# Palliative Care Health Services Delivery Framework

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

### FOCUS AREA 2: ADULTS RECEIVING CARE IN HOSPITAL SETTINGS

Ontario Palliative Care Network | September 2025

Ontario Health

# Executive Summary

In 2019, the Ontario Palliative Care Network (OPCN), in partnership with Ontario Health (OH), introduced the first of three models within the Palliative Care Health Services Delivery Framework (Delivery Framework), focused on palliative care for adults in community settings (Adult Community Model of Care). This extensive framework further incorporates two additional models: one dedicated to adults in hospital settings (Adult Hospital Model of Care) and another for children across all care settings (Pediatric Model of Care).

This document outlines recommendations for the Adult Hospital Model of Care. It was developed through extensive consultations with various Health System Partners, including healthcare professionals, system planners, and patient and family advisors. The objective was to address existing disparities in patients receiving consistent, person-centered, timely, and sustainable palliative care within hospital settings, as outlined in the Ontario Provincial Framework for Palliative Care, which delineates the government's strategic priorities for palliative care.

The recommendations for the Adult Hospital Model of Care focus on three key areas:

I. **Enabling timely and reliable identification of patients with unmet palliative care needs.** This document emphasizes the importance of timely and accurate identification of patients with unmet palliative care needs. Currently, these needs are often recognized late in the disease trajectory, triggered by significant events, or not consistently by providers. To address the palliative care needs of individuals with serious illnesses effectively, proactive, and early identification of patients with unmet needs should be a priority. It is important for all healthcare providers, to have the appropriate knowledge and skills (aligned with the Ontario Palliative Care Competency Framework), to participate in this early identification process. This includes palliative care specialists (with secondary-level competencies in palliative care) and generalist/non-palliative care specialist providers (with primary-level competencies in palliative care). It encourages providers to actively engage in identifying patients sooner, emphasizing the pivotal role of proactive and dependable processes within hospital settings. Given the prevalence of serious illnesses and the multiple demands on palliative care providers, some hospitals may need to initially focus their efforts on populations at highest risk of unmet palliative care needs.

II. **Enhancing palliative care competencies among generalist/non-palliative care specialist providers to optimize the use of palliative care specialists.** With the growing recognition and assessment of palliative care needs, more providers in hospital settings will require primary-level competencies in palliative care (foundational skills and knowledge necessary for providing basic palliative care) to address these needs effectively. An interprofessional team-based approach, strengthened by established connections to Palliative Care Specialists for mentorship and support, will foster continuous experiential learning and enable more providers to deliver quality palliative care to their patients.

III. **Enhancing care coordination and communication within and across settings.** Palliative care often entails multiple transitions between providers and settings, which can be disruptive and distressing for patients, families, and care partners. Whenever possible, patients and their families/care partners should have a designated point of contact to ensure continuity of care. Within the Interprofessional Palliative Care Team, there should always be a provider assigned with responsibility for coordinating a care plan to address palliative care needs across settings and within the hospital environment. Streamlining processes and utilizing digital tools can significantly support care navigation and facilitate smooth patient transfers. Furthermore, when suitable and feasible, patients should be transferred out of acute care settings for palliative and end-of-life care to enhance the overall care experience and alleviate unnecessary strain on hospitals.

**The summarized recommendation statements for the Adult Hospital Model of Care are:**

1) The patient who would benefit from palliative care will be identified early in their illness.
2) Once unmet palliative care needs are identified, the patient and their family/care partners will have these needs assessed through a comprehensive and holistic assessment.
3) The patient and their family/care partners will have access to an interprofessional team.
4) The Core Team will collaborate with the patient (or the substitute decision-maker) and their family/care partners to develop and document a care plan that is based on the patient's wishes, values, and beliefs, and their identified goals of care, and to regularly assess their needs.
5) The patient and their family/care partner will always have a designated health care provider to coordinate their care, and to manage care transitions to other settings.
6) The patient will have 24/7 access to pain and symptom management. This may occur in person or via telemedicine (e.g., telephone support, virtual care, etc.).
7) The patient and their family will have access to psychosocial care to address their needs in a culturally safe manner.
8) The patient and their family/care partner will have access to practical and social support to address their needs in a culturally safe manner.
9) Planning for end-of-life care will begin as early as possible and when it is acceptable to the patient and their family/care partners.
10) The family/care partners of the patient with a life-limiting illness will be supported throughout the person's illness trajectory, at the end of life, and through death and bereavement.
11) French language services will be highly visible and easily accessible for the patient and their family/care partners. Healthcare providers must offer these services, guided by the Active Offer Principle, without waiting to be asked.
12) Patients and their family/care partners will have access to inclusive and equitable palliative care in hospital settings.

**Implementing the Adult Hospital Model of Care recommendations will require:**

- Developing or enhancing reliable site-specific processes for timely identification and assessment of palliative care needs.
- Implementing formal processes (education, maintenance of competencies) to build and sustain primary level capacity for providers in the hospital setting.
- Creating efficient digital communication platforms that are easily accessible by providers in multiple settings.
- Expanding human resources, particularly for nursing and allied health providers.
- Enhancing partnerships between smaller/rural hospitals and larger/urban centres to provide 24/7 specialist support, if this is not available locally.

Importantly, the processes outlined in this document are intended to address the need for smooth transitions between care settings, especially between hospital and community settings (including long-term care homes), ensuring that adults in Ontario's hospitals receive sustainable, efficient, and high-quality palliative care tailored to their specific needs.

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# Overview

The passage of the Compassionate Care Act, 2020 and the corresponding Ontario Provincial Framework for Palliative Care provides a guide for future endeavors to ensure that every Ontarian in need of palliative care, regardless of the care setting, has improved access to high-quality services.

Established in 2016, the Ontario Palliative Care Network (OPCN) is a partnership of health service providers, community and social support service organizations, health systems planners, as well as patient and family/care partner advisors formed to develop a coordinated and standardized approach for delivering palliative care services in the province.

The Provincial Palliative Care Program, an Ontario Health provincial clinical program, is grounded in ongoing engagement and collaborates with health care delivery partners to achieve the Ministry's established strategic priorities for palliative care. The program works closely with Ontario Health Regions and other Ontario Health programs to develop clinical guidance and inform and/or develop policy related to palliative care. The Provincial Palliative Care Program also provides subject matter expertise within Ontario Health, as well as to the government and Health System Partners.

Additionally, the program executes the OPCN mandate and priorities in alignment with Ontario Health's role. The OPCN advises Ontario Health on palliative care priorities and guidance, including the Palliative Care Health Services Delivery Framework (“the Delivery Framework”), which comprises three models of care:

1) Focus Area 1: Adults Receiving Care in Community Settings including primary care, home and community care, and long-term care (“Adult Community Model of Care”),
2) Focus Area 2: Adults Receiving Care in Hospital Settings (“Adult Hospital Model of Care”), and
3) Focus Area 3: Children Receiving Care Across all Settings (“Pediatric Model of Care”).

Following the initial development of the Adult Community Model of Care, in 2019, further work has been undertaken to define the Adult Hospital and Pediatric Models of Care. Each model has been tailored to address the specific challenges and requirements for the population and care settings, ensuring that patients receive the most appropriate, effective, and compassionate care tailored to their individual needs. More specifically, implementation of the Adult Community Model of Care, and the Adult Hospital Model of Care are intended to achieve high quality palliative care, as described in Ontario Health’s quality standard, Palliative Care: Care for Adults with a Serious Illness (‘Palliative Care Quality Standard’).

**This document defines and describes the Adult Hospital Model of Care.**

For **key definitions and terms**, please refer to pages 13-15.

# Background

The Adult Hospital Model of Care has been developed to address the lack of uniformity in person- and family-centred, timely, and sustainable palliative care service access and delivery in the hospital setting. Ontarians with serious illnesses almost invariably receive at least part of their care in a hospital setting, and approximately half will die there [1]. Consequently, hospital-based encounters provide excellent opportunities to identify unmet palliative care needs and integrate a palliative approach to care for those who would benefit. Hospitals are also important partners in transitions of care from one setting to another, which are very common in the final months of life. Moreover, many Ontarians who are approaching the end of life are admitted to hospitals due to limited or inadequate support in other settings to meet their needs (i.e., Alternate Level of Care). The lack of resources for palliative care services in community settings can also limit earlier identification efforts, leading to more individuals with unmet palliative care needs presenting in hospital settings. A substantial component of the current overcapacity crisis in hospital settings could be alleviated with more dedicated palliative and end-of-life beds and resources across all care settings [2, 3].

Palliative care delivery within the hospital setting is complex and not limited to specific providers, palliative care units, or even inpatient care. For existing health human resources to provide more timely palliative care, there is a need to streamline and optimize approaches to ensure providers across hospital settings (including in-patient, out-patient and/or virtually) are working to their full scope of practice.

# Approach

## Targeted Literature Review

In collaboration with clinical expert advisors and Ontario Health's Evidence Search and Review Services, a focused literature review spanning the past decade was conducted in 2021. This review aimed to identify existing service delivery models in pertinent jurisdictions and to understand how various model components addressed challenges in access, quality, and capacity. The review encompassed 47 research studies, covering jurisdictions such as the USA, Canada, the U.K., Netherlands, Denmark, and Australia, with an emphasis on hospital-based scenarios, both inpatient and outpatient, for adults needing palliative care. For a comprehensive list of the referenced studies, please see Appendix A. The insights gathered from this review played a pivotal role in defining the Adult Hospital Model of Care. In addition, emergent literature, including key association guidelines were reviewed during the recommendations development process to ensure alignment (for example, the ASCO Palliative Care Guideline Update).

## Current State Assessment and Gap Analysis

In 2015, Cancer Care Ontario (CCO) assessed the current state of palliative care services in Ontario. Subsequently, the Provincial Palliative Care Units Reference Group and the Palliative Care Units Expert Panel compiled a report[1] aimed to address the research and data gaps identified in CCO's assessment.

## Working Group and Recommendation Development

In 2022, Ontario Health (OH) established the Adult Hospital-based Palliative Models of Care Working Group to guide the development of recommendations for the Adult Hospital Model of Care. Chaired by an OH Provincial Clinical Lead, the group comprised nineteen external advisors from various professional backgrounds (Appendix B). Their mandate included overseeing the work plan, conducting a gap analysis, outlining the composition of hospital-based interprofessional care teams, and co-creating Adult Hospital Model of Care recommendations. Regular meetings were held from Q2 2022/23 through Q4 2023/24.

## Patient Journey Mapping and Focus Groups

A Patient Journey Mapping Workshop was undertaken which involved 12 patients and family/care partners who shared their experiences with palliative care services in Ontario. Their feedback played an essential role in guiding the focus areas of the Working Group. Subsequently, focus groups were organized, engaging individuals from specific equity-deserving groups. The sessions illuminated unique challenges faced by these communities, emphasizing the necessity for tailored care solutions. Feedback from these groups reiterated the need for enhanced general-level palliative competencies among hospital staff. Regional specificities were also highlighted, emphasizing the need for region-centric solutions.

## Consultation Sessions

During Q3 2023/24, consultation sessions were conducted with regional and other Ontario Health (OH) system-level partners (Appendix C) to introduce key concepts and solicit feedback on implementation considerations for the Adult Hospital Model of Care. These consultations provided an enriched understanding of potential implementation strategies and offered insights into feasible ideas and ongoing related initiatives.

## Extensive Review Process

In Q4 2023/24, a comprehensive review of the Adult Hospital Model of Care recommendations was facilitated. A multitude of organizations and associations, including partners within OH and across OH Regions (Appendix D) received the draft document, and were asked for feedback to refine the document, ensuring it resonated with the needs and expectations of the intended audience.

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[1] This report was not published and is not available online.

# Guiding Principles

Aligned with the Quintuple Aim[2], the development of the Adult Hospital Model of Care was guided by the following principles, similar to those adopted for the Adult Community Model of Care [4, 5]:

- Centre around the needs and values of the individual patient and their family/care partners, considering their cultural and linguistic needs.
- Respect and support the important roles of substitute decision makers and family/care partners.
- Enable access to equitable, high-quality, and coordinated care as close to home as possible for all individuals in need.
- Ensure that interprofessional team members have the necessary competencies, including cultural safety and humility, and are working to their full scopes of practice.
- Facilitate capacity, measurement, and evaluation planning to ensure a sustainable care system for the future.

# Scope

This document describes the Adult Hospital Model of Care for adults over 18 years of age with a serious illness along with their family/care partners in hospital settings. Hospital settings include acute care (inpatient and outpatient and/or virtual specialized palliative care services) and those that provide complex continuing care and rehabilitation. It is recognized that throughout the trajectory of illness, people with a serious illness will receive care in multiple settings e.g., at home, in outpatient and inpatient settings. Please refer to the Adult Community Model of Care for recommendations specific to care provided in their usual place of residence. This can include their homes, retirement residences, assisted living facilities, supportive housing, long-term care facilities, First Nations, Inuit, and Métis communities (on and off reserve), Urban Indigenous communities, streets and shelters.

The scope of this document includes several priority populations, including Francophones, Black and racialized people, 2SLGBTQIA+ individuals, immigrants, refugees, newcomers to Ontario, patients with disabilities, low-income individuals, and individuals who are vulnerably housed or experiencing homelessness. The aim is to create a more equitable and inclusive healthcare system that considers the diverse cultural and linguistic needs of individuals and addresses the unique challenges faced by underrepresented communities, ensuring their access to high-quality care.

## Out of Scope

**First Nations, Inuit, Métis, and Urban Indigenous communities.** It is important to note that while some aspects of Indigenous perspectives have been incorporated into this document, engagement with First Nations, Inuit, Métis, and Urban Indigenous communities, nations and organizations has not yet occurred. Representatives from these communities and organizations have emphasized the

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[2] The Quintuple Aim is a framework for healthcare improvement that focuses on increasing population health, improving patient experience, reducing care costs, enhancing care team well-being, and establishing health equity.

importance of culturally appropriate palliative care tailored to their specific needs and people. To achieve this, Ontario Health will facilitate discussions on Indigenous-led engagement to develop distinctions-based Model of Care recommendations for Hospital settings. These recommendations will be designed to reflect the distinct and specific priorities of First Nations, Inuit, and Métis communities, nations and organizations as well as Indigenous service providers. The Provincial Palliative Care Program is actively collaborating with the OH Indigenous Health Equity and Coordination Team to plan these efforts. We acknowledge that proper engagement will require time, and Indigenous-specific Model of Care recommendations will be released once comprehensive engagement is complete.

**Hospital-based Outreach Teams.** The Adult Community Model of Care addresses the role of Physician or Nurse Practitioner-Led Hospital-based Outreach Teams. These healthcare providers extend medical and supportive care services of the hospital into the community. The teams comprise multidisciplinary providers including nurses and social workers. Key functions include transition support, chronic disease management, post-acute care, education, and connecting with community services.

**Medical assistance in dying.** In Ontario, medical assistance in dying is an available healthcare service that may be requested by eligible individuals (as defined by legislation), which includes individuals who have a grievous and irremediable medical condition[3] [6]. All individuals suffering with a grievous and irremediable medical condition would benefit from a palliative approach to care, and should have their palliative care needs identified early, through a comprehensive and holistic assessment. The process to access and determine eligibility for medical assistance in dying requires separate assessments, which are often coordinated by a medical assistance in dying team that is distinct from palliative care. Recognizing that most patients who are considering or requesting medical assistance in dying have palliative care needs [7], it is essential that these patients and their families are offered and have access to the full complement of palliative care services that are required to meet those needs throughout their illness trajectory. This approach ensures that every individual's well-being and comfort are prioritized, independent of their choices related to medical assistance in dying.

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[3] Eligibility for persons suffering solely from a mental illness has been delayed until March 17, 2027.

# How to Use this Document

The Adult Hospital Model of Care aims to provide guidance on how to optimize current palliative care delivery in hospital settings to ensure that the right care is provided by the right provider at the right time. The primary audience of this document are individuals who plan or provide care for patients with a serious illness in hospital settings. They include system planners (e.g., Ministry of Health), Ontario Health Regions, hospitals, providers (e.g., physicians, NPs, RNs, RPNs, allied health) and provider agencies (e.g., contracted nursing agencies, community service agencies).

The Adult Hospital Model of Care is meant to be both aspirational and realistic, describing an ideal state that is achievable across the province in the near term. The ideal state is depicted below in Box 1: "One patient, two scenarios." It illustrates one individual's story in two scenarios: one before the implementation of the Adult Hospital Model of Care and the second one after. The details of this improvement are described in the Adult Hospital Model of Care recommendations, which provide guidance on how palliative care should be organized and delivered to adults in Hospital settings. For two additional case examples please refer to Appendix E.

Rather than being prescriptive, this document encourages adaptation to local needs and resources, with a focus on enhancing current partnerships and collaborations, and establishing new relationships as needed. Leaders across the province, regions, and sub-regions are encouraged to use the Adult Hospital Model of Care as a reference in evaluating resources and ascertaining their capacity to provide high-quality palliative care to the wider population. Implementation is expected to be incremental, starting with specific focus areas and building on existing high-quality services and programs.

## Box 1. Case One: One Patient, Two Scenarios

**Gail is an 80-year-old woman with Parkinson's disease and severe osteoporosis** who fell on ice and broke her hip. She was taken to the Emergency Department (ED) and admitted to the Orthopedic Surgery Service for an operation to repair her hip. Following the operation, she had very poor pain control, developed delirium and confusion, and by the time these issues were resolved, she had become deconditioned and was unable to walk. The Orthopedic Team continued to encourage mobilization, but after three weeks they transferred her to a rehabilitation facility. Gail's wishes for future care should her health deteriorate were not discussed.

While admitted to the rehabilitation facility, she progressed slowly and was given an antibiotic for a presumed urinary tract infection. She then developed a clostridium difficile infection because of the antibiotic and was transferred back to the acute hospital and readmitted to the Orthopedic Surgery Service, with consultation from the Internal Medicine Service. After three weeks of treatment, her clostridium infection resolved, but she was completely bedbound. She had also experienced a cognitive decline and was deemed incapable to make placement-related decisions for herself. Her family agreed to a transfer to a long-term care (LTC) home as a short-stay resident, where she was able to live for another three months in the hope that she might be able to recover and return home. During that time, her palliative care needs continued to be assessed; however, she did not have the cognitive capacity to communicate her wishes and information from the hospital was not available to the LTC home. She declined, and after multiple discussions with her family, her goals of care changed to comfort. However, given that she still had poorly controlled pain and could not take oral pain medication, her family asked for Gail to be transferred to the ED at the end of life to be given injectable comfort medication.

**Gail is an 80-year-old woman with Parkinson's disease and severe osteoporosis.** Because she is followed in a Movement Disorders Clinic at the hospital, the electronic medical record (EMR) flagged her as being at high risk of unmet palliative care needs given her demographics and illnesses. Her Clinic Nurse screened her and found that she was having moderate to severe fatigue and tiredness and was keen to talk about her future care if her condition became worse. Her Neurologist explained to her and her family that although her Parkinson's was under control, she was frail from her multiple medical conditions and was at high risk of having a medical complication such as an infection or a fall. This complication would be more severe for someone like her because of her frailty and could result in death. Gail was consulted on her wishes, and she explained that her current quality of life was good, but that she was "slowing down." She was not sure, but she felt like she would not want anything aggressive or invasive if she deteriorated. She trusted her family to make future decisions on her behalf.

After she fell on the ice and was admitted to the Orthopedic Surgery Service, the EMR again flagged her as being at high risk of unmet palliative care needs given her demographics and illnesses. The Orthopedic Surgery Team met her and her family and explained that she would be at very high risk of deterioration and death following hip surgery given her underlying condition. They discussed the option of surgery or purely comfort care for her hip fracture. She felt that she wanted to try to fix her hip, but that if she could not regain her ability to walk after the operation, she would want to transition to comfort care. After the operation, she had very poor pain control, developed delirium and confusion. Accordingly, the Orthopedic Surgery Team consulted the Palliative Specialist Team to assist with symptom control and planning. The Palliative Specialist Team adjusted her medications to improve pain control, although her delirium did not resolve for several days. By this time, she was deconditioned and unable to ambulate. After discussion with Gail and her family, the decision was made not to pursue rehabilitation, but instead to focus on comfort care. Her Orthopedic Surgery Team developed a care plan along with the Palliative Specialist Team, and this plan was shared with a LTC home that was able to accept her and support her care needs. Once admitted, a member of LTC Team reassessed her needs, and her goals of care, updating her care plan to reflect any changes in consultation with her family. Although she still had some pain, her care team at the LTC home were able to manage this with occasional consultation support from a Palliative Specialist Team in the community. Her family understood her wishes and were confident Gail could be cared for in the LTC home. Four months later, as she approached the end of her life, her care team at the LTC home were able to manage her symptoms using injectable pain medications.

## Key Definitions

For the purposes of the Adult Hospital Model of Care, the Working Group adopted the following definitions for several key terms. Additional terms are defined in Appendix F, and a list of abbreviations is available in Appendix G. Throughout this document, every effort was made to use the most current terms and definitions, however it should be noted that language is continually evolving.

**Patient** in this document refers to a person with a serious illness (see definition for serious illness below).

**Serious Illness** is a health condition that carries a high risk of mortality and either negatively impacts a patient's daily function or quality of life or excessively strains family/care partners [8].

**Family** comprises those closest to a person in terms of knowledge, care, and affection, and may include biological family (i.e., parents, grandparents, and siblings), family through marriage, or family of choice and friends. The person with the serious illness defines their family and who will be involved in their care.

**Care partner** 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 a person with a serious illness [9].

**Palliative Care** is an approach that improves the quality of life of people and their families living with a serious illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical and psychosocial[4].

**Palliative Care Competencies** refers to the knowledge, skills and attitudes that care providers need to deliver high-quality palliative care in Ontario. In alignment with the Ontario Palliative Care Competency Framework, there are two levels of palliative care competencies (Figure 1). **Level 1** competencies (also called primary level competencies) include the shared and profession-specific palliative care competencies for all health professionals and volunteers **who care for people with serious illnesses and their families/care partners** (e.g. generalist and non-palliative care specialist providers). **Level 2** competencies (also called secondary level competencies) outline the shared and profession-specific competencies for health professionals **who specialize or have a practice focused on palliative care** (i.e. Palliative Care Specialists). The competencies apply to all settings of care (e.g. hospital, collaborative care clinic, ambulatory clinic, and community settings).

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[4] Adapted from the World Health Organization and in alignment with the Framework on Palliative Care in Canada. Please see Appendix F for the full descriptive definition from the World Health Organization.

