

Conducting Journey Mapping to Create a Palliative Care Pathway for First Nations Communities: A Step by Step Guide

Developed by the “Improving
End-of-Life Care in First Nations
Communities” Research Project

www.eolfn.lakeheadu.ca

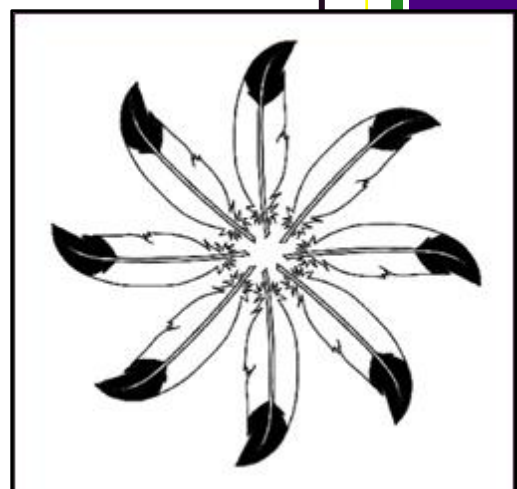


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This Guide to conducting journey mapping was created as a resource to accompany the *Developing Palliative Care Programs in First Nations Communities: A Workbook*. It is not intended to be used separately. The Workbook can be downloaded from the website www.eolfn.lakeheadu.ca. For more information contact eolfn@lakeheadu.ca.

The Guide is based on research done by the Improving End-of-Life Care in First Nations Communities (EOLFN) research team, conducting journey mapping workshops and Leadership Team meetings with Naotkamegwanning First Nation from August 2013 – October 2014. This Guide was written by Jessica Koski, graduate student trainee (Master of Health Sciences) and EOLFN research assistant, and Dr. Mary Lou Kelley.

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All First Nations communities are free to copy and share any part of this Guide in any way that is helpful to them. This Guide may be used and adapted to better fit the needs of the community. We only ask that you acknowledge use of this Guide as indicated below:

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INTRODUCTION

DEFINITIONS

What is Journey Mapping?

In this Guide, journey mapping refers to a process to improve the coordination and integration of care for clients as they access services from multiple programs and health care providers. It is done using a workshop format that brings together internal and external health care providers, Elders, and community leadership. It involves in-depth discussion of how First Nation community members transition through the health care system as they approach end of life, and identifies obstacles and solutions to improve service integration. Journey mapping is a useful tool to help create the Care Pathway that is an important component of the Palliative Care Program guidelines.

In this Guide, the journey mapping process is led by the members of the palliative care Leadership Team that is formed in the First Nation community. Forming the Leadership Team is described in the *Developing Palliative Care Programs in First Nations Communities: A Workbook*, pages 42-44. The Leadership Team creates the community's palliative care guidelines which includes the care pathway. The internal community work described in this journey mapping Guide is therefore done by the Leadership Team.

What is a Care Pathway?

In this Guide, care pathway, or path of care, refers to a diagram or map that outlines the expected care for clients who would benefit by receiving palliative care, including the appropriate timeframes for different phases of palliative care. The care pathway is created by a group of involved care providers during a series of journey mapping workshops in order to become a resource that will guide care for individuals progressing

through their care and treatment. The care pathway focuses on providing clients the best palliative care and most positive outcomes as they move between different health care providers and organizations.

THE GOAL AND OBJECTIVES OF JOURNEY MAPPING

The goal of journey mapping is to create the care pathway, or path of care, for clients who would benefit by palliative care and wish to receive their care at home.

The objectives are:

- Document the existing palliative care services in the First Nation community, called the “current state”;
- Identify both the barriers to receiving palliative care and the capacities (strengths and resources) in the First Nation community for providing better palliative care throughout the client journey;
- Generate ideas to improve palliative care services in the First Nation community throughout the client journey;
- Engage internal (inside the community) and external (outside the community) health care providers to work together as partners to improve palliative care, establishing collaborative relationships within the circle of care;
- Improve communication between internal and external health care partners;
- Increase external health care providers’ understanding of the community and culture, and the First Nation community’s beliefs and practices;
- Create the desired care pathway for clients who want to receive palliative care at home in the First Nation, including documenting in detail what services are needed at each stage of the client journey, who will provide them and how they will be provided.
- Incorporate the community’s traditional beliefs at each step of the care pathway.

THE NAOTKAMEGWANNING PALLIATIVE CARE PATHWAY

Between August 2013 and October 2014, the Naotkamegwanning palliative care Leadership Team created their palliative care pathway. The care pathway was created to improve care for people who would benefit by palliative care. The care pathway, illustrated in the diagram below, consists of nine distinct stages. It begins with the client being identified and ends with case closure after the clients' passing. These nine stages are depicted as a circle and move clockwise.

For clients to receive quality palliative care, each stage in the care pathway requires certain medical and psychosocial supports be available for them and their families at the appropriate time. At each stage of the journey, the traditional beliefs of clients and community practices are also included.

Stages in the journey often involve many health care providers who work in different settings of care such as home or hospital. These care providers and services need to communicate well together and coordinate their services effectively as the clients move through their journey. Transitions between settings of care need to be smooth and well planned.

Internal and external health care providers work together in journey mapping workshops to design the care pathway. At the beginning of the journey mapping process, creating the care pathway is like working on a large puzzle! The health care providers involved need to discuss the internal and external capacities and barriers to care at each stage and generate ideas to improve the clients' journey. They need to determine how they can best work together for the clients' benefit. The conversations that occur during the workshops increase external health care providers' understanding of the First Nations community and culture, and help establish relationships within the circle of care.

The following figure, Figure 1, depicts the nine stages of the Palliative Care Pathway designed by Naotkamegwanning.

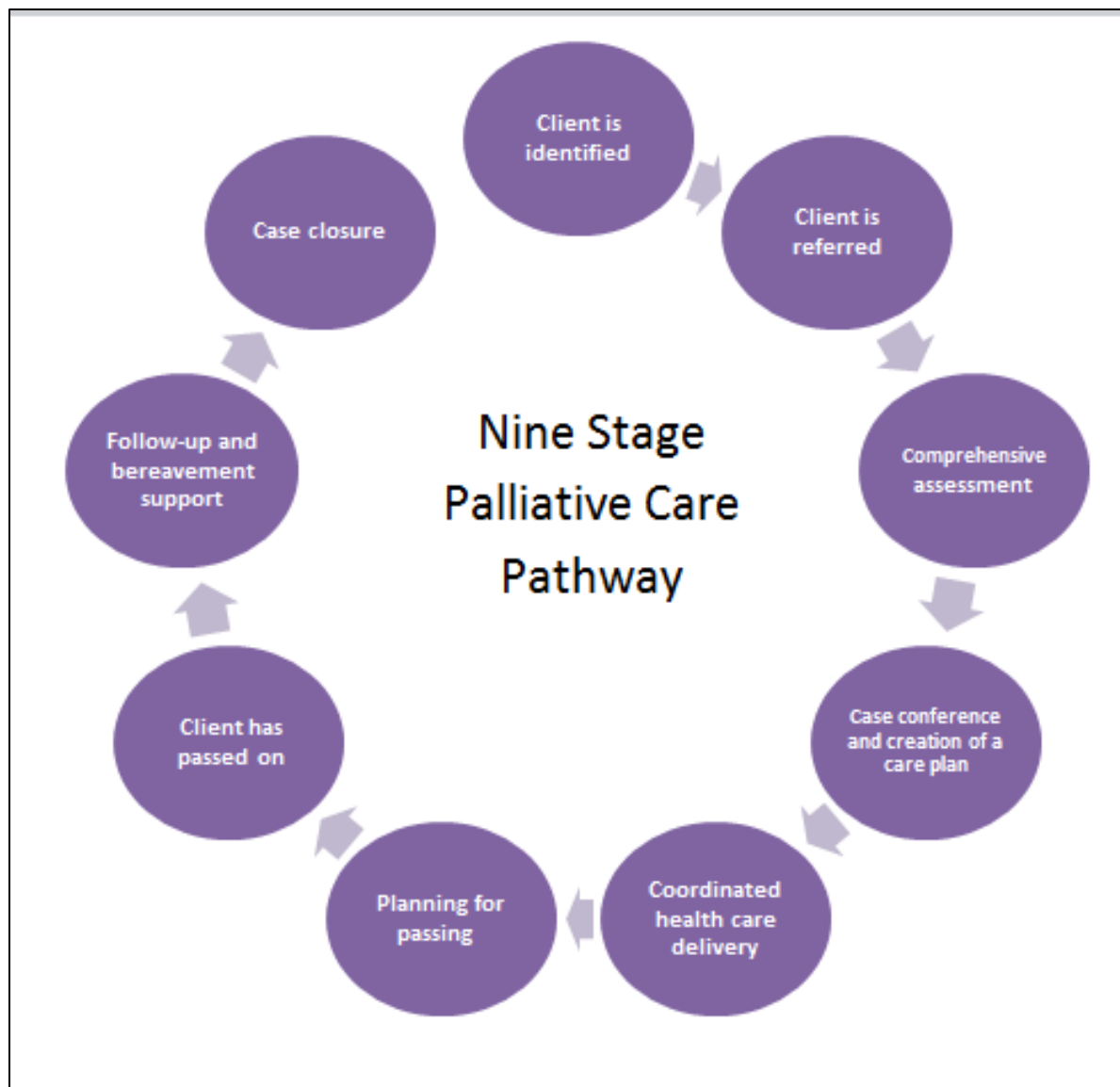


Figure 1: Nootkamegwanning Palliative Care Pathway

This figure of a care pathway can serve as a template to guide a journey mapping process in other First Nations communities. The nine stages are likely applicable in any First Nation community; however, the details of how to implement the services and supports required throughout the care pathway will be different in every community. How the care pathway is implemented depends on the internal capacities in the community and the willingness of external partners to provide services. These details of

service provision need to be discussed and documented through a series of First Nation community palliative care Leadership Team meetings and Journey mapping workshops.

