



10-2014

White Paper: Building a Continuum of End of Life Care in Whatcom County: Train All Clinicians in Palliative Care

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Recommended Citation

Shillam, Casey, "White Paper: Building a Continuum of End of Life Care in Whatcom County: Train All Clinicians in Palliative Care" (2014). *Northwest Life Passages Coalition Documents*. 3.
https://cedar.wvu.edu/nlpc_docs/3

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Building a Continuum of End of Life Care in Whatcom County: Train All Clinicians in Palliative Care

October 2014

Prepared by Casey Shillam, PhD, RN-BC

Overview

Despite the increase in focus and attention on palliative care services in Whatcom County, significant gaps in palliative care knowledge and skills exist among clinicians throughout the care continuum in Whatcom County. It is widely recognized that palliative care improves quality of life for patients with advanced illness and their families, reduces costs, and advances the Triple Aim.

The recommendations provided in this report support the collective recognition that all clinicians caring for patients with serious illness, irrespective of practice discipline, background, or setting, require competency and skill in palliative care. All clinicians (including but not limited to doctors, nurses, social workers, chaplains, complementary care providers, and CNAs) in our region must have core knowledge, skills, and attitudes to provide palliative care in our community, including advance care planning conversation training, pain and symptom management, and strategies to participate in multi-disciplinary palliative care processes.

Goal

To develop a plan to work towards all clinicians in our region to having core knowledge, skills and attitudes to provide palliative care in our community, including advance care planning conversation training, pain and symptom management, and strategies to participate in multi-disciplinary palliative care processes.

Work Group

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This White Paper is one of five working papers, each of which covers a different content area and was developed by a separate Work Group. These papers were used to inform the development of the Blueprint for Community Excellence at End of Life. As such, this White Paper is not to be viewed as a formal or standalone document, but rather as supplemental and expanded material for those who may be interested in additional information and content in a specific area. If there are any discrepancies between this paper and the Blueprint, the Blueprint represents the final decision of the Steering Committee.

WHITE PAPER

Recommendation #1: Core Palliative Care Competencies

Competency in palliative care practice should be required for all clinicians regardless of discipline, specialty, or practice setting. The Palliative Care Clinician Training Task Force conducted a review of current evidence-based literature, existing local resources, and internet resources to identify necessary competencies to demonstrate proficiency in palliative care practice.

Competency #1: Pain and Symptom Management

All clinicians must be able to conduct accurate pain assessments and measurements. Clinicians must have competency in:

- Using valid and reliable tools for measuring pain and associated symptoms to assess and reassess related outcomes as appropriate for the clinical context and population
- Demonstrating collaborative approaches to decision-making, diversity of treatment options, flexibility in care, and treatment based on appropriate understanding of the clinical condition
- Demonstrating the inclusion of the patient and others, as appropriate, in the education and shared decision-making process for pain care
- Identifying a wide range of pain treatment options for a comprehensive pain management plan
- Explaining how health promotion and self-management strategies are important to the management of pain
- Developing a pain treatment plan based on benefits and risks of available treatments
- Monitoring effects of pain management approaches to adjust the plan of care as needed

Competency #2: Communication

Communication competency includes a variety of knowledge, skills, and attitudes for interactions with patients and families, as well as the interdisciplinary team. Clinicians must be able to:

- Assess patient preferences and values to determine goals and priorities
- Demonstrate empathic and compassionate communication

- Demonstrate general interview skills for any Advance Care Planning (ACP) or goals of care discussion
- Affirm relationships and inform patients that the ACP discussion is part of comprehensive healthcare
- Encourage patients to view ACP as a process, with decisions that may change over time

Competency #3: Cultural Competence

According to the National Institutes of Health, culture is described as the combination of a body of knowledge, a body of belief, and a body of behavior, including elements of personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups. Clinicians providing healthcare must do so understanding that the context of culture influences beliefs and belief systems surrounding health, healing, wellness, illness, and disease. Clinicians must be able to:

