

# Hospice Palliative Care Northwest:

## The Vision

### Palliative Care Network Northwest

Results of a Strategic Planning Process from January to May 2001.  
A Proposed Model for an Integrated, Coordinated Regional  
Palliative Care Program

June 5, 2001

## **Forward**

This report is the result of a strategic planning process initiated by Palliative Care Network Northwest (PCNN) in December 2000 and supervised by the Service Committee of PCNN. The report includes data gathered through in-depth interviews in Thunder Bay and district from January 2001 to May 2001. A five-member ad hoc working group analyzed the interview data. In this report, the working group has proposed a model for a regional palliative care program, named Hospice Palliative Care Northwest, the structure and function of which incorporate the major themes found in that data.

Members of the strategic planning working group included:

- Carmell Fitzgerald-Bartman, HBSW, MSW (candidate), School of Social Work, Lakehead University, Thunder Bay, ON
- Mary Lou Kelley, MSW, Associate Professor, School of Social Work, Lakehead University, Thunder Bay, ON
- Barb Linkewich, HBScN, Program Manager, Northwestern Ontario Pain and Symptom Management Team, Thunder Bay, ON
- Kevin Miller, MD, CCFP, Assistant Clinical Professor, Department of Family Medicine, McMaster University and Family Practice Physician, Harbourview Medical Centre, Thunder Bay, ON
- Diana Pallen, MScN, Assistant Professor, School of Nursing, Lakehead University, Thunder Bay, ON
- Larry Librach, MD, CCFP, FCFP, Director of Temmy Latner Centre for Palliative Care (Mt. Sinai Hospital), Director of Palliative Care Sunnybrook & Women's College Health Centre, & Administrator of the Hospice Palliative Care Network Project, Toronto, ON. (Resource person and special consultant to the working group)

The intent of this Strategic Planning report is to provide the members of PCNN with information and a preliminary model for an integrated coordinated regional palliative care program. The report includes a description of the proposed model's structure and function, and offers five governance alternatives for consideration by PCNN and Thunder Bay's health care organizations. While Hospice Palliative Care Northwest would be based in the city of Thunder Bay, the proposed regional model includes outreach and support to district communities in Northwestern Ontario.

Once submitted to PCNN, this strategic planning report becomes their responsibility and the strategic planning working group is disbanded. The working group's intent is that the report will be discussed amongst the PCNN members and then circulated to local and regional health care organizations for consultation. Following sufficient consultation, PCNN will develop the proposal for the Northwestern Ontario regional palliative care program using the resources of their Service Committee. It is the understanding of the working group that Health Canada will be transferring 800 million dollars to the provinces for the enhancement of palliative care services, and that this announcement will be made the end of June 2001. It is the hope of the working group that PCNN will prepare a proposal for funding of Hospice Palliative Care Northwest by June 30, 2001 in order to take advantage of this funding opportunity.

### **Acknowledgments**

The working group would like to thank the many dedicated members of the Pain and Symptom Management Team who agreed to be interviewed for this report. Carmell Fitzgerald-Bartman sensitively and supportively elicited each provider's vision for a palliative care program. The administrators and managers of hospitals and health care agencies also took time out of their busy schedules to participate in the strategic planning process, providing us valuable insight into their organizational visions, priorities and constraints. Suzan Labine conducted thoughtful and skillful interviews of the administrators and we sincerely appreciate her enthusiasm and professional approach. Finally, we thank the regional health care providers who participated in our focus group meeting held during the Northern Lights Palliative Care Conference in Thunder Bay at the end of April. Sonja Habjan of the Northern Educational Centre for Aging and Health (NECAH) capably organized the meeting of regional providers.

The names of everyone interviewed for this report are listed below. Without all of their input, development of this model would not have been possible. We hope that you find the proposed model an accurate manifestation of your collective vision.