PURPOSE OF THE GUIDE

The Guide describes how to conduct journey mapping to create a palliative care pathway for clients that will be part of your community's palliative care program. The palliative care Leadership Team takes an active role throughout the journey mapping process to ensure the care pathway is grounded within the community's culture, traditional beliefs, and practices.

During the series of Leadership Team meetings and journey mapping workshops, the Leadership Team can develop new and existing linkages with internal and external health care providers. The Leadership Team can use these linkages to develop a Clinical Team. The Clinical Team is a working group of health care providers/partners that can assist the Leadership Team to develop the palliative care program. The Clinical Team can remain involved throughout the process of creating the palliative care program guidelines.

This Journey Mapping Guide is intended to be used as part of the work done in Phase 5 of the *Developing Palliative Care Programs in First Nations Communities: A Workbook*. This guide assumes that the reader is familiar with and working through the Workbook.

OVERVIEW OF THE JOURNEY MAPPING PROCESS

This Guide recommends that the journey mapping process be conducted using the six steps that are summarized in the following table. These steps are composed of a sequence of Leadership Team meetings (3) and journey mapping workshops (3). Each

of the six steps has a different purpose that is described in the table. The table also lists all of the relevant documents for each step.

All of the documents referred to can be found in the Appendices of this Guide. The documents are editable to allow them to be adapted as required to suit each community. These documents can also be found as part of the resources and tools that accompany the *Developing Palliative Care in First Nations Communities: A Workbook* (www.eolfn.lakeheadu.ca). All the relevant tools from the Workbook were included in this Guide for the convenience of the users.

The steps are recommended to be done in the order presented in the Guide. Each step builds on the work completed in the previous one. After the six steps are all completed, participants will have created and evaluated the palliative care pathway for their own community.

It is very important that the First Nation community's palliative care Leadership Team guide and control all aspects of the journey mapping process. Journey mapping requires their strong involvement before, during and after each of the workshops.

In the following table, the term **internal** refers to people who are members of the First Nations community. **External** refers to people who are health care providers/regional partners and provide health services to community members but do not live in the community. External health care providers represent organizations such as hospitals, cancer centres, or provincial home care agencies.

Table 2: The Six Steps of Journey Mapping

STEP	MEETING / WORKSHOP TITLE	PURPOSE
Step 1	Leadership Team Meeting #1	Begin the journey mapping process (internal only) Complete or review of the following documents: <i>Community Readiness Worksheets</i> <i>Community Resources Chart</i> <i>Nine Stage Palliative Care Pathway Diagram</i>
Step 2	Journey Mapping Workshop #1	Engage regional partners (internal and external) Review and update the following documents as needed: <i>Community Readiness Worksheets</i> <i>Community Resources Chart</i> Introduce the following documents: <i>Nine Stage Palliative Care Pathway Diagram</i> <i>Documenting the Current State Worksheet</i>
Step 3	Leadership Team Meeting #2	Document the current state and desired future state (internal only) Review and update the following documents as needed: <i>Community Readiness Worksheets</i> <i>Community Resources Chart</i> Review of these documents: <i>Documenting the Current State Worksheet</i> <i>Implementing the Palliative Care Pathway Worksheet</i>
Step 4	Journey Mapping Workshop #2	Document the current state and desired future state (internal and external) Complete the following worksheets: <i>Documenting the Current State Worksheet</i> (stages 1–5) <i>Implementing the Palliative Care Pathway Worksheet</i> (stages 1–5)
Step 5	Leadership Team Meeting #3	Incorporate culture and traditions in the care pathway and create the action plan (internal only) Complete the following worksheets: <i>Documenting the Current State Worksheet</i> (stages 6–9) <i>Implementing the Palliative Care Pathway Worksheet</i> (stages 6–9) <i>Implementing the Palliative Care Pathway Action Plan</i>
Step 6	Journey Mapping Workshop #3	Evaluate the palliative care pathway (internal and external) Reflect on and discuss: Clients that have passed away Complete the following worksheet: <i>Documenting the Current State Worksheet</i> (stages 1–5) as an evaluation tool. Review the following document: <i>Implementing the Palliative Care Pathway Action Plan</i>

The remainder of this Journey Mapping Guide describes the above six steps in great detail.

STEP 1 – LEADERSHIP TEAM

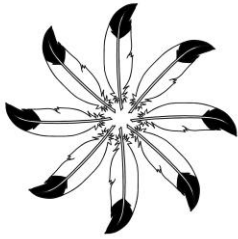
MEETING #1



BEGIN THE JOURNEY MAPPING PROCESS (INTERNAL ONLY)

Preparation for Leadership Team Meeting #1

1. To begin to prepare for the Journey Mapping process, the Community Facilitator should schedule a meeting with the palliative care Leadership Team (This is described in the Workbook in “**Phase 4 – Creating the Palliative Care Program**”).

	<p>It is recommended that this journey mapping discussion be part of a regularly scheduled (e.g. monthly) Leadership Team meeting. The Team can discuss new business related to the overall palliative care program and provide updates on outstanding tasks. This allows the Leadership Team to make progress on multiple agenda items in a single meeting.</p>
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2. To prepare for this Leadership Team meeting, the Community Facilitator should prepare packets for the Leadership Team members. The packets should include:

- **Leadership Team Meeting 1 Agenda**

An editable sample agenda is included in:

-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 2 Leadership Team Meeting 1 Sample Agenda Template**

SAMPLE

<p style="text-align: center;">Palliative Care Program Name Leadership Team Meeting #1 Agenda Date, time and location</p> <p>Traditional opening (Elder name)</p> <p>Standing agenda item: Updates on existing tasks</p> <p>Leadership Team Meeting #1:</p> <ol style="list-style-type: none"> 1. Overview of Journey Mapping <ul style="list-style-type: none"> • Background, definition and purposes of journey mapping and the palliative care pathway 2. Review or completion of the Community Readiness for Palliative Care Program Development Worksheets <ul style="list-style-type: none"> • Chart 1: Assessment of local health infrastructure & palliative care services • Chart 2: Where are palliative care services being provided? • Chart 3: Assessing Community Strengths • Chart 4: Assessing & Prioritizing Gaps in Services and Challenges to Overcome • Chart 5: Plan for Action 3. Review or completion of the Community Resources Chart 4. Determination of which external partners should be invited to the Journey Mapping Workshop #1 5. Review of Nine Stage Palliative Care Pathway Diagram <ul style="list-style-type: none"> • Ensure the nine stage palliative care pathway diagram is structured appropriately for the community and includes language appropriate to the community 6. Discussion of next steps/questions
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- **Community Resources Chart**

The editable worksheets are included in:

-  **Phase 4, Subfolder 4 Developing the Workplan, 1 Community Resources Chart Template**

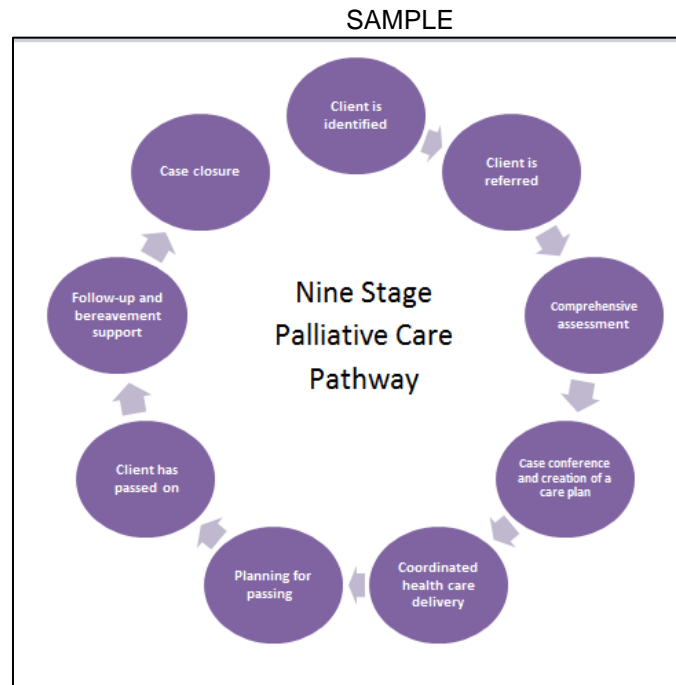
SAMPLE

Community Resources Chart					
OVERARCHING SERVICE	SUB-SERVICE	PROGRAM NAME	PROGRAM DESCRIPTION	ROLE/TITLE	CONTACT INFORMATION
Health	1. Home and Community Care				
	2. Long-term Care				
	3. Diabetes Education				
	4. Community Health				
	5. Community Wellness Program				
	6. Nutrition Programs				
Mental Health	1.				
Social Support	1. Counselling/Social Work				
	2. Spiritual Care/Elder Support				
	3. Bereavement Support Groups				
	4. Advocacy Groups				

- **Nine Stage Palliative Care Pathway Diagram**

The diagram is included in:

-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 3 Nine Stage Palliative Care Pathway Diagram Template**



3. The Community Lead and Community Facilitator should discuss who will facilitate the meetings/workshops and who will record the discussions and decisions made. They could choose to do this work themselves or other people could be chosen. The facilitator and recorder should be two different people. Having these two roles decided early will make things run more smoothly. Having a good recorder is very important for following up after each session.



