people experiencing structural inequities

A VCH-PHC Collaborative Initiative

November 16, 2023



BY
Pallium Canada



*The BC Centre for Palliative Care
is the provincial hub partner of the
Palliative Care ECHO Project in British
Columbia*



x^wməθk^wəy̓əm (Musqueam) Sk̓wx̓wú7mesh (Squamish) and Səlíl̓wətaʔ/Selilwitulh (Tsleil-Waututh) Nations



The BC Centre for Palliative Care, based on what is colonially known as New Westminster, is located on the traditional, ancestral and unceded territory of the Coast Salish peoples

We recognize that all of you joining us online may be participating from traditional territories of other Indigenous peoples. From coast to coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Métis, and First Nations people that call this land home.

What is ECHO?

- **E**xtension for **C**ommunity **H**ealthcare **O**utcomes
- ECHO spreads knowledge across the health system to the front lines of care
- ECHOs "all teach all learn" model connects Content with Context experts

Our Asks of You

- Share your stories and your experience
- Participate in discussion and dialogue
- Build connections with other participants, across disciplines and geographic region



Introductions

Panelists:

Ally Colbourne – Outreach worker – Overdose Outreach Team VCH

Doris Lee Prest - Indigenous Cultural Practitioner VCH

Facilitators:

Umilla Stead - Regional Lead, Palliative Approach to Care Palliative/EOL Care, VCH

Wallace Robinson - Leader for Advance Care Planning PHC

Learning Objectives



By the end of the session, participants will be able to:

*Understand the context
of this Equity SIC
Collaborative*

*See how our paradigm
for SICs with structurally
vulnerable patients has
been shifting*


*Learn from the
experience of our front-
line partners how
important their
conversations are*

How our project started


Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. Set up the conversation <ul style="list-style-type: none"> Introduce purpose Prepare for future decisions Ask permission 	<p>"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — is this okay?"</p>
2. Assess understanding and preferences	<p>"What is your understanding now of where you are with your illness?"</p> <p>"How much information about what is likely to be ahead with your illness would you like from me?"</p>
3. Share prognosis <ul style="list-style-type: none"> Share prognosis Frame as a "wish...worry", "hope...worry" statement Allow silence, explore emotion 	<p>"I want to share with you my understanding of where things are with your illness..."</p> <p><i>Uncertain:</i> "It can be difficult to predict what will happen with your illness. I hope you will continue to live well for a long time but I'm worried that you could get sick quickly, and I think it is important to prepare for that possibility."</p> <p>OR</p> <p><i>Time:</i> "I wish we were not in this situation, but I am worried that time may be as short as ___ (express as a range, e.g. days to weeks, weeks to months, months to a year)."</p> <p>OR</p> <p><i>Function:</i> "I hope that this is not the case, but I'm worried that this may be as strong as you will feel, and things are likely to get more difficult."</p>
4. Explore key topics <ul style="list-style-type: none"> Goals Fears and worries Sources of strength Critical abilities Tradeoffs Family 	<p>"What are your most important goals if your health situation worsens?"</p> <p>"What are your biggest fears and worries about the future with your health?"</p> <p>"What gives you strength as you think about the future with your illness?"</p> <p>"What abilities are so critical to your life that you can't imagine living without them?"</p> <p>"If you become sicker, how much are you willing to go through for the possibility of gaining more time?"</p> <p>"How much does your family know about your priorities and wishes?"</p>
5. Close the conversation <ul style="list-style-type: none"> Summarize Make a recommendation Check in with patient Affirm commitment 	<p>"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I recommend that we _____. This will help us make sure that your treatment plans reflect what's important to you."</p> <p>"How does this plan seem to you?"</p> <p>"I will do everything I can to help you through this."</p>
6. Document your conversation	
7. Communicate with key clinicians	



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A GUIDE FOR SERIOUS ILLNESS CONVERSATIONS WITH STRUCTURALLY VULNERABLE PATIENTS IN HOSPITAL

1 Prepare for the conversation

Review Health Records for: Substitute Decision-Maker, Emergency Contacts, Indigenous Identifier, previously expressed wishes; recent health care visits.

