

Ontario Palliative Care Network

January 16, 2018

Dear Colleagues,

We are pleased to share the Draft (Version 2.0) Palliative Models of Care: Recommendations for Improving Delivery of Palliative Care Services in Ontario with you. These recommendations aim to address the multiple reports over the last decade that have highlighted persistent gaps in the delivery of palliative care services across Ontario, and were developed in consultation with the Health Services Delivery Framework Working Group.

In August 2017, the Ontario Palliative Care Network established a Working Group to develop the recommendations. Members consist of healthcare professionals and administrators engaged in providing palliative care services, as well as patient and family/caregiver representatives. The recommendations are based on a scan of best practices from literature, and builds upon existing models and initiatives underway in the LHINs. A health equity approach was also used to incorporate the needs of First Nations, Inuit, Métis; Francophone; and vulnerably housed/homeless populations.

The result is an initial set of recommendations that clarifies the roles of primary care and specialist teams for the first area of focus of adult patients receiving care within the last year of life and residing at home (e.g. patient's living in their usual place of residence¹ and receiving care in their home, at outpatient clinics, or through their primary care provider). Future areas of focus will include adult patients in a hospital settings, and pediatric patients receiving palliative care services (all settings).

The recommendations aim to provide guidance to healthcare providers and administrators on optimal palliative care service delivery for patients and family/caregivers across the province. They also highlight organizational considerations for the implementation of these recommendations. Following the release of the document, the Ontario Palliative Care Network Secretariat will work with the Regional Palliative Care Networks to support implementation, with the goal of improving access to high quality, high value palliative care in Ontario.

ACTION REQUIRED:

All OPCN Advisory Councils and Regional Tables will be asked to provide their input on Draft Versions 2.0 and 3.0 before Executive Oversight approval in March 2018. We ask that you please review the attached document and provide any comments regarding the clarity of the recommendations and/or your thoughts about barriers and enablers to implementation by email.

We encourage you to share this with your member organizations for feedback. To assist in streamlining this process, we kindly request that you achieve consensus with your member organizations and summarize the feedback into one document. This will clarify for us your organization's position on specific issues.

Please send your feedback to Hasmik Beglaryan, Manager, Models of Care, Cancer Care Ontario, at hasmik.beglaryan@cancercare.on.ca, by **February 5, 2018**. If you have any questions, you can contact Hasmik by email or at 416-971-9800 ext. 3428.

This work requires long-term commitment and strong leadership. We appreciate your support and are looking forward to working with you on this important initiative.

Sincerely,

Robert (Bob) Sauls, MD and Robin Cano, RN
Co-Chairs, Health Services Delivery Framework

¹ *Usual place of residence can include long-term care homes and retirement homes

Palliative Health Services Delivery Framework

Recommendations for a Model of Care to
Improve Palliative Care in Ontario

Part 1: Adults Receiving Care at Home

DRAFT 2: January 10, 2018

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Overview

Background

Palliative care emerged in Ontario in the early 1980's. Until recently, the development of palliative care services has been characterized predominantly by grassroots initiatives in response to local needs. The result has been the development of programs and services in a variety of communities, mostly urban, that each have their own model of care. While there are many similarities between them, each model has evolved as a product of local resources and culture. While these programs have been delivering excellent care, multiples reports over the last decade have highlighted the persistent gaps in the delivery of palliative care services across Ontario. These have included the Declaration of Partnership (2011), the Auditor General of Ontario Report (2014) and the Ontario Hospice Palliative Steering Committee Report (2014). In line with the findings in these reports, the OPCN Current State Assessment (2017) found:

- Significant variation in the availability and delivery of palliative care services within and across Ontario LHINs
- Less than 60% of Ontarians are known to be receiving palliative care in the last year of life²
- Despite the preference to die at home with appropriate support, more than half of deaths in Ontario occur in hospitals and less than 54% of patients receive home care services in their last 30 days of life³

Building on the three strategic goals of the Declaration of Partnership – Quality, Population Health, Sustainability – the aim of the Palliative Health Services Delivery Framework is to describe and recommend a model of care for palliative care that delivers high quality, culturally relevant care to all of the population in need and builds sufficient capacity among the community care providers that will sustain the system over the long term.