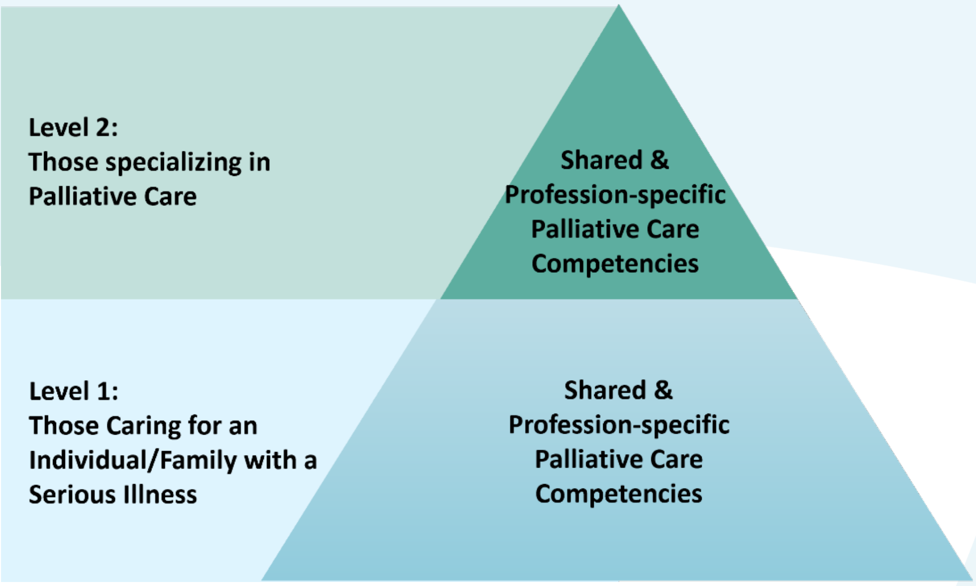


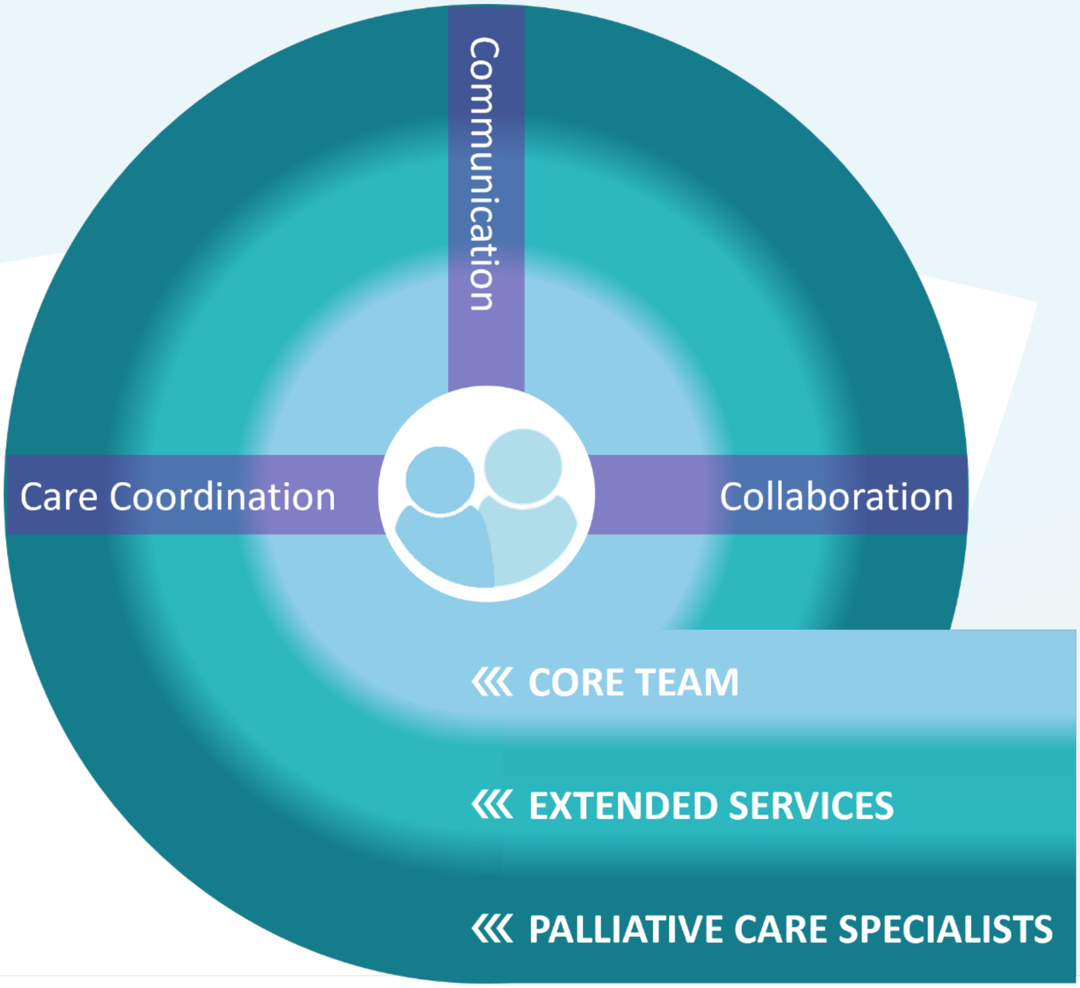
Figure 1. Levels of Palliative Care Competencies

This pyramid-shaped diagram depicts the Ontario Palliative Care Competency Framework with two levels. The bottom, wider section is Level 1, or primary level, and includes the shared and profession-specific palliative care competencies for health professionals and volunteers who care for people with life-limiting conditions and their families/care partners. The narrower top section is Level 2, or secondary level, and outlines the shared and profession-specific competencies for health professionals who specialize or have a practice focused on palliative care. These competencies, applicable across various healthcare settings, aim to improve care and promote interprofessional collaboration.

**Palliative Care Specialists** health professionals with Level 2 competencies in palliative care who specialize or have a practice focused on palliative care (e.g., MD, NP, SW).

**Most Responsible Medical Provider (MRMP)** a physician or nurse practitioner within the Core Team. The MRMP will be responsible for ordering tests, making diagnoses, ordering treatments, and prescribing medications.

**Interprofessional Palliative Care Team** a team consisting of three layers of providers and services (i.e., Core Team, Extended Services, and Palliative Care Specialists) who work together to deliver palliative care to a patient and their family/care partners based on the person's care plan (Figure 2). This team will consist of a **Core Team** that includes an MRMP (physician or nurse practitioner, often from the Current Care Team) along with a provider responsible for care coordination (i.e. Social Worker or RN/RPN), with an established connection to a **Palliative Care Specialist(s)** for consultation and/or direct care as needed. The team will often be expanded to include additional providers **(Extended Services)**, for example, RNs/RPNs, disease-specific specialists, social workers, psychologists, spiritual care providers, pharmacists, personal support workers, dietitians, Indigenous providers, and volunteers. For a detailed description of the composition of the Interprofessional Palliative Care Team, please refer to Recommendation 3 focused on the Interprofessional Team-Based Approach.



| CORE TEAM: | EXTENDED SERVICES: | PALLIATIVE CARE SPECIALISTS: |
|---|---|---|
| MRMP (MD/NP), provider responsible for care coordination, Nurse, Social Worker (as needed), Elder/Healer/Knowledge Carrier (First Nations, Inuit, Métis, and Urban Indigenous) | e.g. Personal Support Workers, Pharmacists, volunteers, Dietitians, Rehabilitation Therapists, Spiritual Care, Psychosocial services, and Recreation therapists | e.g. Palliative Care MD, RN, NP, psychosocial care providers with expertise in palliative care. |

Figure 2. Interprofessional Palliative Care Team for Adults in Hospital Settings

This figure contains a patient and family/care partners icon surrounded by three circular layers. The inner layer is the Core Team. The patient, and family/care partners are at the center, demonstrating their active role on the team, along with providers that include the most responsible physician or nurse practitioner, a designated member for care coordination (i.e., RN/RPN or social worker). The second layer is the Extended Services that includes various care providers including personal support workers, rehabilitation support specialists, other allied health professionals, and disease site specialists. The outer layer is the Palliative Care Specialists that include providers with expertise in palliative care. The diagram illustrates the fluidity in team composition, allowing for changes based on the needs of the patient, and their family/care partners. Lastly, there are three purple bars spanning across the circular layers labeled ‘Coordination’, ‘Communication’, and ‘Collaboration’. These bars represent the essential elements of the model that connect providers and the patient and their family/care partners and ensure continuity in care.

# Recommendations

The Adult Hospital Model of Care recommendations provide guidance on how palliative care services and providers in hospital settings can be organized and coordinated based on the needs of patients and their family/care partners.

The Adult Hospital Model of Care Patient Pathway (Figure 3) depicts the key phases of care planning and delivery for patients and their family/care partners and summarizes the Adult Hospital Model of Care. It incorporates the key domains of care outlined by the Canadian Hospice Palliative Care Association.

The Adult Hospital Model of Care aims to:

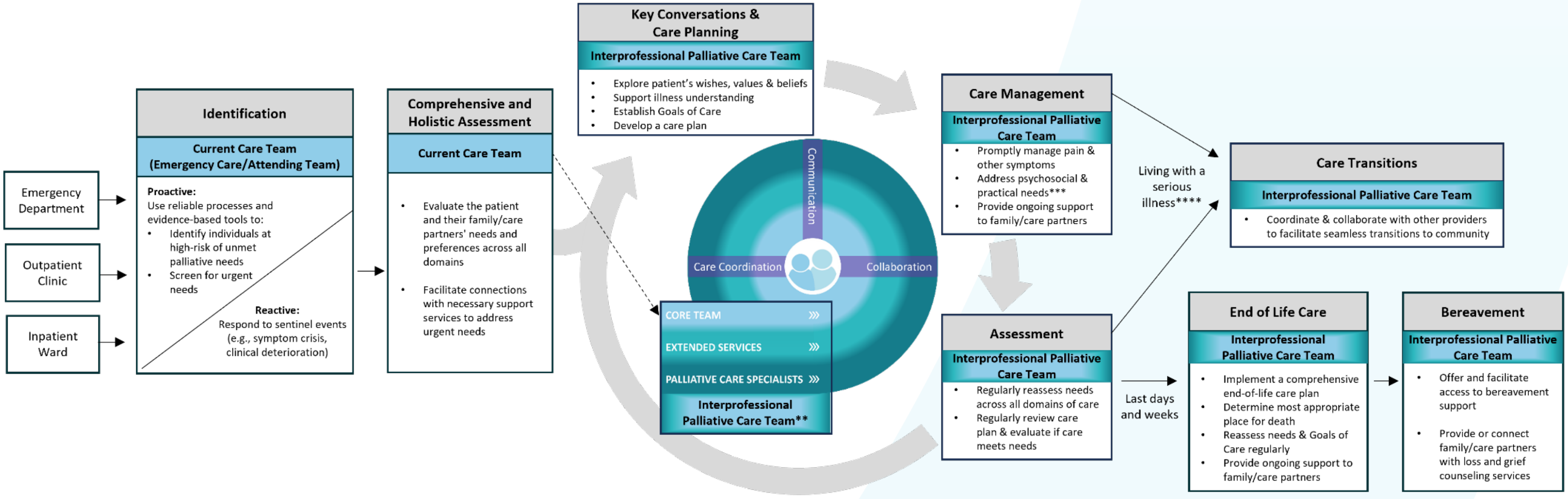
1) Provide role clarity for the members of the Interprofessional Palliative Care Team, to ensure a cohesive and effective approach to patient care;
2) Identify and streamline the processes of care, especially transitions, and outline how services could be connected across care settings; and
3) Identify opportunities to create and/or strengthen support for Interprofessional Palliative Care Teams to provide high quality, person-centred palliative care in Ontario.

The recommendation sections are organized according to how the patient and their family/care partners would experience the continuum of care, from identification through end-of-life care and bereavement. It is recognized that this is not a linear pathway and that the patient and family/care partners receive many of the services described throughout their journey.

To demonstrate the alignment between the Adult Hospital Model of Care and the Palliative Care Quality Standard, the relevant HQO quality statement(s) is cited in a textbox below each recommendation. Finally, at the end of each recommendation section, there is a set of implementation considerations. These considerations are intended to call out areas where efforts are required to address these challenges to enable the implementation of the Adult Hospital Model of Care. The implementation considerations have also been collated in Appendix H, and reorganized by target focus area (provincial, regional, hospital, or team/provider).

It is important to acknowledge that many of the recommendations are applicable beyond palliative care delivery, and as a result the concepts, and work required to implement the recommendations will not be net new. Hospitals should build on and leverage existing partnerships and initiatives where possible.

# Adult Hospital Model of Care Patient Pathway*



Emergency Department

Outpatient Clinic

Inpatient Ward

**Identification**

**Current Care Team (Emergency Care/Attending Team)**

**Proactive:**
Use reliable processes and evidence-based tools to:
- Identify individuals at high-risk of unmet palliative needs
- Screen for urgent needs

**Reactive:**
Respond to sentinel events (e.g., symptom crisis, clinical deterioration)

**Comprehensive and Holistic Assessment**

**Current Care Team**

- Evaluate the patient and their family/care partners' needs and preferences across all domains
- Facilitate connections with necessary support services to address urgent needs

**Key Conversations & Care Planning**

**Interprofessional Palliative Care Team**

- Explore patient's wishes, values & beliefs
- Support illness understanding
- Establish Goals of Care
- Develop a care plan

CORE TEAM »

EXTENDED SERVICES »

PALLIATIVE CARE SPECIALISTS »

**Interprofessional Palliative Care Team****

**Care Management**

**Interprofessional Palliative Care Team**

- Promptly manage pain & other symptoms
- Address psychosocial & practical needs***
- Provide ongoing support to family/care partners

**Assessment**

**Interprofessional Palliative Care Team**

- Regularly reassess needs across all domains of care
- Regularly review care plan & evaluate if care meets needs

Living with a serious illness****

**Care Transitions**

**Interprofessional Palliative Care Team**

- Coordinate & collaborate with other providers to facilitate seamless transitions to community

Last days and weeks

**End of Life Care**

**Interprofessional Palliative Care Team**

- Implement a comprehensive end-of-life care plan
- Determine most appropriate place for death
- Reassess needs & Goals of Care regularly
- Provide ongoing support to family/care partners

**Bereavement**

**Interprofessional Palliative Care Team**

- Offer and facilitate access to bereavement support
- Provide or connect family/care partners with loss and grief counseling services

* Pathway assumes linear flow of care which may not be reflective of the real-life care trajectory

** For First Nations, Inuit, Metis, and urban Indigenous communities, Indigenous Providers, Healers and Elders/Knowledge Keepers will be part of the Interprofessional Palliative Care Team throughout the journey

*** This includes consideration for grief/loss support, which is necessary throughout the continuum of care

**** A person may experience multiple discharges/readmissions within the context of living with a serious illness

Figure 3: Adult Hospital Model of Care Patient Pathway

This diagram provides a high-level summary of the Adult Hospital Model of Care, outlining key processes in care planning and delivery, as well as interactions between patients, family/care partners, and providers over time. It begins with identification and comprehensive assessment, followed by key conversations, care planning, ongoing care, and ongoing reassessment by an Interprofessional Palliative Care Team comprising the Core Team, Extended Services, and Palliative Care Specialists. Depending on the needs and prognosis of the patient, they may transition to other settings to receive ongoing care. As the patient's condition progresses, the focus shifts to end-of-life care and bereavement support for family/care partners.

## Identification of Patients

Timely identification of patients who would benefit from a palliative approach to care is essential for fostering holistic and person-centered care within hospital settings [10]. Currently, the identification process in hospitals tends to be reactive, leading to delays in accessing essential palliative services. This section focuses on establishing proactive measures for timely identification and intervention. By implementing standardized processes and evidence-based tools, individuals with unmet palliative care needs will be identified earlier in their illness trajectory. Challenges persist in ensuring consistent identification across all care teams and settings [10]. The following recommendations aim to enhance the reliability of the identification process, empower patients and their families to actively participate, and foster collaboration among healthcare providers to optimize access to palliative care services.

1. **The patient who would benefit from palliative care will be identified early in their illness.**

**HQO Quality Statement 1:** People with a serious illness have their palliative care needs identified early through a comprehensive and holistic assessment.

**1.1.** The Current Care Team (e.g., disease site teams or hospital unit-based teams) will utilize reliable processes and evidence-based tools (e.g., those outlined in OPCN's Tools for Earlier Identification of Palliative Care) to identify individuals at high risk of having unmet palliative care needs.

**1.2.** Once a patient is identified as having unmet palliative care needs, the health care provider will screen for and document any urgent needs in the electronic medical record (EMR) and indicate the requirement for a comprehensive assessment. If the Current Care Team was not the one who identified the patient's palliative care needs, they will be informed.

**1.3.** If a patient with unmet palliative care needs is an outpatient (not currently receiving care from an inpatient hospital-based team), the Current Care Team will collaborate with other healthcare providers or palliative care services within the hospital or community to ensure appropriate access to supports and services.

**1.4.** The Current Care Team will provide the patient and their family/care partners with information about the nature and benefits of palliative care. This information will be provided in a format that is appropriate to the linguistic and cultural needs of the patient and their family/care partners.

**1.5.** Patients and their family/care partners will be empowered to actively engage in the identification and screening process, ensuring they can effectively communicate their needs to their Current Care Team.

**IMPLEMENTATION CONSIDERATIONS**

- A Provincial Palliative Care Education Strategy is needed to promote the importance of earlier integration of palliative care, and to build primary level palliative care capacity among healthcare professionals across all care settings.
- Hospitals should establish palliative care education plans to build capacity for primary-level palliative care among all hospital health care professionals (across all disease sites, and hospital units). Education is essential for ensuring providers have the competency to identify and address

unmet palliative care needs. The plan should include a focus on ensuring first contact personnel (ED staff, clinic staff, paramedicine, etc.) are educated about timely identification, along with ensuring designated providers in various disease sites and units are trained on the use of standardized identification and screening tools, such as OPCN's OPCN's Tools to Support Earlier Identification for Palliative Care. These designated providers can function as mentors and provide support to other staff within their respective sites or units.

- Reliable processes should be developed and/or implemented in all hospital settings (inpatient, outpatient, and emergency room) to proactively identify individuals at high risk of unmet palliative care needs. Embedding identification tools into EMR systems should be considered to create automated flags. Integration will require changes to relevant hospital policies and procedures and may require updating IT infrastructure. For instance, the Hospital One-year Mortality Risk (HOMR) tool can automatically identify inpatients with an elevated risk of death within the next year using commonly collected hospital EMR data, particularly those with non-cancer illnesses and frailty who may have unmet palliative care needs. As a starting point, patients at higher risk of unmet needs can be prioritized to manage the identification process effectively and prevent overwhelming providers.
- Hospitals should implement evidence-based tools and processes to identify and screen patients with unmet palliative care needs. Tools and processes should be appropriate for the population they were designed for, and customized by setting (e.g., inpatient vs. outpatient), and disease site, leveraging existing workflow whenever possible. For disease site clinics, these tools and processes can be disease-specific, and for other settings, they should be disease-agnostic and include those with multi-morbid frailty.
- Once unmet palliative care needs are identified, a patient's access to primary care, community and social service supports should be assessed to understand available resources to support care transitions. Making connections to home and community supports early can help to reduce the chances of the person reaching the end of their illness and dying in hospital.
- A broadly accessible provincial electronic platform should be made available for providers to enable secure "real-time" exchange of patient information within and across settings and sectors. The platform would ideally enable providers to access assessment results and allow patients and family/care partners to identify their own unmet palliative care needs.

## Comprehensive and Holistic Assessment

Comprehensive and holistic assessments are essential for delivering high-quality palliative care within hospital settings [11]. This section underscores the importance of assessing all eight domains of issues associated with illness and bereavement as outlined by the Canadian Hospice Palliative Care Association including physical, psychological, social, spiritual, practical, disease management (which includes consideration for secondary diagnosis such as dementia, substance use, and trauma), end of life care/death management, and loss/grief (See Figure 1, in A Model to Guide Hospice Palliative Care, page 5). The assessment process will likely need to include a variety of tools and may require support from extended services to assess more complex needs. Through systematic and collaborative approaches, the aim is to identify and respond to any issues an individual, and their families/care partners may face across all domains, in the context of each person's unique characteristics (e.g., demographics, culture, personal values). Inconsistent assessment practices and the lack of standardized tools may lead to potential gaps in care delivery [11]. Therefore, the focus is on providing recommendations to enhance the reliability and effectiveness of the assessment process.

**2. Once unmet palliative care needs are identified, the patient and their family/care partners will have these needs assessed through a comprehensive and holistic assessment.**

**HQO Quality Statement 1:** People with a serious illness have their palliative care needs identified early through a comprehensive and holistic assessment.

**2.1.** The Current Care Team (e.g., disease site team or hospital unit-based team) will screen for any palliative care needs that require urgent interventions (e.g., uncontrolled physical symptoms, urgent needs for personal care services or social work services). A provider on the current care team will either manage the urgent issue(s), or connect the patient and their family/care partners with the appropriate provider to address it (e.g., Palliative Care Specialists, social worker, psychologist).

**2.2.** After addressing urgent issues, the Current Care Team will initiate a comprehensive and holistic assessment of the patient and their family/care partners' needs across all domains of care including consideration for trauma reactions and symptoms. The assessment may be conducted independently by a member of the patient's current care team, or in collaboration with other providers who may become part of the ongoing Interprofessional Palliative Care Team (e.g. for patients being assessed in the ED). This assessment will ideally be in person, though it may occur at a different time or location from the resolution of urgent needs.

**2.3.** The Current Care Team will discuss the role and responsibilities of a substitute decision-maker with the patient and their family/care partners. That same team member will ensure that a substitute decision-maker is identified and documented based on previous advance care planning or relying on the Ontario hierarchy of substitute decision-makers as outlined in Ontario's Health Care Consent Act [12].

  **2.3.1.** If the patient has not previously engaged in Advance Care Planning, the Current Care Team will encourage the patient to have discussions with their substitute decision-maker about their wishes, values and beliefs, to prepare them for future decision-making, in the event the patient becomes incapable.

**2.4.** The patient, their substitute decision-maker and their family/care partners will be connected with formal interpretation services as needed to ensure all assessments take place in the patient's preferred language. The substitute decision-maker or family/care partners should not be responsible for providing translation or interpretation, unless specifically requested by them.

