### Evidence-Informed model of palliative care

**THE PATIENT IS THE CENTRE OF ALL THAT WE DO**

<table>
<thead>
<tr>
<th>Agreement between specialty team &amp; primary care on desired level of support</th>
<th>Core support/advocacy from volunteers, family and friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circle of care involvement (including patients/family/caregiver, and volunteers)</td>
<td>Trusting relationship</td>
</tr>
<tr>
<td>Primary care physician and nurse involvement throughout care trajectory</td>
<td>Conflicts resolution</td>
</tr>
<tr>
<td>Right provider, right time</td>
<td>Shared care arrangement</td>
</tr>
<tr>
<td>Consultation and mentoring</td>
<td>Palliative care embedded in educational programs</td>
</tr>
<tr>
<td>Evidence building – targeted % of providers by sector (includes education &amp; research)</td>
<td>Incentives for specialty training (financial &amp; non-financial)</td>
</tr>
<tr>
<td>Accreditation of facilities</td>
<td>Patient, family/caregiver confidence</td>
</tr>
<tr>
<td>Evidence Based practice guidelines</td>
<td>Standard tool to capture/share data</td>
</tr>
<tr>
<td>Specialty-trained primary care physicians nurses, PSWs</td>
<td>Service contracts reflect competence requirements</td>
</tr>
<tr>
<td>Human resources planning to ensure cultural/linguistic care provision as needed</td>
<td>Community-based basic competency (primary care &amp; staff within community agencies)</td>
</tr>
<tr>
<td>Methods: online resources, workshops, learning networks</td>
<td>Palliative care embedded in educational programs</td>
</tr>
<tr>
<td>Patient, family/caregiver confidence</td>
<td>Evidence based practice guidelines</td>
</tr>
<tr>
<td>Standard tool to capture/share data</td>
<td>Specialty-trained primary care physicians nurses, PSWs</td>
</tr>
<tr>
<td>Service contracts reflect competence requirements</td>
<td>Human resources planning to ensure cultural/linguistic care provision as needed</td>
</tr>
</tbody>
</table>

---

**Primary Care/Allied Health**

(family doctor, nurse practitioner, allied health providers, family health team/organization, walk-in clinics)

**Compassionate Community**

Patient, Family, Caregiver at the Centre of Care

**Systems, people, sectors**

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Long Term Care</th>
<th>Legal Services</th>
<th>Funeral Services</th>
<th>Spiritual Care</th>
<th>Specialist Care i.e. Oncology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated care plan reflects patient's own words: goals, wishes, and advance care planning</td>
<td>Early identification of patients for palliative care</td>
<td>Weekly round with circle of care coordinated by case manager</td>
<td>Standardized equipment</td>
<td>Case management</td>
<td>Single point of access</td>
</tr>
<tr>
<td>Centralized referral/intake by sub-region</td>
<td>Partnership with health, social service, housing, etc.</td>
<td></td>
<td></td>
<td></td>
<td>Navigation</td>
</tr>
<tr>
<td>Dignity in risk assessment (preferred amount of information &amp; involvement in decisions)</td>
<td>Coordinated patient care &amp; services (regardless of entry point) with focus on transitions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Coordination of patient care**

- Primary, secondary, tertiary hospital-based palliative care
- Community Support Services (i.e. transportation, meals on wheels, financial)
- Home & Community Care (Care Coordination & Service Provider Organizations)
- Hospice (residential and visiting), including patient & caregiver support
- Volunteers, Neighbours, Friends, Family Pets
- Emergency Medical Services

**Better communication within circle of care**

- Skype or other means to communicate with family abroad
- Electronic health record
- Hand-held devices to access record from anywhere
- Ontario Telemedicine Network access to specialists
- Access to care & support 24/7 as needed

**All providers kept in the loop at all times**

Examples of South East initiatives, past & present

Circle of Care Involvement (including patients/family, caregivers & volunteers)
- 24/7 Physician or Nurse Practitioner call rotation
- Pain & symptom management consultation services (PPSMCS)
- Hospice symptom response kit
- Medical directives for palliative care
- Specialist consultation service

Coordination of patient care and services (regardless of entry point) with focus on transitions
- Circle of care patient conferences
- EXTRA project: Palliative care transitions from Cancer Centre South Eastern Ontario to community-based care
- INTEGRATE project: Early identification of patients for palliative care
- KGH Palliative Care Pathways
- Hospital to home discharge checklist
- Coordinated care plan (health links)
- Standardized equipment across sectors (single vendor) with delivery prior to discharge
- ESAS (Edmonton Symptom Assessment Scale) & PPS (Palliative Performance Scale)
- Dialysis & Advance Care Planning Project / No dialysis – referral
- Experience Based Design

Better communication within circle of care
- Hospice brochures for hospital staff
- SBAR (Situation, Background, Assessment, Recommendation) assessment tool
- Ontario Telemedicine Network (OTN) connection to specialists
- SHIIP (South East Health Integrated Information Portal) – a web-based portal
- CNEO (Connecting Northern and Eastern Ontario)
- Travelling chart in the home
- Speak Up -for Patients
- Coordinated Care Plan
- Aetionix – an electronic solution

Competency building – targeted % of providers by sector (includes education & research)
- CAPCE (Comprehensive Advanced Palliative Care Education)
- Physician continuing medical education through Queen’s University
- Accreditation of residential hospice programs
- Caregiver handbook
- LEAP (Learning Essential Approaches to Palliative Care) training
- Advance care planning & health care consent eLearning modules and online learning through Hospice Palliative Care Ontario (HPCO)

Cultural competence (Awareness, Resources, Flexibility)
- CCO (Cancer Care Ontario)/LHIN online learning modules on First Nations, Inuit and Metis

The Patient is the Centre of all that we do

Primary Care/Allied Health
(family doctor, nurse practitioner, allied health providers, family health team/organization, walk-in clinics)

Compassionate Community
Patient, Family, Caregiver at the Centre of Care

 Systems, people, sectors

Primary, secondary, tertiary hospital-based palliative care
Community Support Services (i.e. transportation, meals on wheels, financial)
Home & Community Care (Care Coordination & Service Provider Organizations)
Hospice (residential and visiting), including patient & caregiver support
Volunteers, Neighbours, Friends, Family Pets
Emergency Medical Services
Pharmacy
Legal Services
Funeral Services
Spiritual Care
Specialist Care (i.e., Oncology)
Long Term Care

Version: Jul 21, 2017