

1.0 Introduction

This proposal is in response to the Ministry of Health and Long Terms Care’s call to submit proposals for projects that will improve access to hospice and palliative care for homeless Ontarians. This proposal aligns with the key principals of hospice and palliative care, as articulated in the Palliative and End-of-Life Provincial Roundtable Report and the Declaration of Partnership and Commitment to Action.

The ‘Palliative and End-Of-Life Care Provincial Roundtable Report’ (2016) identifies that a number of Ontarians face additional barriers to accessing appropriate palliative and end-of-life services, particularly people who are homeless. The report suggests that “an effective equitable palliative and end-of-life care strategy must acknowledge the challenge of providing care to pediatric, Indigenous, Francophone, LGBTQ, differently-abled and homeless patients, and develop unique approaches to meet their needs”¹.

Further, the ‘Declaration of Partnership and Commitment to Action’² sets the vision for hospice palliative care in Ontario as:

Adults and children with progressive life-limiting illness, their families and their caregivers will receive the holistic, proactive, timely and continuous care and support they need, through the entire spectrum of care both preceding and following death, to:

- *help them live as they choose, and*
- *optimize their quality of life, comfort, dignity and security*

Attaining this vision will have a profound impact on homeless and vulnerably housed populations who currently may not have the same access to the holistic, proactive, timely and continuous hospice palliative care and support that they require in order to optimize their comfort, dignity and security.

2.0 Description of Waterloo Wellington Initiative – ‘Enhanced Palliative Care for Homeless Populations’

2.1 Goals of the Initiative

The goal of this initiative is to ensure equitable access to comprehensive palliative care for homeless and vulnerably housed individuals in Waterloo Wellington to help them receive care in a manner and space that optimizes their quality of life, comfort, dignity and security. This

¹ Palliative and End-Of-Life Care Provincial Roundtable Report - A Report from Parliamentary Assistant John Fraser to the Minister of Health and Long-Term Care (March 2016)

² Advancing High Quality, High Value Palliative Care in Ontario - A Declaration of Partnership and Commitment to Action (December 2011)

model is based on the foundations of the need for early identification of patients who would benefit from a palliative approach to care (i.e. those with a life limiting illness who are in their last year of life) and of enabling the delivery of and/or access to hospice palliative care in a manner that is supportive of an individual's life circumstances. Additionally, this model is supported by broader work across the WW health care system to enhance the capability of primary care providers to deliver a palliative approach to care and to have streamlined access to secondary hospice palliative care expertise when required. By creating mechanisms/ structures/resources to bring the primary care providers, who have knowledge and skill in delivering a palliative approach to care to the homeless/ vulnerably housed individual, this model will optimize the delivery of a palliative approach to care to homeless individuals.

One key focus of the proposed model is to enhance the knowledge about a palliative approach to care, identification of the need for a palliative approach to care and how to refer for hospice palliative care support amongst shelter and community outreach workers. Enabling the shelter and community outreach workers to be "palliative informed" will enable the delivery of the required care in the place where these individuals are with those whom they are comfortable. The experiences of those who work with homeless populations are that the required care will not be accessed if it is only available from unfamiliar people in unfamiliar places. This initiative will educate individuals currently working with this population to identify the need for a palliative approach to care, to know the dimensions of a palliative approach to care and then will support them in either addressing or referring to services that can address the dimensions of a palliative approach to care.

A second key focus is to build capacity in acute care, ED and ambulatory care settings to address the needs of this population in a way that is sensitive to the circumstances of the individual and that enables optimal quality of life, comfort, dignity and security. This model will leverage existing and trusting relationships to support the delivery of required hospice palliative care in settings and by individuals outside of the individuals trusted circle and in settings that may be unfamiliar/uncomfortable to the individual. Through education about the specific needs of the individual and behavior management techniques, shelter and community outreach workers can support primary and acute care providers to successfully address the palliative/pain and symptom management needs of the individual and to successful transition the individual to the next care setting with a comprehensive coordinated care plan.

2.2 Proposed Approach

An environmental scan is currently being completed including existing resources, services and structures to deliver palliative care to homeless individuals, referenced best practices and leading practices from other jurisdictions. The results of this scan and resulting needs analysis will further inform operationalization of this model.