During the 6 steps of the Journey Mapping Process, the facilitator (person leading the meeting) and the recorder (person taking meeting minutes) should not be changed if at all possible. Having the same 2 people doing in these roles for all of the sessions will promote better progress.

4. The Community Facilitator should arrange to have an Elder present at the Leadership Team meeting. The Elder can provide a traditional opening to set a respectful tone for the meeting.



Community members from Naotkamegwanning First Nation indicated having an Elder open meetings and smudging helped put their minds where they should be, because this is a difficult topic to discuss.



Space Preparation for Leadership Team Meeting #1



On the day of the meeting, the workshop facilitator and recorder will prepare the meeting space in advance. This includes arranging the tables and chairs into a circle or square (as appropriate) and distributing the packets.


How to Conduct Leadership Team Meeting #1

1. The meeting facilitator will welcome everyone and ask the Elder to provide a traditional opening. The Leadership Team members may choose to include smudging as part of the opening as well.
2. The facilitator will go around the room and ask the Leadership Team members to provide any updates on outstanding items from previous meetings and discuss any new business. We recommend the journey mapping process be included as part of the regular monthly Leadership Team meeting.
3. The meeting facilitator will provide an overview of Journey Mapping and the Palliative Care Pathway.
 - The meeting facilitator should include the background, definition and objectives of journey mapping as described at the beginning of this Guide.
4. The Leadership Team will review (if previously completed) or complete the five charts included in the *Community Readiness Worksheets*.
 - Chart 1: *Assessment of local health infrastructure & palliative care services*
 - Chart 2: *Where are palliative care services being provided?*
 - Chart 3: *Assessing Community Strengths*
 - Chart 4: *Assessing & Prioritizing Gaps in Services and Challenges to Overcome*
 - Chart 5: *Plan for Action*
 - If previously completed, the Leadership Team may choose to review and expand on the content included in these worksheets and/or update them as necessary.

- If the *Community Readiness Worksheets* were not previously completed, the Leadership Team should complete them during their meeting. It is a fairly lengthy process to complete the worksheets so they may decide to schedule an additional meeting to complete them. These worksheets need to be completed prior to inviting internal and external health care providers to attend Journey Mapping Workshop #1.
- The Community Facilitator will need to record the new or updated information on the *Community Readiness Worksheets*. This may be done electronically or by hand during the meeting. If done by hand, it is recommended that the content later be transferred to the electronic worksheets so that it can be easily shared later on.

5. The Leadership Team will review or complete the *Community Resources Chart*.

- This chart includes the overarching service type, subservice type, program name, program description, role/title, and contact information (if known) of the external partners. Drawing information from this chart, the external partners named are the health care providers that should be invited to attend the Journey Mapping Workshops.

	<p>Examples of external partners include: discharge planners, palliative care nurses or Aboriginal patient navigators from the nearest hospital(s), home care coordinators/case managers (regional/provincial/territorial), telemedicine nurse(s)/staff, regional cancer centre staff, Aboriginal Health Access Centre nurse(s)/manager(s), Home and Community Care nursing provider agencies, and other external health care professionals that provide health care or services to people living in the First Nation community who would benefit from palliative care.</p>
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6. After the *Community Resources Chart* has been completed as much as possible, the Leadership Team determines which external partners should be invited to the Journey Mapping Workshop #1. This workshop is intended to bring together internal and external health care providers that currently provide service or have the potential to provide palliative care for clients in the community. During the workshop, people can begin to better understand one another's roles.

Before or during the Journey Mapping workshop, the palliative care Leadership Team can also invite key internal and external health care providers to become members of a working group called the Clinical Team. The purpose of the Clinical Team working group is to help the Leadership Team create the Care Pathway and required consent and treatment documents for the Palliative Care Program

Guidelines. Development of the Clinical Team Working Group is discussed in the Workbook (pg. 45).

7. The Leadership Team will review the *Nine Stage Palliative Care Pathway Diagram* to ensure the diagram is structured appropriately for the community and includes language appropriate to the community. This diagram will provide a structure to help the internal and external health care providers discuss the services required by clients and families at each stage of the care pathway. The diagram can be revised as needed.
8. The Leadership Team meeting concludes by discussing next steps/questions.

Homework after Leadership Team Meeting to Prepare for Journey Mapping Workshop #1

Identifying the Workshop Participants:

The Community Facilitator may need to phone some of the agencies identified on the *Community Resources Chart* to obtain missing contact information (e.g. email addresses) for people that will be invited. Getting missing information will also finalize the *Community Resources Chart*.

Once the list of invitees for the Workshop is finalized, the Community Facilitator will provide options of dates/times for a face-to-face meeting with the Leadership Team and Clinical Team working group. This Workshop scheduling can be done using a free and user-friendly meeting scheduler tool, such as Meeting Wizard™ (<http://www.meetingwizard.com/>).



Please ensure to allow for varying time zones if relevant

Once a date/time that accommodates the largest number of external partners/key decision makers has been determined, the Community Facilitator will select a suitable and convenient location and schedule the time and date for Journey Mapping Workshop #1.

Preparation of Agenda and Handouts for Journey Mapping Workshop #1

To prepare for the Journey Mapping Workshop #1, the Community Facilitator will create information packets for the participants.

The packets should include:

- ***Journey Mapping Workshop 1 Agenda***
A sample agenda is included in:


-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 4 Journey Mapping Workshop 1 Sample Agenda Template**

SAMPLE

Palliative Care Program Name Journey Mapping Workshop #1 Agenda Date, time and location	
1.	Welcome
2.	Introductions
3.	Traditional opening (Elder name)
4.	Palliative care program (name) overview <ul style="list-style-type: none"> • Vision and intent
5.	Overview of Journey Mapping and the Palliative Care Pathway <ul style="list-style-type: none"> • Background, definition and purposes
6.	Set workshop ground rules (see tips below)
7.	Review of the <i>Community Readiness for Palliative Care Program Development Worksheets</i> <ul style="list-style-type: none"> • Table 1: Assessment of local health infrastructure & palliative care services • Table 2: Where are palliative care services being provided? • Table 3: Assessing Community Strengths • Table 4: Assessing & Prioritizing Gaps in Services and Challenges to Overcome • Table 5: Plan for Action
8.	Overview of the: <ol style="list-style-type: none"> a. Nine stage palliative care pathway diagram b. Documenting the current state worksheet
9.	Discussion of next steps

Tips for a Successful Journey Mapping Workshop:

- Select a meeting location convenient to all participants
- Begin and end on time
- Mute and put away cell phones / take conversations outside of the room
- Begin with a traditional opening
- Include storytelling throughout the workshop
- Focus on the community and the client
- Take breaks as scheduled
- Network with new faces during break times

- **Completed *Community Readiness Worksheets***
 - Chart 1: *Assessment of local health infrastructure & palliative care services*
 - Chart 2: *Where are palliative care services being provided?*
 - Chart 3: *Assessing Community Strengths*
 - Chart 4: *Assessing & Prioritizing Gaps in Services and Challenges to Overcome*
 - Chart 5: *Plan for Action*
- ***Nine Stage Palliative Care Pathway Diagram***
- ***Documenting the Current State Worksheet***
Please see:
 -  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 5 Documenting the Current State Worksheet Template**

SAMPLE

Documenting the Current State				
Stage	What is working well?	Where do things go wrong?	Gaps and unmet needs?	Solutions and Ideas?
Stage 1: <u>How/where is the client identified?</u> (describe how/where here)				
Stage 2: <u>How/where is the client referred?</u> (describe how/where here)				
Stage 3: <u>Is there a comprehensive assessment? Where does it take place and who is involved?</u> (describe here)				
Stage 4: <u>Is there a case conference and development of a care plan? Where does it take place and who is involved?</u> (describe here)				
Stage 5: <u>Who provides the services? How are the services coordinated?</u> (describe here)				
Stages 6 through 9 are internal to the community				

STEP 2 – JOURNEY MAPPING

WORKSHOP #1



ENGAGE REGIONAL PARTNERS (INTERNAL & EXTERNAL)



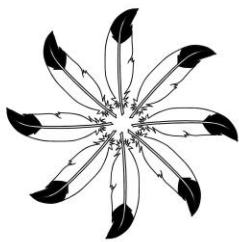
Space Preparation for Journey Mapping Workshop #1



On the day of the workshop, the workshop facilitator and recorder will prepare the meeting space in advance, by arranging the tables and chairs into a circle or square (as appropriate) and distributing the packets.