Approach

This document summarizes the recommendation from the Ontario Palliative Care Network's (OPCN) Palliative Health Services Delivery Framework Working Group (Working Group) - a multi-stakeholder panel from across Ontario (see appendix A for Terms of reference). The Working Group reviewed information from the scientific and grey literature, as well as current practices in Ontario and other jurisdictions. Three sub-groups discussed elements of models of care in detail and identified potential opportunities for change. The Recommendations were informed by the Health Quality Ontario (HQO) Palliative Care Quality Standards and MOHLTC Levels of Care Framework. Earlier work done by the OPCN predecessor, the Ontario Palliative Care Steering Committee was also reviewed and incorporated. A broad consultation with stakeholders helped validate and refine the recommendations. Targeted stakeholder engagement was conducted with FNIM representatives, as well patient and caregiver groups.

The Recommendations are intended for system planners (e.g. LHINs, Regional Palliative Care Networks) and provider agencies (e.g. contracted nursing agencies, allied health service providers), hospitals, specialists, primary care, and other providers who care for patients with life limiting

² Based on Current State Assessment of Palliative Care Service Use: Summary of Findings (2017)

³ Ibid

disease who would benefit from a palliative approach to their care. Implementation of these Recommendations is expected to improve patient experience, access to palliative services, and the use of healthcare resources.

Scope

The recommendations in this document relate to adults with a progressive, life-limiting illness, and for their family and caregivers, and who have been identified as potentially benefitting from a palliative care approach. Within the scope of this work are individuals living at home, which is defined as their usual place of residence and includes the patient's home, retirement residences, assisted living and long-term care facilities. It is acknowledged that throughout the trajectory of illness, this patient population will be receiving care at home, in outpatient settings, and, occasionally, in inpatient settings. The recommendations apply to First Nations Inuit and Metis (FNIM) communities, Francophone, other culturally sensitive populations. As well, in scope for these recommendations are homeless and vulnerably housed patients. The absence of stable, livable home adds another level of complexity to care. Palliative care for vulnerably housed means that care may be provided in different settings, such as shelters, clinics, and streets.

While it is recognized that those who are in the last year of their life will comprise the largest portion of this population, these recommendations will be equally applicable to those who are anticipated to live longer than one year but also may benefit from a palliative care approach.

Future areas of focus will include

- Adult patients in a hospital setting (e.g. acute and complex continuing care)
- Pediatric patients receiving palliative care (all settings)

For the purposes of this work, the Working Group has adopted the following definitions of these key terms:

- Hospice palliative care is a philosophy of care that aims to relieve suffering and improve the quality of living and dying. It strives to help individuals and families to:
 - address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears
 - prepare for and manage end-of-life choices and the dying process
 - cope with loss and grief
 - treat all active issues
 - prevent new issues from occurring, and
 - promote opportunities for meaningful and valuable experiences, and personal and spiritual growth⁴.
- Family consists of those closest to a person in terms of knowledge, care, and affection, and may include biological family, family through marriage, or family of choice and friends. The

⁴ Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action

person with the progressive, life-limiting illness defines their family and who will be involved in their care.⁵ For FNIM, the community has historically been comprised of a larger circle of support, i.e. kinship system that includes the extended family, larger community and Elders.

- A ‘caregiver’ is an unpaid person who provides care and support in a nonprofessional capacity, such as a family member, a friend, or anyone else identified by the person with a progressive, life-limiting illness. Other terms commonly used to describe this role include care partner, informal caregiver, family caregiver, carer, or primary caregiver.⁶
- Primary level palliative care is defined as services provided by clinicians and other care providers who have basic training in palliative care. They provide basic palliative care services to help manage the needs of patients and their family/caregivers.
- Specialist level palliative care is defined as services provided by clinicians who have advanced training in palliative care. The role of specialist palliative care services includes providing direct care to patients with complex palliative care needs, and providing consultation services to support, advise and educate non-specialist clinicians who are providing palliative care.⁷

Principles for Palliative Health Services Delivery Framework

In developing the Recommendation, the Working Group agreed to a number of guiding principles. Specifically, the palliative care models of care should:

- Centre around the needs and values of individual patients, families, and their caregivers acknowledging cultural sensitivities
- Respect and support the important roles of family members and other caregivers outside the formal health care system
- Enable equitable, high-quality, culturally safe, coordinated care as close to home as possible to all of the population in need.
- Ensure that inter-disciplinary team members have the necessary competencies (including cultural competence) and work to their full scope of practice
- Ensure that capacity building is embedded within the framework to ensure a sustainable system of care for the future.