A nurse practitioner (NP), with hospice palliative care experience will be recruited to deliver the proposed model of care. The nurse practitioner, by linking with existing structures, including HealthLinks, Specialized Medical Addictions and Mental Health Outreach Services, Connectivity Tables, CHC programs, shelter and outreach services etc., in each of the four sub-regions of the Waterloo Wellington LHIN will support the following activities:

1. Provide direct hospice palliative care services to the target population including identification and assessment of the need for a palliative approach to care, medical/clinical care, care coordination/facilitation of HPC delivery in situ, harm reduction/risk assessment and management and supported transitions between care settings/providers.
2. Capacity and relationship building in:
 - A. Shelter and Community Outreach System to support:
 - the development of an understanding of the dimensions of a palliative approach to care
 - identification of individuals who would benefit from a palliative approach to care
 - referral to a community service to address the dimensions of a palliative approach to care and/or more complex HPC needs
 - B. ED/Acute Care to support management of palliative homeless population to achieve effective pain and symptom management

2.3 Expected Outcomes

The expected outcomes of this initiative include:

- Enhanced knowledge about a palliative approach to care, identification of the need for a palliative approach to care and how to refer for hospice palliative care support amongst shelter and community outreach workers
- Enhanced capacity in acute care, ED and ambulatory care settings to address the needs of homeless populations in a way that is sensitive to the circumstances of the individual and that enables optimal quality of life, comfort, dignity and security by leveraging existing and trusting relationships to support the delivery of required hospice palliative care.
- Risk mitigation to support delivery of HPC patients who are vulnerably or precariously housed
- Supported discharges and care transitions from ED/acute care vis a vis coordinated, comprehensive care planning

3.0 How the Initiative will Strengthen Hospice Palliative Care for Homeless Populations in Alignment with the Palliative and End-of-Life Care Provincial Roundtable Report and Declaration of Partnership & Commitment to Action

The following table describes how this proposal will strengthen hospice palliative care for homeless populations in alignment with goals and priorities described in the ‘Declaration of Partnership and Commitment to Action’³ and The ‘Palliative and End-Of-Life Care Provincial Roundtable Report’ (2016) / First: Action Plan for Health Care and Patients First: A Roadmap to Strengthen Home and Community Care.

Goals & Priorities for Palliative and End-of-life Care Described in the ‘Declaration of Partnership and Commitment to Action’	How ‘Enhanced Palliative Care for Homeless Populations in Waterloo Wellington’ will Strengthen Hospice Palliative Care for Homeless Populations
<p>Quality - To improve client/family, caregiver and provider experience by delivering high quality, seamless care and support</p>	<p>By delivering care in situ by the preferred, trusted providers, the experience of homeless and vulnerably housed populations will be enhanced. Providers will be empowered with enhanced knowledge of a palliative approach to care and knowledge of how to access existing high quality community hospice palliative care services and supports that can be delivered in a manner that is sensitive to the palliative care needs and life circumstances of the individual.</p> <p>Quality of care / patient outcomes will be enhanced by ensuring that supportive strategies are utilized when pain and symptom management is required in the ED, acute and ambulatory care settings.</p> <p>Additionally, formal relationships will be developed within each subRegion to identify secondary HPC support for the target population.</p>
<p>Population Health - To improve, maintain and support the quality of life and health of people with progressive life-limiting illnesses</p>	<p>By developing a model of care and services that are sensitive to the unique needs of homeless and vulnerably housed individuals, the quality of the last year of their lives will be enhanced. Specifically, by empowering shelter and outreach workers will be empowered to understand the dimensions of, and the need for, a palliative approach to care, in a way that respects and maintains the comfort, dignity and security of homeless individuals, leading to improved quality of life for the target population.</p>
<p>Sustainability - To improve system</p>	<p>By taking a subRegion approach to the development,</p>

³ ADVANCING HIGH QUALITY, HIGH VALUE PALLIATIVE CARE IN ONTARIO - A Declaration of Partnership and Commitment to Action (December 2011)

