



Name: \_\_\_\_\_

# Bringing Vital Services to Canadians

All-Team Collaborative Workshop  
September 1, 2020 / September 22, 2020  
Virtual

## ABOUT THE CANADIAN FOUNDATION FOR HEALTHCARE IMPROVEMENT

The Canadian Foundation for Healthcare Improvement (CFHI) works shoulder-to-shoulder with partners to accelerate the identification, spread and scale of proven healthcare innovations. Together, we're delivering lasting improvement in patient experience, work life of healthcare providers, value for money and the health of everyone in Canada.

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The Canadian Foundation for Healthcare Improvement acknowledges its office in Ottawa is situated on unceded Algonquin Anishinaabeg traditional territory.

General Inquiries: [info@cfhi-fcass.ca](mailto:info@cfhi-fcass.ca) | (613) 728-2238

## ABOUT THE CANADIAN PARTNERSHIP AGAINST CANCER

As the steward of the Canadian Strategy for Cancer Control (the Strategy) the Partnership works to implement the Strategy to reduce the burden of cancer on Canadians. The partner network – cancer agencies, health system leaders and experts, and people affected by cancer – brings a wide variety of expertise to every aspect of our work. After 10 years of collaboration, we are accelerating work that improves the effectiveness and efficiency of the cancer control system, aligning shared priorities and mobilizing positive change across the cancer continuum. The Partnership continues to support the work of the collective cancer community in achieving our shared 30-year goals: a future in which fewer people get cancer, fewer die from cancer and those living with the disease have a better quality of life. The Partnership was created by the federal government in 2006 to move the Strategy into action and receives ongoing funding from Health Canada to continue supporting partners from across Canada.

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

## DOODLING SPACE

Doodling can help you focus and make it easier to listen. It can relieve stress and improve productivity. It can also help in memory retention; doodle a number or word or image that pertains to what's being addressed and it's more likely to stay with you. And there's no such thing as a mistake; they are your doodles, and whatever you create is just right.<sup>1</sup>

We've left space throughout the workbook for doodling. These areas are marked with doodles. Copy the doodles, draw your own and let your pen wander!

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1 Karten, Naomi. Doodle Your Way to Improved Focus and Concentration. July 24, 2017. Accessed on August 10, 2020 at <https://www.techwell.com/techwell-insights/2017/07/doodle-your-way-improved-focus-and-concentration>.

# Hello & Welcome!

Hello and welcome to the Paramedics & Palliative Care Virtual Workshop series!

Much has changed since our in-person workshop last September and though the May 2020 in-person workshop couldn't go ahead as planned, we're happy that we can still come together in this virtual context and hear from some of the speakers that were to join us in May.

We continue to be amazed and inspired by the work that all teams are doing in the face of challenges big and small. Covid-19 no doubt fits into the category of a BIG challenge, but still we hear stories weekly of teams continuing to deliver this incredible work, turning challenges into opportunities and getting creative with their implementation plans.

In these two virtual workshop sessions, we are aiming to provide you with expert insight and support in two key areas that you've identified as important to your work: policy change and creating meaningful relationships within this work.

Though nothing can replace the face-to-face interaction of a workshop, we do hope that these workshops serve as an opportunity to not only hear from the presenters, but to share in learnings with one another and engage across teams to leverage the work of the collective as you continue to move your projects forward.

We invite you to take a look through this workbook ahead of the sessions, if you wish. There is lots to take in and it will all come together during the sessions themselves. We hope that it proves to be a helpful guide and resource over the two sessions. Feel free to jot notes, doodle, brainstorm and engage with it in whatever ways are useful to you.

We look forward to seeing you online on September 1st and 22nd.

All the best,

Your colleagues at CFHI & CPAC



## **DON'T TURN THE PAGE!**

Just kidding - you can turn the page - but we won't be using the next part of the workbook until September 1<sup>st</sup>, 2020.