Tips for a Successful Journey Mapping Workshop:

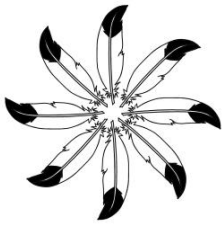
- Select a meeting location convenient to all participants
- Begin and end on time
- Mute and put away cell phones / take conversations outside of the room
- Begin with a traditional opening
- Include storytelling throughout the workshop
- Focus on the community and the client
- Take breaks as scheduled
- Network with participants during break times and make sure participants feel engaged and able to share their ideas



If a Clinical Team working group has already been established, the workshop participants who are members of the Clinical Team can be identified. If no Clinical Team working groups has been established, members of the Leadership Team can use this workshop as an opportunity to invite interested participants to join this working group.

How to Conduct Journey Mapping Workshop #1

1. When everyone arrives, the workshop facilitator welcomes everyone, introduces themselves, and invites each person to introduce themselves to the group. Introductions may include, name, agency, role, why this initiative is important to them, and/or a personal story about themselves.



In the experiences of the EOLFN project, group interaction and participation was best when the participants had a feeling of the personal qualities of the individuals. Personal sharing generated more trust amongst the group.



The recorder will document a list of all the participants either by hand or electronically on a computer.

2. Following introductions, the workshop facilitator introduces the Elder who will provide a traditional opening to set the tone for the workshop.
3. After the traditional opening, the workshop facilitator introduces the information packets and provides an overview of the community's palliative care program.
4. The workshop facilitator provides an overview of journey mapping and the palliative care pathway (as described at the beginning of this Guide).
5. The workshop facilitator may ask the workshop participants to set some ground rules.
 - Please see the "*Tips for a Successful Journey Mapping Workshop*" included on both the *Journey Mapping Workshop Agenda #1* and earlier in the Guide.
6. The workshop facilitator presents the *Community Readiness Worksheets* and engages the participants in discussion, including reviewing them and adding to them.



For each chart below, the recorder will document any changes and/or updates by hand or electronically on the computer.


Chart 1: *Assessment of local health infrastructure & palliative care services*

- The workshop facilitator will go through each agency/provider listed in Chart 1, and the participants will discuss the services provided and how they can be accessed.

- When discussing the last column, “Do they have a representative on the team?”
 - This is the ideal time for the Leadership Team to get commitment from participants and establish the Clinical Team working group, if it has not already been established.
- Before moving on, the workshop facilitator should ask if there are any agencies/providers missing from the list.

Chart 2: *Where are palliative care services being provided?*

- The workshop facilitator will go through each location of where palliative care services are provided as listed in Chart 2.
This includes:
 - In the client’s home
 - In the community
 - In the hospital/clinic
 - In a long-term care home
 - Outside the community
- For each location, the participants will discuss the services provided and whether or not there are any gaps in the services.

	<p>The workshop facilitator can remind the workshop participants that this chart identifies the current gaps in service. Chart 4 (introduced later) assesses and prioritizes the gaps identified here.</p>
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- Before moving on, the workshop facilitator should ask if there are any locations for providing palliative care missing from the list.

Chart 3: *Assessing Community Strengths*

- The workshop facilitator will go through each of the community strengths related to palliative care as listed in Chart 3.

This includes:

- Community characteristics
 - *Assessing Community Strengths – Community characteristics*
This information is internal to the community; however, sharing these strengths with the workshop participants will help external health care providers learn about your community. It also provides an opportunity for the community members/Leadership Team to engage in the conversation by storytelling and providing examples of strengths and traditional practices within the community that impact the way palliative care is provided.

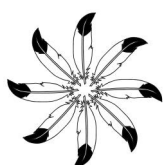
- Service/care provider characteristics
- Type/quality/accessibility/delivery of services

Chart 4: *Assessing & Prioritizing Gaps in Services and Challenges to Overcome*

- The workshop facilitator will review the gaps in services and challenges that the community faces. There may be new gaps identified earlier in the workshop that should be addressed here.
- Workshop participants should also discuss the challenges most important for the community to overcome in order to be successful in providing palliative home care.

Chart 5: *Plan for Action*

- The workshop facilitator will review the Leadership Team's plan for action related to conducting Journey Mapping (the other goals, stages 6-9, for the palliative care program are internal to the community and need not be discussed or shared with external health care providers).
- Based on the discussion that took place in the workshop, the goals may need to be re-prioritized. This can be done by the Leadership Team following the meeting. Once the list of goals has been updated, the actions needed to achieve the goal should be reviewed and documented, followed by a realistic timeline and person or people responsible for achieving the goal.



After the workshop, accomplishing these goals may involve participation from several members of the Clinical Team working group who are health care providers internal and external to the community. There should be a central point of contact in the community that oversees work related to these goals, such as the Community Facilitator/Leadership Team member. This coordination will help ensure progress is being made and other team members have someone to contact, if they have questions.

7. The workshop facilitator should introduce the nine stage palliative care pathway and the *Documenting the Current State Worksheet* to the group. The workshop participants will be expected to review and prepare to provide details related to their agency's role and services during the next Journey Mapping Workshop.
8. The workshop facilitator concludes with a closing and discussion of next steps.
 - Thanks participants for their attendance;
 - Asks the group if there are any questions;
 - Highlights the key points discussed ;

- Asks the group if there is anyone missing from the journey mapping workshop;
- Advises the group that a summary of the worksheets will be sent to everyone in attendance;
- Instructs the group that another journey mapping workshop will be scheduled.

Homework after Journey Mapping Workshop #1

Preparation for Leadership Team Meeting #2

Following the Journey Mapping Workshop #1, the recorder will finalize the meeting minutes (key points), participant list, and new/additional details in the *Community Readiness Worksheets*.


If it was determined at Journey Mapping Workshop #1, that additional agencies/partners should be invited to participate in the journey mapping workshop, the Community Facilitator should update the *Community Resources Chart*. The Community Facilitator may need to phone agencies, introduce the program, and to obtain missing contact information, such as email addresses. These agencies will then be added to the participant list for future journey mapping workshops.

After the documents have been completed, the Community Facilitator should distribute the completed documents to the Leadership Team and schedule a meeting with the Leadership Team.

- The Leadership Team should be informed to come prepared with any questions or comments related to the *Community Readiness Worksheets* and the meeting minutes from Journey Mapping Workshop #1.

Preparation of Agenda and Handouts for Leadership Team Meeting #2

To prepare for this Leadership Team meeting, the Community Facilitator should prepare packets for the Leadership Team. The packets should include:

- ***Leadership Team Meeting 2 Agenda***
A sample agenda is included in:
 -  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 6 Leadership Team Meeting 2 Sample Agenda Template**

SAMPLE



Palliative Care Program Name
Leadership Team Meeting #2
Agenda
Date, time and location

Traditional opening (Elder name)

Standing agenda item: Updates on existing tasks

Leadership Team Meeting #2:

1. Review and approval of the meeting minutes from Leadership Team Meeting #1.
2. Review and approval of the completed *Community Readiness for Palliative Care Program Development Worksheets*
3. Review and complete stages 1 – 5 only of the *Documenting the Current State Worksheet*
 - Ensure community includes their culture and traditions.
4. Review and complete stages 1 – 5 only of the *Implementing the Palliative Care Pathway Worksheet*
 - At this time, the community ensures their culture and traditions have been included in stages 1 -5.
5. Review and update the sample Agenda for Journey Mapping Workshop #2
6. Discussion of next steps

- **Completed meeting minutes from the Journey Mapping Workshop #1**
- **Completed *Community Readiness Worksheets***
 - Chart 1: *Assessment of local health infrastructure & palliative care services*
 - Chart 2: *Where are palliative care services being provided?*
 - Chart 3: *Assessing Community Strengths*
 - Chart 4: *Assessing & Prioritizing Gaps in Services and Challenges to Overcome*
 - Chart 5: *Plan for Action*
- ***Documenting the Current State Worksheet***
The editable worksheet is included in:
 -  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 5 Documenting the Current State Worksheet Template**
- ***Implementing the Palliative Care Pathway Worksheet***
The editable worksheet is included in:
 -  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 7 Implementing the Palliative Care Pathway Worksheet Template**

SAMPLE

Implementing the Palliative Care Pathway Worksheet					
Stages 1-5 with external care partners					
Stages 1-5	What is already in place	Key process and consent	What needs to be accomplished/implemented	Decisions to be made	Stakeholders
Client is Identified	Points of entry Program criteria	Information sharing (what and to whom)			
Client is Referred	Community referral process	Information sharing (what and to whom)			
Comprehensive Assessment		Information sharing (what and to whom)			
Case Conference and Creation of a Care Plan		Information sharing (who is in the Circle of Care)			
Coordinated Health Care Delivery		Information sharing (what and to whom)			

- ***Journey Mapping Workshop 2 Agenda***

A sample agenda is included in:

-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 8 Journey Mapping Workshop 2 Sample Agenda Template**

SAMPLE

Palliative Care Program Name
 Journey Mapping Workshop #2
 Agenda
 Date, time and location

1. Welcome
2. Introductions
3. Traditional opening (Elder name)
4. Review packets and ground rules
5. Discuss questions / provide updates since last workshop
6. Update on the progress of the community's palliative care program
7. Review and complete the *Documenting the Current State Worksheets*
 - Discuss in detail the "who, what, where, when, why and how" (as applicable).
 - How/where is the client identified?
 - How/where is the client referred?
 - Is there a comprehensive assessment? Where does it take place and who is involved?
 - Is there a case conference and development of a care plan? Where does it take place and who is involved?
 - Who provides the services? How are the services coordinated?
8. Interactive Session: Working group answers four questions for each stages 1 - 5 with each response written on a sticky note of a different colour:
 - a. What is working well? (green sticky note)
 - b. Where do things go wrong? (yellow sticky note)
 - c. Where are the gaps and unmet needs? (red sticky note)
 - d. What are your solutions and ideas? (blue sticky note)
9. Review and complete the *Implementing the Care Pathway Worksheets*
 Discuss in detail:
 - a. What is already in place?
 - b. What are the key processes involved? What is the consent process?
 - c. What needs to be accomplished and implemented?
 - d. What decisions need to be made?
 - e. Who are the stakeholders?
10. Conclusion and discussion of next steps

STEP 3 – LEADERSHIP TEAM

MEETING #2



DOCUMENT THE CURRENT STATE AND DESIRED FUTURE STATE (INTERNAL ONLY)



Space Preparation for Leadership Team Meeting #2



On the day of the meeting, the workshop facilitator and recorder will prepare the meeting space in advance, by arranging the tables and chairs into a circle or square (as appropriate) and distributing the packets.