Recommendations

With the focus on adults receiving palliative care at home, these recommendations envision a model where the patient and family/caregiver care is provided a) by a primary level palliative care team with consultation from specialized palliative care providers when needed, b) in a close collaboration between primary and specialist teams..

The most responsible provider (MRP) should be identified through dialogues between primary and specialist palliative care teams. These recommendations aim to clarify the roles of healthcare

⁵ HQO Palliative Care Quality Standard

⁶ ibid

⁷ National consensus statement – Australia 2015

providers to ensure person-centred and continuous care for patients in need for palliative approach. The Patients and family/caregivers are partners in the decision making throughout this journey.

Early Identification, Assessment of Needs, and Coordination

Early identification of palliative care needs of both patients and their family/caregivers and timely access to services, are critical to setting care goals and engaging necessary services to provide high quality care.

Given the complex nature of palliative care and the fact that the provision of palliative care services involves multiple teams and providers, coordination of these services is a critical success factor. Within the current stated there are a variety of designated 'coordination roles'. These have titles such as, "intake coordinator", "community care coordinator", "case manager" or "aboriginal patient navigator". What this model recommends is a functional definition of care coordination that includes:

- Intake and coordination of initial assessment
- Establishment of palliative care services based on assessed needs
- Identification and confirmation of the most responsible medical provider
- Ongoing monitoring of needs and accessing services based on changes in needs
- Ensuring access to supports for family and caregivers

This model envisions that at any one point during the patient and family journey, there will always be an individual identified who is functioning as the care coordinator, irrespective of any other titles they may hold. The key requirement for this role is that the individual has the skills and systems knowledge to perform this function. The specific individual may be from any of a number of professions, e.g. nursing, medicine, social work, and may be serving in other roles in the patient's care team. The care coordinator is able to follow the patient and family across care settings to assist in the maintenance of seamless care with smooth transitions between care settings. The specific individual may change during the patient's journey depending on the patient's location or complexity of needs. The key issue is that if there is a change this is clearly communicated to the patient, family, caregivers and to the members of the interdisciplinary team.

Early Identification of Needs for a Palliative Approach and Accessing Care

1. All member of the patient's current care team (family physician, hospital team, home and community care providers, etc.) should use validated approaches to ensure early identification of patients who would benefit from a palliative approach to their care.
2. Identified patients and their families/caregivers should be referred to a centralized referral and navigation system in order to initiate identification of needs, care planning and establishing their primary care team. The referral and navigation system may be housed in a variety of agencies depending on regional needs and resources.

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Assessment of Needs

3. During the intake process, a coordinator is responsible for ensuring a detailed assessment of the needs of the patient and their family/caregivers, determining the MRP and allocating services. If services are not required at the time of assessment, the patient will remain registered to the program as case management only.
4. The coordinator should ensure the assessment of family/caregiver circumstances to determine the level of their participation in patient care and identify the need for support, training, education, and information.
5. A coordinator with expertise in managing care for vulnerable populations should assess the needs of the patient and connect with appropriate healthcare and social services.