**IMPLEMENTATION CONSIDERATIONS**

- Standardized templates and/or checklists should be developed to guide health care providers through the domains of care outlined by the Canadian Hospice Palliative Care Association, to ensure a comprehensive and holistic assessment. Ideally these should be developed at the provincial level. In the interim, health care providers can leverage the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care (NCP Guidelines, 4th edition) which outlines specific criteria for a comprehensive assessment (See Guideline 1.2, page 24-25).
- Tools to support comprehensive assessments, alongside disease-specific validated instruments, should be integrated into the Electronic Medical Record (EMR). Hospitals should ensure health care providers are trained to understand how to complete comprehensive assessment tools and validated instruments.
- Many patients express frustration having to repeat their story or being asked the same questions by multiple team members. A broadly accessible electronic platform developed at the provincial level should enable providers to access previous assessments and should have the ability to build on these across time and across location of care.
- Trauma-informed approaches are essential for providing person-centred care. Hospitals should ensure healthcare providers are educated on the basics of trauma, de-escalation, patient tracking, and grounding. There are currently no validated screening or assessment tools to identify traumatic stress. Healthcare providers will need to be attentive to potential symptoms and use clinical knowledge and skills to invite exploration as appropriate and within their professional scope of practice. Extended services should be engaged to address identified concerns as needed.
- The assessment process should incorporate questions and prompts for involving substitute decision-makers when appropriate, ensuring their active participation in care discussions.
- Ontario Health should develop disease-specific palliative-focused assessment toolkits to standardize approaches across the province. Disease-specific program areas within Ontario Health (i.e. Ontario Renal Network, CorHealth) should take the lead in creating these toolkits where they do not already exist, in collaboration with the Provincial Palliative Care Program.
- Hospitals should designate and train specific healthcare providers within different disease sites and units, such as RNs/RPNs or social workers, to serve as assessment leads for palliative care. These individuals would be responsible for conducting thorough, in-person assessments and can also mentor and support other staff to develop and enhance their assessment skills.
- Hospitals should support continuing education for healthcare providers on effective palliative care assessment techniques, with a specific focus on empathy, cultural humility, and cultural safety. It is imperative that all providers achieve these competencies to ensure the consistent delivery of palliative care across all units.

## Interprofessional Team-Based Palliative Care

The emphasis on an interprofessional team-based approach is central to delivering effective palliative care within hospital settings. The Adult Hospital Model of Care proposes an interprofessional team-based model. While the composition of the team will vary based on the needs of the patient, and on the local context, it will always consist of three layers of providers and services (i.e., the Core Team, Extended Services, and Palliative Care Specialists) with the patient and family/care partners being at the centre (Figure 2) [13]. Placing the patient and their family/care partners at the centre underscores their pivotal role in decision-making and care planning, ensuring that the team's care revolves around their unique needs, preferences, and goals of care.

The **Core Team** is responsible for providing direct, day-to-day support to the patient and their family/care partners, identifying their care needs, and connecting them with appropriate services. The Core Team comprises a most responsible medical professional (MRMP) (physician or nurse practitioner), and a provider with designated responsibility for care coordination (i.e. Social Worker or RN/RPN). The team's composition varies depending on the needs of the patient, and the capabilities of the team to address them. For instance, members of the patient’s current care team may become part of the Core Team if they have the necessary knowledge and skills. The Core Team has an established relationship with a Palliative Care Specialist Team for advice and mentorship or for direct patient care when the patient’s needs are more complex. All members of the Core Team will have at least primary-level palliative care competencies in palliative care.

**Extended Services** often work very closely with the Core Team. These providers offer direct care and support to the patient and family/care partners and may sometimes provide consultation to the Core Team on issues related to care. These providers may include, but are not limited to, pharmacists, personal support workers, trained volunteers, dietitians, rehabilitation therapists (e.g., physiotherapy, occupational therapy, and speech-language pathology), recreation therapists, social workers, respiratory therapists, spiritual care providers, psychosocial service providers, and Indigenous providers. Extended Services also include specialists with expertise in specific medical fields (e.g., geriatricians, cardiologists, oncologists, nephrologists, addiction services, and chronic pain specialists). At times, the Core Team may expand to include providers from Extended Services to meet the needs and goals of care of the patient. For example, the Core Team may consult or collaborate with a subspecialist to address complex needs related to an underlying disease. Like the Core Team, all providers of Extended Services should have at least primary-level competencies in palliative care.

**Palliative Care Specialists** include but are not limited to, palliative care physicians, NPs, RNs, RPNs, and social workers who have completed additional training in palliative care. These providers work in collaboration with the Core Team to provide shared care to patients and their family/care partners, provide consultation to the Core Team on issues related to patient care and support or may provide direct care.  Like Extended Services, Palliative Care Specialists may become part of the Core Team. For instance, a Palliative Care Specialist may serve as MRMP during end-of-life care to address complex needs. All Palliative Care Specialists must have and maintain secondary-level competencies, in alignment with the Ontario Palliative Care Competency Framework [14][5].

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[5] It is important to note that the palliative care competencies outlined in the Ontario Palliative Care Competency Framework should always be considered in the context of individual competencies, legislative scope of practice, professional standards, and practice guidelines, recognizing that these are updated on a regular basis. For nurses in particular, the palliative care competencies should be considered within the context of the Regulated Health Professions Act, 1991, the Nursing Act, 1991, and the regulatory framework as outlined by the College of Nurses of Ontario.

This section delineates the structure and functions of the Interprofessional Palliative Care Team. It also outlines the importance of ongoing education and collaboration to ensure teams have the appropriate knowledge and skills to deliver integrated, well-coordinated palliative care in the hospital setting.

For more detailed information regarding Palliative Specialist models in ambulatory and inpatient settings, please refer to Appendix I. This appendix provides an overview of guidance for team settings, composition, and care activities. While many teams may currently not meet all these criteria, they represent the ideal goals toward which Palliative Care Specialist teams should work.

**3. The patient and their family/care partners will have access to an interprofessional team.**

**HQO Quality Statement 2:** People with identified palliative care needs have access to palliative care support 24 hours a day, 7 days a week.
**HQO Quality Statement 12:** People with identified palliative care needs receive integrated care from an interprofessional team, which includes volunteers.

**3.1.** All patients will have a Core Team (e.g., a disease site team such as oncology, or a hospital unit-based provider team) that will be responsible for ensuring the consistent delivery of primary-level palliative care throughout the patient's hospital journey.

**3.1.1.** All members of the Core Team will have at least primary-level competencies in palliative care, including training in cultural safety and effective communication. Additionally, they will have a clear understanding of the roles of Extended Service Providers and Palliative Care Specialist Teams and when to seek their consultation.

**3.2.** The MRMP may be a Nurse Practitioner or a physician. The MRMP will be responsible for ordering tests, making diagnoses, ordering treatments, and prescribing medications. The MRMP will receive support from and, in turn, will provide support to the other members of the Interprofessional Palliative Care Team.

**3.3.** A member of the Core Team will have responsibility for care coordination, which will include serving as the central point of contact. Refer to recommendation 5 focused on Care Coordination and Care Transitions for additional details.

**3.4.** The patient (or the substitute decision-maker, if the patient is incapable) and their family/care partners are active, collaborating members of the Core Team.

**3.5.** As the patient and their family/care partners needs increase and/or change over time, the Core Team may need to engage Extended Service providers to address these changing needs.

**3.6.** In cases of escalating or complex needs, the Core Team may need to collaborate with Palliative Care Specialists.

**3.6.1.** Palliative Care Specialists will participate in a consultative capacity, with the potential for a shared-care or takeover role if Level 2 competencies are required or the Core Team's capabilities are exceeded. They may also become involved at the request of a patient or their family/care partner for a second opinion.

**3.6.2.** Palliative Care Specialist involvement becomes essential when one or more of these indicators are present:

- One or more symptoms remain uncontrolled, despite the use of best practices in managing the symptom(s);
- Specialized interventions (e.g., interventional symptom management, palliative sedation, or palliative care unit/hospital admission for symptom management) are required to manage symptoms;
- Clinical syndromes (e.g., agitated delirium) and/or co-morbidities that require specialized expertise;
- Complex psychological and spiritual distress remains unresolved, despite best efforts by the Core Team and Extended Service providers;
- Complex social conditions (e.g., lack of social supports, precarious housing), which require additional expertise to plan and/or manage;
- Difficulties in establishing goals of care and/or obtaining consent for a care plan, despite best efforts to do so; or establishing goals or a care plan is complicated by legal and/or ethical issues; and
- Repeated ED visits and/or hospitalizations because of exacerbation of symptoms or distress.

**3.7.** Every Core Team will have access to Palliative Care Specialists who will be available 24/7 to provide support and consultation to the MRMP in-person or via telephone or other technologies (e.g., telemedicine, virtual care, secure electronic communication).

**3.8.** Education and information on palliative care, care transitions, and the role of Palliative Care Specialists will be provided to the patient and family/care partners as early as possible and throughout their experience. While the Core Team will be responsible for ensuring that education and information is provided, all members of the Interprofessional Palliative Care Team will have a role in supporting the patient and family/care partners with education and information that is culturally safe and appropriate.

**IMPLEMENTATION CONSIDERATIONS**

- Hospitals should prioritize access to dedicated outpatient spaces, including designated clinics, nursing staff, social workers, support staff, as well as clerical staff, to facilitate the provision of interprofessional team-based palliative care.
- Hospitals should devise strategies to build primary-level competencies for hospital staff, with clear timelines and dedicated resources identified for each program. This should include facilitating ongoing education opportunities and providing resources for staff to enhance their skills and stay updated on best practices and evidence-informed approaches in palliative care [15].
- All hospital-based providers working with patients with serious illnesses should strive to acquire primary-level competencies, as outlined in the Ontario Palliative Care Competency Framework. It is also important for hospital providers to understand how palliative care is delivered in their local community, and what supports and services are available (e.g., palliative care specialists, hospice residences, visiting hospice services), to help inform patient decisions.
- The involvement of Palliative Care Specialists has been described as existing along a spectrum, with consultation model at one end, and the takeover model at the other end. Hospital based specialist palliative care teams should periodically reflect on the model they are providing and monitor it. The Consultation-Shared Care-Takeover (C-S-T) Framework provides a tool to guide these reflections and monitoring [16].
- Clinical Leads or Department Heads should take the initiative to organize and conduct regular

interprofessional meetings, providing a forum to discuss complex palliative care cases and share expertise among team members.

- Hospitals should establish policies and procedures to standardize the use of evidence-based communication processes among health care providers to support safe and effective communication practices and transitions in care [15].
- Access to a shared electronic medical record system, available across settings, is required to support communication amongst all Interprofessional Palliative Care Team members.
- Smaller, and/or more rural hospitals may have challenges accessing Extended Services, and Palliative Care Specialists. Enhancing partnerships with larger/urban centres, and leveraging technology, where appropriate, can help to ensure access.
- Hospitals should ensure health care providers are educated on the use of technology and virtual care delivery processes, supporting protected time for continuing education to enhance skills in delivering palliative care virtually [17].
- Hospitals should ensure health care providers receive ongoing education and skills training on stress management and have opportunities and resources for debriefing. Hospitals should also ensure adequate staffing levels to mitigate the risk of burnout and compassion fatigue among healthcare providers [18].
- A provincially led review and revision of palliative care funding mechanisms is required to support an interprofessional team-based approach to palliative care. Efficient allocation of provincial resources is essential to support the roles and responsibilities of the Interprofessional Palliative Care Team. This includes comprehensive health human resources capacity planning and integrated funding models tailored to address patient needs across all domains and demand for services.

## Key Conversations, Care Planning, and Reassessment

Engaging the patient, their substitute decision-maker, and their family/care partners in conversations about their serious illness can be difficult but is essential for ensuring they understand the illness and how it will progress to prepare them for future decision-making. These conversations should aim to build on previous Advance Care Planning and goals of care efforts (i.e. occurring prior to admission), to ensure continuity in person-centred care. Ongoing discussions to explore the patient’s preferences, needs, values, expectations, concerns and goals of care, as well as the family/care partner’s concerns, provide the foundation and framework for developing a comprehensive person-centred care plan. Involving the substitute decision-maker, and their family/care partners in conversations and care planning is important for fostering a shared understanding, provided the patient has given consent to include them. Ongoing assessments of the patient's needs are essential for ensuring the care plan is meeting the identified needs, preferences, and goals of the patient. This section explores the critical processes for regularly engaging in key conversations, and for establishing and documenting a care plan, emphasizing the need for continuous evaluation. There is also an emphasis on leveraging an interdisciplinary approach to conversations and care planning. Including nurses and social workers in these discussions would enable them to work to scope, and often provides increased satisfaction in their work, while taking some of the burden away from the MRMP. Current challenges in this area include provider discomfort with navigating difficult conversations, discrepancies between care and patient preferences, and inconsistencies in care across settings [19]. The following recommendations aim to ensure that patients and their families receive comprehensive and person-centered care tailored to their unique needs.

**4. The Core Team will collaborate with the patient (or the substitute decision-maker) and their family/care partners to develop and document a care plan that is based on the patient's wishes, values, and beliefs, and their identified goals of care, and to regularly assess their needs**.

**HQO Quality Statement 3:** People with a serious illness know who their substitute decision-maker is. They engage in ongoing communication with their substitute decision-maker about their wishes, values, and beliefs, so that the substitute decision-maker is empowered to participate in the health care consent process if required.
**HQO Quality Statement 4:** People with identified palliative care needs or their substitute decision-makers have discussions with their interprofessional health care team about their goals of care to help inform their health care decisions. These values-based discussions focus on ensuring an accurate understanding of both the illness and treatment options so the person or their substitute decision-maker has the information they need to give or refuse consent to treatment.
**HQO Quality Statement 5:** People with identified palliative care needs collaborate with their primary care provider and other health care professionals to develop an individualized, person-centred care plan that is reviewed and updated regularly.

**4.1.** The Core Team and/or other members of the Interprofessional Palliative Care Team will have discussions with the patient, their substitute decision-maker, and their family/care partners (assuming the patient or substitute decision-maker agrees to share that information with them) to explore the patient's wishes, values, beliefs, and to help them understand the patient's illness.

**4.1.1.** The Core Team and/or other members of the Interprofessional Palliative Care Team will assess and address the patient (or substitute decision-maker, if the patient is incapable) and the family/care partners information needs and understanding of the disease, address any gaps between reality and expectation, foster realistic hope and provide opportunities to explore prognosis and life expectancy, along with preparedness for death.

**4.2.** The Core Team and/or other members of the Interprofessional Palliative Care Team will have discussions with the patient (or the substitute decision-maker, if the patient is incapable) to identify their goals of care. These goals should reflect the patient's wishes and values and be realistic in the context of the patient's prognosis and the limitations of medical treatment.

**4.2.1.** The Core Team will review and confirm the individual's goals of care regularly and in the event of a change in health status.

**4.3.** The Core Team will review available care and treatment options with the patient (or the substitute decision-maker, if the patient is incapable), support them in making decisions and obtain consent for a care plan.

**4.3.1.** If a patient makes any treatment decisions relevant to their current condition (i.e., provides consent), these decisions can be incorporated into their Plan of Treatment.

**4.4.** The Core Team will collaborate with the patient (or the substitute decision-maker, if the patient is incapable), their family/care partners, and other members of the Interprofessional Palliative Care Team to develop and maintain an up-to-date care plan.

**4.4.1.** The care plan will include specific elements of treatment aimed at meeting the holistic needs of the patient and achieving their identified goals of care and will include proactive considerations for end-of-life planning.

**4.4.2.** The care plan will be available to the patient, their substitute decision-maker (when appropriate), and the Interprofessional Palliative Care Team, ideally through a single electronic platform.

**4.4.3.** A dedicated member of the Core Team will ensure that each element of the care plan is implemented by the most appropriate provider.

**4.4.4.** A member of the Core Team will be assigned as the primary point of contact for managing, documenting, and updating the care plan.

**4.5.** The Core Team will ensure that the needs of the patient and their family/care partners are periodically reassessed, particularly in response to changes in the patient's condition, care preferences, and goals of care. Any identified changes will be documented in the care plan.

**IMPLEMENTATION CONSIDERATIONS**

- Communication skills training programs that emphasize active listening and exploration of patient values and wishes are needed for providers in hospital settings. Various Advance Care Planning, goals of care discussions and consent training opportunities offered through Hospice Palliative Care Ontario, and The Canadian Serious Illness Conversation course offered by Pallium Canada are examples of education that could be leveraged.
- A centralized repository of standard visual aids, decision trees, and other interactive tools should be established to facilitate discussions about illness understanding and decision-making. These resources should be written in plain language, ideally in multiple languages, and should be easily accessible and relevant to different disease contexts. Delivering forms of culturally safe and accessible care to support the decision-making process of patients, their families and substitute
- Efforts should be made to ensure the effective implementation of standardized palliative and goals of care documentation across provincial healthcare settings. Collaboration with regional and provincial authorities may be necessary to establish clear guidelines and protocols.
- A provincial electronic platform for documenting and managing care plans should be made available, that includes a focus on seamless integration with existing systems and accessibility for all members of the Interprofessional Palliative Care Team, and other providers across settings.
- Strategies should be developed to ensure that patient-facing versions of care plans are readily accessible and effectively shared with patients and their family/care partners, enhancing their involvement in decision-making processes.
- Clear procedures should be established for scheduling and conducting regular reassessments during clinic visits, hospital admissions, or in response to changes in the patient's clinical status, ensuring continuity and responsiveness in care delivery.
- Hospitals should participate in provincially led patient and caregiver experience surveys.

## Care Coordination and Care Transitions

Ensuring seamless transitions between hospital and community settings is paramount in palliative care [11]. The current landscape often lacks the necessary coordination, leading to fragmented care experiences for patients with serious illnesses [20]. This section delves into the strategies and collaborative efforts required to bridge this gap, emphasizing the importance of continuous communication, and coordinated care plans. The goal of this section is to establish robust care coordination mechanisms that facilitate seamless transitions for patients with identified palliative care needs. By designating a healthcare provider responsible for care coordination and fostering communication among various Health System Partners, including patients, family/care partners, and healthcare teams, the aim is to enhance collaboration and streamline transitions across care settings.

### 5. The patient and their family/care partner will always have a designated health care provider to coordinate their care, and to manage care transitions to other settings.

**HQO Quality Statement 10:** People with identified palliative care needs experience seamless transitions in care that are coordinated effectively among settings and health care providers.

Ontario Health Quality Standard for Transitions Between Hospitals and Home

**5.1.** Following the development of the care plan, a member of the Core Team will be designated with the responsibility for care coordination. This provider will be the key point of contact, responsible for organizing care and services, liaising with other healthcare providers, and managing care transitions.

**5.1.1.** The designated team member will ensure ongoing communication and collaboration with the patient and their family/care partners, directing them to services as required, and acting as their advocate when needed.

**5.1.2.** The designated team member will facilitate seamless communication between the Core Team, Extended Service providers and Palliative Specialists (when involved) to address identified needs, as required. This will include scheduling regular collaborative meetings.

**5.1.3.** The designated team member will connect with the patient’s primary care and home and community care providers, and other involved care teams (such as long-term care (LTC) facilities, and/or specialized disease clinics, etc.) following admission or intake to exchange relevant information, and to provide regular updates.

**5.2.** If the patient is discharged or transferred, the designated team member will communicate with the receiving community or facility-based team to ensure a cohesive understanding of the patient's condition and care plan prior to and following transfer. A closed loop communication process will help to facilitate seamless transitions for the patient and family/care partners.

**5.2.1.** The designated team member will connect with the patient’s primary care and home and community care providers, and other involved care teams (such as long-term care (LTC) facilities, and/or specialized disease clinics, etc.) early in the discharge or transfer process to ensure an MRMP and other appropriate supports are in place.

**5.2.2.** The designated team member will engage the patient and their family/care partner in transition planning, including development of a transition plan, providing information on whom to contact when help is required, and ensuring completion of a medication review. The patient and their family/care partner will also be offered education, training, and support to manage their health care needs at home.

**5.2.3.** The designated team member will follow-up with the patient and their family/care partner following discharge to home to support the transition in care.

**5.2.4.** For patients without a primary care provider or clinic affiliation, the designated team member will initiate referrals to primary care providers, outpatient hospital-based clinics, and/or other community-based clinics or teams to ensure ongoing palliative care support.

**5.2.5.** For patients managed in outpatient settings, the designated team member may coordinate direct admissions to palliative settings, bypassing the emergency department or the hospital entirely.

**IMPLEMENTATION CONSIDERATIONS**

- A broadly accessible provincial electronic platform should be made available that could support standardized communication to primary care and community care providers at discharge.
- Hospitals should establish standardized discharge planning protocols for patients receiving palliative care, ensuring that all necessary arrangements and supports are in place prior to discharge. This may include ensuring the patient has an MRMP, medication management, equipment provision, home care services, and follow-up appointments.
- Hospital administrators can leverage the Registered Nurses' Association of Ontario's Transitions in Care and Services Best Practice Guideline to support the development of policies, procedures, protocols and educational programs to support service delivery [21].
- To avoid issues with medication coverage, or ordering during transitions of care, discharge order sets should ideally include medications that are covered by Ontario Drug Benefits (ODB). If medications require Palliative Care Facilitated Access (PCFA) authorization, the Core Team should ensure that the patient is connected with a palliative care provider in the community to support ongoing access to medications as needed.
- Disease site-teams and hospital unit-based teams should be aware of, and familiar with Ontario Health's Quality Standard for Transitions Between Hospital and Home, and should work towards achieving high-quality care in alignment with the quality statements outlined.
- Disease site-teams and hospital unit-based teams should regularly update the patient's primary care and home and community care providers, and other involved care teams (such as long-term care (LTC) facilities, and/or specialized disease clinics, etc.) throughout the patient's stay in hospital, not just at discharge. These updates can help to support transitions back to community and ensure patients and care partners do not need to repeat their stories and information when returning to another setting.
- Disease site-teams and hospital unit-based teams should collaborate with community paramedicine providers in care planning and information sharing through platforms like HPG and CHRIS, facilitated by EMRs.
- Hospitals should establish resources and relationships with community-based service providers who have primary-level palliative care competencies who can help to address identified palliative care needs, particularly for patients who do not have primary care providers. The Core Team should ensure the patient is connected to a primary care team on discharge and confirm that connection is made. Ideally if the connection is new the Core Team should facilitate an initial contact between patient and primary care team.
- Disease site-teams and hospital unit-based teams should be aware of, and familiar with local

palliative care supports and services, including hospice resources (e.g. available hospice residence beds, visiting hospice services), to support meaningful referrals.

- Disease site-teams and hospital unit-based teams should leverage and implement existing educational materials and resources to inform patients and their family/care partners about the discharge process, available support services, and self-management strategies. Providing clear and accessible information can empower patients and families to actively participate in their care transitions.
- Ontario Health Regions should offer training sessions to healthcare providers involved in palliative care to enhance their understanding of care coordination principles, communication strategies, and the importance of collaborative teamwork. Training sessions could focus on topics such as effective communication, conflict resolution, and interprofessional collaboration.
- Ontario Health Regions should explore the use of technology-enabled solutions, such as telehealth platforms, mobile applications, and remote monitoring devices, to support ongoing bi-directional communication and coordination between healthcare providers, patients, and family/care partners during care transitions.