How to Conduct Leadership Team Meeting #2

1. The meeting facilitator will welcome everyone and ask the Elder to provide a traditional opening. The Leadership Team may choose to include smudging as part of the opening as well.
2. The facilitator will go around the room and ask members of the Leadership Team to provide updates on any outstanding items from previous meetings and discuss any new business.
3. The Leadership Team will discuss any questions or comments related to the *Community Readiness Worksheets* and meeting minutes from the Journey Mapping Workshop #1. This should include discussion on any action items that arose during the workshop.



The recorder will document any updates to the meeting minutes, *Community Readiness Worksheets* and the sample agenda for Journey Mapping Workshop #2.

- Once the Leadership Team has discussed the *Community Readiness Worksheets* and meeting minutes they will be considered final and ready to distribute to the external partners.
4. The Leadership Team will review and complete steps 1 – 5 of the *Documenting the Current State Worksheet* from the community's perspective ensuring the community's culture and traditions are included in each step.
 - Steps 6 – 9 will be completed later following Journey Mapping Workshop #2.
 - There may be a lot of unknowns at this point which can be discussed with the workshop participants during Journey Mapping Workshop #2.

- The recorder will document any changes to the *Documenting the Current State Worksheet* steps 1 – 5.
5. The Leadership Team will review and complete stages 1 – 5 of the *Implementing the Palliative Care Pathway Worksheet* from the community's perspective ensuring the community's culture and traditions are included in each step.
- Stages 6 – 9 will be completed later following Journey Mapping Workshop #2.
 - There may be a lot of unknowns at this point which can be discussed with the workshop participants during Journey Mapping Workshop #2.
 - The recorder will document any changes to the *Implementing the Palliative Care Pathway Worksheet* steps 1 – 5.
6. The Leadership Team should review the sample agenda for Journey Mapping Workshop #2.



The recorder will make any requested any changes to the agenda.

7. The Leadership Team meeting concludes by discussing next steps/questions.

Homework after Leadership Team Meeting #2

Preparation for Journey Mapping Workshop #2

Following the Leadership Team meeting, the Community Facilitator will distribute the finalized documents to the Journey Mapping Workshop #2 participants and any new participants that have been added.

The documents should include:

- Meeting minutes from Journey Mapping Workshop #1
- List of participants from Journey Mapping Workshop #1
- Completed *Community Readiness Worksheets*
- *Nine Stage Palliative Care Pathway Diagram*
- *Documenting the Current State Worksheet* (with notes from Leadership Team meeting #2)
- *Palliative Care Pathway Worksheet* (with notes from Leadership Team meeting #2)
- *Agenda for Journey Mapping Workshop #2* (as finalized by the Leadership Team)

Please advise the external health care providers that they will need to discuss the documents internally within their organizations, management and decision makers. This is so that they can come to the journey mapping workshop and indicate what services can be provided and how.

In addition, the Community Facilitator will also provide dates/times for a follow-up face-to-face meeting with the Leadership Team and internal and external partners for Journey Mapping Workshop #2. This can be done using a free and user-friendly meeting scheduler tool, such as Meeting Wizard™ (<http://www.meetingwizard.com/>).



Please ensure to allow for varying time zones if appropriate.

The time allotted between Journey Mapping Workshop #1 and #2 will vary in each community. It is recommended, where possible, that Journey Mapping Workshop #2 be scheduled within 2 months of Journey Mapping Workshop #1. This will help keep the participants actively involved and making progress.

Once a date/time that accommodates the largest number of participants has been determined, the Community Facilitator will select a location and schedule the Journey Mapping Workshop #2.

- Please ask participants to be prepared to discuss the *Documenting the Current State Worksheet* from the perspective of their agency.
- Please ask the participants to bring the documents they received at Journey Mapping Workshop #1 to Journey Mapping Workshop #2.

Preparation of Agenda and Handouts for Journey Mapping Workshop #2

To prepare for the Journey Mapping Workshop #2, the Community Facilitator will create packets for the participants. The packets should include:

- ***Journey Mapping Workshop 2 Agenda***

A sample agenda is included in:

-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 8 Journey Mapping Workshop 2 Sample Agenda**

- **Finalized documents from Journey Mapping Workshop #1**

- Meeting minutes
- Participant list

- ***Nine Stage Palliative Care Pathway Diagram***

Please see:

-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 3 Nine Stage Palliative Care Pathway Diagram Template**

- **Completed *Documenting the Current State Worksheet***

- Steps 1 – 5 were completed by the Leadership Team in Leadership Team meeting #2
- **Completed *Implementing the Palliative Care Pathway Worksheet***
 - Steps 1 – 5 were completed by the Leadership Team in Leadership Team meeting #2

Preparation of Supplies for Journey Mapping Workshop #2

The following supplies are necessary for Journey Mapping Workshop #2:

- Four different coloured sticky notes (size 3 in. x 3 in. or larger)
 - Green, red, yellow, blue
- Tape
- Markers
- A roll of white paper

Prior to the Journey Mapping #2 Workshop, the Community Facilitator or recorder will draw out steps 1-5 of the *Documenting the Current State Worksheet* on the roll of white paper with one stage per sheet, per the example below.

Each of the Stages below is prepared on a separate sheet for the workshop:

Stage 1:	What is working well?	Where do things go wrong?	Gaps and unmet needs?	Solutions and ideas?
How/where is the client identified?				

Stage 2:	What is working well?	Where do things go wrong?	Gaps and unmet needs?	Solutions and ideas?
How/where is the client referred?				

Stage 3:	What is working well?	Where do things go wrong?	Gaps and unmet needs?	Solutions and ideas?
Is there a comprehensive assessment? Where does it take				

place and who is involved?				
----------------------------	--	--	--	--

Stage 4:	What is working well?	Where do things go wrong?	Gaps and unmet needs?	Solutions and ideas?
Is there a case conference and development of a care plan? Where does it take place and who is involved?				

Stage 5:	What is working well?	Where do things go wrong?	Gaps and unmet needs?	Solutions and ideas?
Who provides the services? How are the services coordinated?				

Next, the Community Facilitator or recorder will draw out stages 1-5 of the *Implementing the Palliative Care Pathway Worksheet* on the long paper with one stage per sheet.

Each of the Stages below is prepared on a separate sheet for the workshop:

Stage 1	What is already in place	Key process and consent	What needs to be accomplished/ implemented	Decisions to be made	Stakeholders
Client is Identified					

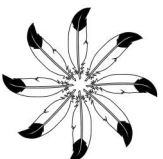
Stage 2	What is already in place	Key process and consent	What needs to be accomplished/ implemented	Decisions to be made	Stakeholders
Client is Referred					

Stage 3	What is already in place	Key process and consent	What needs to be accomplished/implemented	Decisions to be made	Stakeholders
Comprehensive Assessment					

Stage 4	What is already in place	Key process and consent	What needs to be accomplished/implemented	Decisions to be made	Stakeholders
Case Conference and Creation of a Care Plan					

Stage 5	What is already in place	Key process and consent	What needs to be accomplished/implemented	Decisions to be made	Stakeholders
Coordinated Health Care Delivery					

The Community Facilitator or recorder will also draw out the *Nine Stage Palliative Care Pathway* on the roll of paper.



All of these worksheets should be rolled up together and set aside until the day of the Journey Mapping Workshop #2.

STEP 4 – JOURNEY MAPPING

WORKSHOP #2



DOCUMENT THE CURRENT STATE AND DESIRED FUTURE STATE (INTERNAL AND EXTERNAL)



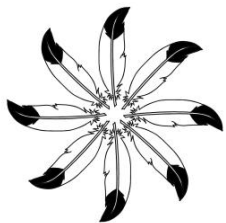
Space Preparation for Journey Mapping Workshop #2



On the day of the workshop, the workshop facilitator and recorder will prepare the meeting space in advance, by arranging the tables and chairs into a circle or square as appropriate, distributing the packets, and taping the completed worksheets (on the rolled paper) up on the wall.