Care Coordination

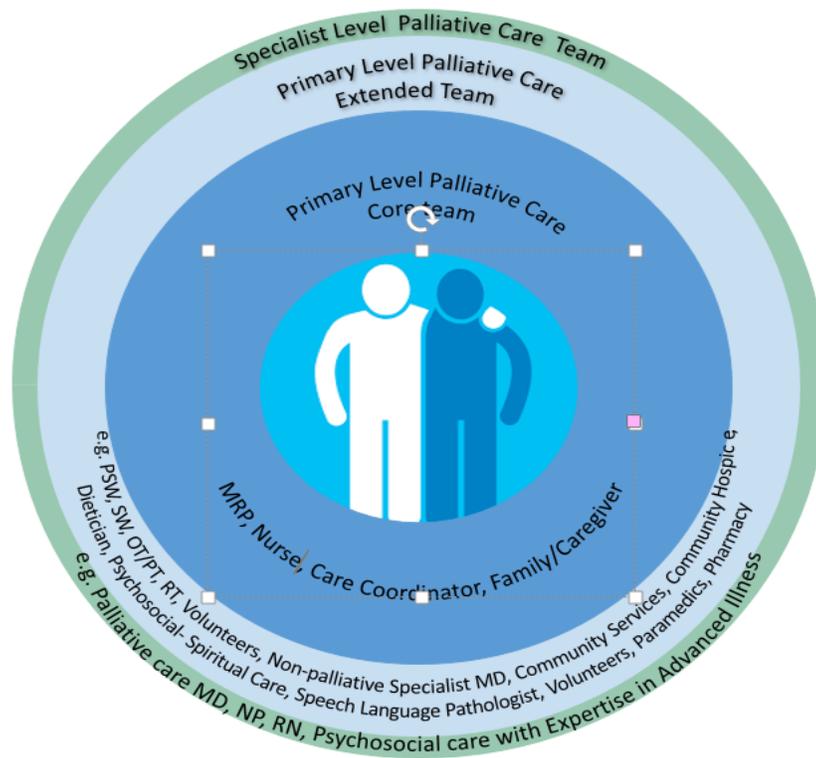
6. Upon assessing the needs of the patient and the family/caregivers, the Coordinator will make referrals to appropriate services and teams. This will include identification and confirmation of the core primary care team (MRP, nurse and ongoing care coordinator) as well as the secondary level experts who will be available to that primary level team.
7. When working with culturally diverse populations, every effort should be made to connect the patient and family/caregivers with interpreter services (French, First Nations, Inuit, and other), if needed, to ensure that the information is clear and understandable.

[Rationale for Recommendations Related to Assessment of Patient and Family/Caregiver Needs](#)
[Insert a paragraph]

Palliative Care Team

Patients and families have been shown to have better outcomes from palliative care when care is provided by a collaborative, interdisciplinary team⁸. Members of the team are depicted below in Figure 1. Clarity of team roles and well-established mechanisms of communication are critical to ensuring that care is well coordinated and delivered by the most appropriate provider.

⁸ H.Seow et al (2014)



The primary level palliative care core team acts as first-line support for patients and their family/caregivers. A small team of primary level palliative care providers – a care coordinator, an MRP (MD or NP), a nurse (RN or RPN) and the family/caregivers, act as the core team. This team should be in place for every patient. These recommendations envision that for long-term sustainability, the MRP will ideally be the patient’s family physician.

An extended primary level palliative care team includes personal support workers (PSW), pharmacy, volunteers, PT/OT, social workers, spiritual care providers, and community hospice and community service agency providers. It also includes specialist teams in other medical fields, e.g. those providing care to patients with cancer as well as chronic illnesses such as heart, lung, renal diseases, etc. The members of the extended primary level palliative care team are brought in as needed. All primary level team members of both core and extended team, who are health care providers, should have and maintain primary level competency in palliative care.

The specialist teams are involved on an ‘as needed’ basis. Members of the specialist palliative team may include an MD, NP, RN, All members of the specialist team should have and maintain secondary or tertiary level competencies in palliative care (see Appendix D). The key roles of the specialist palliative care team are:

- a. Providing consultation, both formal and informal,
- b. Providing education and mentorship to primary level palliative care providers, both formal and informal,
- c. Contributing to capacity building activities within regions and care communities and working in partnership with Regional Palliative Care Programs, and,
- d. May be a primary provider (MRP) in instances where care needs are complex.