<p>performance by delivering better care more cost-effectively and creating a continuously self-improving system</p>	<p>implementation and on-going improvement of a system to support enhanced access to palliative care for homeless populations, existing structures, programs and relationships will be optimized. Specifically, HealthLink, Connectivity Tables and Primary Care Tables will be leveraged to support enhanced care for homeless populations with palliative care needs Regional performance/outcomes will be monitored by the WW Integrated Hospice Palliative Care Program.</p> <p>A Homeless HPC Collaborative will meet quarterly to share lessons learned and support knowledge translation and spread across the region.</p>
<p>Expand access and equity in the palliative system</p>	<p>This proposal describes a comprehensive approach to hospice palliative care that will expand equitable access to hospice palliative care for homeless and vulnerably housed individuals by supporting delivery of the required care earlier and in the setting and by the individuals who are best positioned to taking this care to them.</p>
<p>Establish clear oversight and accountability</p>	<p>Oversight and accountability for this care will be embedded within existing WW Integrated Hospice Palliative Care Regional Program structures.</p>
<p>Introduce new supports for caregivers</p>	<p>This proposal will enhance supports for the caregivers of these homeless individuals who are often health and social service partners (e.g. housing service agencies, and shelters) and other community representatives by empowering them with the knowledge to identify the need for a palliative approach to care and how to access the required hospice palliative care services</p>
<p>Support enhanced public education</p>	<p>Not a major focus of this initiative.</p>
<p>Implement a comprehensive approach to palliative and end-of-life care at home and in the community</p>	<p>This proposed model addresses the needed capacity to serve the palliative care needs of homeless individuals across both the shelter/community out-reach system and the health care system. By empowering the individuals that are closest to the target population with the knowledge to address the palliative and end-of-life care needs AND by supporting the traditional health care system to meet the unique needs of this population in a sensitive and meaningful way, this comprehensive model will support enhanced delivery of palliative care to this population in the community.</p>

4.0 Key Project Partners

4.1 Working Group

Health Partners	Andrea Simard Simard	Paramed
	Chris Bigelow	WW Palliative Pain & Symptom Management Consultant
	Nancy DiPietro	Langs Community Health Centre & Cambridge Health Link
	Kerry-Lynn Wilkie	
	Eric Goldberg	Kitchener Downtown Community Health Centre
	Laura Greenway	Right at Home Canada
	MacDonald, Janice	Guelph General Hospital
	Rachael Halligan	Clinical Co-Lead, WW Integrated Hospice Palliative Care Regional Program
	Shobbrook, Cindy	
	Philippi, Blair	Waterloo Wellington LHIN
	Farwell, Sarah	
	Kim Robinson	Innisfree and Lisaard House
	Judy Nairn	Hospice of Waterloo Region
	Jan Klotz	Guelph Community Health Centre
	Raechelle Devereaux	
	Royanne Gale	Care Partners
	Shelley Fraser	Bayshore
	Nael Abumustafa	Grand River Hospital
	Shelly Redman	
	Suzanne Trivers	Mount Forest Family Health Team & Rural Wellington Health Link
Tracy Croft		
Todd Fraleigh	Hospice Wellington	
Jennifer Fillingham	Centre for Family Medicine & KW4 Health Link	
Jennifer Mains	The Working Centre	
Social Service Partners	Amber Robertson	Region of Waterloo
	Julie Wheeler	
	Ashley Grinham	House of Friendship
	Pam M	
	Ron Flaming	
Stuart Beumer	County of Wellington, Social Services	
Community Members	Tanya Darisi	The O'Halloran Group
	Members of the Participatory Action Group	

4.2 Consulting Stakeholders

Stakeholder	Sector/Role
Lori Hasulo	Physician with Guelph CHC with a long history of serving the homeless population
Dr. Ian Digby WW LHIN ED Physician Lead Kim Crawford Director ED, Guelph General Hospital Jill Schitka Director ED, Grand River Hospital	Emergency Department

Cathy Middleton	YMCA Emergency shelter for women, supportive housing
Rob Smith	SHOW (Supportive Housing)
Gayle Hoekstra	Director of Guelph Shelter
Gayle Parker	NP supporting Cambridge Shelter
Heather Kerr , Don Roth, Raechelle Devereaux	SOS (Guelph Community Health Centre)
Rumball, Jackie	NP delivering weekly outreach clinics at the Welcome In Drop In in Guelph, as well as the Wyndham House youth shelter program
Community Members	Key / Coordinating Contact
Community Voices Project (Part of Guelph & Wellington Task Force on Poverty Elimination)	Dominica McPherson
Participatory Action Group	Bradley Berg
Cambridge Shelter Corp	Gayle Parker
Hospitality House	Barb Crockard