## Management of Pain and Other Symptoms

Effective pain and symptom management, available round-the-clock, is fundamental to comprehensive palliative care in hospitals [22]. This section addresses the critical need for structured approaches and collaborative efforts aimed at proficiently managing pain and other symptoms that patients may encounter. The gap lies in the inconsistent access to timely pain and symptom management, leading to suboptimal patient outcomes and experiences [22]. The goal of this section is to establish robust mechanisms to ensure uninterrupted access to pain and symptom management, facilitated by the Core Team or on-call providers, accessible 24/7 via telemedicine channels such as telephone support or virtual care. These efforts aim to optimize patient comfort, improve quality of life, and enhance overall palliative care delivery in hospital settings.

**6. The patient will have 24/7 access to pain and symptom management. This may occur in person or via telemedicine (e.g., telephone support, virtual care, etc.).**

**HQO Quality Statement 2:** People with identified palliative care needs have access to palliative care support 24 hours a day, 7 days a week.
**HQO Quality Statement 6:** People with identified palliative care needs have their pain and other symptoms managed effectively, in a timely manner.

**6.1.** The MRMP will use standardized screening tools to regularly reassess symptoms, make diagnoses, prescribe medications, and order other treatments. The MRMP will collaborate with Extended Service Providers (e.g., physiotherapists to assess pain mobility, or teams who support ‘responsive expressions’, to support assessments for patients who are non-verbal or with cognitive impairment) or may seek consultation from Palliative Care Specialists, when needed (please refer to Recommendation 3.6 for further guidance).

**6.2.** The RN or RPN will use standardized tools to screen for, assess, monitor, and manage the patient’s symptoms and will consult with the MRMP as needed.

**6.3.** The Core Team will engage or consult with the appropriate Extended Service providers to address specific symptom management needs (e.g., dieticians, speech language pathologists, physiotherapists).

**6.4.** A member of the Core Team (MRMP, or RN/RPN) or the hospital pharmacist will work in partnership with the patient and their care partner to complete a medication review on admission and again before discharge. This review should include information about medication reconciliation, adherence, and optimization, as well as effective use, and access in the community. The medication review should also be carefully communicated to primary care and home care providers.

**6.5.** Pharmacists, in consultation with the Core Team, will play a role in symptom management, medication safety and reconciliation and will support treatment decisions throughout the patient's journey.

**6.6.** Where appropriate, technology-based healthcare services (e.g., telemedicine virtual care, videoconferencing, e-shift) will be leveraged to bridge current service gaps and improve access to services, particularly for rural and isolated communities.

**IMPLEMENTATION CONSIDERATIONS**

- Hospitals should implement standardized symptom management guidelines and order sets within their EMRs to ensure evidence-based and consistent symptom management for all patients receiving palliative care. The utilization of clear, accessible guidelines supports healthcare providers in making informed, timely decisions regarding patient care. Implementation should be supported by comprehensive training to ensure providers are proficient in utilizing these tools for symptom management.
- Prior to discharge, patients, families and care partners should be informed about medications available for symptom management, their side effects and how to obtain them (e.g., do they have to call an RN/RPN for a PRN, or will it be regularly scheduled). Ideally these should be available in written form as a reference as well.
- Disease site-teams and hospital unit-based teams should receive ongoing education about comprehensive symptom screening and the use of symptom assessment tools (see Guideline 2.2, page 14 in the NCP Guidelines, 4th edition, for more information about screening and assessing physical aspects of care, as well as pages 71-74 for a fulsome list of physical assessment tools).
- Hospitals should establish mechanisms for documenting symptoms across time and monitoring efficacy of treatment.
- Hospitals should ensure access to on-call Palliative Care Specialists to provide expert support for non-specialist providers, especially in managing complex symptoms. This support could be facilitated through direct staffing arrangements or via telemedicine collaborations with larger centers, ensuring round-the-clock access to palliative care expertise.
- Hospitals should provide healthcare providers with the tools and resources to support the delivery of safe and effective virtual care, including regularly updated policy and procedures [17].
- Hospitals should leverage technology not only for telemedicine and virtual care but also to facilitate access to on-call Palliative Care Specialists and the use of standardized order sets. This strategy ensures that even remote or smaller facilities have the necessary support and resources to manage symptoms effectively, utilizing digital tools to bridge gaps in care and expertise.
- The role of the on-call Palliative Care Specialist should be clearly defined within the

Interprofessional Palliative Care Team. Their expertise is recommended to be integrated into the collaborative care model, facilitating seamless consultation and support for complex case management. This enhances the team's ability to deliver comprehensive symptom management.

## Management of Psychosocial Needs

Psychosocial care refers to the integrated approach to addressing the psychological and social aspects of patients' and their family/care partners' well-being within the context of palliative care. This encompasses the identification and support of emotional, mental, spiritual, and social needs, alongside the physical aspects of care. Psychosocial care is integral to the holistic management of patients and their family/care partners within the palliative care spectrum [23, 24]. Gaps exist in consistently identifying and addressing these needs across care settings, leading to suboptimal outcomes and experiences for patients and their family/care partners [23, 24]. Psychological distress is commonly experienced among those with palliative care needs; however, is often under-detected and under-treated. It may be experienced by the patient as well as their family/care partners. Emotional distress can impact the ability to make decisions related to care and is a key element of quality of life. Psychological screening plays an important role in improving detection and management of distress. The goal of this section is to establish structured approaches to identify and address psychosocial needs effectively, thereby enhancing the overall quality of palliative care delivery and ensuring comprehensive support for patients and their family/care partners.

**7. The patient and their family will have access to psychosocial care to address their needs in a culturally safe manner.**

**HQO Quality Statement 7:** People with identified palliative care needs receive timely psychosocial support to address their mental, emotional, social, cultural, and spiritual needs.

**7.1.** The Core Team will regularly screen for psychosocial needs of the patient and their family/care partners in a culturally safe manner.

**7.1.1.** The Core Team will engage Extended Service providers with expertise in spiritual care to support open and neutral assessment of the patient's faith, religious and/or spiritual practices and preferences (where possible – or their family members or care partners) to ensure delivery of culturally safe care.

**7.2.** The Core Team will engage Extended Service providers with expertise in psychosocial care (e.g., social workers, trained volunteers, Indigenous providers, grief counsellors, and mental health professionals) and/or Palliative Care Specialists to support assessment of psychosocial needs, including consideration for grief and loss.

**7.3.** The Core Team will provide psychosocial support to address identified needs within their scope of practice to all patients and their family/care partners. The Core Team will refer to Extended Service providers with expertise in psychosocial care (e.g., social workers, trained volunteers, Indigenous providers, grief counsellors, and mental health professionals) and/or Palliative Care Specialists to address needs that are more extensive or complex than the Core Team can manage.

## 8. The patient and their family/care partner will have access to practical and social support to address their needs in a culturally safe manner.

**HQO Quality Statement 7:** People with identified palliative care needs receive timely psychosocial support to address their mental, emotional, social, cultural, and spiritual needs.

**8.1.** The Core Team and Extended Service providers will regularly assess and document the patient's ability to perform activities of daily living (ADL) and instrumental activities of daily living (IADL). The Core Team will engage the appropriate Extended Service providers such as personal support workers, physiotherapists, occupational therapists, social workers, or others to provide practical support as needed.

**8.2.** The Core Team will regularly assess the patient and their family/care partners' transportation needs to ensure that their access to care is not impeded. This assessment may include the needs of dependents, such as children and others in the household receiving care or being supported by the patient.

**8.3.** The Core Team will identify challenges experienced by the patient and their family/care partners related to the social determinants of health. Specifically, financial insecurity, unstable housing, and food insecurity will be included as a part of the comprehensive and holistic assessment. Extended Services will be engaged to address these needs and advocate for support, where appropriate.

### IMPLEMENTATION CONSIDERATIONS

- A single screening tool cannot cover all aspects of the psychosocial domain. Teams will need to consider various tools to further explore concerns raised by patients or their family/care partners. Please refer to Appendix J for examples of suggested psychosocial screening tools.
- Hospitals should be aware of common barriers within their region, including socioeconomic factors that may impact access to care, and develop mitigation strategies to address them. For example, in areas with no public transit, systems should be in place to address transportation barriers. The Core Team should be able to implement strategies seamlessly, to remove as many barriers to care as possible.
- A comprehensive health human resources plan should be developed at a provincial level. This plan should ensure access to psychosocial service providers specializing in palliative care, particularly within communities. Prioritization should be placed on increasing capacity to provide equitable access to in-home services, including hospice volunteers and personal support, through both in-person visits and virtual platforms.
- Ontario Health Regions should prioritize the establishment of robust networks comprising resources and professionals, such as social workers, grief counselors, spiritual care providers, and community-based supports. These networks should facilitate seamless access to psychosocial care for patients and their families, thereby ensuring holistic support throughout the palliative care journey.
- Ontario Health Regions should take proactive steps to initiate programs and partnerships aimed at addressing broader social determinants of health, including financial counseling, food banks, and housing assistance. By addressing these underlying factors, regions can significantly improve the overall well-being and outcomes of patients and their families.

## End-of-Life Care

Navigating the final stages of life requires not only medical expertise but also compassionate and comprehensive support for both patients and their family/care partners [25, 26, 27]. As individuals approach the end of life, meticulous planning and ongoing discussions with healthcare professionals become paramount in ensuring a dignified and comfortable experience. Gaps exist in effectively addressing the dynamic needs and preferences of patients and their families [25, 26, 27]. Recognizing these challenges, the goal of this section is to outline systematic approaches and thoughtful considerations essential in facilitating a compassionate and dignified end-of-life experience. By providing structured guidance on planning, symptom management, communication, and access to appropriate care settings, this section aims to enhance the quality of end-of-life care delivery and support for patients and their family/care partners.

**9. Planning for end-of-life care will begin as early as possible and when it is acceptable to the patient and their family/care partners.**

**HQO Quality Statement 11:** People with identified palliative care needs, their substitute decision-maker, their family, and their family/care partners have ongoing discussions with their health care professionals about their preferred setting of care and place of death.

**9.1.** A designated member of the Core Team will reconfirm the communication and linguistic needs of the patient at the end of life. Interpretation/translation services will be available to communicate any information to the patient in their preferred language.

**9.2.** A designated member of the Core Team will engage the patient (or their substitute decision maker, if the patient is incapable) and their family/care partners in key conversations to revisit goals of care and to discuss and document key treatment decisions. This will include:

- **9.2.1.** Reviewing patient preferences and goals of care regularly, particularly when there is a change in clinical status.
- **9.2.2.** Discussing the risks and benefits of resuscitation and other life-sustaining measures with the patient (or substitute decision-maker, if the patient is incapable) and their family/care partners before placing an order to withhold resuscitative measures in the EMR[6].

**9.3.** The Core Team (and possibly the Palliative Care Specialists) will work with the patient, substitute decision-maker, and their family/care partners to proactively develop, document and implement a comprehensive end-of-life care plan. The plan will clearly indicate who is responsible for managing the patient’s symptoms, and whom to contact if help is required. The plan will also contain information about the pronouncement of death, completion of the

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[6] When the goals of care are comfort-oriented, aggressive, or invasive forms of life sustaining therapy (e.g. CPR, intubation) are generally not appropriate, and this should be discussed with the patient and their family/care partner. Importantly, consent is not required to write a do-not-resuscitate (DNR) order in the hospital, but this must be communicated with patient/family members consistent with the CPSO policy. Patients and family members who do not agree to a DNR order may not be appropriate for a care plan focused purely on comfort care, as they may have unrealistic care expectations. If the patient, substitute decision-maker, family and/or care partners disagree with decisions of the medical team, the team should follow the steps outlined in the CPSO Policy “Decision Making for End of Life Care”. Nurses have a professional obligation to meet the standards and practices outlined by the College of Nurses of Ontario.

death certificate, and post-death care, regardless of the setting. The planning process will include:

- **9.3.1.** Preparing and supporting the family/care partners to understand what to expect, and plan for with end-stage disease and as death nears, including understanding probable symptoms. The level of detail provided should be based on the identified preferences of the patient and their family/care partners.
- **9.3.2.** Discussing emergency and crisis management plans, including who to contact, and when to use or avoid Emergency Medical Services.
- **9.3.3.** Exploring place-of death preferences and the resources required (e.g., home, hospice, palliative care unit, long term care or nursing home) to assess whether this is realistic. This should include backup planning, in case preferences or needs change.
- **9.3.4.** Ordering emergency symptom relief medications to ensure these are available to manage potential end-of-life crises.

**9.4.** If the patient is discharged to a community setting, the Core Team will work with the patient, (or substitute decision-maker, if the patient is incapable) and their family/care partners to facilitate a seamless transition. This process will include:

- **9.4.1.** Connecting with the patient's primary care team (or, other community providers) to ensure an MRMP is in place, and that local processes and procedures for managing an expected death in the home are initiated (often referred to as an "Expected Death in the Home" (EDITH) Protocol or similar).
- **9.4.2.** Introducing the patient and family to resources in community (e.g., respite, day hospice programs, volunteer services, support groups, etc.).
- **9.4.3.** Ensuring resources and services are in place to support the patient and their family/caregiver, and address identified needs.
- **9.4.4.** Anticipating/planning for pain and symptom management, including ordering emergency symptom relief medications to ensure these are available in the home.
- **9.4.5.** Discussing the risks and benefits of resuscitation and other life-sustaining measures with the patient and their family/care partners before completing the 'Do Not Resuscitate' Confirmation Form (DNR-C). The Core Team will document this in the patient's record.

**9.5.** When death is approaching, a designated member of the Core Team will ensure that the patient and their family/care partners' psychosocial needs are periodically reassessed and monitored. The Core Team will revisit and reinforce prior education on what to expect at end of life and provide real-time support for families/care partners. The care plan will be adjusted as needed.

**9.6.** In communities where designated palliative care beds (e.g., palliative care units or hospice residences) exist, information about these beds will be offered to the patient and their family/care partner as needed. These services will be accessed according to the patient's care plan as necessary.

**9.7.** A member of the Core Team will discuss with patients and families/care partners whether there are any cultural, religious, or spiritual practices that would be important to consider around the time of death. Any identified requests will be documented in the EMR and communicated to the broader Interprofessional Palliative Care Team. Every effort will be made to accommodate these requests.

**9.8.** When a patient dies in the hospital, a member of the Core Team will notify the patient's primary care and home and community care providers, or other involved care teams (such as long-term care (LTC) facilities, and/or specialized disease clinics, etc.) and share appropriate details.

**IMPLEMENTATION CONSIDERATIONS**

- Hospitals should establish a process to ensure that all families/care partners are offered comprehensive information and education about what to expect during the dying process, procedures for after death, and key points of contact.
- Hospitals should plan for inpatients who may need to receive end-of-life care within their facility, with consideration for beds in appropriate settings (i.e. privacy), and staff with competencies to provide care. An overview of ideal standards for team settings, composition, and care activities are outlined in Appendix I.
- Hospitals should streamline processes for death pronouncement and death certificate completion to alleviate any added stress on the family (e.g., Electronic Medical Certificate of Death).
- Hospitals should ensure staff are educated on diverse death-related cultural, religious, and spiritual practices to ensure respectful and culturally safe care. Organizational policies should be established to accommodate cultural needs and religious practices or rituals, such as providing extra time after death, facilitating smudging ceremonies, or arranging direct transport to the funeral home.
- Hospital administrators can leverage the Registered Nurses' Association of Ontario's End-of-Life Care During the Last Days and Hours Best Practice Guideline to support the development of policies, procedures, protocols, educational programs, and assessment and documentation tools [18].
- Hospitals should collaborate with external grief counselors or bereavement support groups to ensure continuous and tailored support for families/care partners even after the patient's death. Additionally, offering memory-making or memorial activities within the hospital can provide opportunities for families/care partners to honour the memory of the deceased patient.
- Grieving takes time, so it is important to extend "check-in" periods beyond just a few weeks. Investments are required to address how best to support families and care partners for a longer period using community resources and services.
- Hospitals should develop or partner with programs that offer debriefing, and bereavement supports to staff after any death.

## Family and Care Partner Support

From the initial diagnosis through the end-of-life phase and into bereavement, the needs of family members and care partners evolve and require tailored support [28, 29, 30]. Significant gaps persist in effectively meeting the diverse needs of these individuals, often resulting in heightened distress and diminished coping abilities [28, 29, 30]. This section aims to enhance the well-being and resilience of family members and care partners, ensuring they receive the support necessary to navigate the complexities of caregiving, end-of-life decision-making, and grief with compassion and dignity.

## 10. The family/care partners of the patient with a life-limiting illness will be supported throughout the person's illness trajectory, at the end of life, and through death and bereavement.

**HQO Quality Statement 8:** People with a serious illness, their future substitute decision-maker, their family/care partners are offered education about palliative care and information about available resources and supports.
**HQO Quality Statement 9:** Family/care partners of people with identified palliative care needs are offered ongoing assessment of their needs, and are given access to resources, respite care, and grief and bereavement support, consistent with their preferences.

**10.1.** The Core Team and Extended Service providers will continuously assess the physical, practical, psychosocial, and informational needs of family/care partners in a culturally safe manner. Core Team members will ensure relevant providers are engaged as necessary, particularly Child Life Specialists (or similar professionals) to help provide developmentally appropriate support to dependent children.

**10.2.** Members of the Core Team and/or Extended Service providers will provide psychosocial support to family/care partners within their scope of practice. Palliative Care Specialists will be consulted when the needs of family/care partners are more complex. Age-appropriate assessments will be conducted for young children and teens as needed, with essential support provided accordingly.

**10.3.** The Core Team and Extended Service providers will ensure that family/care partners are offered appropriate and culturally relevant educational materials covering a wide range of topics (e.g., caregiving, anticipatory guidance, community-based services and supports). These educational resources will be available in multiple languages and presented in various formats (e.g. face-to-face sessions, written materials, digital resources).

**10.4.** The Core Team and/or Extended Service providers will arrange culturally safe bereavement support and counseling for family/care partners throughout their journey. Guidance and resources related to grief and bereavement will be offered to all patients and families/care partners. Supports will be person-centered, ensuring that information and care are offered early and consistently.

**10.5.** After the death of the patient, the Core Team will support the family/care partners in transitioning their care to appropriate community resources (e.g., bereavement information and education, one-on-one counseling, peer and/or group sessions, their primary care provider). The unique needs of youth and young children will also be considered. The Core Team will follow up with the family/care partners to evaluate the effectiveness of services and to address any gaps in care.

### IMPLEMENTATION CONSIDERATIONS

- Hospitals should establish or leverage existing programs and resources specifically tailored to support family/care partners, ensuring that staff are well-trained to address their unique challenges [31].
- Integration of standardized family/care partner assessment tools, such as the Family Needs Assessment Tool (FNAT) or the McGill Quality of Life Questionnaire (MQOL-Family), into the patient's care journey should be prioritized.
- Hospitals should provide education for families and care partners on preventing burnout and

managing symptoms of stress as they care for persons at the end of life, including awareness of respite services.

- Collaboration with community partners, such as hospices, should be pursued to establish or leverage existing connections to grief and bereavement supports, covering practical, informational, psychosocial, physical, and emotional dimensions of care.
- Offering workshops, webinars, and online resources customized for family/care partners should be facilitated to guide them through care, system navigation, and resource availability.
- Structured emotional support avenues, such as peer support groups or counseling sessions, should be established or leveraged, ensuring multilingual and culturally appropriate options.
- Development of a physical or digital hub centralizing resources for family/care partners, regularly updated and user-friendly, should be prioritized to enhance accessibility and relevance.
- Patients may need help in supporting any dependent children (3-17y) with understanding the diagnosis, implications on family life, prognosis updates, emotional expression, parenting guidance during stressful times, Mental Health issue mitigation via open honest communication, legacy building and end of life support. Access to Child Life Specialists (CLS) or similar professionals should be provided to aid in offering age-appropriate interventions, such as assessments and resources for family members who are 18 years of age and younger.

## Palliative Care for Francophones

Providing accessible and visible French language services is necessary for meeting the palliative care needs of Francophone patients and their families or care partners. Adhering to the Active Offer Principle, healthcare providers should proactively provide these services without awaiting a request. Significant gaps exist in ensuring consistent and comprehensive access to French language palliative care services, leading to potential disparities in care delivery. Therefore, the goal of this section is to outline strategic approaches and resources necessary to ensure that linguistic preferences are respected and incorporated throughout the care journey. By standardizing the documentation of linguistic identity, promoting French language communication in all patient interactions, and leveraging innovative solutions such as virtual care, this section aims to enhance the visibility and accessibility of French language palliative care services, thereby improving the quality of care for Francophone patients and their family/care partners.

**11. French language services will be highly visible and easily accessible for the patient and their family/care partners. Healthcare providers must offer these services, guided by the Active Offer Principle, without waiting to be asked.**

**11.1.** All members of the Interprofessional Palliative Care Team will ensure that conversations with Francophone patients (or their substitute decision-maker, if the patient is incapable) and their families/care partners are conducted in their comfort language. This is particularly important for discussions about advance care planning, illness understanding, goals of care, treatment options, and obtaining consent.

**11.2.** All members of the Interprofessional Palliative Care Team will ensure that patients and their family/care partners have access to plain language and inclusive educational materials in their preferred language, facilitating their ability to make informed decisions and actively engage in their care.

**11.3.** Where bilingual human resources are limited, the Interprofessional Palliative Care Team will leverage virtual care innovations (e.g., telemedicine) to improve access to French language services for Francophone patients and their family/care partners.

**11.4.** The Interprofessional Palliative Care Team will engage formal, third-party interpretation services when palliative care services are not available in French. The substitute decision-maker or family/care partners should not be used as translators or interpreters.

**IMPLEMENTATION CONSIDERATIONS**

- Hospitals should ensure all healthcare providers are educated on the Active Offer of French Language Health Services. The online training courses developed by the Réseau du mieux-être Francophone du nord and Entité 3 can be used to enhance staff capabilities in offering French-language services
- Hospitals should identify the linguistic capabilities and fluency of all staff to support patient access to care in their preferred language, including French. Refer to French Language Oral and Written Skill Proficiency – Self Assessment
- Hospitals should encourage all French-speaking staff to wear a "Je parle français" button or lanyard to help patients and other staff members identify French-speaking team members.