**Direct Care Providers, Pain and Symptom Management Team:**

Marilyn Arthur	Gerontologist
Sue Bailey	Nurse (acute care)
Lois Blundon	Nurse (hospice)
Helen Bogget	Occupational Therapist
Linda Byerley	Care Coordinator
Dr. Geoff Davis	Physician
Leona DiCasimiro	Physiotherapist
Meta Evans	Nurse (community)
Sister Sheila Fortune	Spiritual advisor
Cathy Gauley	Care Coordinator
Kathy Kortess-Miller	Social Worker (hospice)
Barb Linkewich	Program Manager, PSMT
Anne McGoey	Nurse Practitioner, PSMT
Lorraine Partanen	Care Coordinator
Marg Poling	Nurse (community)
Theresa Trainer	Social Worker (cancer care)
Joan Williams	Volunteer Coordinator

**Health Care Administrators and Managers:**

Tracy Buckler & Lois Blundon	St. Joseph's Care Group
Dr.H.S. Dhaliwal	Northwestern Ontario Regional Cancer Centre
Mary Anne Fish	Saint Elizabeth Health Care
Val Gosse	Central Park Lodge
Don Holmstrom	Thunder Bay Homes for the Aged
Mary Lou Kelley	NECAH, Lakehead University
Laura Kokocinski	Community Care Access Centre
Harriet Laudadio & Donna Opie	Victorian Order of Nurses
A. March, B. Sellick, J. Williams	Via Vitae
Lori Marshall	Thunder Bay Regional Hospital
Dan McGoey	Wesway Inc.
Sheila Woodford	Com Care Canada Ltd.
Roberta Woods	Bayshore Health Service

**Regional Providers:**

Joyce Appel-Volunteer Coordinator	Ear Falls
Maryann Couch-Case Manager	Atikokan
Peggy Davis-Social Worker	Geraldton
Irene Desjardines-Nurse/Volunteer	Marathon
Colleen Harder-Case Manager	Dryden
Marilyn Janicki-Case Manager	Red Lake
Wilma Sletmoen-Volunteer Coordinator	Fort Frances
Dr. Bryan MacLeod-Physician	Marathon
Pam Miller-Volunteer	Dryden
Althea Rasmussen-Nurse/Volunteer	Marathon
Karen Shagouchi-Homemaker Supervisor	Dryden
Sue Straight-Volunteer	Kenora
Darlene Wells-Nurse, Long-term Care	Sioux Lookout
Marlene Whiteside-Nurse	Dryden

*We thank you all,*

*The Strategic Planning Working Group*

## **Background to Palliative Care Network Northwest's Strategic Planning Process**

Over the past ten years in Thunder Bay, many health and community organizations have developed or expanded palliative care services for people living with a terminal illness and their families. To date, however, service development has occurred incrementally with each service or program developing in response to a specific client population, service gap or to a newly emerging client need. While existing programs now provide excellent service to a steadily increasing number of clients in hospitals, in long-term care and in community settings, both consumers and service providers have identified a need for easier access to services, greater coordination of available resources, and enhanced service in areas where there are documented gaps. Research conducted by Sellick, Kelley, Linkewich & Plumridge (1997), McLean, Cain & Sellick (1998) and MacLean, Kelley, Arthur and Stones (2000) have documented these regional service delivery issues in palliative care.

Palliative Care Network Northwest (PCNN) is proud of the services it has already helped to develop such as the Northwestern Ontario Pain and Symptom Management team and the palliative care nurse practitioner. PCNN is now committed to moving beyond developing individual services and seeks to work towards advancing the overall system of palliative care provision both at the community and regional levels. PCNN has thus undertaken this strategic planning initiative to develop a more comprehensive, coordinated system of care to serve palliative clients in Thunder Bay and region. The desired outcome of the palliative care strategic planning was the creation of a model for a *Thunder Bay Palliative Care Program* that would incorporate all existing palliative care services, strengthen the cooperative relationships between them, and provide direction for future service development.

***Strategic Planning Goal:***

***By June 30, 2001 to develop a model for a Palliative Care Service for Thunder Bay that is accessible, comprehensive, integrated, sustainable, effective, efficient, equitable, and accountable. It must have the capacity to support regional palliative care provision.***  
*(Motion approved by PCNN Dec. 8, 2000)*

## **The Mandate and History of Palliative Care Network Northwest**

The mandate of Palliative Care Network Northwest (PCNN) is to promote excellence in palliative care services through interagency collaboration, education and research. Today it is a consortium of twenty-nine palliative care provider organizations, groups or constituencies. (See Appendix A for membership) PCNN members represent all disciplines, including volunteers, and work in hospitals, community care agencies, long-term care facilities, and the Northwestern Ontario Regional Cancer Centre. Representation includes the City and District of Thunder Bay and Kenora-Rainy River District.