# Welcome to Our First Virtual Workshop!

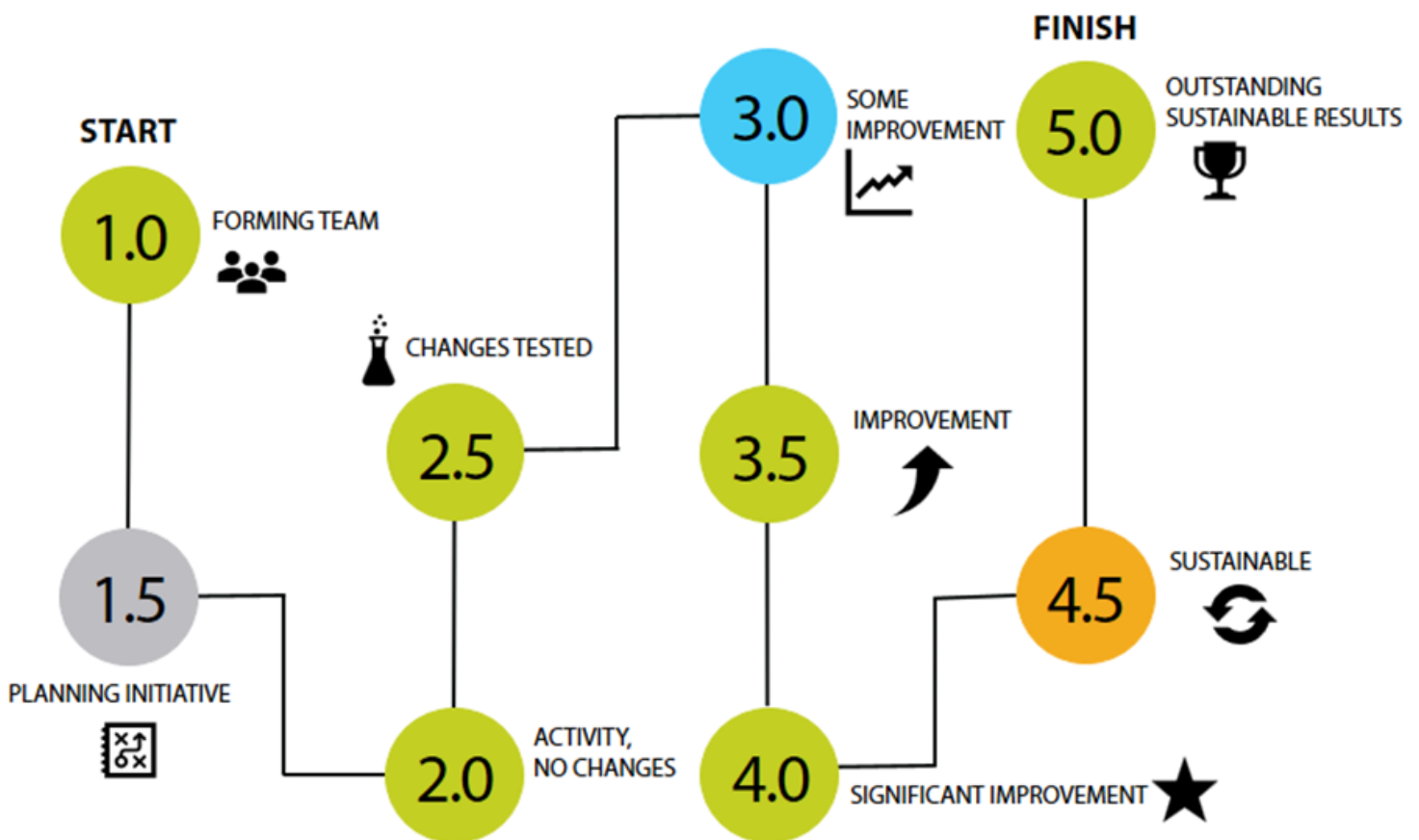
## COLLABORATIVE ASSESSMENT SCALE

The following scale has been adapted from the Institute for Healthcare Improvement (IHI) and enables you to reflect on where your team is currently with regards to the collaboration and how you progress through the stages of the collaborative over time.

**While we are waiting for the session to begin, please select the stage you feel best reflects where your team is at currently.**

**Note:** This scale is intended to follow progress over time. Teams will be provided with an opportunity to complete the scale six-months and one year after the end of the collaborative to continue to track their progress past the formal end of the program.

## Mapping the Quality Improvement Journey



# September 1, 2020

## POLICY BARRIERS AND FACILITATORS FOR SCALE AND SPREAD

SEPTEMBER 1, 2020		
TIME	ACTIVITY	WHO
13:00- 13:05	Overview of Virtual Workshop	Canadian Foundation for Healthcare Improvement
13:00 -13:15	Welcome and Introduction	Maria Judd
13:15 - 14:15	Breaking Down Policy Barriers	Laura Nieuwendyk and Candace Nykiforuk
14:15 -15:00	Health System Change: The Policy Role	Jenny Buckley
15:00 -15:20	Panel Discussion – Q & A	Laura Nieuwendyk, Candace Nykiforuk, Maria Judd and Jenny Buckley
15:20 - 15:30	Summary and Close	Canadian Foundation for Healthcare Improvement



# Presenter Biographies

## LAURA NIEWENDYK



Laura is the Senior Program Lead in the Policy, Location, and Access in Community Environments (PLACE) Research Lab. Within the PLACE Research Lab she provides leadership and direction to the development and operations, maintains effective day-to-day operations, and upholds key local, provincial and national partnerships. She contributes to research and evaluation activities and associated knowledge exchange, strategic planning, grant development, financial planning and management, communications and community engagement. Laura completed her Masters of Science in Health Promotion through the School of Public Health, University of Alberta in 2009. Since then she has been working in the PLACE Research Lab. She was heavily involved with the original development of the Policy Readiness Tool in 2011 and has supported the updating and dissemination of the tool since then.

## CANDACE NYKIFORUK



Dr. Candace Nykiforuk is a Professor and Associate Dean (Research and Research Programs) with the School of Public Health at the University of Alberta. She is also the Lead Investigator of the Policy, Location and Access in Community Environments (PLACE) Research Lab. Her research examines how community environment – social, built, and policy factors – interplay with people’s circumstances to impact individual and societal well-being. She also has expertise in the development and diffusion of healthy public policies. Dr. Nykiforuk has an extensive track record mobilizing scientific evidence into practice-based tools and strategies through collaborative knowledge exchange. Her partner-based work has directly informed policy in municipal and provincial governments, school communities, and national NGO strategic directions. She has been honoured with numerous awards for innovative social science and engaged scholarship. Dr. Nykiforuk led the development of the Policy Readiness Tool in close collaboration with her research team and as well as policy professionals and practitioners.

## JENNY BUCKLEY



Jenny Buckley has more than twenty years of health policy experience, examining issues and challenges across the continuum of health care. She is currently a Senior Improvement Lead with the Canadian Foundation for Healthcare Improvement helping teams to make improvements in care for their patients and communities. Jenny is a graduate of the University of Western Ontario (MA History) and the University of London (MSc Public Policy and Management).

# Assessing Readiness for Policy Change

Before you work with a community or organization to encourage policy change, it is important to understand the level of readiness for policy change. This will give you a better grasp of the community or organization's characteristics and will enable you to tailor your advocacy strategies to the group that you are working with.

Fill out the questionnaire on the following page to determine the policy readiness of your target. Your responses to the questions will reveal whether you are working with an Innovator, Majority type or Late Adopter. Choose the most appropriate answer (A, B or C) in each row. Select the response that best describes the community or organization that you plan to work with. Once you have completed the questionnaire, tally up the total number of As, Bs and Cs.

## WHAT IF I AM UNSURE ABOUT HOW TO ANSWER THESE QUESTIONS?

If you are unsure as to how best to answer these questions, we suggest that you work with someone who is familiar with (or works closely with) the community or organization to answer the questions. If you are still unable to answer one of the questions, leave the response section for this question blank.

**Important Disclaimer:** You will notice that the questions sound very similar. This was done purposely to provide you with a comprehensive understanding of your target and its innovation characteristics. **Please read each question carefully.**

In addition, the questions used are a good starting point for thinking about the characteristics of the community or organization you are working with and approaching the issue from a perspective that works for them. In other words, the Tool is not meant to provide you with a definitive adopter category for the place you are working with, rather it is a starting point for engaging in the policy process.

### Try it Online

Visit the tool online <http://policyreadinesstool.com/the-tool/overview/> to complete the questionnaire digitally (as either an individual or a group) and access your results anytime and anywhere. The online tool allows you to compile scores from your colleagues to determine the level of readiness of your community or organization as a whole.