## Equitable and Inclusive Palliative Care

Ensuring equitable and inclusive palliative care for all patients and their family/care partners, is a cornerstone of compassionate and person-centered care [32]. To ensure care is equitable, and inclusive, improved access is required for Black people, racialized individuals, members of the 2SLGBTQIA+ community, immigrants, refugees, newcomers to Ontario, individuals with intellectual and developmental disabilities, individuals with low income, individuals who are vulnerably housed or experiencing homelessness, individuals without legal status in Canada and lacking OHIP coverage, and individuals at the intersections of many of these identities. Significant gaps persist in providing tailored support and resources for individuals from these communities. These gaps often lead to disparities in access to palliative care services, diminished quality of care, and increased distress for patients and their families [32]. This section aims to address these challenges by delineating key strategies, educational resources, and collaborative efforts required to foster a culturally competent, accessible, and responsive palliative care environment within hospital settings.

**12. Patients and their family/care partners will have access to inclusive and equitable palliative care in hospital settings.**

**12.1.** All members of the Interprofessional Palliative Care Team will offer care that is culturally safe and inclusive, as determined by the patient, including consideration for gender inclusive language.

**12.2.** All members of the Interprofessional Palliative Care Team will seek a comprehensive understanding of the patient's unique needs, language, culture, and personal preferences to provide meaningful, person-centered care.

**12.3.** The Core Team will involve relevant individuals in care (e.g., religious leaders, spiritual healers, community members, support workers), as required, respecting the patient's preferences and needs.

**12.4.** All members of the Interprofessional Palliative Care Team will ensure that patients and their family/care partners have access to plain language and inclusive educational materials in their preferred language, facilitating their ability to make informed decisions and actively engage in their care.

**12.5.** All members of the Interprofessional Palliative Care Team will provide access to culturally safe spaces within the hospital, including spaces for ceremonies and faith-based observances, to foster an inclusive environment where patients and their family/care partners from diverse backgrounds feel welcomed and respected.

**IMPLEMENTATION CONSIDERATIONS**

- Hospitals should identify or collaborate with organizations offering cultural competency education tailored to the specific needs of the patient population. Formats should include in-person sessions, virtual workshops, or self-paced online modules. Content should include a focus on trauma-informed approaches, harm reduction, and anti-oppressive practices, and should be interactive, incorporating real-life case studies to enhance learning and application.
- Hospitals should establish protocols for conducting comprehensive cultural assessments at the onset and throughout the continuum of illness. These assessments should encompass cultural, religious, and personal preferences to inform person-centered care planning and delivery.
- Hospitals should ensure healthcare providers are educated on gender inclusive language, including its implementation into the electronic health record system to support person-centred care [33].
- Hospitals should actively engage with equity-deserving communities through regular meetings, forums, and collaborative events focused on palliative care. These platforms should serve as opportunities for information sharing, strategy development, and feedback exchange to ensure responsiveness to community needs and preferences.
- Hospitals should collaborate with Patient and Family Advisory Councils and interpretation services to help address language and cultural considerations.

# Broader Areas for System Improvement

The Working Group has identified key system-level considerations and opportunities for the successful implementation of the Adult Hospital Model of Care.

## Engaging Administration and Administrators

Hospital administration and administrators are responsible for establishing strategic priorities, determining resource allocations, as well as making decisions on the use of digital platforms and tools. Given their important roles, they will be key enablers of implementation and will need to be engaged and involved in planning efforts to successfully spread and scale the Adult Hospital Model of Care across the province.

## Achieving Competency

The Ontario Palliative Care Competency Framework, which outlines necessary palliative care competencies for healthcare providers, is key to enhancing care delivery province-wide.

- Responsibility for maintaining competencies is shared between providers and hospitals.
- Colleges and universities in Ontario play a pivotal role in nurturing these competencies by embedding palliative care competencies into existing curricula, and offering education tailored to the diverse needs of the population.

## Human Resources Capacity Building

The availability of skilled human resources is a key factor in the successful implementation of the model.

- A provincial-level health human resource plan should be developed and consistently reviewed. This plan, informed by regional data, will help to ensure a sufficient number of Palliative Care Specialists, along with the other necessary providers (including nurses and allied health) to support an interprofessional approach to palliative care in hospital settings.
- Ongoing education and opportunities for specialization within palliative care should be offered to existing healthcare providers. This strategy not only enhances the skills and knowledge of the current workforce but also helps build capacity by encouraging more professionals to enter and excel in the field of palliative care.

## Information Systems Integration

Seamless information system integration is essential for addressing fragmented patient records and ensuring efficient care coordination.

- Central to OH's Digital Health Strategy is the initiative to establish a centralized, province-wide patient information system, aimed at enabling secure and efficient health record exchange and enhancing community care.
- Developing and implementing provincial standards for information exchange is necessary, with regional adoption required for a cohesive care delivery model.

- Unique opportunities exist for localized innovations to complement OH's efforts and meet regional needs.
- Developing AI-based predictive models to identify patients potentially benefiting from early palliative care interventions.
- Deploying digital health tools, such as mobile health apps and patient portals, to support active health management and improve communication with care teams.
- Initiating data integration and sharing within healthcare communities, possibly through regional health information exchanges.
- Enhancing virtual care to include teleconsultations, remote monitoring, and provider-to-provider communication for consultations and referrals.
- Leveraging patient portals to empower patients and their caregivers to actively participate in their care, to the level that they choose. Patient portals can be used to monitor for symptoms regularly with active reach out based on symptom and informational needs identified by patients.

## Service Expansion

Expanding palliative care services improves accessibility and tailors care to individual needs in diverse settings.

- Palliative Care Specialist physician staffing levels have increased in recent years in Ontario, and this should continue. There is a need to also increase the number of other allied health professionals, particularly specialized nurses and social workers to support assessment, coordination, transitions and capacity-building across the healthcare system.
- Outpatient palliative care services should be available in all hospitals[7], tailored to the patient population and team size, ensuring every patient in need can access a supportive clinic. The ideal composition for outpatient teams is outlined in Appendix I.
- Sometimes, integrated palliative programs that support both hospital and community settings, can be more efficient in supporting patient needs as they transition between settings. Consideration should be given to developing such models with active participation by hospitals and outpatient clinics (e.g. cancer centres).
- Inpatient palliative care beds should be available in all tertiary or quaternary hospitals for complex cases that cannot be transferred, whether through floating beds or a standalone Palliative Care Unit (PCU), ensuring access for all patients who require them. The criteria and process for admission to these beds should be defined and available to all system partners. The ideal composition for inpatient teams in described in Appendix I.
- There are many patients within acute hospitals who require palliative care support, that no longer require admission to an acute care facility but do not meet the criteria for palliative care units and hospice residence beds due to their longer (or unclear) prognosis. These patients account for a substantial proportion of those admitted as Alternate Level of Care to acute facilities. Timely access to long-term care beds and other alternatives are needed to meet the needs of these patients, while helping to reduce the strain on acute care beds.
- Palliative care services should be available in the home and community sector to support patients

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[7] If a hospital does not have space for an outpatient palliative care service, the hospital must have the ability to engage an outpatient palliative care service, especially for discharge of those patients admitted with palliative care following.

to die at home when appropriate and desired by the patient. It is essential for Ontario Health Teams to integrate palliative care into their service delivery planning to support transitions across settings and sectors. The Adult Community Model of Care provides recommendations to guide the organization and delivery of palliative care services in community settings to improve access across Ontario.

- Pediatric cases that are managed by Palliative Care providers are increasingly surviving to adulthood and require transition to an adult hospital-based team that is competent to manage their needs. Recommendations to guide these transitions are outlined in the Pediatric Model of Care document.

### Enhancing Data Collection for Continuous Quality Improvement

Improving the data collection process required for evaluating performance and identifying opportunities for service enhancement.

- The OPCN will establish clear quality measures and measurable goals for hospitals providing palliative care, focusing on key metrics to identify successes and areas needing improvement. These efforts will aim to align palliative care quality with patient needs and health system objectives.

In conclusion, the Adult Hospital Model of Care emphasizes 3 key areas for focused attention:

1) Timely and reliable identification of patients with unmet palliative care needs
2) Enhancing palliative care competencies among generalist/non-palliative care specialist providers to optimize the use of Palliative Care Specialists
3) Enhancing care coordination and communication within and across settings.

There are also various system-level considerations and opportunities including engaging governance/administration, achieving competency, building human resources, integrating information systems, expanding services, and enhancing data collection that can be leveraged to build a comprehensive strategy for advancing palliative care in Ontario. Through strategic planning, continuous evaluation, and technology adoption, a cohesive, efficient, and person-centered palliative care system becomes achievable, setting a standard for high-quality care delivery across the healthcare spectrum.

# Next Steps

The Adult Hospital Model of Care describes a system of care that needs to be planned through the collaboration of multiple layers of the health care system. The planning environment in hospitals is especially complex, and various system-level partners, particularly hospital administration and administrators, will need to be engaged to collaboratively plan for implementation. Following implementation planning, the work will shift towards testing the Adult Hospital Model of Care. Collective implementation and evaluation will help to identify Health Human Resource needs, funding, and policy limitations, and will inform capacity planning efforts, as well as refinements to the Adult Hospital Model of Care.

## APPENDIX A: REFERENCES FOR THE LITERATURE REVIEW

1. Aggarwal SK, Ghosh A, Cheng MJ, Luton K, Lowet PF, Berger A. Initiating pain and palliative care outpatient services for the suburban underserved in Montgomery County, Maryland: Lessons learned at the NIH Clinical Center and MobileMed. Palliative and Supportive Care. 2016 Aug 1;14(4):381–6.
2. Atayee RS, Sam AM, Edmonds KP. Patterns of Palliative Care Pharmacist Interventions and Outcomes as Part of Inpatient Palliative Care Consult Service. Journal of Palliative Medicine. 2018 Dec 1;21(12):1761–7.
3. Bailey FA, Williams BR, Woodby LL, Goode PS, Redden DT, Houston TK, et al. Intervention to improve care at life’s end in inpatient settings: The BEACON trial. In: Journal of General Internal Medicine. Springer New York LLC; 2014. p. 836–43.
4. Becker CL, Arnold RM, Park SY, Rosenzweig M, Smith TJ, White DB, et al. A cluster randomized trial of a primary palliative care intervention (CONNECT) for patients with advanced cancer: Protocol and key design considerations. Contemporary Clinical Trials. 2017 Mar 1; 54:98–104.
5. Bekelman DB, Nowels CT, Allen LA, Shakar S, Kutner JS, Matlock DD. Outpatient palliative care for chronic heart failure: A case series. Journal of Palliative Medicine. 2011 Jul 1;14(7):815–21.
6. Benton K, Zerbo KR, Decker M, Buck B. Development and Evaluation of an Outpatient Palliative Care Clinic. Journal of Hospice and Palliative Nursing. 2019 Apr 1;21(2):160–6.
7. Blinderman CD, Adelman R, Kumaraiah D, Pan CX, Palathra BC, Kaley K, et al. A Comprehensive Approach to Palliative Care during the Coronavirus Pandemic. Journal of Palliative Medicine. 2021 Jul 1;24(7):1017–22.
8. Boddaert MS, Stoppelenburg A, Hasselaar J, van der Linden YM, Vissers KCP, Raijmakers NJH, et al. Specialist palliative care teams and characteristics related to referral rate: a national cross-sectional survey among hospitals in the Netherlands. BMC Palliative Care. 2021 Dec 1;20(1).
9. Brown CRL, Hsu AT, Kendall C, Marshall D, Pereira J, Prentice M, et al. How are physicians delivering palliative care? A population-based retrospective cohort study describing the mix of generalist and specialist palliative care models in the last year of life. Palliative Medicine. 2018 Sep 1;32(8):1334–43.
10. Brown CRL, Webber C, Seow HY, Howard M, Hsu AT, Isenberg SR, et al. Impact of physician-based palliative care delivery models on health care utilization outcomes: A population-based retrospective cohort study. Palliative Medicine. 2021 Jun 1;35(6):1170–80.
11. Chapman EJ, Pini S, Edwards Z, Elmokhallalati Y, Murtagh FEM, Bennett MI. Conceptualising effective symptom management in palliative care: a novel model derived from qualitative data. BMC Palliative Care. 2022 Dec 4;21(1):17.
12. Cherniwchan HR. Harnessing New and Existing Virtual Platforms to Meet the Demand for Increased Inpatient Palliative Care Services During the COVID-19 Pandemic: A 5 Key Themes Literature Review of the Characteristics and Barriers of These Evolving Technologies. American Journal of Hospice and Palliative Medicine. 2022 May 1;39(5):591–7.
13. Dalgaard KM, Bergenholtz H, Nielsen ME, Timm H. Early integration of palliative care in hospitals: A systematic review on methods, barriers, and outcome. Palliative and Supportive Care. 2014 Dec 13;12(6):495–513.
14. Dayer LE, McDade ER, Harrington S. Pharmacist-Delivered Patient Care in an Interdisciplinary Team-Based Institutional Palliative Care Clinic, 2012 to 2018. Vol. 36, Journal of Palliative Care. SAGE Publications Ltd; 2021. p. 188–93.

15. DiScala SL, Onofrio S, Miller M, Nazario M, Silverman M. Integration of a Clinical Pharmacist into an Interdisciplinary Palliative Care Outpatient Clinic. American Journal of Hospice and Palliative Medicine. 2017 Nov 1;34(9):814–9.
16. Feldenzer K, Rosenzweig M, Soodalter JA, Schenker Y. Nurses' perspectives on the personal and professional impact of providing nurse-led primary palliative care in outpatient oncology settings. International Journal of Palliative Nursing. 2019 Jan 2;25(1):30–7.
17. Gibbs KD, Mahon MM, Truss M, Eyring K. An assessment of hospital-based palliative care in maryland: Infrastructure, barriers, and opportunities. Journal of Pain and Symptom Management. 2015 Jun 1;49(6):1102–8.
18. Grant M, Hudson P, Forrest A, Collins A, Israel F. Developing a model of bereavement care in an adult tertiary hospital. Vol. 45, Australian Health Review. CSIRO; 2021. p. 110–6.
19. Hall KL, Rafalson L, Mariano K, Michalek A. Evaluation of Hospital-Based Palliative Care Programs. American Journal of Hospice and Palliative Medicine. 2016 Feb 1;33(1):77–83.
20. Hall S, Thompson J, Davies A. An evaluation of the activity of a 7-day, nurse-led specialist palliative care service in an acute district general hospital. International journal of Palliative Nursing. 2013;19(3):148–51.
21. Hannon B, Mak E, al Awamer A, Banerjee S, Blake C, Kaya E, et al. Palliative care provision at a tertiary cancer center during a global pandemic. Supportive Care in Cancer [Internet]. 2021 Sep 15; 29:2501–7. Available from: https://doi.org/10.1007/s00520-020-05767-5
22. Hoek PD, Schers HJ, Bronkhorst EM, Vissers KCP, Hasselaar JGJ. The effect of weekly specialist palliative care teleconsultations in patients with advanced cancer -A randomized clinical trial. BMC Medicine. 2017;15(1).
23. Humphreys J, Schoenherr L, Elia G, Saks NT, Brown C, Barbour S, et al. Rapid Implementation of Inpatient Telepalliative Medicine Consultations During COVID-19 Pandemic. Journal of Pain and Symptom Management. 2020 Jul 1;60(1): e54–9.
24. Killackey T, Lovrics E, Saunders S, Isenberg SR. Palliative care transitions from acute care to community-based care: A qualitative systematic review of the experiences and perspectives of health care providers. Palliative Medicine. 2020 Dec 8;34(10):1316–31.
25. Kluger BM, Persenaire MJ, Holden SK, Palmer LT, Redwine HM, Berk J, et al. Implementation issues relevant to outpatient neurology palliative care. Annals of Palliative Medicine. 2018 Jul 1;7(3):339–48.
26. Lefresne S, Berthelet E, Cashman R, Levy K, Liu M, Carolan H, et al. The Vancouver rapid access clinic for palliative lung radiation, providing more than just rapid access. Supportive Care in Cancer. 2015 Jan 1;23(1):125–32.
27. Michel C, Seipp H, Kuss K, Hach M, Kussin A, Riera-Knorrenschild J, et al. Key aspects of psychosocial needs in palliative care - a qualitative analysis within the setting of a palliative care unit in comparison with specialised palliative home care. BMC Palliative Care. 2023 Jul 21;22(1):100.
28. Milberg A, Liljeroos M, Wåhlberg R, Krevers B. Sense of support within the family: a cross-sectional study of family members in palliative home care. BMC Palliative Care. 2020 Dec 7;19(1):120.
29. Moran ME, Soltis M, Politis T, Gothard MD, George RL. Improving a mature palliative care program at a Level I trauma center. Journal of Trauma Nursing. 2021 Mar 1;28(2):119–25.
30. Nottelmann L, Groenvold M, Vejlgaard TB, Petersen MA, Jensen LH. Early, integrated palliative rehabilitation improves quality of life of patients with newly diagnosed advanced cancer: The Pal-Rehab randomized controlled trial. Palliative Medicine. 2021 Jul 1;35(7):1344–55.

31. Nottelmann L, Jensen LH, Vejlgaard TB, Groenvold M. A new model of early, integrated palliative care: palliative rehabilitation for newly diagnosed patients with non-resectable cancer. Supportive Care in Cancer. 2019 Sep 1;27(9):3291–300.
32. O'Connor M, Palfreyman S, Le B, Lau R. Establishing a nurse practitioner model to enhance continuity between palliative care settings. International Journal of Palliative Nursing. 2016;22(12):581–5.
33. O'Sullivan A, Alvariza A, Öhlén J, Larsdotter C. Support received by family members before, at and after an ill person's death. BMC Palliative Care. 2021 Dec 24;20(1):92.
34. Patterson KR, Croom AR, Teverovsky EG, Arnold R. Current state of psychiatric involvement on palliative care consult services: Results of a national survey. Journal of Pain and Symptom Management. 2014;47(6):1019–27.
35. Quigley DD, McCleskey SG. Improving Care Experiences for Patients and Caregivers at End of Life: A Systematic Review. American Journal of Hospice and Palliative Medicine®. 2021 Jan 19;38(1):84–93.
36. Rabow MW, Parrish M, Kinderman A, Freedman J, Harris H, Cox D, et al. Staffing in California Public Hospital Palliative Care Clinics: A Report from the California Health Care Foundation Palliative Care in Public Hospitals Learning Community. Journal of Palliative Medicine. 2021 Jul 1;24(7):1045–50.
37. Rosenberg M, Rosenberg L. Integrated model of palliative care in the emergency department. Vol. 14, Western Journal of Emergency Medicine. 2013. p. 633–6.
38. Tanuseputro P. Medical aid in dying: What matters most? Canadian Medical Association Journal [Internet]. 2017 Jan 23;189(3): E99–100. Available from: http://www.cmaj.ca/content/189/3/E99
39. Vahedi Nikbakht-Van de Sande CVM, Braat C, Visser AP, Delnoij DMJ, van Staa AL. Why a carefully designed, nurse-led intervention failed to meet expectations: The case of the care programme for palliative radiotherapy. European Journal of Oncology Nursing. 2014 Apr;18(2):151–8.
40. van Vliet LM, Gao W, DiFrancesco D, Crosby V, Wilcock A, Byrne A, et al. How integrated are neurology and palliative care services? Results of a multicentre mapping exercise. BMC Neurology. 2016 May 10;16(1).
41. Venkatasalu MR, Clarke A, Atkinson J. "Being a conduit" between hospital and home: Stakeholders' views and perceptions of a nurse-led Palliative Care Discharge Facilitator Service in an acute hospital setting. Journal of Clinical Nursing. 2015 Jun 1;24(11–12):1676–85.
42. Watanabe SM, Fairchild A, Pituskin E, Borgersen P, Hanson J, Fassbender K. Improving access to specialist multidisciplinary palliative care consultation for rural cancer patients by videoconferencing: Report of a pilot project. Supportive Care in Cancer. 2013 Apr;21(4):1201–7.
43. Wentlandt K, Dall'Osto A, Freeman N, Le LW, Kaya E, Ross H, et al. The Transplant Palliative Care Clinic: An early palliative care model for patients in a transplant program. Clinical Transplantation. 2016 Dec 1;30(12):1591–6.
44. Westfall K, Moore D, Meeneghan M, Jarr S, Valgus J, Bernard S. The Impact on Resource Utilization of Supportive Care Consults on Patients at the University of North Carolina Hospital, 2010-2012. Journal of Palliative Medicine. 2018 Feb 1;21(2):216–9.
45. Wiencek C, Coyne P. Palliative Care Delivery Models. Seminars in Oncology Nursing. 2014 Nov 1;30(4):227–33.

46. Yang GM, Ewing G, Booth S. What is the role of specialist palliative care in an acute hospital setting? A qualitative study exploring views of patients and carers. Palliative Medicine. 2012 Dec;26(8):1011–7.
47. Zhang H, Barysauskas C, Rickerson E, Catalano P, Jacobson J, Dalby C, et al. The Intensive Palliative Care Unit: Changing Outcomes for Hospitalized Cancer Patients in an Academic Medical Center. Journal of Palliative Medicine. 2017 Mar 1;20(3):285–9.