PCNN began in 1992 as an interagency committee initiated by the Thunder Bay Regional Cancer Centre. The palliative care committee applied to the Ontario Ministry of Health and received approval to develop the Pain and Symptom Management Team (PSMT) in 1993. The committee formalized itself as PCNN in 1994, the year the PSMT began providing service. In 1999, PCNN applied for and received funding for a full-time nurse practitioner. The nurse practitioner began her work for the PSMT in 2000, making a valuable contribution to clinical care of dying people in Thunder Bay.

## **The Mandate of the Northwestern Ontario Pain and Symptom Management Team**

The Pain and Symptom Management Team (PSMT) was founded in 1993 and has as its goal to ensure care delivery systems are in place to provide quality palliative care through Northwestern Ontario. The Northwestern Ontario Cancer Centre sponsored the PSMT from 1994 to 2000. Since the fall of 2000, the Thunder Bay Community Care Access Centre has sponsored the Team. The goal of the PSMT is achieved through five activities and their corresponding program outcomes:

- Coordination: A coordinated network, which links local, regional and provincial resources is available and utilized by service providers and consumers.
- Consultation: Palliative Care symptom management is available to individuals, care providers and health care professionals in all settings.
- Collaboration/Facilitation: Collaborative partnerships exist to identify and address service needs and gaps.
- Education/Skill Development: Service providers who deliver palliative care consistently apply knowledge and skills regarding pain and symptom assessment and management.
- Research and Evaluation: Cooperative research initiatives are promoted

Through these activities, the PSMT strives to bring community partners together to improve palliative care. The full-time program manager, a nurse, coordinates the team. She is assisted by a nurse practitioner who is available to provide clinical care under the guidance of the program's palliative care physician. An administrative assistant answers calls on the 1-800 "Caring Connections" telephone line. These calls originate with families and regional health care professionals who are seeking information regarding the care of people who are dying; the calls are referred to the program manager or another appropriate resource person on the volunteer interdisciplinary team. The PSMT program manager is linked with many community palliative care experts throughout the region to whom callers can be referred. The administrative assistant also prepares the quarterly PCNN newsletter, a valuable information resource for regional providers.

In addition to the paid staff, the PSMT presently has a volunteer interdisciplinary team of approximately fifteen palliative care providers and hospice volunteers. Members of the PSMT meet monthly. The PSMT staff and volunteer team members provide clinical consultation to patients, families and other health care professionals, deliver palliative care education and participate in research projects such as the development and evaluation of the In-Home Palliative Care Chart. They participate in weekly "rounds" at the Cancer Centre organized to present cases, solve clinical problems and address gaps in service. There is a long-term care subcommittee, which focuses on palliative care in nursing homes and homes for the aged. Team members carry a pager during evenings and weekends to respond to in-coming calls on the 1-800 "Caring Connection" telephone line. Through ad-hoc committees, the team develops educational resource material for families such as the pamphlets "Food for Thought" and "When Someone You Love is Dying". The program manager of the PSMT is the chair of the PCNN Service Committee, which has been instrumental in this strategic planning exercise.

The PSMT team members also have collaborative relationships with health care providers who function as "resource persons" in most community health and social service agencies and long-term care facilities in Thunder Bay. Thunder Bay's community health care providers must be commended as over the last seven years they have developed a high level of expertise in palliative care. They selflessly volunteer their time to support patients who are dying and their families and participate in the NECAH palliative care education.

Given its current resources and activities, the PSMT is ideally suited to form the core of a new integrated, regional, palliative care program in Northwestern Ontario.

*“We need to move towards more innovative ways of thinking and that means partnerships. We need a broader vision of how things can happen. One of the things I believe in strongly is having a broad community base of core expertise in each agency, supported by interdisciplinary experts in palliative care. This is part of what the PSMT is designed to do. I see my role as the linkage between all, bringing together all of the parties.”*

(Barb Linkewich, Program Manager, PSMT)

### **Strategic Planning Data Collection:**

#### **Data Collection Process:**

The strategic planning working group reviewed fifteen documents or program evaluations related to palliative care provision with the purpose of identifying any common features and relevant recommendations. These documents described models of palliative care delivery in rural and urban settings, and were drawn from across Canada. In addition, original data were collected from three sources: palliative care providers who were members of the Pain and Symptom Management Team; administrators or managers of Thunder Bay hospitals and agencies that provide service to dying people and their families; and regional palliative care providers. The original data was gathered through in-depth interviews and a focus group, which were conducted from January to May 2001.