*Excerpt from: Nykiforuk, C.I.J., Atkey, K.M., & Nieuwendyk, L.M. (2019). Policy Readiness Tool: Understanding Readiness for Policy Change and Strategies for Taking Action (2nd ed.). Edmonton, AB: School of Public Health, University of Alberta. Pages 4-6.*

*Available at <http://policyreadinesstool.com/en/>*

## QUESTIONNAIRE FOR ASSESSING POLICY READINESS

A	B	C	RESPONSE
The community or organization is comfortable being among the first to try new policies and initiatives.	The community or organization usually goes along with other groups' recommendations about trying new policies and initiatives.	The community or organization is uncomfortable trying new policies and initiatives.	
The community or organization enjoys being the first in the province to try something new.	The community or organization prefers to try new things after seeing other groups successfully use them.	The community or organization prefers to use things it is currently using.	
The community or organization likes to try things that are seen on TV or read about.	The community or organization prefers to try things that are seen on TV or read about only after seeing other groups successfully use them.	The community or organization prefers not to try things that are seen on TV or read about until they have been thoroughly tested.	
The community or organization is always looking for something new to benefit its members.	The community or organization sometimes looks for new things to try to benefit its members.	The community or organization likes using more traditional things to benefit its members.	
If the community or organization doesn't know what to do, it asks other groups for advice.	If the community or organization doesn't know what to do, it sometimes asks other groups for advice.	If the community or organization doesn't know what to do, it tries and figure it out itself.	
Incentives would motivate my community or organization to consider trying something new.	Incentives might motivate my community or organization to consider trying something new.	Incentives would not motivate my community or organization to consider trying something new.	
It is very important to the community or organization's professional reputation to be the first to try something new.	It is somewhat important to the community or organization's professional reputation to be the first to try something new.	It is not important to the community or organization's professional reputation to be the first to try something new.	
The community or organization likes to be the first to try new programs.	The community or organization prefers to wait until other gorups use a program before trying it.	The community or organization likes to wait until a program is thoroughly tested before trying it.	
The community or organization likes to be the first in the province to try new materials.	The community or organization prefers to try new materials after seeing other groups successfully use them.	The community or organization is uncomfortable trying new materials.	
The community or organization prefers to be one of the first in the province to try new policies or initiatives.	The community or organization prefers to wait until a policy or initiative has been implemented in other places before adopting it.	The community or organization prefers to wait for the province to adopt policies or initiatives to create a level-playing field for all communities or organizations.	
As one of the first groups in the province to try new policies or initiatives, the community or organization encourages other groups to follow suit.	Encouragement from other groups is the only reason the community or organization would adopt a new policy or initiative.	Encouragement from the province is the only reason the community or organization would adopt a new policy or initiative.	

**Total A's:** \_\_\_\_\_

**Total B's:** \_\_\_\_\_

**Total C's:** \_\_\_\_\_

## RESULTS

### Mostly As: the group is an Innovator

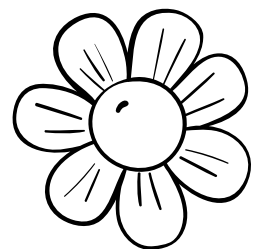
Innovator communities or organizations are described as adventurous and often serve as role models for other groups. They are attracted by high-reward policies, bylaws or initiatives and have a greater tendency to take risks. Innovators have the ability to cope with elevated levels of uncertainty about the policy they are adopting. They are typically willing to tolerate initial problems that may accompany new policies and they are able to identify solutions for these problems.

### Mostly B's, the group is in the Majority

Majority communities or organizations are described as deliberate because they require time to determine whether to adopt a new initiative. This group seldom leads the pack when it comes to adopting new initiatives or policies and is of the philosophy that it is better to change as a group than to be one of the first to change. Considering this, they tend to adopt new initiatives or policies at about the same time as the average community or organization.

### Mostly Cs, the group is a Late Adopter

Late Adopter communities or organizations are described as traditional, skeptical of new ideas and eager to maintain the status quo. They usually wait until a policy or new initiative has been adopted by the majority of other groups before implementing it themselves. They may need to be pressured into policy change, or they may never adopt the new policy or initiative unless required to.



# Policy Case Study #1

## HIGH LEVEL OVERVIEW

- 22:00 - EMS deployed lights and sirens for an approximately 70 year female coughing up blood
- Patient is connected to the Palliative Care program, and they had called the RN prior to EMS and the RN is on-route
- The patient has a MLVST for limited interventions with no CPR, but her wishes are to die in hospital and family wants her transported to hospital to prolong her life until her sister from another province can arrive to say good-bye
- It has been 1 week since the Paramedic completed her LEAP training, but the program has not officially launched yet

## BACKGROUND INFORMATION

- Patient has a history of lung and skin CA with mets and had been receiving palliative care by the palliative care program for an unknown period of time
- The patient had been shopping earlier in the day and had no complaints
- At approximately 22:00 the patient began coughing up small amounts of blood. Family called the palliative care RN, who was on-route, then called EMS when the amount of blood increased
- When EMS arrived, there were 2 kidney basins of blood on scene, the patient was on a NRB applied by family and blood was pooling in her airway
- The patient was repeatedly requesting to lie down. She was ashen and diaphoretic, with laboured and irregular breathing, SpO2 was 41% on the NRB
- The patient takes Hydromorph PO, but nothing was taken prior to arrival as the events transpired quickly

## WHAT OCCURRED

- EMS immediately turned up the oxygen to 15 LPM, suctioned the patient's airway, and started an IV.
- The family wanted the patient transported to ER, but the Paramedic explained to the family that death was imminent and would die on-route and that the goal at this moment was to sedate the patient to make her comfortable. The family agreed.
- As the paramedic was drawing up midazolam, the patient began agonal respirations. The paramedic confirmed the patient had died and informed family
- The paramedic then informed EMS communications and the EMS supervisor that this was a palliative death, so police were not required
- The RN arrived on scene right after death notification. Paramedics attempted to explain to RN what had occurred and they confirmed death at 23:09. The RN walked by paramedics without listening and told them as it was her patient; she had to be the one to confirm death. The RN did not further engage paramedics to discuss events

## OUTCOME

- Paramedics gave condolences to family and left patient with RN on-scene to make arrangements.
- Paramedics sought out project lead to the call and express their frustration with attitude of RN and unwillingness to listen. She discussed with palliative team manager. It was determined that the palliative team did not have information regarding paramedic scope of practice and death in the field.

## POLICY SCENARIO

You are working with palliative homecare toward improvement in collaborative practice.