## APPENDIX B: ADULT HOSPITAL WORKING GROUP MEMBERSHIP

| Member Name | Title | Association |
|---|---|---|
| James Downar (chair) | Clinical Lead, Adult Hospital-Based Palliative Care | The Ottawa Hospital |
| Vivian Sim | Patient and Family Advisor | Ontario |
| Barbara Shakell-Barkey | Patient and Family Advisor | Ontario |
| Jonathan Ailon | Internal Medicine and Palliative Care Physician | St. Michael's Hospital |
| Sally Baerg | Nurse Practitioner | Home & Community Care Support Services |
| Candice Bottle | Social Worker | Geraldton District Hospital |
| Alison Crombeen | Palliative Care Physician | Bluewater Health & St. Joseph's Hospice |
| Janet Gordon | Registered Nurse, Chief Operating Officer | Sioux Lookout First Nations Health Authority |
| Laura Harild | Palliative Care Physician | Trillium Health Partners |
| Leonie Herx | Palliative Care Physician | Kingston Health Sciences Centre |
| Tracey Human | Registered Nurse, Palliative Pain and Symptom Management Consultant (PPSMC), Director PPSMC Toronto Region | Dorothy Ley Hospice - Mississauga |
| Tarek Kazem | Palliative Care Physician | Halton Healthcare |
| Brooke MacDonald | Social Worker | Sunnybrook Health Sciences Centre |
| Lori Van Manen | Registered Nurse, Program Operational Director | Kingston Health Sciences Centre |
| Tara Moffatt | Advanced Practice Nurse-Clinical Nurse Specialist-Palliative Pain and Symptom Management Consultant (PPSMC) | Nipissing and Parry Sound Districts |
| Tayeez Mushani | Registered Nurse | Southlake Regional Health Centre |
| Christine Pun | Emergency and Palliative Care Physician | Health Sciences North |
| Aynharan Sinnarajah | Palliative Care Physician | Lakeridge Health |
| Peter Tanuseputro | Palliative Care Physician | Ottawa Hospital Research Institute |

## APPENDIX C: CONSULTATION SESSIONS

### EXTERNAL TO ONTARIO HEALTH

- Ontario Hospital Association Physician Leadership Table
- Hospice Palliative Care Ontario – Hospice Medical and Executive Directors
- Focus Group Session with Rural and Remote Health Care Providers
- Patient and Family Advisor Focus Group Sessions – Rural, Remote, French, and other Equity-Deserving populations
- Ministry of Health – Hospital Branch
- Ministry of Health – Community Branch
- Ministry of Long-term Care

- Registered Nurses' Association of Ontario (RNAO)

## ONTARIO HEALTH

- Ontario Palliative Care Network Planning and Performance Council
- Ontario Palliative Care Network Oversight Council
- Ontario Health Provincial Leadership Council
- Regional Cancer Centres and Regional Cancer Programs
- Cancer Care Ontario Cancer Programs – Provincial Clinical Leads
- Ontario Health Regions – Vice-Presidents, Access, and Flow
- Ontario Renal Network
- Integrated Health Systems Long-term Care – Director Meeting
- Home and Community Care Support Services

## APPENDIX D: EXTERNAL REVIEW PROCESS

The following partners received the draft and were asked to provide feedback:

- Access Alliance
- Advantage Ontario
- Alliance for Healthier Communities (formerly Association of Ontario Health Centres (AOHC)
- ALS Canada, Ontario Division (Coalition member)
- Alzheimer’s Society Ontario (Coalition member)
- Association of Family Health Teams of Ontario (Coalition member)
- Baycrest
- Bayshore Healthcare
- Bereavement Authority of Ontario
- Bereavement Ontario Network (BON) (Coalition Member)
- Canadian Association for Spiritual Care
- Canadian Cancer Society, Ontario Division (CCS) (Coalition Member)
- Canadian Frailty Network
- Canadian Hospice Palliative Care Association (CHPCA)
- Canadian Partnership Against Cancer
- Canadian Society of Palliative Care Physicians
- Canadian Virtual Hospice
- CarePartners
- Catholic Health Association of Ontario (CHAO) (Coalition Member)
- CBI Health
- Centre for Education and Research on Aging and Health
- Centre for Effective Practice
- Centre for Studies in Aging and Health (Providence Care) and Seniors Health Knowledge Network (Sagelink)
- Chair of the Minister’s Patient and Family Advisory Council
- College of Physicians and Surgeons (CPSO)
- College of Respiratory Therapists
- Community Palliative On Call Physicians
- Community Paramedic Chiefs
- de Souza Institute
- Dying with Dignity
- Global Institute of Psychosocial, Palliative and End of Life Care
- Healthcare Excellence Canada (Formerly the Canadian foundation for Healthcare Improvement and Canadian Patient Safety Institute
- Heart and Stroke Foundation of Ontario (Coalition member)
- Home Care Ontario
- Multicultural Health and Community Services
- Nurse Practitioners Association of Ontario (Coalition member)
- OMA Section on Palliative Care
- OMA, Section on Hospital Medicine
- OMA, Section on General and Family Practice
- Ontario Association of Paramedic Chiefs (Coalition Member)

- Ontario Caregiver Organization (Coalition Member)
- Ontario College of Certified Social Workers and Social Service Workers
- Ontario College of Family Physicians (Coalition member)
- Ontario College of Pharmacists
- Ontario Community Support Association (Coalition Member)
- Ontario Long Term Care Association
- Ontario Paramedic Association
- Ontario Pharmacists Association
- Ontario Physiotherapy Association
- Ontario Psychiatric Association
- Ontario Psychological Association
- Pallium Canada
- ParaMed - Extendicare
- Palliative Care Physicians
- Providence Care
- Provincial Geriatrics Leadership Ontario
- Provincial Palliative Symptom Management Consultant Network (PPSMCs)
- Registered Practical Nurses Association of Ontario (WeRPN) (Coalition Member)
- Registered Nurses’ Association of Ontario (RNAO)
- Spectrum
- SRT Med-Staff
- St. Elizabeth HealthCare
- Therapeutic Recreation Ontario
- University Coalition Members
- Visiting Homemakers Association, VHA Home HealthCare (VHA)
- VON

## APPENDIX E: ADDITIONAL CASE EXAMPLES

Below are two additional case examples, each showing two scenarios: one before the implementation of the Adult Hospital Model of Care and the second one after.

### CASE TWO: PALLIATIVE CARE INTEGRATION FOR A PATIENT WITH A CARDIAC EVENT

**Prior to Implementation of the Adult Hospital Model of Care**

Denise is a 75-year-old woman with a long history of worsening coronary artery disease who comes to the Emergency Department (ED) after a heart attack. She is admitted to the cardiology ward for treatment and monitoring. After several days, she is discharged home to follow up with her usual cardiologist in a few weeks. Her cardiologist sends her for a procedure to assess her heart for fixable problems. Following the procedure, she develops chest pain and shortness of breath again and is admitted to hospital for monitoring and treatment. After several days in hospital with ongoing symptoms, she tells her nurse that she does not want any more testing or treatments, and that she would rather go home and be kept comfortable. Her nurse informs the Cardiology Team of this conversation, and the social worker arranges a home discharge with her family and supportive services. On arrival at home, seeing that the patient is experiencing pain and shortness of breath, her home care nurse contacts the hospital team to order comfort medications. The cardiologist, who does not feel experienced enough to manage symptoms for a community-based patient, instructs the patient to return to the ED for readmission to hospital. On arrival, the cardiologist consults the Palliative Specialist Team to arrange comfort care at home. After three days, all team members have met the patient and her family, all arrangements are made with the home care provider, and a home-visiting palliative care physician is consulted to manage her care at home. Three weeks after discharge, she develops worsening shortness of breath and chest pain and is no longer communicative. Her Palliative Specialist orders a symptom relief kit and supplies (which arrive in 4 hours) to help manage these acute symptoms. Unfortunately, the symptoms persist, and the Palliative Specialist advises a transfer to a community hospice or palliative care unit bed. Her family hesitates because she was so firm on staying at home until death, but because she is so symptomatic, they reluctantly agree after a lengthy discussion. The Community Team arranges a transfer to a community hospice the following day for end-of-life care, and she dies in the company of her family. Her family are upset because they feel that her death was not as comfortable as they had imagined it would be, and they feel guilty about not respecting her wish to die at home. The Hospice Team offers the family the opportunity to join their bereavement support group.

**Following Implementation of the Adult Hospital Model of Care Recommendations**

Denise is a 75-year-old woman with a long history of worsening coronary artery disease who comes to the ED after a heart attack. She is admitted to the cardiology ward for treatment and monitoring, and an automated system identifies that she is at high risk of unmet palliative care needs given her demographics and illnesses. Her Cardiology Team screens her for unmet needs and finds that she has moderate to severe pain and shortness of breath, and she is keen to talk to her Cardiology Team about her future care. During a comprehensive assessment, the Cardiology Team learns that her symptoms have been slowly worsening for months, and that she has had a slow decline over that time to the point that she is not able to do all of her activities of daily living, and that her goals of care are to focus on quality of life and stay at home until the end of her life. She understands that her heart disease is getting worse and although there may be invasive options to help manage her coronary artery disease, she does not want any invasive treatments or life-prolonging therapy.

The Cardiology Team developed a plan for comfort-focused care at home, using palliative care skills learned in training they had received across their department. Recognizing that Denise's symptoms were severe despite optimal medical therapy, they consulted the Palliative Specialist Team for help with symptom management and discharge planning. Together, the two Teams establish a plan of care, and this care plan is communicated to the home care service and community palliative care provider electronically. On review of Denise's case, the Community Team are concerned that Denise is at risk of sudden symptoms from her heart disease. They advise the Palliative Specialist Team to order a symptom relief kit and supplies, to arrive at her home before discharge. The Community Team also advises the Palliative Specialist Team to prepare the patient and family for the possibility of developing worsening symptoms that cannot be managed at home, and of being unable to speak for herself at that time. The Palliative Specialist Team explains the option of admission to a palliative care unit or hospice bed in such an event, and Denise agrees (in front of her family) that this makes sense as a backup plan. The Palliative Specialist Team also explains the likely course of her future illness, the common symptoms that people experience as they near death, and how families are affected by grief. Denise and her family are given information about supportive services, including grief and bereavement support.

On discharge home, she receives a visit from her home care team and palliative care provider, who are already familiar with the plan due to their involvement in developing it. When she deteriorates three weeks later, her team are immediately able to give her medications from the symptom relief kit. And when these symptoms persist despite the medications, the Home Care Team, and Palliative Specialist both suggest a transfer to hospice, consistent with their earlier discussion. The family agrees, knowing this was what Denise wanted. She dies in the company of her family, who experience normal grief. They were aware of normal grief responses and had already arranged to follow up with the bereavement support service at the hospice.

### CASE THREE: GOALS OF CARE AND SYMPTOM MANAGEMENT IN ADVANCED CANCER

#### Prior to Implementation of the Adult Hospital Model of Care

Luke is a 53-year-old patient with advanced colon cancer receiving treatment at a community hospital's Cancer Centre, His cancer was inoperable at the time of diagnosis, and a recent CT scan revealed that the cancer progressed despite three months of his second line of therapy. Luke was experiencing fatigue and some abdominal pain from his cancer, but he was focused on "beating" the cancer and did not want to discuss his symptoms, so his oncologist offered him an experimental therapy as part of a study. The oncologist offered a referral to the Palliative Specialist Team for his symptoms, but Luke did not feel ready for that.

After three months of treatment, Luke's fatigue had worsened to the point that he was unable to leave his house and was unable to eat consistently or sleep due to his persistent abdominal pain. A repeat CT scan showed that some of his metastases had decreased in size, but others had grown, and new metastases had appeared. Luke and his family were encouraged by the fact that some had shrunk and pushed to continue the therapy. His oncologist again suggested a palliative care referral, but Luke and his family preferred to wait, so his oncologist prescribed an oral analgesic to help with the pain.

Two weeks later, Luke presented to the Emergency Department in a pain crisis and was admitted to the oncology service. He agreed to a consultation from the Palliative Specialist Team. He was given injectable pain medications and hydration, which relieved his pain. The Palliative Specialist Team also explored his Goals of Care, and he was clear that he wanted to pursue more chemotherapy if possible and wanted “everything” done (e.g. CPR) in the event of a deterioration. After receiving his next dose of chemotherapy, he developed a severe infection that led to multiple organ failure, and he was transferred to the ICU. Despite the efforts of the ICU team, he deteriorated and died in the ICU. His family included two small children, who had not been told the severity of the situation, and they struggled with severe grief symptoms. The ICU team suggested that they follow up with their family physician to arrange bereavement support.

**Following Implementation of the Adult Hospital Model of Care Recommendations**

Luke is a 53-year-old patient with advanced colon cancer receiving treatment at a community hospital's Cancer Centre. His cancer was inoperable at the time of diagnosis, and a recent CT scan revealed that the cancer progressed despite three months of his second line of therapy. He was eligible for experimental therapy, but because of his poor response to multiple lines of chemotherapy the cancer clinic screened him for unmet palliative care needs and found that he had moderate pain and severe fatigue but was not ready to talk about his Goals of Care beyond “beating” the cancer. His Oncologist prescribed pain medication and discussed the meaning of the CT scan with Luke and his wife. She explained the need to prepare for the possibility that experimental chemotherapy would not work, and that there would be no further cancer treatment options at that point. She emphasized that she would continue to manage his care, but she also explained the importance of preparing his family for this possibility, and the stress involved in substitute decision-making near the end of life, and the loss of a family member without preparation. Luke agreed to have the cancer clinic Social Worker meet his family and provide support.

After three months of experimental treatment and worsening symptoms, Luke’s CT scan revealed that some of his metastases had decreased in size, but others had grown, and new metastases had appeared. Luke’s oncologist explained that this confirmed what she had feared- that his cancer was progressing and that he had no further cancer treatment options. Luke found this difficult, but he agreed to a referral to the Palliative Specialist Team to manage his more complicated symptoms, with the understanding that if he somehow experienced an improvement in the future, he could still be eligible for more treatment. The Palliative Specialist Team established a treatment plan that focused on comfort care at home with a continuous pump for pain medication and supportive services, but with the understanding that he would still want to return to the Emergency Department in the event of a deterioration.

Three weeks later at home, he developed an infection and decreased level of consciousness. Consistent with his goals of care, he was brought to the ED and given antibiotics. The Oncology and Palliative Specialist Team were aware of his situation in the community thanks to a shared data platform. After discussion with his wife, his family understood that he was almost certainly at the end of his life, so the decision was taken to continue his antibiotics in case this event proved reversible but admit him to the palliative care unit for comfort-focused care. He died the following day, surrounded by family. His family experienced severe grief, but they received follow-up from the social worker at the Cancer Centre, with whom they already had an established relationship.

## APPENDIX F: GLOSSARY

**Active offer:** The regular and permanent offer of services to the Francophone population. It is the result of a rigorous and innovative process for planning and delivering services in French across the entire health care continuum. It requires partners to exercise appropriate leadership with respect to health services in French and depends on accountability at several levels: system level, organization level, professional level, and individual level [34].

**Advance Care Planning (ACP):** In Ontario, advance care planning is an iterative process that involves the mentally capable patient in:

IDENTIFYING their future Substitute Decision Maker by either

- Confirming their satisfaction with their default/automatic Substitute Decision Maker in the Substitute Decision Maker hierarchy list in the Health Care Consent Act OR
- Choosing someone else to act as Substitute Decision Maker by preparing a Power of Attorney for Personal Care (a formal written document).

SHARING their wishes, values, and beliefs through conversations with the substitute decision-maker and others that clarify their wishes, values, and beliefs, and more generally, how they would like to be cared for in the event of incapacity to give or refuse consent. Rather than being a single event, advance care planning is ongoing and dynamic, with the potential for personal preferences to change over time as health status changes. It may be initiated at any point in the health care process and may involve individuals who are currently healthy [35].

**Artificial Intelligence (AI):** A branch of computer science dedicated to creating systems capable of performing tasks that typically require human intelligence. These tasks include learning from data, recognizing patterns, making decisions, and understanding natural language. AI technologies, such as machine learning, natural language processing, and robotics, enable machines to improve their performance over time based on experience, akin to the way humans learn. AI is increasingly applied across various fields to enhance efficiency, accuracy, and innovation.

**Bereavement:** The period following a death and encompasses grief and mourning (the outward expression of that grief). Bereavement can last months or even years. Following rituals and gathering to provide comfort and support to the bereaved is often an important part of the mourning experience and is seen across many cultures.

**Consent (Health Care Consent):** An informed and contextualized decision involving a mentally capable person and a healthcare provider as outlined in the Ontario Health Care Consent Act (1996, S.O. 1996, c. 2, Sched. A). Healthcare providers proposing treatment must obtain informed consent from either a capable patient or their Substitute Decision Maker if they do not have the mental capacity. This discussion must address the patient’s present condition (context), available treatment options, risks/benefits/side effects, alternatives to treatment and what would happen without the proposed treatment [35].

**Comprehensive and Holistic Assessment:** Includes a full examination of the domains of care associated with illness and bereavement, including disease management, physical, psychological, social, cultural, legal, ethical, spiritual, practical, end-of-life care, loss, and grief. The comprehensive and holistic assessment considers a person’s socio-cultural context and initial assessments should include inquiry about a person’s first language and comfort language [9].

**Cultural Safety:** Is predicated on understanding the power differentials inherent in health service delivery and redressing these inequities through educational processes. Addressing inequities, through the lens of cultural safety, enables health professionals to: improve health care access for clients or individuals, aggregates and populations; acknowledge that we are all bearers of culture; expose the social, political and historical contexts of health care; enable practitioners to consider difficult concepts, such as racism, discrimination and prejudice; understand that cultural safety is determined by those to whom health professionals provide care; understand the limitations of “culture” in terms of having people access and safely move through health care systems and encounters with care providers; and challenge unequal power relations [36].

**First Nations, Inuit, Métis and Urban Indigenous**: Refers to the First Nations, Inuit, Métis, and Urban Indigenous peoples of Ontario. Here, ‘Urban Indigenous’ refers to First Nations, Inuit, and Métis peoples living in cities and towns in Ontario. More than 85 percent of Ontario’s Indigenous people live off-reserve in urban or rural communities; these are self-organized, self-determining Indigenous communities, analogous to a reserve community. This language shift is part of Canada’s commitment to a renewed, nation-to-nation relationship with Indigenous peoples in recognition of rights, respect, and partnership; and reflects culturally safe terminology determined by extensive engagement across Ontario with today’s Indigenous peoples.

**Goals of Care Discussion:** A discussion between a patient (or their Substitute Decision Maker if the patient lacks capacity) and healthcare provider(s) that addresses the patient’s goals for his or her care in the context of healthcare consent and decision-making in advanced illness. The purpose of these discussions is to outline the patient’s values, beliefs, wishes, perception of quality of life and what he or she characterizes as meaningful and important. Other elements include the patient’s understanding of current health conditions, prognosis, and likely course of events if his or her goals of care are applied to potential treatment decisions. The goals of care discussion provide the foundation for decision-making and will often include the development of (and obtaining informed consent to) a plan of treatment.

**Grief:** An expected response and adaptive reaction to the many losses that may be experienced by an individual and their family and friends because of a serious illness or a death. These losses may include lost routines, jobs, and plans for the future. Grief can be a strong, sometimes overwhelming emotion for people, and can be particularly intense during bereavement.

**Healer:** The Creator and the spirits work through Healers to help people. Healers are guided by spirit, the Creator and spirit helpers, which come in many forms. Each Healer has their own unique way and medicines that they work with; some may work with plants, some may counsel, some may heal with laying of their hands, singing and drumming in prayer. They may also work through ceremonies (e.g., sweat lodge, the shaking tent) to provide healing [37].

**Hospice:** Is a community-based organization (or a program offered by a multi-service organization) that provides support to individuals living with a progressive, life-limiting illness and their care partners, family members, and friends. Support is provided to the service recipient in a variety of settings, including where the individual lives or in a homelike setting. The goal of hospice care is to enhance the quality of life of the individual and the well-being of anyone that is impacted by the person’s illness or death. Volunteers play an integral role in achieving that goal. A hospice provides services such as hospice-trained volunteers, day programs, psychosocial supports, grief and bereavement support, spiritual care, care partner support, wellness programs, complementary therapies, children's programs, outreach/shared care teams, and end-of-life care within a hospice residence.

**Indigenous Elder/ Knowledge Keeper:** Someone who follows the teachings of their ancestors and knows how to put those into practice. Traditional Elders teach and share the wisdom they have gained of the culture, history, and the language. The sharing of their wisdom is healing. An Elder does not have to be a senior but could be someone younger who has many teachings and who has earned the respect of their community by contributing to its spiritual development. These individuals are designated by their community. The role of the Elder and Knowledge Keeper may have varying responsibilities according to their ancestral knowledge and communities.

**Indigenous Providers:** These providers organize and deliver cultural-based services in First Nations, Inuit, Métis, and Urban Indigenous communities to support community knowledge about Indigenous services availability locally and regionally. These providers include but are not limited to: Indigenous Community Health/Wellness Workers, Counsellors, Band Council Members, Métis (e.g., Community Support Services, Aging at Home Services) and Inuit partners.

**Linguistic Identity:** Refers to the linguistic group to which a person belongs or with which a person identifies. This variable generally remains unchanged over time. There is a distinction between establishing a patient's linguistic identity and her linguistic preference. The patient may express a preference for English for a variety of reasons (timeliness of care, fear of receiving lower level of care, etc.), but as the illness progresses and under stress, linguistic preference should be reassessed [38].

**Ontario Health atHome:** The organization responsible for coordinating in-home and community-based care for the residents of Ontario.

**Ontario Palliative Care Network (OPCN):** A partnership of health service providers, community and social support service organizations, health systems planners, as well as patient and family/care partner advisors established in 2016 to act as the Ministry's principal adviser for high-quality, coordinated palliative care in Ontario. The OPCN's work is person centred, focused on supporting quality palliative care for all people in Ontario, no matter what their age or illness.

**Palliative Approach:** Care that focuses on meeting a person's and family's full range of needs – physical, psychosocial, and spiritual – at all stages of a serious illness. It reinforces the person's autonomy and right to be actively involved in his or her own care – and strives to give individuals and families a greater sense of control. It enhances quality of life *throughout* the course of a person's illness or the process of aging rather than being seen as a discrete service offered to dying person's when treatment is no longer effective [39]. The term 'palliative approach to care' is often used to refer to palliative care delivered at a primary or generalist level of competency (e.g., nurse practitioners, physicians, disease-specific specialists, etc. with Level 1 competencies in palliative care) as opposed to palliative care delivered by specialist-level palliative care providers (i.e., providers with Level 2 competencies in palliative care).

**Palliative Care:** As an approach that improves the quality of life of persons and their families living with serious illnesses, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

Palliative Care:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten or postpone death;
- Integrates the psychological and spiritual aspects of care;
- Offers a support system to help persons live as actively as possible until death;
- Offers a support system to help the family cope during the person's illness and in their own bereavement;
- Uses a team approach to address the needs of persons and their families, including bereavement counselling, if indicated;
- Will enhance quality of life, and may also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

**Psychosocial Care:** Refers to a holistic approach to patient care that addresses both the psychological and social factors affecting individuals facing health challenges. This type of care encompasses a wide range of services and interventions designed to support the emotional, mental, social, and spiritual well-being of patients and their families. Psychosocial care is integral to comprehensive health care delivery, recognizing the complex interplay between psychological health and social well-being in overall health outcomes.

**Substitute Decision-Maker:** The person or persons who would have the legal authority to make health decisions if the patient is not capable of making their own decisions. This would include treatment and care plan decisions, providing consent for those decisions and decisions about the sharing of the patient’s personal health information. The person or persons identified as the substitute decision-maker will be the highest-ranking person(s) in the substitute decision-maker hierarchy in the Ontario Health Care Consent Act and meets the requirements to be an substitute decision-maker [12].

**Telemedicine:** Refers to the use of telecommunications technology to provide, enhance, or facilitate health care services remotely. It encompasses a broad range of technologies and services to provide patient care and transmit medical, imaging, and health informatics data from one site to another. Telemedicine enables healthcare providers in Ontario to diagnose, consult, treat, educate, and care for patients at a distance using telecommunications and digital communication technologies.