#### **Document Review:**

The working group reviewed the following documents:

- ✓ A Research Report on Alternative Models of Health System Delivery and Access to Specialty Services in Rural Canada (Health Canada, 1999);
- ✓ Palliative Care in Rural Canada (MacLean, Kelley, Arthur & Stones, 1999);
- ✓ Giving Support and Getting Help: Informal Caregivers Experiences with Palliative Care Services (MacLean, Cain & Sellick, 1998);
- ✓ Palliative Care: Towards a Consensus in Standardized Principles of Practice (Canadian Palliative Care Association, CPCA Website 2001);
- ✓ A Rural Palliative Care Home Care Model: The Development and Evaluation of an Integrated Palliative Care Program in Nova Scotia and Prince Edward Island (2001);
- ✓ The Lakeland (AB) Integrated Community-Based Palliative Care Primary Health Care Project- Final Independent Evaluation Report (2000);
- ✓ Victoria Hospice Society Guide to Services (2000);
- ✓ Hospice Palliative Care Network Project: Toronto (2000);
- ✓ Integrated Delivery System for Palliative Care -Final Report of the Ottawa-Carleton

- Regional Palliative Care Association Working Group;
- ✓ Palliative Care Report-Summary of Recommendations of the Palliative Care Team, Timmins, ON (1998);
  - ✓ Palliative Care in the City of London, ON-A Patient-Centred Approach (1998);
  - ✓ The Hospital for Sick Children-Palliative Care and Bereavement Care Frameworks for Practice (1999);
  - ✓ Report of the PCNN Strategic Planning Day and Final Report (May, June 2000);
  - ✓ Regional Gaps, Challenges and Recommendations in Palliative Care, PCNN (Nov. 1996);
  - ✓ Ontario Palliative Care Educators Forum Recommendations (NECAH, Toronto 1998);

The national research documents provided the working group with a broad framework for developing the regional model. The Health Canada Report recommends that the success of rural health delivery models be evaluated in terms of accessibility, availability, effectiveness, efficiency and accountability. The working group found these criteria helpful and used them as a framework to organize the data collected from direct service providers. *Palliative Care in Rural Canada* reviewed palliative care delivery in six provinces of Canada, and recommends that developing a model of palliative care in rural Canada must address the following components: a philosophy, definition and guidelines for rural palliative care; maintaining the integrity of the rural community; accessibility of services; teamwork; consultant/specialist support; flexibility in providing services; education for the health care professional; social support for the family and health care professional; cultural awareness. The working group incorporated these recommendations in their work. The MacLean report on Caregiver Support provided seventeen recommendations to improve support for caregivers, the majority of which are addressed in the proposed model. These recommendations included the provision of social, financial and educational support of family caregivers. The Canadian Association of Palliative Care Standards of Practice provided a framework to ensure that the proposed model would meet CPCA standards.

Detailed program evaluations of palliative care programs in other parts of Canada revealed features and recommendations, which were considered relevant by the working group. Providing detailed descriptions of these programs is beyond the scope of this report, however they are all available for review in the NECAH office. This report can only include some highlights to illustrate the diversity amongst programs, each of which has unique strengths and has been developed to address the needs of its home community.

Victoria Hospice Society, Victoria, B.C., is an integrated program that includes hospital services, a volunteer program, a community-counseling program and a bereavement-counseling program under the governance of an independent foundation. Victoria Hospice provides interdisciplinary team care for clients in their own homes, in a hospital-based hospice unit, in acute hospitals and in residential facilities. In a city of 500,000 people, there are only seven acute hospice care beds and ten long-term care hospice beds. Most palliative clients in Victoria are cared for by the provincial home care program, supported by the hospice palliative care specialists through home visits, a 24/7 response team which provides crisis intervention and support for home death, case conferencing and clinical education. Patients are usually registered for the Hospice Program by their family physician or home care nurse. In rural British Columbia, Saltspring Island has a palliative care program, which successfully incorporates an in-home medication kit and the extensive use of volunteers. The palliative care team is coordinated out of the hospital and there is no dedicated staff or funding for palliative care outside of normal hospital and home care budgets. The Saltspring Island program relies on Victoria Hospice for education and clinical consultation.