Who are their trusted community providers? Can you call & consult?

Do you have sufficient background knowledge in principles of cultural safety & humility to engage with Indigenous patients safely? If not, engage with the VCH Indigenous Patient Experience Team* for supports and resources.

*VCH Indigenous Patient Experience Team:

Info about/initialhealth@vch.ca
intake line: 1-877-876-1131

For information about services provided by this team, go to: <https://one.vch.ca/dept-project/indigenous-cultural-safety/Pagine/Absorbnak-Patient-Navigator-Program.aspx>

2 Introduce the conversation safely

- Identify yourself and your role
- Allow ample time for the patient to introduce themselves
- Introduce the purpose of the conversation
- Take time to establish rapport
- Ensure privacy

"I'd like to talk with you about your health and planning for the future. Is now a good time?"

3 Assess & address patient needs

Are their basic needs met?

- Withdrawal
- Pain
- Food
- Clothing

Do they want additional supports involved?

- Family or friends
- Trusted community providers
- Indigenous Wellness Liaison¹
- Peer support

Offer to use technology to connect (facetime; zoom) or reconvene when person is available.

"I want to start by checking in and seeing if there is anything you need right now to feel more comfortable"

"Is there anyone that you would like included in our conversation, for example... (give options)?"

PAUSE to address any needs / locate supports before resuming.

A Guide for Serious Illness Conversations with Structurally Vulnerable Populations including Persons who use Illicit Drugs

1. Setting up for the conversation

- Consider timing of the conversation: client- or clinician-centered timing? Was there a recent serious event, such as an overdose? Timing of appointment related to cheque day?
- Allow ample time both to address the person's reason for the clinical encounter and have the conversation
- Would they like to have someone with them during or after the conversation? Outreach worker? Elder? Friend?
- Review any available previous documentation

2. Introducing and asking permission for the conversation

- Be humble, establish rapport, ensure privacy
- Identify yourself and your role
- Allow ample time for the client to introduce themselves
- Introduce the purpose of the conversation
- Allow time for the client to give permission or refuse, and be respectful of the response

3. Assess & address patient needs before proceeding

Are their basic needs met?

- In Withdrawal?
- In Pain?
- Hungry?
- Need Clothing?
- Are they warm?
- Feel safe?

Do they want additional supports involved?

- Family or friends
- Trusted community providers
- Indigenous Wellness Liaison¹
- Peer support

Offer to use technology to connect (facetime; zoom) or reconvene when person is available.

PAUSE to address any needs/locate supports before resuming

4. Assess understanding and share concerns/prognosis

What's your understanding of your health right now?

(If substance-use related concerns:) "What are your thoughts about your (insert substance of choice) use right now?"

"Would it be ok if I shared our understanding of what's going on?" (Share medical understanding, any updates, or prognosis "...")

e.g. in terms of uncertainty:

"It can be difficult to predict what will happen with your illness. I hope you will continue to live well for a long time but I'm worried that you could get sick quickly and I think it is important to prepare for that possibility."

or in terms of time:

"I wish you were not in this situation, but I am worried that time may be as short as... (express in range: days to weeks, weeks to months, months to a year)."

or if OUD:

If sharing a prognosis, consider using the **"wish...worry"** framework:

Joining a larger community

Improving Equity in Access to Palliative Care

Joint Initiative: Healthcare Excellence Canada (HEC) and the Canadian Partnership Against Cancer (CAPC)

Supporting projects to improve access to palliative approaches to care with and for people experiencing homelessness or vulnerable housing

Opportunity to *pause...* and learn from the people we serve



Learning What Matters: *care planning in the context of inequities*

Project goals

Understand the care planning preferences of people living with a serious illness including substance use disorders who are experiencing homelessness and other structural vulnerabilities



Develop, implement and evaluate patient-informed best practice guidance for serious illness care planning conversations