**Trauma-Informed Approach:** Recognizes that underlying trauma is integrated into how patients and their families may react to, and cope with the challenges of physical and psychological symptoms, loss and the grieving process. The approach is applied universally to ensure that persons are not further traumatized while accessing care, rather than focusing specifically on treatment or disclosure of events. There are six key principles that include safety;

trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; cultural, historical & gender issues [40].

**Videoconferencing:** Refers to the use of video technology to conduct real-time visual and audio communication between patients and healthcare providers, or among healthcare professionals, for the purposes of consultation, diagnosis, treatment, education, and collaboration on patient care. Videoconferencing is a key component of virtual care and telemedicine services, enabling more personal interaction than voice calls or text-based communication, thus facilitating more thorough assessments and fostering a stronger provider-patient relationship.

**Virtual Care:** Refers to a suite of methods by which patients receive healthcare services from providers via technology, rather than through direct in-person visits. This can include consultations via video calls, telephone calls, messaging platforms, and other digital means. Virtual care encompasses telemedicine but extends to a broader range of services and technologies, including the use of health apps, remote monitoring, and electronic health records. It aims to improve access to care, particularly for remote or underserved communities, and to enhance the convenience and efficiency of healthcare delivery.

**Vulnerably Housed**: A term that includes low income, socially marginalized individuals living in single room occupancy (SRO) hotels and rooming houses. These individuals often have unstable living arrangements, resulting in frequent transitions between homelessness and vulnerable housing.

## APPENDIX G: ABBREVIATIONS

| | |
|---|---|
| **ADL** | Activities of Daily Living |
| **CCC** | Complex Continuing Care |
| **CNS** | Clinical Nurse Specialist |
| **DNR** | Do Not Resuscitate |
| **DNR-C** | Do Not Resuscitate Confirmation Form |
| **ED** | Emergency Department |
| **EOL** | End of Life |
| **EMR** | Electronic Medical Record |
| **FNIMUI** | First Nations, Inuit, Métis, and Urban Indigenous |
| **HQO** | Health Quality Ontario |
| **IADL** | Instrumental Activities of Daily Living |
| **ICU** | Intensive Care Unit |
| **LTC** | Long-Term Care |
| **MD** | Doctor of Medicine |
| **MOC** | Model of Care |
| **MRMP** | Most Responsible Medical Professional |
| **NIHB** | Non-Insured Health Benefits |
| **NP** | Nurse Practitioner |
| **OPCN** | Ontario Palliative Care Network |
| **OT** | Occupational Therapist |
| **PCU** | Palliative Care Unit |
| **PSW** | Personal Support Worker |
| **PT** | Physical Therapist |
| **RD** | Registered Dietitian |
| **RN** | Registered Nurse |
| **RPh** | Registered Pharmacist |
| **RPN** | Registered Practical Nurse |
| **RTC** | Registered Therapeutic Counsellor |
| **SLP** | Speech-Language Pathologist |
| **SW** | Social Worker |
| **2SLGBTQIA+** | Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and Additional People |

## APPENDIX H: IMPLEMENTATION CONSIDERATIONS

### PROVINCIAL LEVEL

- A Provincial Palliative Care Education Strategy is needed to promote the importance of earlier integration of palliative care, and to build primary level palliative care capacity among healthcare professionals across all care settings.
- A broadly accessible provincial electronic platform should be made available for providers to enable secure “real-time” exchange of patient information within and across settings and sectors. The platform would ideally enable providers to access assessment results and allow patients and family/care partners to identify their own unmet palliative care needs.
- Standardized templates and/or checklists should be developed to guide health care providers through the domains of care outlined by the Canadian Hospice Palliative Care Association, to ensure a comprehensive and holistic assessment. Ideally these should be developed at the provincial level. In the interim, health care providers can leverage the National Consensus Project’s Clinical Practice Guidelines for Quality Palliative Care (NCP Guidelines, 4th edition) which outlines specific criteria for a comprehensive assessment (See Guideline 1.2, page 24-25).
- Many patients express frustration having to repeat their story or being asked the same questions by multiple team members. A broadly accessible electronic platform developed at the provincial level should enable providers to access previous assessments and should have the ability to build on these across time and across location of care.
- Ontario Health should develop disease-specific palliative-focused assessment toolkits to standardize approaches across the province. Disease-specific program areas within Ontario Health (i.e. Ontario Renal Network, CorHealth) should take the lead in creating these toolkits where they do not already exist, in collaboration with the Provincial Palliative Care Program.
- A provincially led review and revision of palliative care funding mechanisms is required to support an interprofessional team-based approach to palliative care. Efficient allocation of provincial resources is essential to support the roles and responsibilities of the Interprofessional Palliative Care Team. This includes comprehensive health human resources capacity planning and integrated funding models tailored to address patient needs across all domains and demand for services.
- Efforts should be made to ensure the effective implementation of standardized palliative and goals of care documentation across provincial healthcare settings. Collaboration with regional and provincial authorities may be necessary to establish clear guidelines and protocols.
- A provincial electronic platform for documenting and managing care plans should be made available, that includes a focus on seamless integration with existing systems and accessibility for all members of the Interprofessional Palliative Care Team, as well as other providers across settings.
- A broadly accessible provincial electronic platform should be made available that could support standardized communication to primary care and community care providers at discharge.
- Access to a shared electronic medical record system, available across settings, is required to support communication amongst all Interprofessional Palliative Care Team members.
- A comprehensive health human resources plan should be developed at a provincial level. This plan should ensure access to psychosocial service providers specializing in palliative care, particularly within communities. Prioritization should be placed on increasing capacity to provide equitable access to in-home services, including hospice volunteers and personal support, through both in-

person visits and virtual platforms.

## HOSPITAL LEVEL

- Hospitals should establish palliative care education plans to build capacity for primary-level palliative care among all hospital health care professionals (across all disease sites, and hospital units). Education is essential for ensuring providers have the competency to identify and address unmet palliative care needs. The plan should include a focus on ensuring first contact personnel (ED staff, clinic staff, paramedicine, etc.) are educated about timely identification, along with ensuring designated providers in various disease sites and units are trained on the use of standardized identification and screening tools, such as OPCN's Tools to Support Earlier Identification for Palliative Care. These designated providers can function as mentors and provide support to other staff within their respective sites or units.
- Reliable processes should be developed and/or implemented in all hospital settings (inpatient, outpatient, and emergency room) to proactively identify individuals at high risk of unmet palliative care needs. Embedding identification tools into EMR systems, should be considered to create automated flags. Integration will require making changes to relevant hospital policies and procedures and may require updating IT infrastructure. For instance, the Hospital One-year Mortality Risk (HOMR) tool can automatically identify inpatients with an elevated risk of death within the next year using commonly collected hospital EMR data, particularly those with non-cancer illnesses and frailty who may have unmet palliative care needs. As a starting point, patients at higher risk of unmet needs can be prioritized to manage the identification process effectively and prevent overwhelming providers.
- Hospitals should implement evidence-based tools and processes to identify and screen for patients with unmet palliative care needs. Tools and processes should be appropriate for the population they were designed for, and customized by setting (e.g., inpatient vs. outpatient), and disease site, leveraging existing workflow whenever possible. For disease site clinics, these tools and processes can be disease-specific, and for other settings, they should be disease-agnostic and include those with multi-morbid frailty.
- Tools to support comprehensive assessments, alongside disease-specific validated instruments, should be integrated into the Electronic Medical Record (EMR). Hospitals should ensure health care providers are trained to understand how to complete comprehensive assessment tools and validated instruments.
- Trauma-informed approaches are essential for providing person-centred care. Hospitals should ensure healthcare providers are educated on the basics of trauma, de-escalation, patient tracking, and grounding. There are currently no validated screening or assessment tools to identify traumatic stress. Healthcare providers will need to be attentive to potential symptoms and use clinical knowledge and skills to invite exploration as appropriate and within their professional scope of practice. Extended services should be engaged to help address identified concerns as needed.
- Hospitals should designate and train specific healthcare providers within different disease sites and units, such as RNs/RPNs or social workers, to serve as assessment leads for palliative care. These individuals would be responsible for conducting thorough, in-person assessments and can also mentor and support other staff to develop and enhance their assessment skills.
- Hospitals should support continuing education for healthcare providers on effective palliative care assessment techniques, with a specific focus on empathy, cultural humility, and cultural safety. It

is imperative that all providers achieve these competencies to ensure the consistent delivery of palliative care across all units. Hospitals should prioritize access to dedicated outpatient spaces, including designated clinics, nursing staff, social workers, support staff, as well as clerical staff, to facilitate the provision of interprofessional team-based palliative care.

- Hospitals should devise strategies to build primary-level competencies for hospital staff, with clear timelines and dedicated resources identified for each program. This should include facilitating ongoing education opportunities and providing resources for staff to enhance their skills and stay updated on best practices and evidence-informed approaches in palliative care [15].
- Hospitals should establish policies and procedures to standardize the use of evidence-based communication processes among health care providers to support safe and effective communication practices and transitions in care [15].
- Smaller, and/or more rural hospitals may have challenges accessing Extended Services, and Palliative Care Specialists. Enhancing partnerships with larger/urban centres, and leveraging technology, where appropriate, can help to ensure access.
- Hospitals should ensure health care providers are educated on the use of technology and virtual care delivery processes, supporting protected time for continuing education to enhance skills in delivering palliative care virtually [17].
- Hospitals should ensure health care providers receive ongoing education and skills training on stress management and have opportunities and resources for debriefing. Hospitals should also ensure adequate staffing levels to mitigate the risk of burnout and compassion fatigue among healthcare providers [18].
- Communication skills training programs that emphasize active listening and exploration of patient values and wishes are needed for providers in hospital settings. Various Advance Care Planning, goals of care discussions and consent training opportunities offered through Hospice Palliative Care Ontario, and The Canadian Serious Illness Conversation course offered by Pallium Canada are examples of education that could be leveraged.
- Clear procedures should be established for scheduling and conducting regular reassessments during clinic visits, hospital admissions, or in response to changes in the patient's clinical status, ensuring continuity and responsiveness in care delivery.
- Hospitals should participate in provincially led patient and caregiver experience surveys.
- Hospitals should establish standardized discharge planning protocols for patients receiving palliative care, ensuring that all necessary arrangements and supports are in place prior to discharge. This may include ensuring the patient has an MRMP, medication management, equipment provision, home care services, and follow-up appointments.
- Hospital administrators can leverage the Registered Nurses’ Association of Ontario’s Transitions in Care and Services Best Practice Guideline to support the development of policies, procedures, protocols and educational programs to support service delivery [21].
- To avoid issues with medication coverage, or ordering during transitions of care, discharge order sets should ideally include medications that are covered by Ontario Drug Benefits (ODB). If medications require Palliative Care Facilitated Access (PCFA) authorization, the Core Team should ensure that the patient is connected with a palliative care provider in the community to support ongoing access to medications as needed.
- Hospitals should establish resources and relationships with community-based service providers who have primary-level palliative care competencies who can help to address identified palliative

care needs, particularly for patients who do not have primary care providers. The Core Team should ensure the patient is connected to a primary care team on discharge and confirm that connection is made. Ideally if the connection is new the Core Team should facilitate an initial contact between patient and primary care team

- Hospitals should implement standardized symptom management guidelines and order sets within their EMRs to ensure evidence-based and consistent symptom management for all patients receiving palliative care. The utilization of clear, accessible guidelines supports healthcare providers in making informed, timely decisions regarding patient care. Implementation should be supported by comprehensive training to ensure providers are proficient in utilizing these tools for symptom management.
- Hospitals should establish mechanisms for documenting symptoms across time and monitoring efficacy of treatment.
- Hospitals should ensure access to on-call Palliative Care Specialists to provide expert support for non-specialist providers, especially in managing complex symptoms. This support could be facilitated through direct staffing arrangements or via telemedicine collaborations with larger centers, ensuring round-the-clock access to palliative care expertise.
- Hospitals should provide healthcare providers with the tools and resources to support the delivery of safe and effective virtual care, including regularly updated policy and procedures [17].
- Hospitals should leverage technology not only for telemedicine and virtual care but also to facilitate access to on-call Palliative Care Specialists and the use of standardized order sets. This strategy ensures that even remote or smaller facilities have the necessary support and resources to manage symptoms effectively, utilizing digital tools to bridge gaps in care and expertise.
- Hospitals should be aware of common barriers within their region, including socioeconomic factors that may impact access to care, and develop mitigation strategies to address them. For example, in areas with no public transit, systems should be in place to address transportation barriers. The Core Team should be able to implement strategies seamlessly, to remove as many barriers to care as possible.
- Hospitals should establish a process to ensure that all families/care partners are offered comprehensive information and education about what to expect during the dying process, procedures for after death, and key points of contact.
- Hospitals should plan for inpatients who may need to receive end-of-life care within their facility, with consideration for beds in appropriate settings (i.e. privacy), and staff with competencies to provide care. An overview of ideal standards for team settings, composition, and care activities are outlined in Appendix I.
- Hospitals should streamline processes for death pronouncement and death certificate completion to alleviate any added stress on the family (e.g., Electronic Medical Certificate of Death).
- Hospitals should ensure staff are educated on diverse death-related cultural, religious, and spiritual practices to ensure respectful and culturally safe care. Organizational policies should be established to accommodate cultural needs and religious practices or rituals, such as providing extra time after death, facilitating smudging ceremonies, or arranging direct transport to the funeral home.
- Hospital administrators can leverage the Registered Nurses' Association of Ontario's End-of-Life Care During the Last Days and Hours Best Practice Guideline to support the development of policies, procedures, protocols, educational programs, and assessment and documentation tools

[18].

- Hospitals should collaborate with external grief counselors or bereavement support groups to ensure continuous and tailored support for families/care partners even after the patient’s death. Additionally, offering memory-making or memorial activities within the hospital can provide opportunities for families/care partners to honour the memory of the deceased patient.
- Hospitals should develop or partner with programs that offer debriefing, and bereavement supports to staff after any death.
- Hospitals should establish or leverage existing programs and resources specifically tailored to support family/care partners, ensuring that staff are well-trained to address their unique challenges [31].
- Hospitals should provide education for families and care partners on preventing burnout and managing symptoms of stress as they care for persons at the end of life, including awareness of respite services.
- Hospitals should ensure all healthcare providers are educated on the Active Offer of French Language Health Services. The online training courses developed by the Réseau du mieux-être Francophone du nord and Entité 3 can be used to enhance staff capabilities in offering French-language services
- Hospitals should identify the linguistic capabilities and fluency of all staff to support patient access to care in their preferred language, including French. Refer to French Language Oral and Written Skill Proficiency – Self Assessment
- Hospitals should encourage all French-speaking staff to wear a "Je parle français" button or lanyard to help patients and other staff members identify French-speaking team members.
- Hospitals should identify or collaborate with organizations offering cultural competency education tailored to the specific needs of the patient population. Formats should include in-person sessions, virtual workshops, or self-paced online modules. Content should include a focus on trauma-informed approaches, harm reduction, and anti-oppressive practices, and should be interactive, incorporating real-life case studies to enhance learning and application.
- Hospitals should establish protocols for conducting comprehensive cultural assessments at the onset and throughout the continuum of illness. These assessments should encompass cultural, religious, and personal preferences to inform person-centered care planning and delivery.
- Hospitals should ensure healthcare providers are educated on gender inclusive language, including its implementation into the electronic health record system to support person-centred care [33].
- Hospitals should actively engage with equity-deserving communities through regular meetings, forums, and collaborative events focused on palliative care. These platforms should serve as opportunities for information sharing, strategy development, and feedback exchange to ensure responsiveness to community needs and preferences.
- Hospitals should collaborate with Patient and Family Advisory Councils and interpretation services to help address language and cultural considerations.

### REGIONAL LEVEL

- Ontario Health Regions should offer training sessions to healthcare providers involved in palliative care to enhance their understanding of care coordination principles, communication strategies, and the importance of collaborative teamwork. Training sessions could focus on topics such as effective communication, conflict resolution, and interprofessional collaboration.

- Ontario Health Regions should explore the use of technology-enabled solutions, such as telehealth platforms, mobile applications, and remote monitoring devices, to support ongoing bi-directional communication and coordination between healthcare providers, patients, and family/care partners during care transitions.
- A centralized repository of standard visual aids, decision trees, and other interactive tools should be established to facilitate discussions about illness understanding and decision-making. These resources should be written in plain language, ideally in multiple languages, and should be easily accessible and relevant to different disease contexts. Delivering forms of culturally safe and accessible care to support the decision-making process of patients, their families and substitute decision makers, such as having written text available in languages that are commonly spoken within the regions of each hospital will support the delivery of patient-and family-centered care.
- Ontario Health Regions should prioritize the establishment of robust networks comprising resources and professionals, such as social workers, grief counselors, spiritual care providers, and community-based supports. These networks should facilitate seamless access to psychosocial care for patients and their families, thereby ensuring holistic support throughout the palliative care journey.
- Ontario Health Regions should take proactive steps to initiate programs and partnerships aimed at addressing broader social determinants of health, including financial counseling, food banks, and housing assistance. By addressing these underlying factors, regions can significantly improve the overall well-being and outcomes of patients and their families.

### TEAM OR PROVIDER LEVEL

- All hospital-based providers working with patients with serious illnesses should strive to acquire primary-level competencies, as outlined in the Ontario Palliative Care Competency Framework. It is also important for hospital providers to understand how palliative care is delivered in their local community, and what supports and services are available (e.g., palliative care specialists, hospice residences, visiting hospice services), to help inform patient decisions.
- Once unmet palliative care needs are identified, a patient’s access to primary care, community and social service supports should be assessed to understand available resources to support care transitions. Making connections to home and community supports early can help to reduce the chances of the person reaching the end of their illness and dying in hospital.
- The assessment process should incorporate questions and prompts for involving substitute decision-makers when appropriate, ensuring their active participation in care discussions.
- The involvement of Palliative Care Specialists has been described as existing along a spectrum, with consultation model at one end, and the takeover model at the other end. Hospital based specialist palliative care teams should periodically reflect on the model they are providing and monitor it. The Consultation-Shared Care-Takeover (C-S-T) Framework provides a tool to guide these reflections and monitoring [16].
- Clinical Leads or Department Heads should take the initiative to organize and conduct regular interprofessional meetings, providing a forum to discuss complex palliative care cases and share expertise among team members.
- Strategies should be developed to ensure that patient-facing versions of care plans are readily accessible and effectively shared with patients and their family/care partners, enhancing their

involvement in decision-making processes.

- Prior to discharge, patients, families and care partners should be informed about medications available for symptom management, their side effects and how to obtain them (e.g., do they have to call an RN/RPN for a PRN, or will it be regularly scheduled). Ideally these should be available in written form as a reference as well.
- Disease site-teams and hospital unit-based teams should be aware of, and familiar with Ontario Health's Quality Standard for Transitions Between Hospital and Home, and should work towards achieving high-quality care in alignment with the quality statements outlined.
- Disease site-teams and hospital unit-based teams should regularly update the patient's primary care and home and community care providers, and other involved care teams (such as long-term care (LTC) facilities, and/or specialized disease clinics, etc.) throughout the patient's stay in hospital, not just at discharge. These updates can help to support transitions back to community and ensure patients and care partners do not need to repeat their stories and information when returning to another setting.
- Disease site-teams and hospital unit-based teams should collaborate with community paramedicine providers in care planning and information sharing through platforms like HPG and CHRIS, facilitated by EMRs.
- Disease site-teams and hospital unit-based teams should be aware of, and familiar with local palliative care supports and services, including hospice resources (e.g. available hospice residence beds, visiting hospice services), to support meaningful referrals.
- Disease site-teams and hospital unit-based teams should leverage and implement existing educational materials and resources to inform patients and their family/care partners about the discharge process, available support services, and self-management strategies. Providing clear and accessible information can empower patients and families to actively participate in their care transitions.
- Disease site-teams and hospital unit-based teams should receive ongoing education about comprehensive symptom screening and the use of symptom assessment tools (see Guideline 2.2, page 14 in the NCP Guidelines, 4th edition, for more information about screening and assessing physical aspects of care, as well as pages 71-74 for a fulsome list of physical assessment tools).
- The role of the on-call Palliative Care Specialist should be clearly defined within the Interprofessional Palliative Care Team. Their expertise is recommended to be integrated into the collaborative care model, facilitating seamless consultation and support for complex case management. This enhances the team's ability to deliver comprehensive symptom management
- A single screening tool cannot cover all aspects of the psychosocial domain. Teams will need to consider various tools to further explore concerns raised by patients or their family/care partners. Please refer to Appendix J for examples of suggested psychosocial screening tools.
- Grieving takes time, so it is important to extend "check-in" periods beyond just a few weeks. Investments are required to address how best to support families and care partners for a longer period using community resources and services.
- Integration of standardized family/care partner assessment tools, such as the Family Needs Assessment Tool (FNAT) or the McGill Quality of Life Questionnaire (MQOL-Family), into the patient's care journey should be prioritized.
- Collaboration with community partners, such as hospices, should be pursued to establish or leverage existing connections to grief and bereavement supports, covering practical,

informational, psychosocial, physical, and emotional dimensions of care.

- Offering workshops, webinars, and online resources customized for family/care partners should be facilitated to guide them through care, system navigation, and resource availability.
- Structured emotional support avenues, such as peer support groups or counseling sessions, should be established or leveraged, ensuring multilingual and culturally appropriate options.
- Development of a physical or digital hub centralizing resources for family/care partners, regularly updated and user-friendly, should be prioritized to enhance accessibility and relevance.
- Patients may need help in supporting any dependent children (3-17y) with understanding the diagnosis, implications on family life, prognosis updates, emotional expression, parenting guidance during stressful times, Mental Health issue mitigation via open honest communication, legacy building and end of life support. Access to Child Life Specialists (CLS) or similar professionals should be provided to aid in offering age-appropriate interventions, such as assessments and resources for family members who are 18 years of age and younger.

# APPENDIX I: PALLIATIVE SPECIALIST MODELS IN HOSPITAL SETTINGS

**Tables 1 to 4** provide an overview of ideal standards for team settings, composition, and care activities. While many teams may not currently meet all these criteria, they represent the goals teams should aspire to achieve.