The Rural Palliative Care Home Care Project was an inter-provincial initiative funded by the Federal Health Transition Fund to implement and evaluate a palliative care program in three rural communities in Nova Scotia and Prince Edward Island. Key elements of the integrated palliative care program were: access and referral through a regional single entry point; a common palliative care assessment tool and a palliative home chart used collaboratively with all agencies and interdisciplinary team members; coordination through an identified case manager for each client and family; weekly palliative care rounds; care delivery by an interdisciplinary team; consultation/resource teams to provide consultation and leadership in palliative care; linkage with community resources to provide volunteer support, equipment access and public awareness. The project evaluation provided seven recommendations some of which included having home as the preferred setting for palliative care, program funding for service, education and research; clinical education of providers; strong linkages to Cancer Centres and other specialty centers of consultation; income assistance and job security for families; and development of an information system and ongoing evaluation strategy.

The Lakeland Integrated Community-Based Palliative Care Primary Health Care project was one of twenty-seven projects funded as part of Alberta's Primary Health Care Project. This pilot involved only cancer patients with intake via family physicians or cancer specialists. The intended project outcome was the development and implementation of a regional case management system for the delivery of integrated palliative care in the Lakeland District. The components of the case management model included: central intake registry (palliative care data

base); use of three common assessment tools (CAGE questionnaire, Mini-Mental State Questionnaire, Edmonton Symptom Assessment Scale), development of care plans and a palliative care flow sheet to document care delivery; and development of a “communication passport” as a client-focused communication strategy. The program was based out of the Lakeland Regional Health Authority and included a Palliative Care Physician Consultant and a Project Coordinator (nurse) who also served as Palliative Care Nurse Consultant. Project accomplishments were: a central intake/referral system; the development of regional guidelines for acute care, home care, continuing care and rehabilitation services; the delivery of clinical education by the physician and nurse consultant; and volunteer training. The Edmonton Team served as mentors for the project. Challenges included: turf protection by some family physicians who were reluctant to seek consultation; inability of physicians to bill for telephone consultations; the need for more resources to manage the administrative aspects of data collection and program management; lack of nursing staff across care delivery sites to provide palliative care; difficulty accessing medication and equipment in rural areas; lack of knowledge about the pilot by family physicians; lack of follow-up bereavement support for families.

The Hospice Palliative Care Network Project (HPCNet) is a joint project of the Temmy Latner Centre for Palliative Care and the Toronto Community Care Access Centre. This community –based project works closely with five community hospice organizations. Funded as a two year pilot project by the Ontario Ministry of Health, HPCNet aims to develop an innovative model of home palliative care coordination and service delivery which will eventually serve more patients and families than is currently possible. It is an objective of the Project that every palliative care patient within the test area is seen by a palliative care physician, and has access to nursing, home care and hospice and volunteer services. The Project is based at the Community Care Access Centre and intake is through the CCAC and Temmy Latner Centre for Palliative Care. There is no disease specificity or time limitation on patient prognosis. Anyone who is facing a life threatening illness and receiving services from the Toronto CCAC is assessed for admission using the following two screening questions: Would you be surprised if this patient died in the next six months? If the patient has an advanced, life-threatening illness, are there currently any unmet symptom control issues or support needs? Periodic sweeps of patient cases are done to ensure that all patients living in the project area and meeting the admission criteria are enrolled under the care of one of the three interdisciplinary clinical palliative care teams. Each team cares for 80 patients and provides clinical services; educational services; evaluation and research services. They have weekly clinical rounds in a community location convenient to providers. Project physicians are paid by the Ministry of Health (MOH) under the Alternate Payment Program and physicians participate in clinical service, on-call coverage, education and research. The MOH also funded some administrative support, some capital, communication and

travel expenses, and an external evaluator. The physician group, Toronto Palliative Care Associates, provided additional funding. The remainder of the cost was absorbed within the normal budgets of the CCAC, the community hospice programs and Mt. Sinai hospital. The Toronto CCAC has made a major financial commitment to this project by hiring within their staffing complement a significant number of staff that provide support to HPCNet or have clinical expertise in palliative care.