# Policy Case Study #2

## OVERVIEW

- 66 year-old woman
- Diagnosed with juvenile arthritis at the age of 6, in a wheelchair since age 10
- Referred to palliative care for end stage rheumatoid arthritis with severe deformities and fusion of most joints including spine, shoulders, elbows, wrists, hips, SI joints, knees and ankles
- Pre-approved for the palliative care unit and followed by community health (home care) nurse
- Lives at home with husband, who provides majority of care
- Both are on wait list of a long-term care facility that can accommodate them together

## BACKGROUND INFORMATION

- First call in May for uncontrolled pain
- Call frequency began to rise in October from 2 to 3 times per month, to weekly, and by November calls were coming in daily (usually at night)
- ACP required for care on daily basis
- Paramedics were administering high doses SQ morphine to assist patient with night time pain
- Patient stated to paramedics that SQ dosing worked better, helped her sleep better throughout night

## SYSTEM FACTORS

- Delay in identifying increase in calls and assumption follow up care would address problem
- Multiple prescribers managing her pain
- GP doing bulk of prescribing, not comfortable with high doses of narcotics
- Paramedics have urgent response, medications work quicker than the PO morphine
- Level of care required greater than what patient was receiving – awaiting long term care placement
- When daily calls began to occur, palliative care team decided she was no longer suitable to be followed by the service, making her technically ineligible for our program

## POLICY SCENARIO

You are working with palliative homecare toward clarity on eligibility for the palliative program and improved interdisciplinary care for high needs patients.



# Policy Case Study #3

## OVERVIEW

- Call to 911 for a 15- year old patient who is not breathing
- Caller is very upset and sounds frantic
- Call taker determines this is a cardiac arrest. Paramedics, fire, and police are dispatched. Fire arrives first and starts resuscitation. Paramedics arrive approximately 6 minutes later

## BACKGROUND INFORMATION

- Paramedics palliative care program has been launched
- Once on scene, paramedics determine patient had a known diagnosis of brain tumor, multiple years of treatment but had recent recurrence, no additional curative therapy available and family had been providing palliative support at home
- Mom had gone to deliver regular pain medications and found he was not breathing and called 911

## WHAT OCCURRED

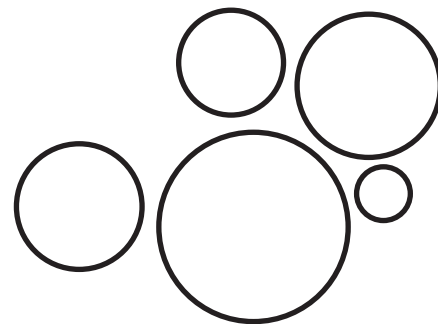
- On arrival crew learned that the patient was being followed by palliative care, and had goals of care including no resuscitation
- Paramedics asked fire department to stop resuscitation – fire was concerned about this request but did cease on explanation and then left
- Police then arrived, saw opiates in the home and began to treat home as a crime scene and contacted medical examiner

## OUTCOME

- Family was very upset, stressed and blamed themselves for the chaotic scene. They also felt they had done their son an injustice.

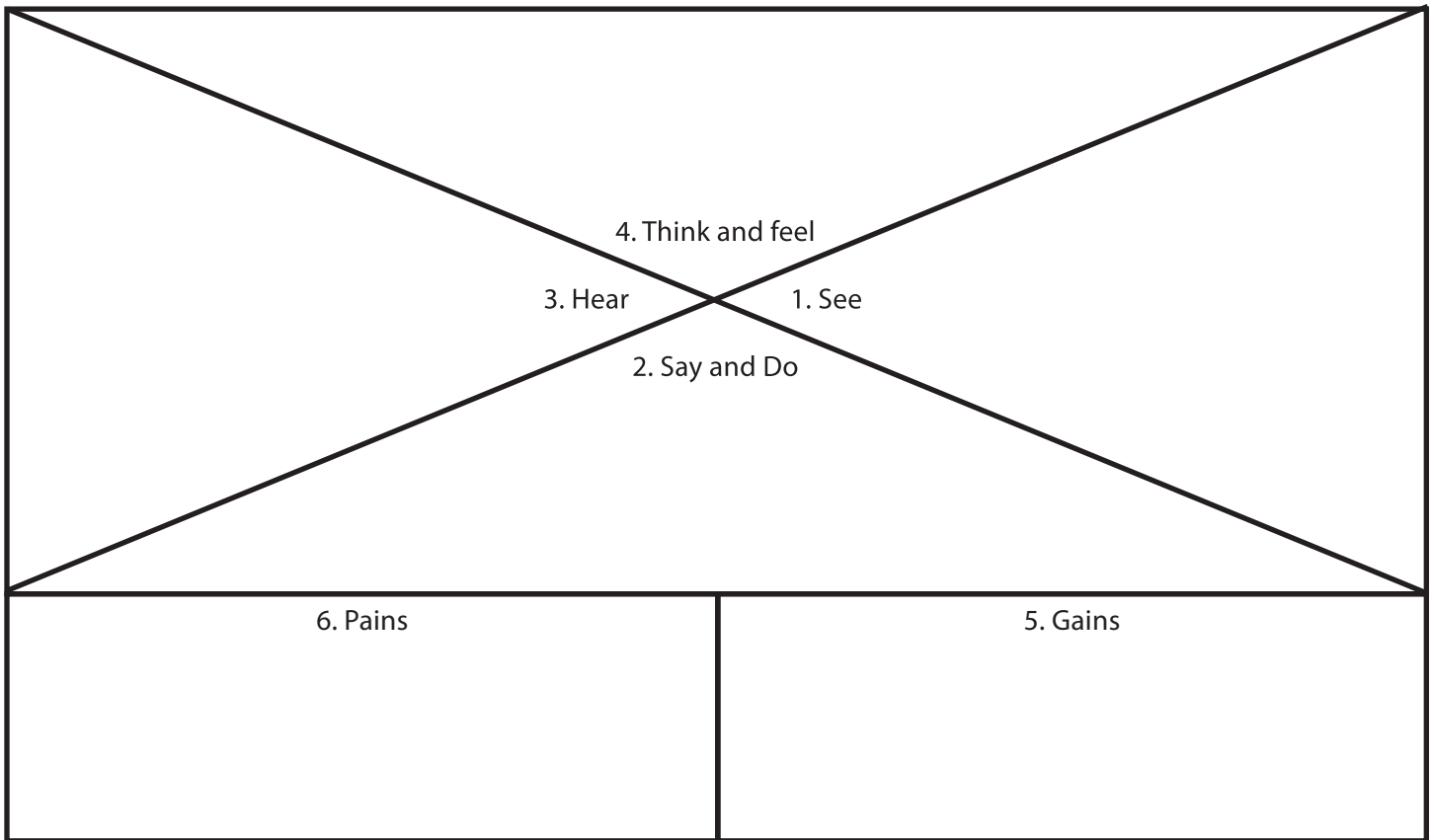
## POLICY SCENARIO

You are working with the police service to better manage expected death at home.