How to Conduct Journey Mapping Workshop #2

1. When everyone arrives, the workshop facilitator welcomes everyone, introduces themselves, and invites each person to introduce themselves to the group. Introductions may include, name, agency, role, why this initiative is important to them, and/or a personal story about themselves. Ideally the participants have been at the Journey Mapping Workshop #1 and relationships are forming. However, some new faces may be added now.



In the experiences of the EOLFN project, group interaction and participation was best when the participants had a feeling of the personal qualities of the individuals. Personal conversation generated more trust amongst the group.



The recorder will document the names of all the participants by hand or electronically on the computer.

2. Following introductions, the workshop facilitator introduces the Elder who will provide a traditional opening to set the tone for the workshop.

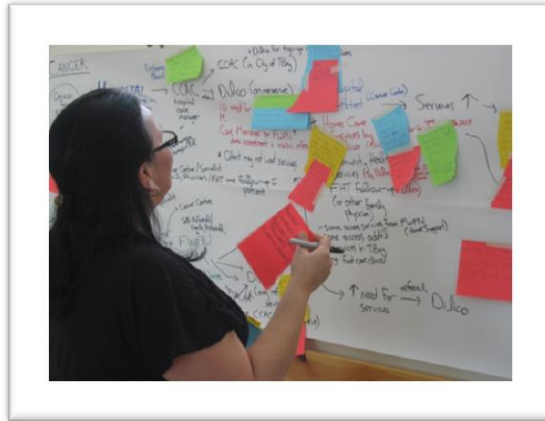
3. After the traditional opening, the workshop facilitator introduces the packets and goes through each handout. The workshop facilitator reminds the workshop participants of the ground rules.
 - Please see the “*Tips for a Successful Journey Mapping Workshop*” included on the *Journey Mapping Meeting #2 Sample Agenda*.
4. The workshop participants are invited to provide updates on tasks, and ask or answer any questions that arose in the previous Journey Mapping Workshop #2.
5. The workshop facilitator and members of the palliative care Leadership Team provide an update to the participants on the progress of the community’s palliative care program and palliative care program guidelines.
6. The workshop facilitator presents the *Documenting the Current State Worksheets* and engages the participants in discussing them. Worksheets are reviewed and added to as appropriate.



For each chart below, the recorder will document any changes and/or updates by hand or electronically.

7. The workshop facilitator takes the participants through the series of stages 1 – 5 to discuss what is happening today with a client who is seriously ill and would benefit by palliative care. This is considered to be documenting the current state.
8. Beginning with stage one of the *Documenting the Current State Worksheet*, the group discusses in detail the “who, what, where, when, why and how” (as applicable).
 - a. How/where is the client identified?
 - b. How/where is the client referred?
 - c. Is there a comprehensive assessment? Where does it take place and who is involved?
 - d. Is there a case conference and development of a care plan? Where does it take place and who is involved?
 - e. Who provides the services? How are the services coordinated?
9. Continuing on stage one, the workshop facilitator then asks participants to answer four questions with each response written on a specific coloured sticky note:
 - a. What is working well? (green sticky note)
 - b. Where do things go wrong? (yellow sticky note)
 - c. Where are the gaps and unmet needs? (red sticky note)
 - d. What are your solutions and ideas? (blue sticky note)

10. Once participants are done answering the four questions, they would place their different coloured sticky notes beside stage one on the worksheet.
11. The process described above is then repeated for stages 2 – 5.



12. When stages 1 – 5 are complete, the workshop facilitator asks if there are any questions from the group.
13. The second half of the workshop involves adding to the *Implementing the Palliative Care Pathway Worksheets*. The workshop facilitator takes the group through the series of stages 1 - 5 to discuss the desired care path for a client who is seriously ill. This is considered documenting the future state.
14. Beginning with stage one of the *Implementing the Palliative Care Path Worksheet* (posted on the wall) the workshop facilitator then asks everyone to discuss:
 - a. What is already in place?
 - b. What are the key processes involved? What is the consent process?
 - c. What needs to be accomplished and implemented?
 - d. What decisions need to be made?
 - e. Who are the stakeholders?

For each stage and question listed above, the workshop facilitator will document key points on the worksheets on the wall.



The recorder documents the details electronically.

15. The process described in #5 above is then repeated for stages 2 – 5 of the *Implementing the Palliative Care Pathway Worksheet*

16. When stages 1 – 5 are complete, the workshop facilitator asks if there are any questions from the group.
17. The workshop facilitator concludes with a closing and discussion of next steps.
 - Thanks participants for their attendance;
 - Highlights the key points discussed;
 - Advises the group that a summary report and action plan will be sent to everyone in attendance;
 - Indicates that teleconferences will be scheduled with individual organizations to review the action plan.

Homework after the Journey Mapping Workshop #2:

Preparation for Leadership Team Meeting #3

Following the Journey Mapping Workshop #2, the recorder will finalize the meeting minutes (key points), participant list, the *Documenting the Current State Worksheets* and the *Implementing the Palliative Care Pathway Worksheet* of each stage (1 – 5) by ensuring the information from the roll of paper is included on what has been documented electronically.

The next steps will be for the Leadership Team to meet to develop their action plan for stages 6-9 internally as a community. These four stages are especially important ones to incorporate the community's culture and traditions into the care pathway. The Leadership Team will then develop an action plan for the external providers who are involved in providing care during that time.

Preparation of Agenda and Handouts for Leadership Team Meeting #3

After the documents have been completed, the Community Facilitator should distribute the completed documents to the Leadership Team and schedule a meeting with the Leadership Team.

- The Leadership Team should be informed to come prepared with any questions or comments related to the *Documenting the Current State Worksheets*, the *Implementing the Palliative Care Pathway Worksheets* and the meeting minutes from Journey Mapping Workshop #2.
- If possible, it is recommended that this Leadership Team meeting be a part of a regularly scheduled (e.g. monthly) meeting, so the group can discuss new business related to the overall palliative care program and provide updates on outstanding tasks. This allows the Leadership Team to make progress on multiple agenda items in a single meeting.

To prepare for the Leadership Team Meeting #3, the Community Facilitator will create packets for the Leadership Team.

The packets should include:

- **Leadership Team Meeting 3 Agenda**

A sample agenda is included in:


-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 9 Leadership Team Meeting 3 Sample Agenda Template**

SAMPLE

<p>Palliative Care Program Name</p> <p>Leadership Team Meeting #3</p> <p>Agenda</p> <p>Date, time and location</p> <p>Traditional opening (Elder name)</p> <p>Standing agenda item: Updates on existing tasks</p> <p>Leadership Team Meeting #3:</p> <ol style="list-style-type: none"> 1. Review and approval of the meeting minutes from the Journey Mapping Workshop #2. 2. Review and approval of the completed stages 1 – 5 of the <i>Documenting the Current State Worksheets</i> from the Journey Mapping Workshop #2. 3. Review and approval of the completed stages 1 – 5 of the <i>Implementing the Care Pathway Worksheets</i> from the Journey Mapping Workshop #2. 4. Complete stages 6 – 9 of the <i>Documenting the Current State Worksheet</i> 5. Complete stages 6 – 9 of the <i>Implementing the Care Pathway Worksheets</i> 6. Begin creating the Palliative Care Program Action Plan <ul style="list-style-type: none"> • What needs to be accomplished/implemented (this column would be completed in advance for stages 1 – 5). • Timeframe • Who is involved (agency/individual) • Tasks 7. Review and update the sample Agenda for Journey Mapping Workshop #3 8. Discussion of next steps <ul style="list-style-type: none"> • Scheduling individual teleconferences to discuss the action plan
--

- **Meeting minutes and participant list**
- ***Documenting the Current State Worksheets***
 - Revised following Journey Mapping Workshop #2
- ***Implementing the Palliative Care Pathway Worksheets***
 - Revised following Journey Mapping Workshop #2
- ***Nine Stage Palliative Care Pathway Diagram***

Please see:

 -  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 3 Nine Stage Palliative Care Pathway Diagram Template**
- ***Implementing the Palliative Care Pathway Action Plan Worksheet***

Please see:

-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 10 Implementing the Palliative Care Pathway Action Plan Worksheet Template**



Prior to distribution of the action plan, the recorder can transfer the data from the “What needs to be accomplished / implemented” column of the *Implementing the Palliative Care Pathway Worksheet* to the *Implementing the Palliative Care Pathway Action Plan Worksheet*.

SAMPLE

Stages	What needs to be accomplished/ implemented	Timeframe	Who is involved (agency/individual)	Tasks
Stage 1: Client is Identified				
Stage 2: Client is Referred				
Stage 3: Comprehensive Assessment				
Stage 4: Case Conference and Creation of a Care Plan				
Stage 5: Coordinated Health Care Delivery				
Stage 6: Planning for Passing				
Stage 7: Client has Passed on				
Stage 8: Follow-up and Bereavement Support				
Stage 9: Case Closure				

STEP 5 – LEADERSHIP TEAM

MEETING #3



INCORPORATE CULTURE & TRADITIONS IN THE CARE PATHWAY & CREATE THE ACTION PLAN (INTERNAL ONLY)



Space Preparation for Leadership Team Meeting #3



On the day of the meeting, the workshop facilitator and recorder will prepare the meeting space in advance, by arranging the tables and chairs into a circle or square (as appropriate) and distributing the packets.