### **Direct Care Providers in Thunder Bay:**

Carmell Fitzgerald-Bartman, a Lakehead University Master of Social Work student, interviewed sixteen palliative care providers who were active members of the Northwestern Ontario Pain and Symptom Management Team. She also interviewed the Associate Director of the Northern Educational Centre for Aging and Health, Lakehead University, who organized education for regional providers. Those interviewed were purposely selected to provide perspectives from many disciplines: physician, volunteer, nurse practitioner, acute hospital nurse, occupational therapist, community nurse, CCAC care coordinator, physiotherapist, social worker, and spiritual advisor. The providers interviewed practised in hospitals, long-term care facilities and community settings. During their interviews, several providers also spoke from a personal perspective about a family member who was receiving palliative care or shared their experience in the death of a loved one.

The provider interviews were approached as “conversations”. The meetings were face-to-face using the Appreciative Inquiry approach. Appreciate Inquiry starts with a grounded observation of “the best of what is”, then through vision and logic collaboratively articulates, “what might be”, ensuring the consent of those in the community of “what should be” and collectively considers “what can be” (Bushe 1995). The Appreciative Inquiry method was used to elicit a common vision of “best practices” for the preferred model of palliative care.

During their interviews, participants were asked to discuss:

- Their role in palliative care;
- Their “best experiences” working collaboratively in a community setting;
- Their “best present experiences” in palliative care;
- Their vision of a model for an integrated palliative program;
- Their needs in a formal palliative care system for provision of the best possible care.

Interviews were audio taped and transcribed. Data were categorized to develop the structure and functions of a regional model of palliative care delivery, and are presented in Table I: Providers’ Vision for Palliative Care Program.

*All providers strongly agreed that an integrated Palliative Care Program was needed to improve the quality of care for people who are dying and their families. Specific obstacles, challenges and gaps in the current care system have been well documented by PCNN in their recent strategic planning workshops and meetings and will not be repeated here. Providers further agreed that the new program model should be client-centered. In this case, “client” referred to the dying person and family; the desire is to have seamless transitions for clients between agencies and providers.*

### **Administrators and Managers of Palliative Care Provider Organizations:**

Suzan Labine interviewed administrators and managers using the following questions as an interview guide:

- ✓ What is your organization’s role and mandate in caring for people who are dying in Thunder Bay and region?
- ✓ Do you think PCNN should pursue developing a more formalized, integrated, comprehensive system of palliative care for Northwestern Ontario?
- ✓ If yes, what is your vision for such a program? What services should be provided? How would you like the program to work? What is your vision of your agency’s role in a formal, community-wide palliative care program? Do you have any proposals or plans at present that would relate to this?
- ✓ If no, in your opinion, what action should be taken for increasing and improving palliative care services in Thunder Bay and district? Does your agency have a role in this approach? If so, what is it? Do you have any proposal or plans at present in relation to palliative care?

The intended outcome was to identify those community health and social service organizations that should be included in an integrated, regional palliative care program, and to clarify their role in the program.

Palliative Care provision varied greatly amongst the organizations consulted. Via Vitae is the only agency to exclusively deliver palliative care, however, they think their program lacks visibility and is underutilized. Accessing funding has also been an ongoing challenge for Via Vitae. Given resources, they would like to expand their program to fill gaps in service.