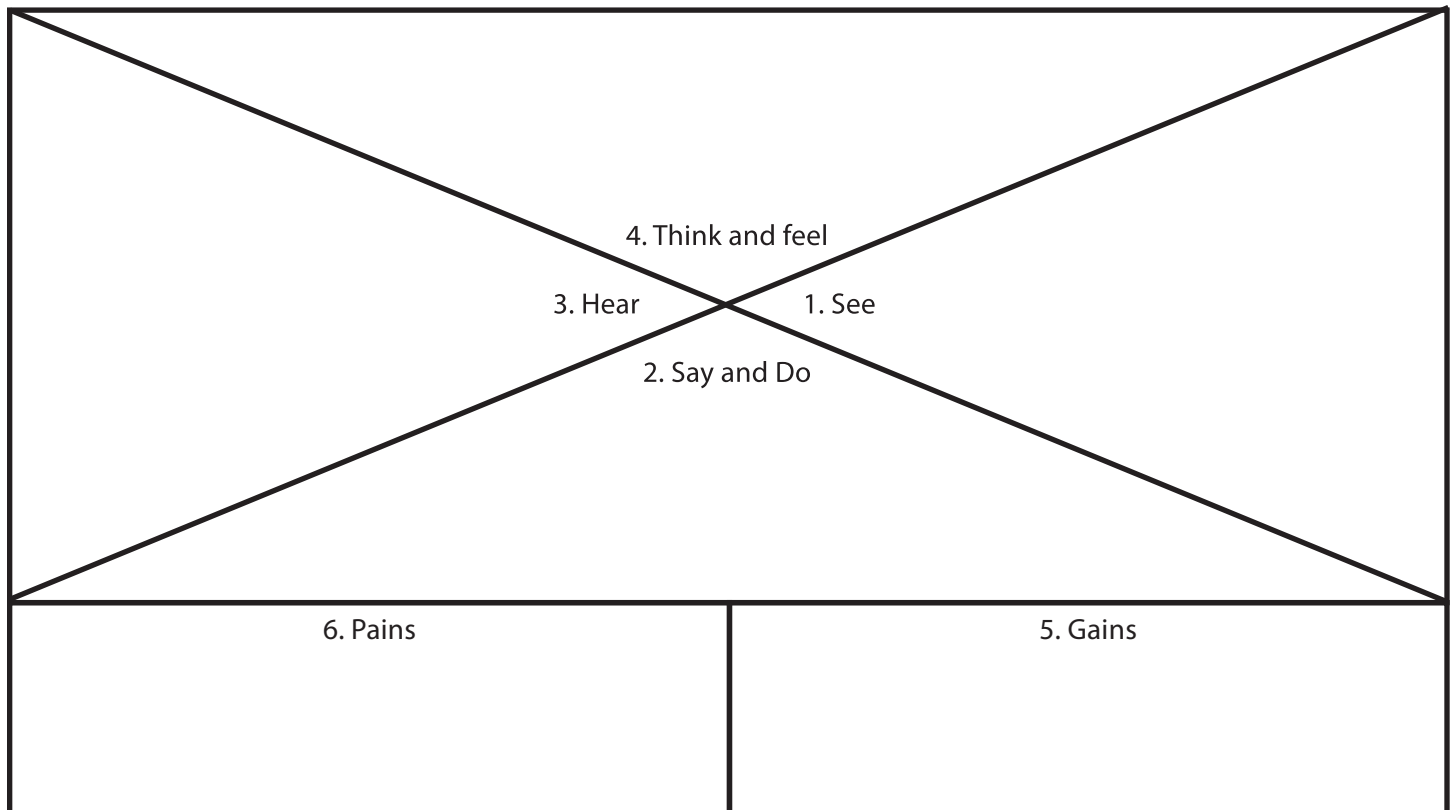


# Empathy Maps

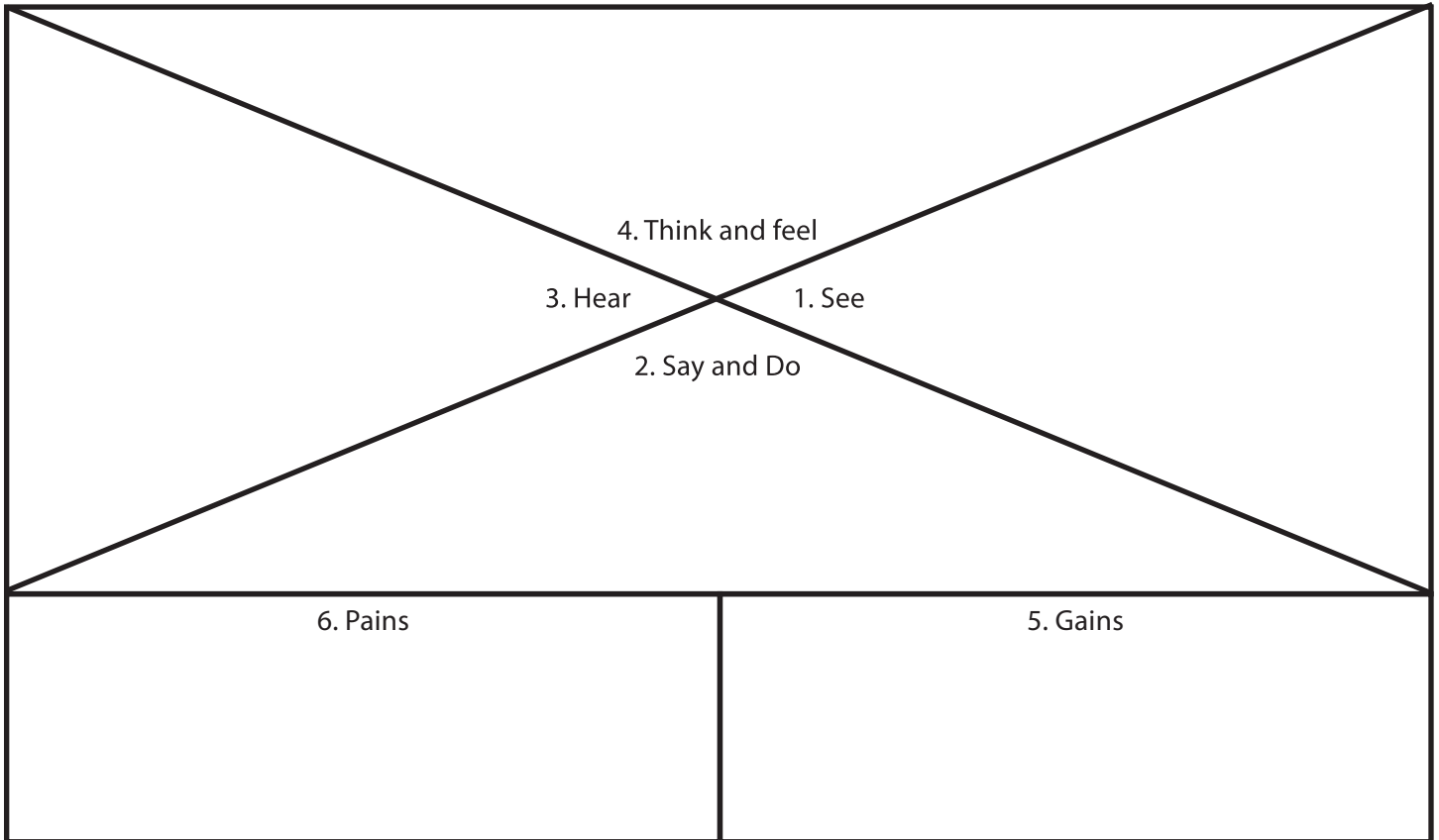
## IMPLEMENT THE POLICY



## CREATE THE POLICY



## FAMILY AND CAREGIVERS

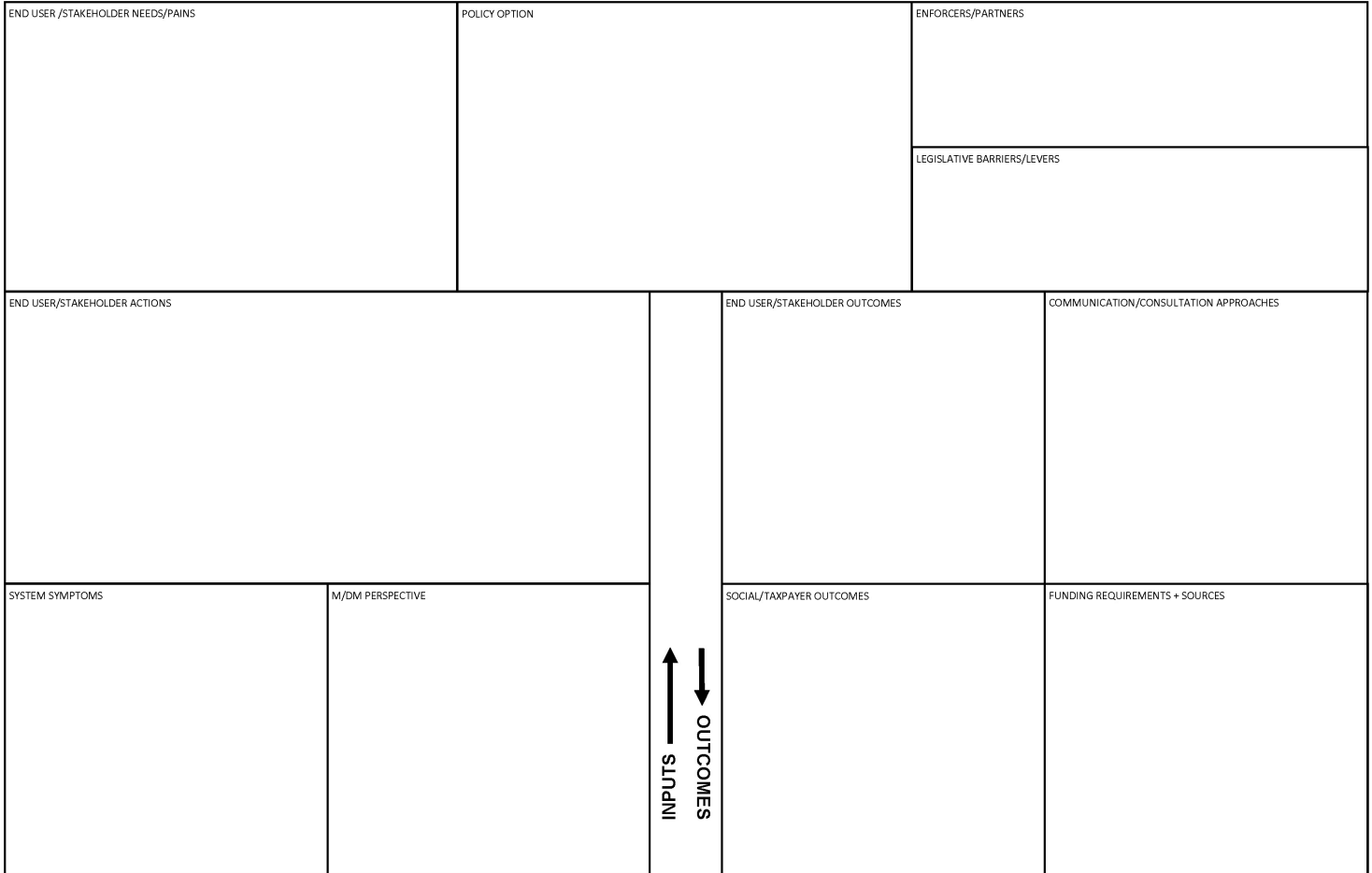


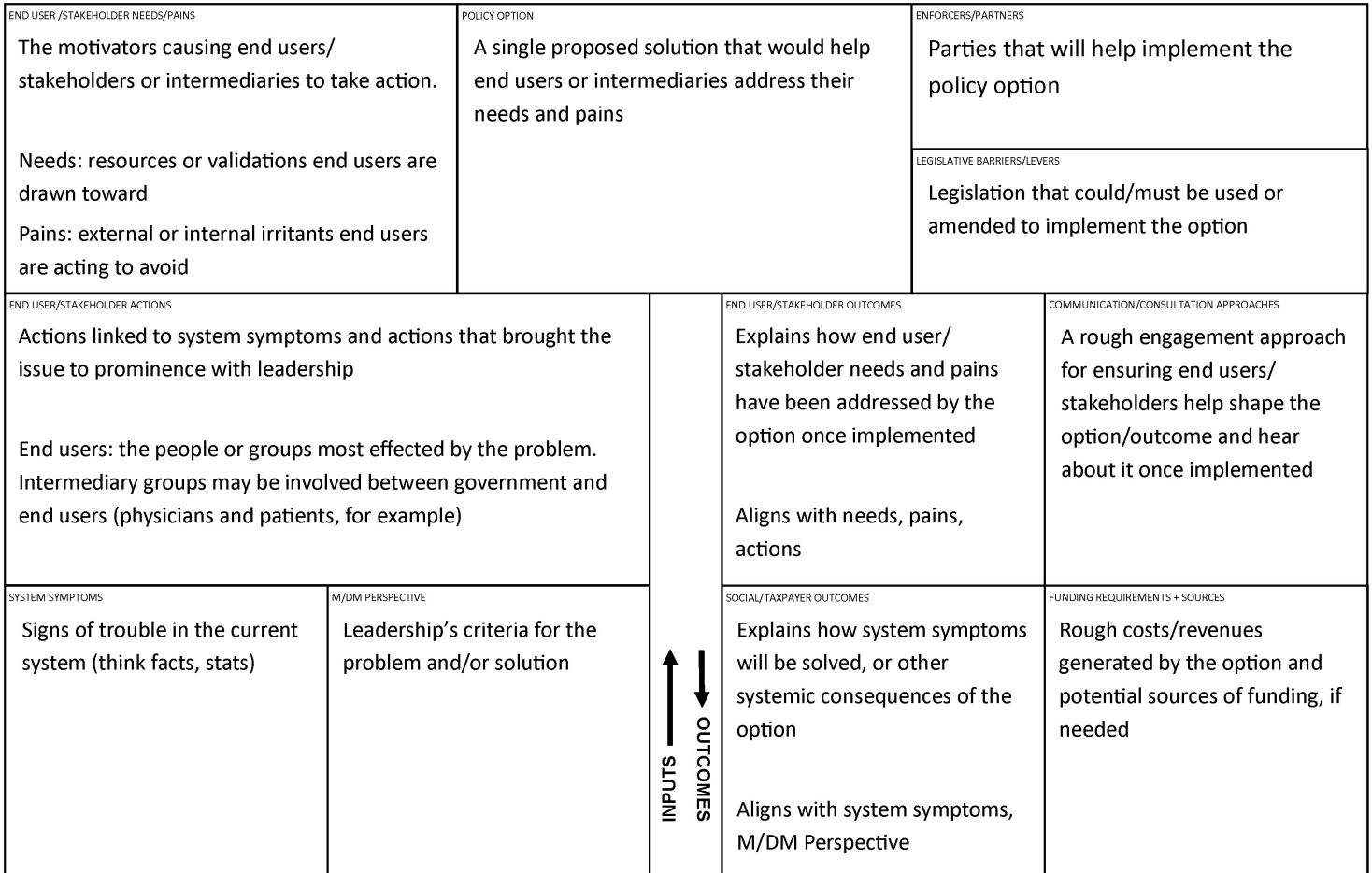
# Journey Map Template

	Phase 1			Phase 2				Phase 3	
	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Etc.
<b>Touch points/ Action steps</b>									
<b>Policy Users Needs and Pains</b>									
<b>Policy Implementers Needs and Pains</b>									
<b>Policy-Makers Needs and Pains</b>									
<b>Evidence Supporting Touch Point/ Action Item</b>									

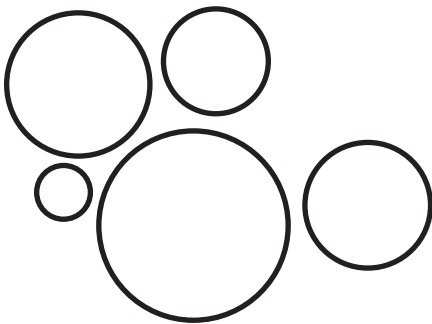
# Policy Canvas

This material is designed by Richard Liebrecht (richard@thepivotgroup.ca) from The Pivot Group.