How to Conduct Leadership Team Meeting #3

1. The meeting facilitator will welcome everyone and ask the Elder to provide a traditional opening. The Leadership Team may choose to include smudging as part of the opening as well.
2. The Leadership Team will go around the room and provide updates on any outstanding items and from previous meetings and discuss any new business.
3. The Leadership Team will review and approve the meeting minutes from the Journey Mapping Workshop #2. This should include discussion on any action items that arose during the workshop.
4. The Leadership Team will discuss any questions or comments related to both the *Documenting the Current State Worksheets* and the *Implementing the Palliative Care Pathway Worksheets* from the Journey Mapping Workshop #2. This should include discussion on any action items that arose during the workshop.



The recorder will document any updates to these worksheets and the meeting minutes.

- Once the Leadership Team had discussed these documents, they will be considered final and ready to distribute to the external partners.
5. The Leadership Team will complete stages 6 – 9 of the *Documenting the Current State Worksheet* from the community's perspective.



The recorder will document the information discussed in the *Documenting the Current State Worksheet* steps 6 - 9.

6. The Leadership Team will complete stages 6 – 9 of the *Implementing the Palliative Care Pathway Worksheets* from the community's perspective.



The recorder will document the information discussed in the *Implementing the Palliative Care Pathway Worksheet* steps 6 - 9.

7. The Leadership Team should begin to create the Palliative Care Pathway Action Plan using the worksheet included in the packets. Beginning with stage 1, the Leadership Team will create an action plan for each stage, including:
 - Review what needs to be accomplished/implemented (this column would have been completed in advance for stages 1 – 5)
 - Timeframe
 - Who is involved (agency/individual)
 - Tasks



The recorder will document all action items and details in the *Implementing the Palliative Care Pathway Action Plan*.

8. The Leadership Team should review the agenda for Journey Mapping Workshop #2.
 - The recorder will document any changes to the agenda.
9. The Leadership Team meeting concludes by discussing next steps/questions.
 - Following the Leadership Team meeting, individual teleconferences will be scheduled with external partners to discuss their role in the palliative care pathway action plan.

Homework after Leadership Team Meeting #3



Please note: There are two parts to this homework:

Part 1: Preparation for implementation of the Palliative Care Pathway Action Plan which takes place immediately following the Leadership Team Meeting #3, and

Part 2: Preparation for Journey Mapping Workshop #3 which takes place after approximately three clients have passed away.

Preparation for Implementation of the Palliative Care Pathway Action Plan

Following the Leadership Team meeting #3, the Community Facilitator will distribute the finalized documents to the Journey Mapping Workshop participants.

The documents should include:

- Meeting minutes from Journey Mapping Workshop #2
- List of participants from Journey Mapping Workshop #2
- Completed *Documenting the Current State Worksheet*
- Completed *Implementing the Palliative Care Pathway Worksheet*
- Completed *Implementing Palliative Care Pathway Action Plan*

Please advise the external health care providers that they will need to discuss the documents internally within their organizations, management and decision makers.

Each individual agency should then be contacted by the Community Facilitator to discuss dates/times for a follow-up teleconference or face-to-face meeting to discuss their role in the Palliative Care Pathway Action Plan. This scheduling can be done using a free and user-friendly meeting scheduler tool, such as Meeting Wizard™ (<http://www.meetingwizard.com/>).



Please ensure to allow for varying time zones if necessary.

Please ask each agency to be prepared to discuss the *Implementing Palliative Care Pathway Action Plan* document from the perspective of their agency during the meeting/telephone call.

- The action plan will be used as a guide to facilitate this discussion and formalize the working relationship.
- Following this discussion/meeting, the action plan may need to be revised and agreed upon.
- The *Implementing the Palliative Care Pathway Action Plan* is considered a dynamic document that should be continuously edited and updated.



The recorder is responsible for updating and revising the Palliative Care Pathway Action Plan.

Preparation for Journey Mapping Workshop #3

After the new care pathway has been used to provide care for approximately three clients that have passed away, the 9 stages of the process should be revisited and revised as necessary. Thus, the time allotted between Journey Mapping Workshop #2 and #3 will vary in each community.

The Leadership Team should discuss how to best discuss and evaluate the services and care provided to the clients so that improvements can be made, while at the same time respecting privacy and confidentiality for those clients

The Community Facilitator will provide dates/times for a follow-up face-to-face meeting with the Leadership Team and internal and external health care providers for Journey Mapping Workshop #3. This scheduling can be done using a free and user-friendly meeting scheduler tool, such as Meeting Wizard™ (<http://www.meetingwizard.com/>).



Please ensure to allow for varying time zones if necessary.

The Leadership Team may choose to schedule Journey Mapping Workshop #3 in the afternoon following the Community Celebration. A description of the “Community Celebration” is at the end of the Guide.

Once a date/time that accommodates the largest number of external partners/key decision makers has been determined, the Community Facilitator will select a location and schedule the Journey Mapping Workshop #3.

- Please ask the participants to bring the documents they received at Journey Mapping Workshop #1 and #2 to Journey Mapping Workshop #3.

Preparation of Agenda and Handouts for Journey Mapping Workshop #3

To prepare for the Journey Mapping Workshop #3, the Community Facilitator will create packets for the participants. The packets should include:

- ***Journey Mapping Workshop 3 Agenda***

A sample agenda is included in:


-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 11 Journey Mapping Workshop 3 Sample Agenda Template**

SAMPLE

Palliative Care Program Name Journey Mapping Workshop #3 Agenda Date, time and location	
1.	Welcome
2.	Introductions
3.	Traditional opening (Elder name)
4.	Review packets and ground rules
5.	Discuss questions / provide updates since last workshop <ul style="list-style-type: none"> • Including updates of the tasks on the Palliative Care Pathway Action Plan
6.	Update on the progress of the community's palliative care program
7.	The workshop facilitator presents the circumstances in which one client passed away
8.	Use the <i>Evaluating the Palliative Care Pathway Worksheet Template</i> to evaluate the quality of the care provided by discussing: <ol style="list-style-type: none"> How/where was the client identified? How/where was the client referred? Was there a comprehensive assessment? Where did it take place and who was involved? Was there a case conference and development of a care plan? Where did it take place and who was involved? Who provided the services? How were the services coordinated?
9.	Interactive session: Working group answers four questions for each stage 1 - 5 with each response written on a sticky note of a different colour. <ol style="list-style-type: none"> What worked well? (green sticky note) Where did things go wrong? (yellow sticky note) What were the gaps and unmet needs? (red sticky note) What are your solutions and ideas? (blue sticky note)
10.	Conclusion and discussion of next steps

Tips for a Successful Journey Mapping Workshop:

- o Select a meeting location convenient to all participants
- o Begin and end on time
- o Mute and put away cell phones / take conversations outside of the room
- o Begin with a traditional opening
- o Include storytelling throughout the workshop
- o Focus on the community and the client
- o Take breaks as scheduled
- o Network with new faces during break times

- **Finalized documents from Journey Mapping Workshop #2**
 - o Meeting minutes
 - o Participant list
- **Updated *Implementing the Palliative Care Pathway Action Plan***
 - o This would have been updated by the recorder following the individual teleconferences/face-to-face meetings with key partners.
- ***Nine Stage Palliative Care Pathway Diagram***
Please see:
 - o  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 3 Nine Stage Palliative Care Pathway Diagram Template**
- ***Evaluating the Palliative Care Pathway Worksheet***
This worksheet is similar to the *Documenting the Current State Worksheet* but it has been changed to past tense with the intention of using it as a tool to evaluate the experience of the clients that have passed away.

Please see:

-  **Phase 5, Subfolder 2 Building External Linkages, section 4 – Journey Mapping, 12 Evaluating the Palliative Care Pathway Worksheet Template**

SAMPLE

Evaluating the Palliative Care Pathway Worksheet (Use one chart for each client discussed)				
Stages	What worked well?	Where did things go wrong?	Gaps and unmet needs?	Solutions and ideas?
Stage 1: How/where was the client identified? (describe how/where here)				
Stage 2: How/where was the client referred? (describe how/where here)				
Stage 3: Was there a comprehensive assessment? Where did it take place and who was involved? (describe here)				
Stage 4: Was there a case conference and development of a care plan? Where did it take place and who was involved? (describe here)				
Stage 5: Who provided the services? How were the services coordinated? (describe here)				
Stages 6 through 9 are internal to the community				

Preparation of Supplies for Journey Mapping Workshop #3

The following supplies are necessary for Journey Mapping Workshop #3:

- Four different coloured sticky notes (size 3 in. x 3 in. or larger)
 - Green, red, yellow, blue
- Tape
- Markers
- A roll of white paper

Prior to the Journey Mapping #3 Workshop, the Community Facilitator or recorder will draw out stages 1-5 of the *Evaluating the Palliative Care Pathway Worksheet* on the roll of white paper with one stage per sheet, per the example below.

Stage 1:	What worked well?	Where did things go wrong?	Gaps and unmet needs?	Solutions and ideas?
How/where was the client identified?				

Stage 2:	What worked well?	Where did things go wrong?	Gaps and unmet needs?	Solutions and ideas?
How/where was the client referred?				