- Demonstrate and promote culturally and spiritually sensitive and competent palliative care by respecting diversity in culture, spirituality, gender, socio-economic status, and sexual orientation
- Identify legal parameters for special and vulnerable populations (e.g., LGBT, refugees)
- Identify, explore, respect, and support diverse populations in their death rituals, family roles, and communication norms

Competency #4: Optimal Resource Utilization and Care Coordination

There is often confusion between the overlapping services of case management and care coordination. A 2009 Commonwealth Fund publication defines case management as a process that tends to be focused on a limited set of predetermined diseases or conditions and guided by potential health care cost savings. The process can include assessment, planning, implementation of services, monitoring, and subsequent reassessment. Traditionally, case management services are provided in a benefits package, often supported by a health plan or managed care organization. Individuals who receive case management typically require services likely to result in high costs and have complex medical needs.

In contrast, care coordination can be provided to any patient and includes a range of medical and social support services beyond medical case management. The goal of care coordination is to help link patients and families to services that optimize outcomes articulated in a patient-centered care plan. In addition to case management services, care coordination may also address the social, developmental, educational, and financial needs of patients and family. Care coordination often includes activities that may or may not be covered by defined benefit packages offered by managed care organizations. In order to effectively coordinate care for patients and families, clinicians must have

competency and skill in understanding available resources and how to systematically evaluate the need for those services by patients and families. Clinicians must be able to:

- Identify community resources for patients with serious illness and their families
- Identify patients who are appropriate for care coordination, palliative care, and hospice services
- Advocate for patient-centered systems of care for patients and their caregivers throughout the continuum of care

Recommendation #2: Convene a Cross-organizational Work Team

To ensure all clinicians are prepared to practice the aforementioned competencies, a comprehensive work-plan must be established. The Palliative Care Clinician Training Task Force recommends convening a cross-organizational work team to identify strategies to ensure education for clinicians, patients, and families, including an evaluation of challenges and barriers to implementation of education strategies. Such strategies may include:

- Build the case for why palliative care competency should be required by all clinicians regardless of discipline, specialty, or practice setting
- Ensure familiarity with what other specialties and disciplines do in their scope of practice
- Incorporate in education curricula the competencies outlined in this report as a necessary skill for practice in this community
- Charge professional organizations with the task of creating a comprehensive plan of phasing in education strategies for each discipline

Additionally, this work team will define the outcome measures associated with successful implementation of this recommendation. Such a proxy measure for goal attainment may include the number of physicians and nurses trained in palliative care content at PeaceHealth St. Joseph's Medical Center and/or the number of nurses demonstrating palliative care competency in Western Washington University's RN-to-BSN program.

APPENDICES

Appendix A: Challenges and Barriers

A preliminary evaluation of challenges and barriers to implementation of clinician training strategies found the following:

- Legislation – there is some but it is not easily enforced
- Difficulty with schedules, access, and time of trainings that are offered
- Distribution of announcements for training opportunities – right list at the right time
- Addressing varied learning styles
- Courage of educators to actually test the competency
- Comfort with the scope of responsibility (i.e., “That’s not my job” mentality)
- Sharing the number of completed ACPs – publish performance
- No incentives tied to the performance of palliative care competency

Appendix B: Overview of Current Palliative Care Training Practices and Opportunities

ELEMENTS OF THE WHATCOM PALLIATIVE COMMUNITY



WAHA is a 501(c)(3) nonprofit organization with a mission *to connect people to health care and to facilitate transformation of the current system into one that improves health, reduces costs, and improves the experience of care.* The WAHA Leadership Board includes consumers and community leaders from the nonprofit, business, and governmental sectors, as well as many local healthcare organizations.

If you have questions or comments regarding this report, please contact Mary Ann Percy at mpercy@hinet.org or 360-788-6526.



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