5.0 Key Risks and Mitigation Plans

A key risk to this initiative is the inherent risk to all one-time funded initiatives i.e. the start-stop-start cycle. This risk will be mitigated by setting the clear expectation with system stakeholders that the model is temporary pending evaluation and on-going funding from the Ministry of Health. This risk will also be mitigated by linking service provision with existing providers who have existing relationship with the target populations so as to minimize the start-up/orientation time. Finally, this risk will be mitigated through the core focus on capacity building in that at the end of the project the participating agencies will have enhance resources/skills and knowledge that can be embedded into their longer term practices.

Another key risk is the limited funding available to support the significant and vast palliative care needs of this population. To mitigate this risk, the project will be scoped and scaled according to the relative homeless population in each region. Additionally, sub-regions may decide to prioritize certain aspects of the proposed model given local needs.

6.0 Project Implementation Plan

6.1 Key Timelines & Milestones

WW IHPC Activities	Date	MOH Activities
Final Proposal Submission	March 15, 2017	
MOH Evaluation of Proposals	March 2017	
Continued Stakeholder Engagement		
Recruitment of Nurse Practitioner	April 2017	Mentorship and regular networking/meetings to build capacity as projects are implemented
Design of Sub-Region Plans		
Notification to Successful Applicants		
Baseline Measurement		
Implementation of Sub-Region Plans	May – Dec 2017	
Initiation of NP Secondment		
End of NP Secondment	November 2017	
Evaluation of Outcomes	November – December 2017	
	December 2017	Provincial forum to showcase projects and share best practices in the final phase of the projects
Final Report (including funding requirements to sustain the project) to the MOH	January 2018	
	February 2018	Ministry to consider potential phase 2 funding to sustain models of palliative care for homeless Ontarians

6.2 Deliverables

1. Greater understanding, by health/social service providers and planners, of the nature and extent of palliative care needs of homeless/precariously housed individuals in each sub-region.
2. Mechanism to link with Health Link teams, community outreach teams and/or to activate a Coordinated Care Plan to support homeless/precariously housed individuals with palliative care needs.
3. Improved access to primary and secondary palliative care services for homeless/precariously housed individuals in each sub-region.
4. Enhanced knowledge and skills amongst outreach workers/shelter staff regarding a palliative approach to care and existing services in each sub-region.



5. Consistent, best practice approach to support emergency departments and acute care hospitals to address the palliative pain and symptom management needs of homeless/ precariously housed individuals including accompaniment.

6. Regional process to support risk assessment and mitigation in situations when homeless/precariouly housed individuals require palliative care.

6.3 Performance Metrics to Evaluate the Success of the Project

- Increased # of palliative (i.e. in their last year of life) homeless / vulnerably housed individuals on Health Link coordinated care plans
- Number of homeless/precariouly housed individuals served by this project
- Number of providers receiving education
- Reported improvement in the knowledge and experience of shelter and outreach workers in identifying and addressing palliative care needs
- Reported change in practice /policies of shelter and outreach workers in identifying and addressing palliative care needs
- Reported change in experience of homeless / vulnerably housed individuals
- Reported change in experience of shelter and outreach workers
- Number of consultations to other providers provided
- Number of homeless/precariouly housing situations undergoing risk assessment/management to address a palliative care need

7.0 Budget

Amount	Activity
\$70,000	6 month secondment of a 1.0 FTE Hospice Palliative Care Nurse Practitioner
\$30,000	Education/Capacity Building

8.0 Letters of Support from Key Partners including the LHIN and Regional Palliative Care Program

Letters of support from key partners including the WWLHIN (Gloria Cardoso) and the executive co-leads of the WW Integrated Hospice Palliative Care Regional Program (Susan Robertson and Gloria Cardoso) are included in the e-mail accompanying this submission.

9.0 Applicant Contact Details

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