**DON'T TURN THE PAGE!**  
Just kidding - you can turn the page - but we won't be using the next part of the workbook until September 22<sup>nd</sup>, 2020.

# Welcome to Our Second Virtual Workshop!

While we're waiting for the session to begin, please answer one of the following in the chat box, or draw/write an answer here.

**What partnerships and relationships have been developed to facilitate this project?**

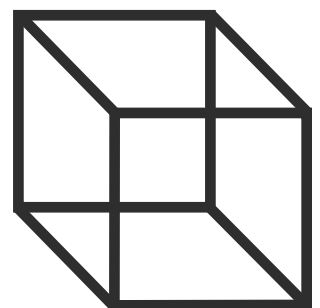
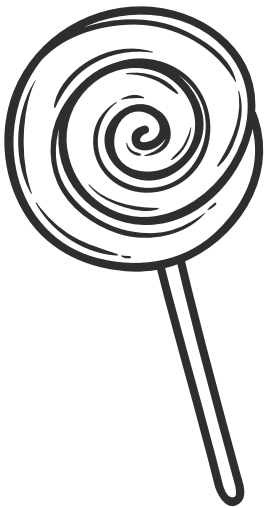
**How have partnerships with First Nations, Inuit, and/or Métis populations been developed?**

**What are you doing to sustain newly-made partnerships?**

# September 22, 2020

## EMBEDDING PSYCHOLOGICAL SUPPORT FOR PARAMEDICS DELIVERING PALLIATIVE CARE

SEPTEMBER 22, 2020		
TIME	ACTIVITY	WHO
13:00 -13:15	Welcome and Introduction	CFHI & CPAC
13:15- 14:15	Making Meaningful Connections at the End of Life	Chris MacKinnon
14:15-15:00	Boots On...Boots Off – Being Present	Ian McEwan
15:00-15:20	Panel Discussion – Q & A	Chris MacKinnon and Ian McEwan
15:20 - 15:30	Summary and Close	Canadian Foundation for Healthcare Improvement



# Presenter Biographies

## CHRIS MACKINNON



Dr. Chris MacKinnon holds appointments in the Department of Oncology at McGill and the Portland Institute for Loss and Transition in Oregon. He is the director of a private psychology clinic in Montreal and has been a practicing psychologist for 14 years specializing in loss and life transition. Dr MacKinnon is a Psychosocial Content Specialist with the Canadian Virtual Hospice, as well as teaching in the Palliative Care McGill Post-Graduate Medical fellowship program. He serves on the executive of the International Congress on Palliative Care and the advisory board for the Montreal Palliative Care Institute.