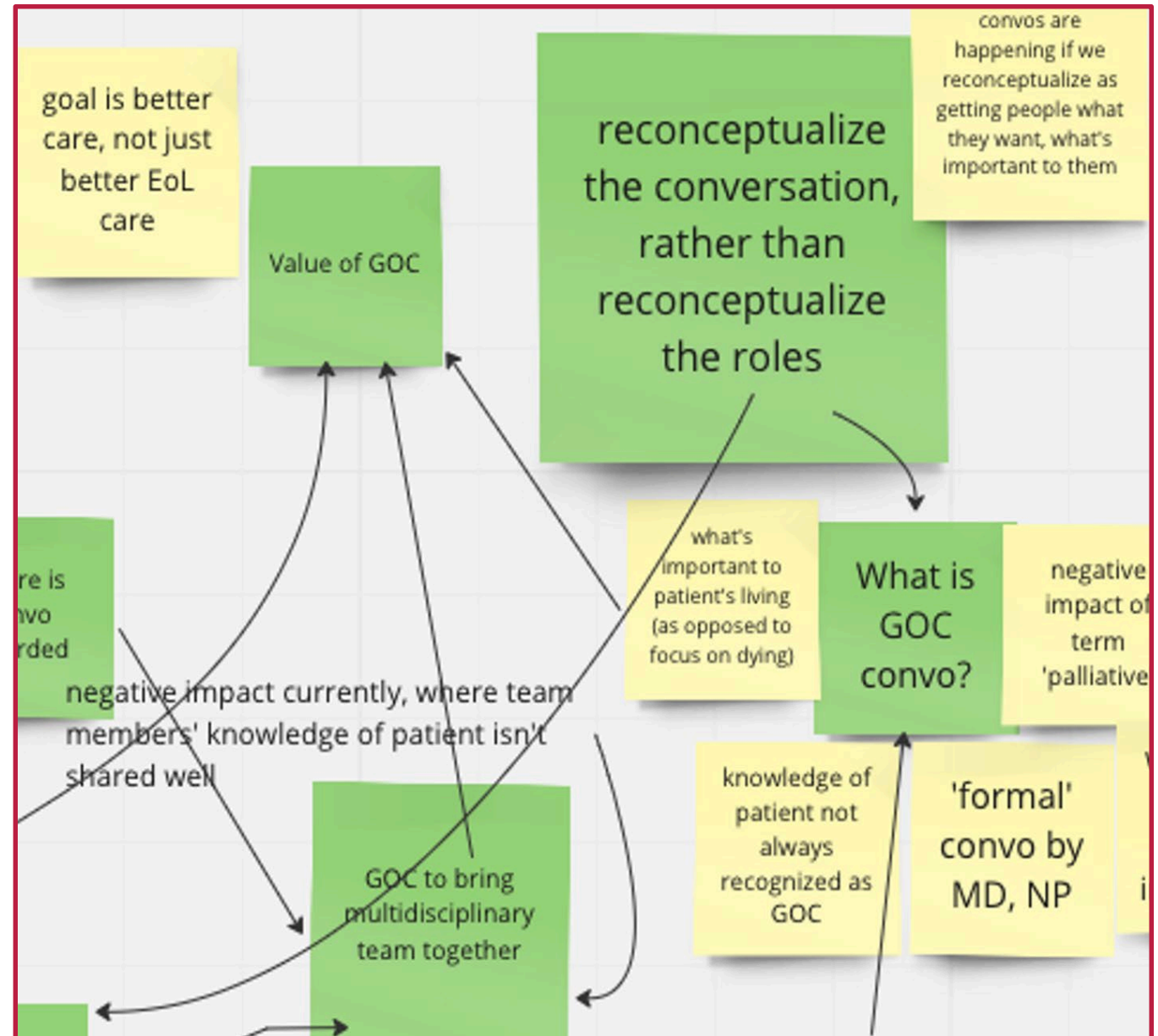
Break down barriers and improve communication and collaboration between the community care and acute care teams who provide care to patients in this community.