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8. All patients with palliative care needs and their family/caregivers should have 24/7 access to a core primary level team. Every attempt will be made to find a primary care MD or NP for a patient who has a life limiting illness.
9. Within the primary care palliative care team, the role of care coordination should be clearly identified. A designated Community Care Coordinator will be responsible to ensure that all elements of the care plan are implemented by the most appropriate team member and that team members understand each other's roles. Community Care Coordinator should engage members of the extended primary team as their services are required
10. A specialist palliative care team should be available to support/consult the members of the primary level team. The primary level team will have 24/7 access to the specialist team for medical issues and support.
11. Indicators which would suggest that the primary level team may need assistance from one or more members of the specialist level team include:
 - a. One or more symptoms remain uncontrolled despite the use of best primary level practices to manage that symptom(s).
 - b. Tertiary interventions are required to manage symptoms (e.g. radiation, surgery, interventional symptom management, and hospice or hospital admission for symptom management).
 - c. Clinical syndromes or co-morbidities that require specialized expertise.
 - d. Psychological distress for patients or caregivers that remains unresolved despite use of best practices at the primary level to address it.
 - e. Complex social conditions that require additional expertise to manage and/or plan.
 - f. Establishing goals of care or a care plan remains challenging despite best efforts to do so or is complicated by difficult ethical issues.
 - g. Repeated ER visits and/or hospitalizations because of exacerbation of symptoms or other reasons for distress.
 - h. Patient care needs exceed the physical or emotional capacity of the family and informal caregiver(s).
12. The specialist team should provide consultation in-person or via telephone or other technologies (e.g. OTN, email, eConsult) across all of the domains of palliative care (or medical issues).
13. Both the primary and specialist level palliative care teams will have access to the documentation of the patient's care plan and ongoing care details. They will also participate in a clear communication process to ensure good coordination and understanding of the care plan.
14. Interpreter services should be available to First Nations, Inuit, Francophones, and representatives of other cultural/ethnic groups if requested.

Rationale for Recommendations Related to the Composition of the Palliative Care Team

[Insert a paragraph]

Planning

Care planning starts immediately after the initial assessment of patient and caregiver needs. Care planning needs to be based on informed decisions and choices by and on behalf of the patient. Most importantly, care planning needs to be preceded by a conversations with patients, their substitute decision makers and their family members about the patient's current health status and the treatment and care options. Previous advance care planning can be valuable to inform these conversations. These conversations should be culturally appropriate and safe and lead to an understanding of the patient's goals of care, which inform the specific elements of the care plan and ensure that the needs of the patient and family are met.

15. The primary level team should identify and confirm the Substitute Decision Maker with the patient. This may be based on a previously completed Power of Attorney for Personal Care or on the provincial hierarchy of Substitute Decision Makers.
16. The physician/NP along with other members of the primary level team should engage the patient, family and substitute decision maker(s) in a discussion about goals of care. This will involve a discussion about the patient and family's understanding of the illness, prognosis and treatment options. This conversation will need to be sensitive to the patient's and family's readiness and for engaging in care planning. These conversations may need to be revisited at times when the patient's condition changes.
17. Guided by the goals of care, the primary level team with the patient, family and caregivers will develop a plan of care.
18. The MRP will be responsible for implementing the medical aspects of the care plan. The care plan will be documented and available to the patient, family and caregivers as well as all of the members of the primary level team. The care plan and documentation will be updated regularly.

Rationale for Recommendations Related to Planning Palliative Care

[Insert a paragraph]

Delivery of Care

The care plan will establish roles and tasks for which the members of the primary level team will be accountable. Palliative care services should be available to patients and their family/caregivers 24/7.

19. Where appropriate, technology-based healthcare services (e.g. OTN virtual services, PCVC⁹, e-shift) should be leveraged to bridge current service gap and improve access to services for rural and isolated communities.

Physical and Disease Management

20. The primary level team RN should provide pain and symptom management in collaboration with the MRP.
 - a. RN should provide day-to-day symptom assessment, management and monitoring.

⁹ PCVC – personal videoconferencing

- b. RN or RPN with RN supervision should conduct tasks associated with symptom management (e.g. management of tubes and infusion pumps, wound care) in collaboration of the primary level physician or NP. With appropriate training and education, family/caregiver, if willing and able, may carry out some tasks with guidance from the RN.
 - c. MRP on the primary level core team should be responsible for prescribing medications and ordering treatments which require such an order. MRP may seek consultation on new medication orders from a specialist team (MD or NP).
 - d. The primary team RN should regularly assess cognitive and functional needs of the patient. When issues cannot be addressed by the core team, the RN should consult with OT/PT or other appropriate extended team members and arrange service as needed.
21. RN on the core team should assess and monitor and manage the patient's underlying illness(es) under the supervision of the family physician or NP. In cases when the primary level care team cannot meet the disease management needs, MD or NP should seek consultation with a specialist team member or with a disease-specific specialist (e.g. cardiologist, nephrologist)