## IAN MCEWAN



Ian has worked in Emergency Medical Services for 25 years, for 17 as an Advanced Life Support paramedic on the ground, in many capacities, on the streets of Calgary, Alberta. At the same time he also flew with the critical care fixed wing flight program for 11 years.

After obtaining a Bachelors degree in Communications from Royal Roads University he sought out something new and left the street to work as a Clinical Educator specializing in high fidelity simulation where he was for almost 6 years. He was always interested in patient safety, so when an opportunity arose as a Senior Quality Assurance Strategist, he leapt at the chance and this is where he has been since. His first major assignment was the provincial lead of the Emergency Medical Services Palliative and End-Of-Life Care Assess Treat and Refer program (EMS PEOLC ATR).

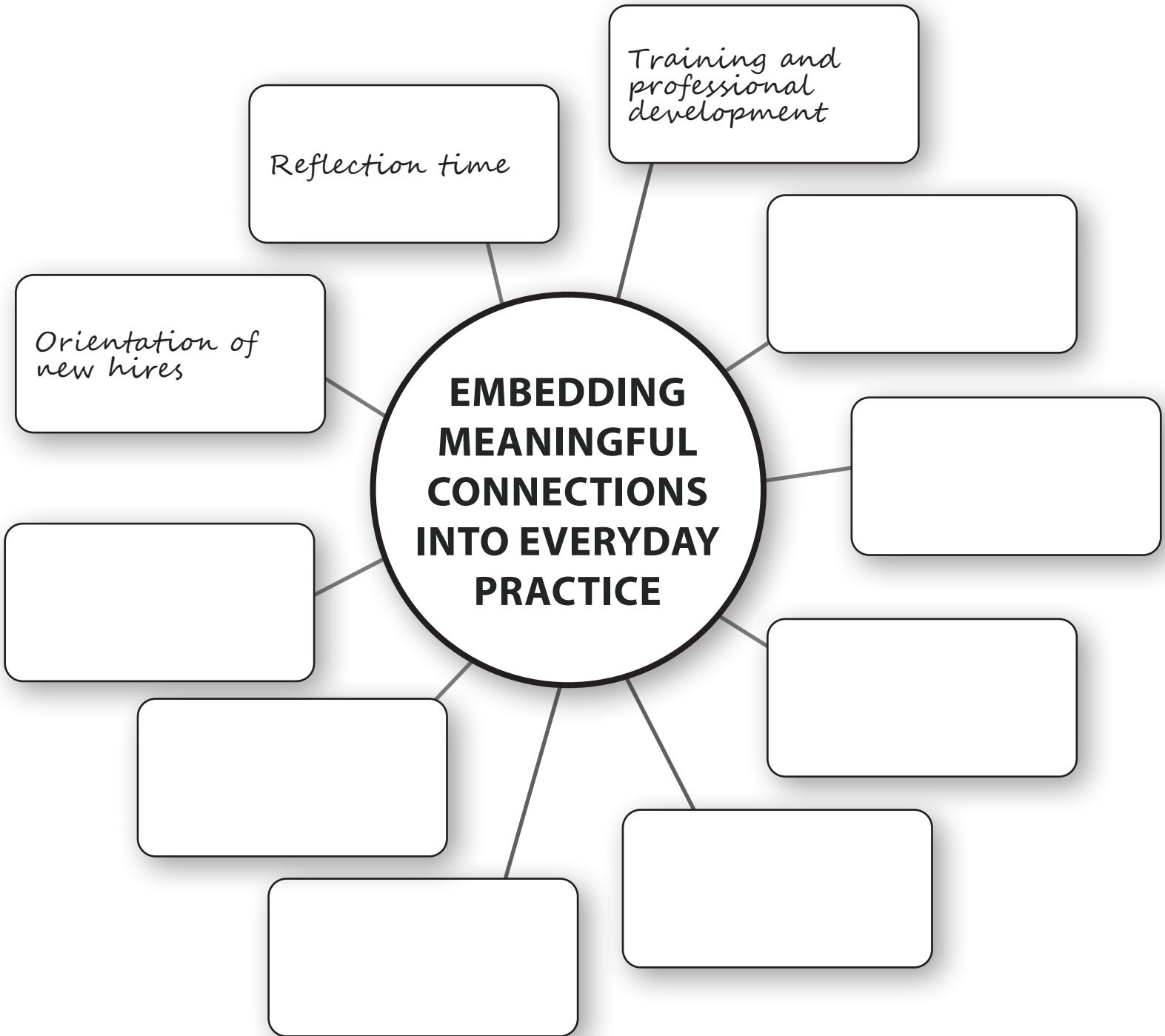
He volunteers with the Canadian Organization of Paramedic Regulators as an exam question writer/editor and he is also a palliative coach with the Canadian Foundation for Healthcare Improvement.

For many years he has taught all disciplines (and BLS, ACLS and The Difficult Airway Course) at a private paramedic school in Calgary.

Most importantly, he is married for 23 years, he and his wife Jennifer have 2 wonderful children, Beth(17) and Zachary (15), and they also have a furry baby, Fallon.



# Mind Map

Map out your ideas for ways to embed and sustain meaningful connections within EMS.



# What Kind of Ripple Are You Making in the Room?

Write out what comes to mind when you think about these two ways of working (words, thoughts, feelings, expressions). For each way of working, think about what that might be like for the patient, for their family, for the paramedic, for the other health providers.

BOOTS ON	BOOTS OFF
 An illustration of a person's legs from the knees down, wearing light blue trousers and tan work boots with laces. The person is standing on a light blue surface.	 An illustration of a person's legs from the knees down, wearing light blue trousers with the cuffs rolled up and light blue slippers. The person is standing on a light blue surface.