Where we stand

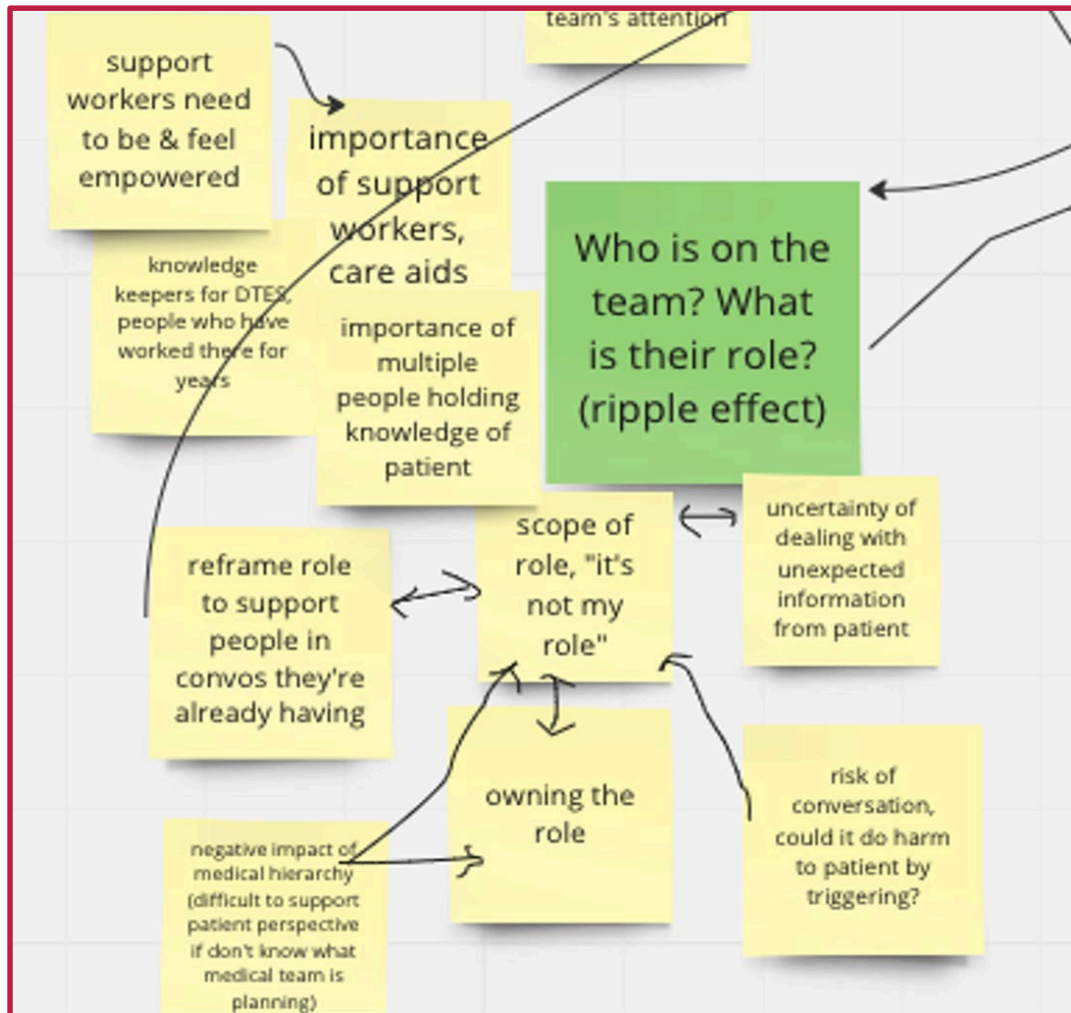
Interviews with our working group

- What conversations are happening, how, with whom?
- How do we frame our questions and approach?
- Who else do we need to learn from?

12 interviews completed,
analysis underway; Round 2
begins in ~1/12



Shifting our conversation paradigm: *how and who?*



- **How** – hearing what matters can happen in brief moments
- **Who** – support workers including community liaison workers, outreach workers, peer support workers witness those brief moments
- Valuable information about what is important to the client may be lost as there isn't infrastructure to capture and communicate it



Outreach perspectives: Ally and Doris

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

Stay connected: www.echopalliative.com



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