**Table I: Providers Vision for Palliative Care Program**

Accessibility to Program	Availability of Resources	Effectiveness of Care	Efficiency of Service	Accountability to Client and Funders
<ul style="list-style-type: none"> <li>• Clients have 24/7 access to PSMT</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing education for care providers</li> </ul>	<ul style="list-style-type: none"> <li>• Flexibility in service provision to meet client need</li> </ul>	<ul style="list-style-type: none"> <li>• A common site for shared information, a client data base and integrated health care record</li> </ul>	<ul style="list-style-type: none"> <li>• Care outcome measures collected</li> </ul>
<ul style="list-style-type: none"> <li>• Program treats people with all diagnoses, regardless of care setting and financial means</li> </ul>	<ul style="list-style-type: none"> <li>• Alternate sites for death and respite care available: hospital, hospice, LTC, community</li> </ul>	<ul style="list-style-type: none"> <li>• Real choices for client when choosing sit of death</li> </ul>	<ul style="list-style-type: none"> <li>• Open and timely communication among providers</li> </ul>	<ul style="list-style-type: none"> <li>• Client staisfactin measures collected</li> </ul>
<ul style="list-style-type: none"> <li>• Regional clients have access to Thunder Bay palliative care services as needed</li> </ul>	<ul style="list-style-type: none"> <li>• Designated palliative care areas in acute care hospital (i.e. Emergency, ICU)</li> </ul>	<ul style="list-style-type: none"> <li>• Family and friends are involved (normalcy)</li> </ul>	<ul style="list-style-type: none"> <li>• Strong linkages between organizations</li> </ul>	<ul style="list-style-type: none"> <li>• Program utilization &amp; administrative statistics collected (MDS?)</li> </ul>
<ul style="list-style-type: none"> <li>• Rural providers have 24/7 access to consultation &amp; specialist support from palliative care team</li> </ul>	<ul style="list-style-type: none"> <li>• Complementary therapies are available and offered</li> </ul>	<ul style="list-style-type: none"> <li>• Clients are well informed and prepared fro what to expect</li> </ul>	<ul style="list-style-type: none"> <li>• Each organization has identified staff who are educated and comfortable with providing palliative care</li> </ul>	<ul style="list-style-type: none"> <li>• Active programs of research and development</li> </ul>
	<ul style="list-style-type: none"> <li>• A greater number of specialized palliative care providers are available: physicians, nurse practitioners, nurses, counselors.</li> </ul>	<ul style="list-style-type: none"> <li>• Universal use of the In-Home Chart, common assessment tools, care plans and protocols</li> </ul>	<ul style="list-style-type: none"> <li>• Strong linkages with provincial experts for consultation, program development, research and education</li> </ul>	
	<ul style="list-style-type: none"> <li>• Early and ongoing access to volunteer help and support</li> </ul>	<ul style="list-style-type: none"> <li>• Client is well supported with timely pain &amp; symptom management (conventional and complementary treatments)</li> </ul>	<ul style="list-style-type: none"> <li>• Regularly scheduled interdisciplinary, interagency, client conferencing</li> </ul>	
	<ul style="list-style-type: none"> <li>• Access to services needed for home death, including home visits by providers</li> </ul>	<ul style="list-style-type: none"> <li>• Client has access to financial assistance if needed for medical equipment, medications and other uninsured costs of home death</li> </ul>	<ul style="list-style-type: none"> <li>• Strong communication linkages between local and regional spiritual advisors</li> </ul>	
	<ul style="list-style-type: none"> <li>• Access to opioids and all needed medications at home</li> </ul>	<ul style="list-style-type: none"> <li>• End-of-life directives in place for all clients</li> </ul>		
	<ul style="list-style-type: none"> <li>• On-call roster of palliative care providers available 24/7, including physicians</li> </ul>	<ul style="list-style-type: none"> <li>• Family is supported with counseling, culturally sensitive practice &amp; bereavement caree</li> </ul>		
	<ul style="list-style-type: none"> <li>• Grief, bereavement and psych-social counseling available fro families and providers (telephone &amp; face to face)</li> </ul>	<ul style="list-style-type: none"> <li>• Family physicians remain involved with client &amp; family</li> </ul>		
	<ul style="list-style-type: none"> <li>• Spiritual and/or religious support is available prior to the final stages</li> </ul>	<ul style="list-style-type: none"> <li>• Continuity and consistency of service providers ensured</li> </ul>		
	<ul style="list-style-type: none"> <li>• All care settings/providers can access clinical consultation 24/7</li> </ul>	<ul style="list-style-type: none"> <li>• A clear plan of care with regular, ongoing revisions</li> </ul>		
	<ul style="list-style-type: none"> <li>• Palliative care education for family physicians, oncologists, nurses, team members, the public</li> </ul>	<ul style="list-style-type: none"> <li>• Continuity of care between settings; smooth transitions for clients</li> </ul>		

The Northwestern Ontario Regional Cancer Centre is very active and experienced in providing palliative care but their mandate is limited to cancer patients; about 50% of their clients are described as palliative. They provide interdisciplinary care to palliative patients who are able to visit the Centre and see palliative care as one of their important functions. While recognizing the need to provide palliative care, the NWORCC places priority on cancer research and treatment. They experience obstacles with the current system for delivering palliative care in the community.

Most people, who now die in Thunder Bay, die in Thunder Bay Regional Hospital (TBRH). Although TBRH does not have a designated area for palliative care, they do have a 0.5 palliative care coordinator under contract from St. Joseph's Care Group. If TBRH chose to develop a palliative care service, an excellent model for palliative care in acute care settings exists in Oshawa, Ontario. Lori Marshall, Vice President of Patient Care Service, is knowledgeable about the Oshawa model.

