Ontario Renal Network

# A Palliative Approach to CKD:
## Goals of Care Conversations

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## Background

- As outlined in the Ontario Renal Plan II, the goal of the ORN Palliative Care portfolio is to establish an integrated process for early identification and management of people with chronic kidney disease (CKD) who would benefit from palliative care
- Of 5,507 Ontario patients who died on dialysis from 2010 – 2012, 59% used the emergency department, and 38% received care in an intensive care unit in the last 30 days of life[1]
- Advance Care Planning and Goals of Care (GOC) conversations were a key recommendation outlined in the ORN Palliative Care Report and in alignment with provincial direction[2]
- A current state analysis of the 26 Regional Renal Programs processes indicated a system gap for Goals of Care conversations.
- Treatment decisions should align with a patient's wishes, values, and beliefs, based on their current health condition, and the healthcare team should be aware of and able to follow patient preferences

## Methods

- Identified Local Clinical Champions for palliative care in each Regional Renal Program
- Collaborated with Pallium Canada to develop and deliver Learning Essential Approaches to Palliative Care (LEAP) Renal
- Developed education resources on GOC conversations
- Implemented the PCDM initiative to ensure all CKD patients will have had a GOC conversation by 2019, with annual re-assessment
- Collected GOC conversation data

## Person-Centred Decision-Making Continuum

In Ontario, **Advance Care Planning**, **Goals of Care**, and **Health Care Consent** are situated along a continuum that comprise the person-centered decision-making process[3]:


## Results

- One nephrologist champion and one multidisciplinary champion identified in each Regional Renal Program
- Over 400 renal healthcare providers trained in LEAP Renal across 24 of 26 Regional Renal Programs in fiscal year 2016 – 2017; Overall knowledge quiz results increased by 6 points from pre- to post-survey
- A standard approach to the provincial collection for GOC conversations data was developed
- Over 300 multidisciplinary healthcare providers trained on GOC and Treatment Decisions & Informed Consent assessments
- A data submission tool developed to capture patient's GOC and Treatment Decisions & Informed Consent assessments as part of the PCDM initiative

### Education Materials Developed

**Provider Resources**

- Person-Centred Decision-Making
- Discussing Prognostication with CKD Patients on Dialysis
- Approaches to Goals of Care Conversations

**Patient Resources**

- Advanced Chronic Kidney Disease: Making Decisions About Your Care

**Patient & Provider Resources**

- Advance Care Planning, Goals of Care, and Treatment Decisions & Informed Consent: Frequently Asked Questions

## Patient Perspective

*"The successes were in the initiation of conversations upfront, the plans in place and the services arranged to support Mom's wishes."*

Brian T's mother, Doris, died in 2015 and the age of 90, after choosing to withdraw from dialysis.

## Next Steps

- Collection of GOC conversation data, and evaluation will continue in 2017/2018
- Expand LEAP Renal implementation to additional CKD healthcare providers across the 26 Regional Renal Programs
- Implementation of phase 2 of GOC conversation data collection; will include Multi-Care Kidney Clinic patients and all chronic dialysis patients

## References

1. Nesrallah G, Dixon S, MacKinnon M, et al. Palliative and end-of-life care service utilization patterns among Ontario residents dying on dialysis between 2010–2012. Poster session presented at: CSN Annual General Meeting; April 2015; Montreal, QC
2. ORN. (2016). Palliative Care Report. Retrieved from: http://www.renalnetwork.on.ca/common/pages/UserFile.aspx?fileId=360709
3. Adapted from: ©2016 by Dr Nadia Incardona and Dr Jeff Myers. Advance Care Planning Conversation Guide.


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