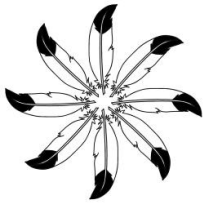
Stage 3:	What worked well?	Where did things go wrong?	Gaps and unmet needs?	Solutions and ideas?
Was there a comprehensive assessment? Where did it take place and who was involved?				

Stage 4:	What worked well?	Where did things go wrong?	Gaps and unmet needs?	Solutions and ideas?
Was there a case conference and development of a care plan? Where did it take place and who was involved?				

Stage 5:	What worked well?	Where did things go wrong?	Gaps and unmet needs?	Solutions and ideas?
Who provided the services? How were the services coordinated?				

The Community Facilitator or recorder will also draw out the *Nine Stage Palliative Care Pathway* on the roll of paper.

The five steps and the *Nine Stage Palliative Care Pathway Diagram* should be rolled up together and set aside until the day of the Journey Mapping Workshop #3.



The workshop facilitator should be prepared to discuss the care and services provided for each client that has passed away (review stages 1-5 of the care pathway) to identify areas for future improvement. Consideration needs to be given to how best do this with privacy, confidentiality, and respect for the clients.

STEP 6 – JOURNEY MAPPING

WORKSHOP #3



EVALUATE THE PALLIATIVE CARE PATHWAY (INTERNAL AND EXTERNAL)



Space Preparation for Journey Mapping Workshop #3



On the day of the workshop, the workshop facilitator and recorder will prepare the meeting space in advance, by arranging the tables and chairs into a circle or square, distributing the packets, and taping the completed worksheets of the rolled paper up on the wall.

How to Conduct Journey Mapping Workshop #3

1. When everyone arrives, the workshop facilitator welcomes everyone, introduces themselves, and invites each person to introduce themselves to the group (if there are new members). Introductions may include, name, agency, role, why this initiative is important to them, and/or a personal story about themselves.



The recorder will document all the participants by hand or electronically.

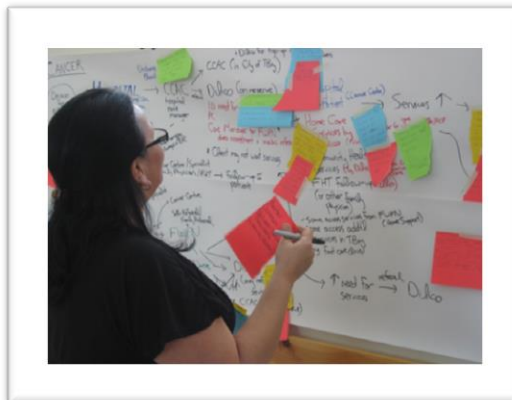
2. Following introductions, the workshop facilitator introduces the Elder who will provide a traditional opening to set the tone for the workshop.
3. After the traditional opening, the workshop facilitator introduces the packets and goes through each handout. The workshop facilitator reminds the workshop participants of the ground rules.
 - Please see the “Tips for a Successful Journey Mapping Workshop” included on the *Journey Mapping Sample Agenda #3*.
4. The Clinical Team working group is invited to provide updates on tasks in the Palliative Care Pathway Action Plan and ask or answer any questions that arose since the previous Journey Mapping Workshop.
5. The workshop facilitator provides an update to the Clinical Team working group on the progress of the community’s palliative care program.
6. The workshop facilitator presents a description of the care and service provided to one of the clients who has passed away.
 - The clients will be presented and then documented one-by-one.

- Attention should be given to how best to do this respectfully and to ensure privacy and anonymity for the clients, especially if there are people present who were not directly involved in the client's care.
7. After the client's circumstances have been presented, the group will use the *Evaluating the Palliative Care Pathway Worksheet* (posted on the wall) to evaluate the care provision by discussing:
 - a. How/where was the client identified?
 - b. How/where was the client referred?
 - c. Was there a comprehensive assessment? Where did it take place and who was involved?
 - d. Was there a case conference and development of a care plan? Where did it take place and who was involved?
 - e. Who provided the services? How were the services coordinated?

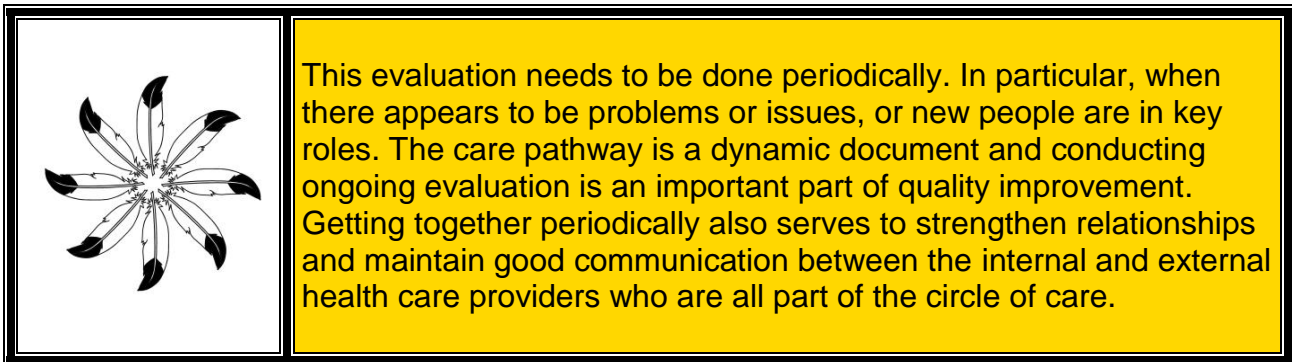


The recorder will document any changes and/or updates by hand or electronically.

8. The workshop facilitator then asks everyone to answer four questions with each response written on a specific coloured sticky note:
 - a. What worked well? (green sticky note)
 - b. Where did things go wrong? (yellow sticky note)
 - c. What were the gaps and unmet needs? (red sticky note)
 - d. What are your solutions and ideas? (blue sticky note)
9. Once they are done answering the four questions, they would place their different coloured sticky notes beside stage one.
10. The process described in above in stages 6 – 9 is then repeated for each client that has passed away.



11. When stages 1 – 5 are complete for each case, the workshop facilitator asks if there are any questions from the group. (Stages 6-9 are later evaluated by the Leadership Team as they are internal to the community.)
12. The workshop facilitator concludes with a closing and discussion of next steps.
 - Thanks participants for their attendance;
 - Highlights the key points discussed;
 - Advises the group that a summary and meeting minutes will be sent to everyone in attendance.



Next Steps for the Leadership Team

The next steps are for the Leadership Team to meet to evaluate the care pathway for stages 6 – 9 using the *Evaluating the Palliative Care Pathway Worksheet*. The Leadership Team should also discuss the implementation details of the care pathway, revise them as required, and then distribute and communicate these updates to the workshop participants.

Community Celebration

- Once the care pathway has been developed and implemented, the Leadership Team should organize a celebration.
- The celebration would begin with an information session about the palliative care program in the morning with the community, Leadership Team and external partners.

CONCLUSION

For First Nations communities, carrying out Journey Mapping requires a major commitment of time and resources. In Naotkamegwanning First Nation, the process of completing all of the six steps took over a year. However, we did not have the benefit of this Guide to follow; we needed to plan the steps and create all of the resources.

It must be recognized that journey mapping is only one of the important strategies for developing palliative care programs in First Nations communities. It is intended to be used along with the other strategies described in *Developing Palliative Care Programs in First Nations Communities: A Workbook*. Once completed, the care pathway becomes a key component of the community's Palliative Care Program Guidelines.

With the assistance of this Guide, we expect that the Journey Mapping process (apart from the evaluation) could be completed in six months of dedicated effort. After six months, the new care pathway could be put into practice. However, the pace of work in each community will vary depending on their circumstances. The care pathway is also a dynamic document that will need ongoing evaluation and revision based on experience or as people or organizations change.

There are many benefits of palliative care Journey Mapping for clients, families, internal health care providers in First Nations communities and external health care organizations who provide service to people living in a First Nation community. For clients and families, their care is more coordinated and transitions are smoother between settings of care. They have more choice, know what to expect and have a greater sense of control over their care. For internal and external health care providers, relationships and communication improve. They all become clearer on how best to work together and better understand the role each plays in their clients' care. Health care providers in the First Nation community become more confident in their abilities and further empowered to build their knowledge and skills to provide palliative care. In the health care system, it promotes greater efficiency as clients who wish to be cared for in

the First Nation community can receive home care, reducing unnecessary and costly visits to hospital or unwanted admissions to long term care homes that are far away from home.

Journey mapping, however, does not offer the complete solution to providing palliative care for clients at home. Our experience conducting journey mapping in the EOLFN project also allowed us to identify challenges and barriers that exist for First Nations clients who wish to receive their palliative care at home. Despite having the care pathway, there was a need for specialized medical equipment in the home, additional nursing, personal support and home making visits afterhours and access to on call nursing support (telephone). Jurisdictional issues needed to be managed. The Leadership Team in the First Nations communities engaged in a lot of advocacy to access additional resources with their own Band Council, with their regional Home and Community Care Program, and with federal and provincial health funders and policy makers. This is discussed in more detail in the Workbook.

The EOLFN research team wishes you great success in your journey mapping process.