Psychological, Social and Spiritual

22. RN and or MD/NP on the primary level care team should provide culturally sensitive support and counselling for psychological and emotional needs (e.g. fear, anxiety, and depression) of the patient and their family/caregivers.
23. When the psychological distress for patients or caregivers remains unresolved despite best efforts to address them, the member of the primary level team who has the function of care coordination should seek assistance from other members of the extended primary team such as a social worker, spiritual care provider, hospice staff or other providers of psychosocial/spiritual care.
24. Where needed a Social Worker should assess legal, financial, and other social issues and consult or refer to financial/legal consultant, or other appropriate professionals.
25. For complex social conditions that require additional resources to manage and/or plan (e.g. unstable housing, complex family dynamics), the Social Worker or a Community Care Coordinator should seek consultation with other appropriate professional and/or coordinate with specialized services such as shelters, flexible homes, etc.
26. A member of the primary level palliative care team should assess spiritual needs of the patient and their family/caregivers, such as existential concerns, rites and rituals. Spirituals care providers, specific to the faith communities or beliefs of patients and families, should be engaged where needed. If needed, appropriate spiritual care providers should be engaged to address more complex needs.
27. The needs of the patient, nearing end of life should be re-assessed and appropriate services, such as financial, psychological, legal and spiritual care should be organized to provide comfort to dying patient.
28. Placeholder: Statement about the role of community hospice

Practical

29. After assessing the needs for assistance with ADL and IADL, the Community Care Coordinator should connect with PT/OT, Personal Support Workers and volunteers. The intensity of personal support should be determined using the Levels of Care framework and re-assessed as the functional status of the patient continues to deteriorate, or as the patient's circumstances change.

End of Life/ Death management

30. As the patient enters the end of life phase of illness, primary team members should revisit the conversation about goals of care in order to confirm or adjust the elements of the care plan that need to be adapted in recognition of a change in the patient's status.
31. End of life care needs for the patient, family and caregivers need to be assessed by primary team members and services adjusted to meet those needs. Issues such as preferred place of death and plans for pronouncement of death should be discussed and planned at reasonable intervals, recognizing that the preferences may change nearing end of life.

Loss and Grief

32. Bereavement support and loss and grief counseling should be provided to the family and caregivers throughout the journey and after the death of the patient, in a respectful and culturally sensitive manner. Bereavement information and education should be available, as well as one-on-one counseling and/or group sessions, which should be provided in accordance with the needs and preferences of the family/caregivers.

Supports for Family and Caregivers

Family and informal caregivers are key members of the primary level team. Studies show that only 10% of end of life care is provided by the formal healthcare system and the rest (90%) is provided by family and caregivers (ref). Their roles range from just being a family to providing patient advocacy and navigation to medical care and emotional support. Supporting family and informal caregivers and preventing burnout is key to maintaining this valuable resource and supporting care at home.

33. The primary team should provide information about informal caregiving to all identified caregivers; which includes but is not limited to what to expect/anticipate, as well as when and who to call for information services and/or support.
34. The primary team members should regularly assess the needs of the family and caregivers. These needs may involve the domains of emotional, informational and practical needs. The ability of the family and caregivers both physically and emotionally to care for the patient needs to be regularly assessed.
35. The Community Care Coordinator will work with the patient and family to address and determine their needs, and provide access where possible to services to meet their needs.
36. When patient care needs exceed the physical or emotional capacity of the caregiver(s), the Community Care Coordinator or RN should determine the levels and types of services necessary to provide respite and support to the family/caregivers. This could include pre planned process

to access inpatient admission while avoiding the ER, additional respite services, access to paid providers for respite and additional care needs.

[Insert a paragraph]

Rationale for Recommendations Related to Supports for Family and Caregivers

Palliative Care for First Nations, Inuit, and Metis (FNIM) Population

FNIM communities face unique challenges when diagnosed with a life limiting illness. Geographic isolation, lack of services, language barrier, housing and food insecurity, lack of trust for healthcare providers and lack of understanding in cultural beliefs, values and end of life practices of FNIM communities, pose significant challenges to access to palliative services.