## Table 1: Acute Hospital In-Patient Palliative Specialist Models

| Service Type | Types of Hospitals (examples) | Eligibility Criteria | Suggested Team Composition | Care Activities |
|---|---|---|---|---|
| **Palliative Care Unit** | Acute Academic Hospitals<br>Large community hospitals with regional cancer centers and ICUs. | Acute, refractory, or complex symptom management.<br>Complex psychosocial issues.<br>Palliative care needs that require management by providers with Level 2 competencies (too complex or beyond the competencies of the disease-site team or hospital unit-based team).<br>Palliative care needs that cannot be met in patients' preferred setting (care partner burnout/fatigue, lack of home and/or community EOL supports). | **PCU Team:**<br>Level 2 competencies: MD and/or NP (Dyad, where possible), RN/RPN, CNS, SW, RPh, Spiritual Care, PSW, Care Coordinator (if not designated as a function of another PCU Team member).<br>**Extended PCU Services:**<br>Level 2 competencies: OT, PT, SLP, RD, RTC, Psychologist/Psychiatrist, and access to other providers with expertise to address identified needs.<br>Can be shared with other sub-acute hospital units/beds but must have dedicated FTE to PCU. | 24/7 access to MD and/or NP with Level 2 PC competencies.<br>Daily assessment by MD and/or NP with Level 2 PC competencies; Other providers assess as needed.<br>24/7 RN/RPN presence.<br>Conduct complex assessment/reassessment of palliative care needs, participate in goals of care discussions, and develop or participate in the development of care plans as needed.<br>Facilitate and support care coordination and discharge/transition planning.<br>Extended Service providers consult/provide care based on identified needs.<br>MRMP is the MD and/or NP from the PCU Team. |
| **Palliative Care Beds (on a ward with other services)** | Small community hospitals with ICUs and/or specializing in end-stage organ failure.<br><br>Large community hospitals with a Regional Cancer Centre, specializing in end-stage organ failure, with an ICU; building towards a PCU (but not yet having a critical mass of providers with Level 2 competencies). | Acute, refractory, or complex symptom management**.**<br>Complex psychosocial issues**.**<br>Palliative care needs that require management by providers with Level 2 competencies (too complex or beyond the competencies of the disease-site team or hospital unit-based team). Palliative care needs that cannot be met in patients' preferred setting (care partner burnout/fatigue, lack of home and/or community EOL supports). | **Palliative Care Bed Team:**<br>Level 2 competencies: MD and/or NP (Dyad, where possible), CNS, and a Care Coordinator (if not designated as a function of another Dedicated Bed Team member).<br>Level 1 or Level 2 competencies: RN and/or RPN, SW, RPh, Spiritual Care.<br>**Extended Palliative Care Bed Services:**<br>Level 1 or 2 competencies: OT, PT, SLP, RD, Recreational Therapist, Psychologist/Psychiatrist, and access to other providers with expertise to address identified needs. | 24/7 access to MD and/or NP with Level 2 PC competencies.<br>Daily assessment by MD and/or NP with Level 2 PC competencies; Other providers assess as needed.<br>24/7 RN/RPN presence.<br>Conduct complex assessment/reassessment of palliative care needs, participate in goals of care discussions, and develop or participate in the development of care plans as needed.<br>Facilitate and support care coordination and discharge/transition planning.<br>Extended Service providers consult/provide care based on identified needs.<br>MRMP is the MD, NP, or Dyad from the Palliative Care Bed Team. |
| **Palliative Specialist Consult Team** | All hospitals should have a Palliative Specialist Consult Team (either on site or virtually in rare cases). | Acute, refractory, or complex symptom management.<br>Complex psychosocial issues<br>Palliative care needs that require management by providers with Level 2 competencies (too complex or beyond the competencies of the disease-site team or hospital unit-based team), but do not require 24/7 care by an Interprofessional Palliative Care Team with Level 2 competencies.<br>Patients' medical condition/needs are sufficiently complex to require intensive management by disease site teams or hospital unit-based teams instead of Palliative Specialists (e.g., LVAD) | **Consult Team:**<br>Level 2 competencies: MD, and/or NP (Dyad, where possible) CNS, RN and/or RPN.<br>**Extended Consult Team Services:**<br>CNS (if not on consult team), SW, Spiritual Care, RPh, OT, PT, SLP, RD, Recreational Therapist, Psychologist/Psychiatrist, and access to other providers with expertise to address identified needs.<br>Can be shared with other hospital units/services but must have dedicated FTE to the Consult Team. | Available by phone 24/7, and available in person during daytime hours.<br>Provide consultative support when palliative care needs are complex or beyond the palliative care competencies of the disease site teams or hospital unit-based teams.<br>Conduct complex assessment/reassessment of palliative care needs, participate in goals of care discussions, and develop or participate in the development of care plans as needed.<br>Facilitate and support care coordination and discharge/transition planning.<br>Provide guidance in use of best practice guidelines/tools; patient family supports.<br>Provide mentorship to build primary level palliative care capacity (providers with Level 2 palliative care competencies training others to achieve Level 1 competencies).<br>MRMP is an MD or NP from a referring disease-site/hospital team. |

## Table 2: Sub-Acute Hospital In-Patient Palliative Specialist Models

| Service Type | Types of Hospitals (examples) | Eligibility Criteria | Suggested Team Composition | Care Activities |
|---|---|---|---|---|
| **Palliative Care Units (PCU)** | All Complex Continuing Care (CCC) hospitals, and CCC units in community hospitals. | Patients who no longer require care in an acute hospital but have ongoing complex symptoms or support needs that cannot be managed well at home or in hospice settings.<br>Patients with end-of-life care needs (and shorter life expectancy) who are unable to access preferred place of death due to inadequate home and community care resources. | **PCU Team:**<br>Level 2 competencies: MD, and/or NP (Dyad, where possible), RN/RPN, CNS, SW, RPh, Spiritual Care, PSW, and a Care Coordinator (if not designated as a function of another PCU Team member).<br>**Extended PCU Services:**<br>Level 2 competencies: OT, PT, SLP, RD, Recreational Therapist, Psychologist/Psychiatrist, and access to other providers with expertise to address identified needs. Can be shared with other sub-acute hospital units/beds, but must have dedicated FTE to PCU. | 24/7 access to MD and/or NP with Level 2 PC competencies.<br>Daily assessment by MD and/or NP with Level 2 PC competencies; Other providers assess as needed.<br>24/7 RN/RPN presence.<br>Conduct complex assessment/reassessment of palliative care needs, participate in goals of care discussions, and develop or participate in the development of care plans as needed.<br>Facilitate and support care coordination and discharge/transition planning. Extended Service providers consult/provide care based on identified needs.<br>MRMP is the MD, NP, or Dyad in the PCU. |
| **Palliative Specialist Consult Team** | All sub-acute settings should have Palliative Specialist Consult Team (either on site or virtually in rare cases). | Acute, refractory, or complex symptom management.<br>Complex psychosocial issues<br>Palliative care needs that require management by providers with Level 2 competencies (too complex or beyond the competencies of the disease-site team or hospital unit-based team), but do not require 24/7 care by an Interprofessional Palliative Care Team with Level 2 competencies.<br>Patients' medical condition/needs require care on a specific service or enrolled in a sub-acute program where goals are rehabilitative. | **Consult Team:**<br>Level 2 competencies: MD and/or NP (Dyad, where possible), RN and/or RPN.<br>**Extended Consult Team Services:**<br>Level 2 competencies: CNS, SW, Spiritual Care, RPh, OT, PT, SLP, RD, Recreational Therapist, Psychologist/Psychiatrist, and access to other providers with expertise to address identified needs. Can be shared with other hospital units/services but must have dedicated FTE to the Consult Team. | Available by phone 24/7, and available in person during daytime hours.<br>Provide consultative support when needs are complex or beyond the palliative care competencies of the disease site teams or hospital unit-based teams.<br>Conduct complex assessments/reassessments of palliative care needs, psychosocial care, crisis symptom management, participate in goals of care discussions and develop or participate in the development of care plans as needed.<br>Facilitate and support care coordination and discharge/transition planning.<br>Provide guidance in use of best practice guidelines/tools; patient family supports referrals for external supports, and Home & Community Care.<br>Provide mentorship to build primary level palliative care capacity (providers with Level 2 palliative care competencies training others to achieve Level 1 competencies).<br>MRMP is the MD, or NP, \from a referring disease site/hospital team. |

## Table 3: Acute Hospital Ambulatory Palliative Specialist Models

| Service Type | Types of Hospitals | Eligibility Criteria | Team Composition | Care Activities |
|---|---|---|---|---|
| **Embedded Palliative Care Clinic within a disease site clinic (e.g., cancer)** | Any hospital with disease site clinics/ambulatory units. | Acute, refractory, or complex symptom management.<br>Complex psychosocial issues<br>Palliative care needs require management by providers with Level 2 competencies (too complex or beyond the competencies of the disease-site clinic), | **Embedded Clinic Team:**<br>Level 2 competencies: MD, and/or NP (Dyad, where possible).<br>Level 1 or 2 Competencies: RN or RPN or CNS, SW, RPh, Care Coordinator (if not designated as a function of another Clinic Team member)<br>**Extended Clinic Team Services:**<br>Level 1 or 2 Competencies: CNS (if not on clinic team), OT, PT, SLP, Spiritual Care, RD, Psychologist/Psychiatrist, and access to other providers with expertise to address identified needs (providers may be from Ontario Health atHome and/or in-patient setting). | Assessment by MD or NP with Level 2 competencies on each visit, other providers as needed<br>Weekday access to Consult Team members, responding within 2 business days.<br>Conduct complex assessment/reassessment of palliative care needs, participate in goals of care discussions, and develop or participate in the development of care plans as needed.<br>Facilitate and support care coordination and discharge/transition planning.<br>Overall care is managed by the disease-site ambulatory clinic.<br>MRMP is an MD or NP from a referring disease-site team/hospital clinic team. |
| **Dedicated PC Clinic – stand-alone and disease agnostic** | Hospitals with a substantially mixed referral base (e.g., cancer and non-cancer illness) that cannot easily be managed in one or more embedded clinics. | Acute, refractory, or complex symptom management.<br>Complex psychosocial issues<br>Palliative care needs that require management by providers with Level 2 competencies (too complex or beyond the competencies of the disease-site clinic). | **Ambulatory Palliative Care Team:**<br>Level 2 competencies: MD and/or NP (Dyad, where possible) RN or RPN or CNS, SW, Clerk, RPh, Spiritual Care, Care Coordinator (if not designated as a function of another Clinic Team member).<br>**Extended Clinic Team Services:**<br>Level 2 competencies: CNS (if not already on clinic team), OT, PT, SLP, RD, Psychologist/Psychiatrist, and access to other providers with expertise to address identified needs (providers may be from Ontario Health atHome and/or in-patient setting). | Assessment by MD or NP with Level 2 competencies on each visit, other providers as needed.<br>Weekday access to MD or NP with Level 2 competencies, ideally responding same day.<br>Weekday access to other Ambulatory Palliative Care Team members, responding within 2 business days.<br>Conduct complex assessment/reassessment of palliative care needs, participate in goals of care discussions, and develop or participate in the development of care plans as needed.<br>Facilitate and support care coordination and discharge/transition planning.<br>Ongoing palliative management of patients who cannot be followed in a disease-site ambulatory clinic for any reason (e.g., disease-site team has signed off).<br>MRMP is the MD, NP or Dyad in the palliative clinic or the MD/NP from a referring disease site/hospital team. |
| **ED Consult** | All EDs should have access to a Palliative Specialist Consult model, whether in -house, or virtual. | Acute, refractory, or complex symptom management.<br>Complex psychosocial issues<br>Palliative care needs that require management by providers with Level 2 competencies (too complex or beyond the competencies of the Emergency Department team). | **Consult Team:**<br>Level 2 competencies: MD and/or NP (Dyad, where possible) CNS, RN and/or RPN.<br>**Extended Consult Team Services:**<br>CNS (if not on consult team), SW, Spiritual Care, RPh, OT, PT, SLP, RD, Recreational Therapist, Psychologist/Psychiatrist, and access to other providers with expertise to address identified needs.<br>Can be shared with other hospital units/services but must have dedicated FTE to the Consult Team. | Assessment by MD or NP with Level 2 competencies, other providers as needed.<br>24/7 access to MD or NP with Level 2 competencies (in-person during weekdays, virtually after hours).<br>Conduct complex assessment/reassessment of palliative care needs, participate in goals of care discussions, and develop or participate in the development of care plans as needed.<br>Facilitate and support care coordination and discharge/transition planning.<br>MRMP is an MD or NP from ED team.<br>Consultation should ideally be from providers familiar with local resources and context, especially if planning for imminent discharge and focusing on care coordination.<br>If virtual support provided by geographically distant specialist providers, this should be focused on symptoms. |

## Table 4 Sub-Acute Hospital Ambulatory Palliative Specialist Models

| Service Type | Types of Hospitals | Eligibility Criteria | Team Composition | Care Activities |
|---|---|---|---|---|
| **Standalone or Embedded Clinic** | All sub-acute hospitals (rehab and CCC) should have access to Palliative Specialist teams for outpatients.<br>Can be standalone, embedded in other clinics, or in rare cases can be virtual consultation. | Acute, refractory, or complex symptom management.<br>Complex psychosocial issues.<br>Palliative care needs that require management by providers with Level 2 competencies (too complex or beyond the competencies of the disease-site team or hospital unit-based team). | **Consult Team:**<br>Level 2 competencies: MD and/or NP (Dyad, where possible) RN or RPN or CNS.<br>Level 1 or 2 Competencies: RN and/or RPN, SW, RPh, Care Coordinator (if not designated as a function of another Core Team member).<br>**Extended Consult Team Services:**<br>Level 1 or 2 Competencies: CNS (if not already on the consult team) OT, PT, SLP, RD, Psychologist/Psychiatrist (providers may be from Ontario Health atHome and/or in-patient). | Assessment by MD or NP with Level 2. competencies on each visit, other providers as needed.<br>Weekday access to Consult Team, responding within 2 business days.<br>Conduct complex assessment/reassessment of palliative care needs, participate in goals of care discussions, and develop or participate in the development of care plans as needed.<br>Facilitate and support care coordination and discharge/transition planning.<br>Patients are managed by disease-site ambulatory clinic.<br>MRMP is a MD or NP from a referring disease-site clinic team. |

## APPENDIX J: SUGGESTED PSYCHOSOCIAL SCREENING TOOLS

Several psychosocial screening tools have been developed, evaluated and implemented extensively within the cancer care system and are also applicable in palliative care settings. Tools to support psychosocial screening may include:

- **Distress Thermometer (DT)**: A rapid screening tool for assessing psychological distress, recommended by the 2019 NCCN Clinical Practice Guidelines in Oncology for Distress Management V.2.2019. Further reading: PMC Article.
- **Canadian Problem Checklist with ESAS-R (COMPASS)**: Developed by CancerCare Manitoba, this tool combines symptom assessment with a problem checklist. COMPASS Tool.
- **Algorithm for Cancer-Related Distress, Depression & Global Anxiety**: Provides a team-based approach to managing anxiety. CAPCO Guidelines.
- **FICA Spiritual History Tool**: Guides conversations about spirituality in clinical settings, covering Faith, Importance, Community, and Address in care. FICA Tool Information.
- **HOPE Model**: A brief spiritual screening tool for assessing spiritual issues. Comparative insights: Saguil, A., and Phelps, K. The Spiritual Assessment. Am Fam Physician. 2012 Sep 15;86(6):546-550. AFP Article.

## REFERENCES

[1] Statistics Canada, " Table 13-10-0715-01 Deaths, by place of death (hospital or non-hospital)," 2023.

[2] Canadian Institute for Health Information, "Access to Palliative Care in Canada," CIHI, Ottawa, ON, 2023.

[3] C.D. Howe Institute, "Expensive Endings: Reining In the High Cost of End-of-Life Care in Canada," C.D. Howe Institute Commentar, Toronto, 2021.

[4] S. Nundy, L. A. Cooper and K. S. Mate, "The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity," *JAMA,* vol. 327, no. 6, p. 521–522, 2022.

[5] D. Itchhaporia , "The Evolution of the Quintuple Aim: Health Equity, Health Outcomes, and the Economy," *Journal of the American College of Cardiology,,* vol. 78, no. 22, p. 2262–2264, 2021.

[6] Statutes of Canada, "Bill C-7 (Royal Assent), Chapter 2: An Act to amend the Criminal Code (medical assistance in dying)," Ottawa, 2021.

[7] P. Tanuseputro, "Medical aid in dying: What matters most?," *CMAJ,* vol. 189, no. 3, pp. E99-E100, 23 January 2017.

[8] A. S. Kelley and E. Bollens-Lund, "Identifying the Population with Serious Illness: The "Denominator" Challenge," *J Palliat Med,* vol. 21, no. S2, pp. S7-S16, Mar 2018.

[9] Ontario Health: Health Quality, "Quality Standards: Palliative Care: Care for Adults With a Progressive, Life-Limiting Illness," Toronto, 2018.

[10] K. M. Dalgaard, H. Bergenholtz, M. E. Nielsen and H. Timm, "Early integration of palliative care in hospitals: A systematic review on methods, barriers, and outcome," *Palliative & supportive care,* vol. 12, no. 6, p. 495–513, 2014.

[11] N. Ahmed, S. H. Ahmedzai, K. Collins and B. Noble, "Holistic assessment of supportive and palliative care needs: the evidence for routine systematic questioning.," *BMJ supportive & palliative care,* vol. 4, no. 3, p. 238–246, 2014.

[12] "Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A," 1996 - current as of May 2023.

[13] Ontario Palliative Care Network, "Palliative Care Health Services Delivery: Recommendations for a Model of Care to Improve Palliative Care in Ontario - Focus Area 1: Adults Receiving Care in Community Settings," Ontario Health, Toronto, 2019.

[14] Ontario Palliative Care Network, "Ontario Palliative Care Competency Framework," Ontario Health, Toronto, 2019.

[15] Registered Nurses’ Association of Ontario, "A Palliative Approach to Care in the Last 12 Months of Life," Registered Nurses’ Association of Ontario, Toronto, ON, 2020.

[16] J. Pereira, C. Klinger, H. Seow, D. Marshall and L. Herx, "Are We Consulting, Sharing Care, or Taking Over? A Conceptual Framework," *Palliative medicine reports,* vol. 5, no. 1, p. 104–115, 2024.

[17] Registered Nurses’ Association of Ontario, "Clinical practice in a digital health environment," Registered Nurses’ Association of Ontario, Toronto, ON, 2024.

[18] Registered Nurses’ Association of Ontario, "End-of-life during the last days and hours," Registered Nurses’ Association of Ontario, Toronto, ON, 2011.

[19] S. Boa, E. Duncan, E. Haraldsdottir and S. Wyke, "Goal setting in palliative care: A structured review," *Progress in Palliative Care,* vol. 22, no. 6, p. 326–333, 2014.

[20] T. Killackey, E. Lovrics, S. Saunders and S. R. Isenberg, "Palliative care transitions from acute care to community-based care: A qualitative systematic review of the experiences and perspectives of health care providers.," *Palliative medicine,* vol. 34, no. 10, p. 1316–1331, 2020.

[21] Registered Nurses' Association of Ontario, "Transitions in care and services," Registered Nurses' Association of Ontario, Toronto,ON, 2023.

[22] E. Chapman, S. Pini and Z. e. a. Edwards, "Conceptualising effective symptom management in palliative care: a novel model derived from qualitative data," *BMC Palliat Care,* vol. 21, p. 17, 2022.

[23] C. Michel, H. Seipp, K. Kuss, M. Hach, A. Kussin, J. Riera-Knorrenschild and S. & Bösner, "Key aspects of psychosocial needs in palliative care - a qualitative analysis within the setting of a palliative care unit in comparison with specialised palliative home care," *BMC palliative care,* vol. 22, no. 1, p. 100, 2023.

[24] P. L. Hudson, C. Remedios and K. & Thomas, "A systematic review of psychosocial interventions for family carers of palliative care patients," *BMC palliative care,* vol. 9, p. 17, 2010.

[25] E. S. K., "End-of-life care: improving quality of life at the end of life," *Professional case management,* vol. 12, no. 6, p. 339–344, 2007.

[26] D. D. Quigley and S. G. & McCleskey, "Improving Care Experiences for Patients and Caregivers at End of Life: A Systematic Review," *The American journal of hospice & palliative care,* vol. 38, no. 1, p. 84–93, 2021.

[27] S. Ekberg, R. Parry, V. Land, K. Ekberg, M. Pino, C. Antaki, L. Jenkins and B. & Whittaker, "Communicating with patients and families about illness progression and end of life: a review of studies using direct observation of clinical practice," *BMC palliative care,* vol. 20, no. 1, p. 186, 2021.

[28] A. O'Sullivan, A. Alvariza and J. e. a. Öhlén, "Support received by family members before, at and after an ill person's death," *BMC Palliat Care,* vol. 20, p. 92, 2021.

[29] A. Milberg, M. Liljeroos and R. e. a. Wåhlberg, "Sense of support within the family: a cross-sectional study of family members in palliative home care," *BMC Palliat Care,* vol. 19, p. 120, 2020.

[30] Y. N. Becqué, J. A. C. Rietjens, A. van der Heide and E. Witkamp, "How nurses support family caregivers in the complex context of end-of-life home care: a qualitative study," *BMC palliative care,* vol. 20, no. 1, p. 162, 2021.

[31] Registered Nurses' Association of Ontario, "Person- and family-centred care," Registered Nurses' Association of Ontario, Toronto, ON, 2015.

[32] D. Stienstra and H. M. Chochinov, "Palliative care for vulnerable populations," *Palliative & supportive care,* vol. 10, no. 1, pp. 37-42, 2012.

[33] Registered Nurses' Association of Ontario, "Promoting 2SLGBTqi+ health equity," Registered Nurses' Association of Ontario, Toronto, ON, 2021.

[34] Office of the French Language Services Commissioner of Ontario, "Special report active offer of services in French: the cornerstone for achieving the objectives of Ontario's French Language Services Act," Queen's Printer for Ontario, Toronto, 2016.

[35] Ontario Palliative Care Network, "Key palliative care concepts and terms," 20 July 2017. [Online]. Available: https://dev.ontariopalliativecarenetwork.ca/sites/opcn/files/2021-01/KEYPALLIATIVECARECONCEPTSANDTERMS.pdf.

[36] J. Mills, T. Wand and J. A. Fraser, "Exploring the meaning and practice of self-care among palliative care nurses and doctors: a qualitative study," *BMC Palliat Care,* vol. 17, p. 63, 2018.

[37] Anishnawbe Health Toronto, "Approaching A Traditional Healer, Elder Or Medicine Person," Toronto, 2000.

[38] S. Bowens, "Language Barriers in Access to Health Care," Health Canada, Ottawa, 2001.

[39] Canadian Hospice Palliative Care Association, "The Way Forward InitiativeL An Integrated Palliative Approach to Care," 2014.

[40] Registered Nurses' Association of Ontario, "Crisis intervention for adults using a trauma-informed approach: Initial four weeks of management (3rd ed.)," Registered Nurses' Association of Ontario, Toronto, ON, 2017.

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