This document recognizes that the overall recommendations address some palliative care needs of FNIM communities, however it includes the section below to highlight specific issues unique this population,

37. In effort of harmonizing healthcare services, a collaborative approach should be used to bring together traditional and western medicine. Healers and Elders should be consulted for medical, psychosocial and spiritual needs, where requested by Aboriginal patients.
38. Aboriginal Patient Navigators should play an important role in connecting the patient and the family/caregivers to culturally appropriate palliative care. Involving them early will contribute to better coordination and continuity of care. Patient Navigators' role includes helping with discharge planning, arranging language and cultural translation services, and connecting with traditional healers.¹⁰
39. Palliative care outreach teams should be used to provide home based palliative care. Comprised of Palliative MD/CNS, and psychosocial/bereavement worker, the outreach team works closely with the local primary care.
40. Care coordinators should work closely with inpatient care settings and local health and social programs to ensure continuity of care for patients living on and off-reserve.

Rationale for Recommendations Related to Palliative Care for FNIM Populations

Notes: Outreach teams (Six nations) GIPPEC

Implementation Considerations

Transitioning from current state to future state

- Evolution of existing models and culture of care
- Engaging primary care

¹⁰ FN advisory cmtee (2017_) Home and community care in First nations Communities in Ontario

- Transition of specialist roles

Funding

- Physician funding and incentive structures (AFP)
- Community funding envelope for palliative care including training and capacity building

Information Systems

- single clinical platform/information system (EMR); Documentation and access to information

Capacity building

Importance of sustainable roles, and succession planning as with the current climate of retirement, we are at risk of loss of a great volume of knowledge exiting the system (seasoned RN's, RPNs and PSW's in particular)

- Training and Education, Ensuring that palliative capacity is built across the three levels of service delivery; primary care, secondary care and tertiary/quaternary care.
 - Role of Specialist Palliative care team in capacity building (for Primary care)
 - Cultural competence –general and priority populations
 - Role of PPSMC in education and capacity building
 - Lack of knowledge about existing role and resources;
 - Knowledge of existing services for FNIM communities
 - Educate patients on specific types of care using different formats (online, in person training, pamphlets) considering different learning needs for family/caregivers
 - Training modules for PSW, volunteer and other non-regulated providers
- Availability of interpreter services
- Availability of volunteers in hospice palliative care
- Increase capacity for home visits (Primary care providers do not conduct home visits – can they bill?); visiting nurses (has there been government investment in this?), consider outreach teams and e-shifts. reluctant to go on to on reserve communities (FNIM)

Standardized tools/ mechanisms

- Centralized care coordination and navigation (this is key particularly to effective transitions). Development of a standardized tool/algorithm for triage for palliative care.
- Care plans for providers as well as patients and family/caregivers; leveraging Healthlinks collaborative care plans
- Identifying patients. Determining how to track referrals to and services accessed through the central navigation and coordination system by system user; provider, patient, caregiver, other?
- Protocol for FNIM to return home to die

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- Communication tools are key in effective transitions between settings
- Communication tools for patients, e.g. palliative care passport, palliative care binder, circulatory sheet of paper etc. – considering patients and their family's desire for information. Availability in several languages (French and main ethnic minorities).
- Between providers – eConsult, EMR, Palliative MCCs

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Appendix B: Glossary

Term	Definition
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Advance Care: Plan (ACP) Care Plan Goals of Care Care Wishes Power of Attorney	
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Substitute Decision Maker	
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Care plan

Palliative specialist Care coordinator Nurse Navigator	
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Appendix C: Providers and their Roles

Service	Description	Primary level	Specialist level
Personal support			1.
Symptom management		RN, NP, under supervision of MD	
Navigation/co ordination		Care coordinator, nurse, social worker, Physician	1.
Final Decisions on treatment/care		MRP (physician or NP)	1.

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Acknowledgements

OPCN would like to acknowledge the contribution and expertise of the working group that developed this document.

[Palliative Health Service Delivery Framework Working Group](#)

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