St. Joseph's Care group operates a ten-bed hospice unit. The hospice unit has a full interdisciplinary team and operates at full capacity almost all of the time. They see unmet needs in care for people who are dying. If resources were available, would like to expand their palliative care services to include respite care, day hospice, chronic care beds and a freestanding community hospice.

Wesway is experiencing palliative care as an emerging issue within their mandate of caregiver support. At present, however, palliative care is not formally part of their mandate. Wesway is interested in accessing more palliative care education for its staff.

Long-term care facilities view palliative care as an integral part of their care. Residents most often remain in their home facility to die rather than be transferred to hospital. This presents clinical challenges such as tube feeding and hydration; ready access to the expertise of the palliative care team is important. Maintaining sufficient staff with knowledge and experience in palliative care is difficult. The Homes for the Aged presently have designated palliative rooms. Central Park Lodge is in the process of building three new facilities, which will include space appropriate for palliation.

The Community Care Access Centre (CCAC) currently hosts the Pain and Symptom Management Team. The mandate and activities of the PSMT have been described on page six. CCAC has no specific mandate for palliative care; their global mandate is to provide a single point of access for individuals to community care, including information and referral, eligibility

determination for in-home services, case management, coordinated service planning and assessment for eligibility into long-term care facilities. Three ministries fund their services. Referrals can come from any source. The CCAC feels that it is well positioned to provide a single point of access for community-based palliative care services and to coordinate this care as they have a database of all services available. CCAC recommends a network of services based on integration and collaboration, rather than creation of a new organization to deliver palliative care services. They are limited in their service flexibility by their contracts with the Ministry of Health and provider agencies. Community palliative care services are an area into which CCAC intend to expand. They feel confident that most community needs are being met under their current direction. They have identified a position for a palliative care coordinator for the next budget year who will advocate, coordinate community care, liaise with acute and complex care settings, and work closely with clients and families. CCAC does not feel that this initiative by PCNN to develop a palliative program is timely with the current Ministry of Health agenda, although they indicated support of the process.

The home care provider agencies primarily contract their services through the CCAC, which means that the CCAC exercises much control over their service provision. Home care providers include the Victorian Order of Nurses, St. Elizabeth Health Care, Bayshore Health Services and Comcare. Home care agencies have seen an increase in palliative referrals although they are not necessarily formally designated as palliative. The PSMT is frequently used as a resource for consultation and support. V.O.N. identifies palliative care as an area in which they excel. Overall, communication is identified as a problem among provider organizations and with the CCAC care coordinators; the competitive nature of the contracting process with CCAC is a disincentive to increasing collaboration. More case conferencing for care planning is needed. There is a need for more home care service in the region. Access to educational programs in palliative care is important but the shortage of nursing staff creates a challenge for attending education.

The Northern Educational Centre for Aging and Health (NECAH) has managed the funding for physician and interdisciplinary palliative care education for Northwestern Ontario since 1993. To date, the educational model has been a “train-the-trainer” model in which regional physicians; long-term care facilities and community agencies attend a 30-hour annual conference to become resource persons to their agencies and colleagues. This educational approach is recently challenged by the shortage of health care providers, the high turnover of staff, and the inability of agencies to free staff to attend education. Over three hundred regional provides have now become palliative care “trainers”. The development of a new regional palliative program would provide an opportunity to redesign the educational programs NECAH provides. In

consultation with the palliative care program, greater emphasis would be placed on the delivery of specialized clinical education and on creating specialists who could provide consultation throughout the region and on-site in long-term care facilities. The new palliative care certificate offered by Lakehead University will meet some of the demand previously met by annual conferences. NECAH is committed to adapting their palliative care education to meet the changing educational needs identified by regional providers.

*All administrators and managers supported the development of an integrated, regional palliative care program to some extent.* Dr. Dhaliwal, CEO of the Northwestern Ontario Regional Cancer was strongly in favour of the PCNN initiative and described a palliative care program as “long overdue”. Dr. Dhaliwal suggested that partner organizations should contribute in-kind resources and expertise to support an integrated palliative care program and committed the Cancer Centre to doing so. Problems experienced in varying degrees by all provider agencies included: shortage of nursing staff and other health care professionals, inflexible mandates and funding allocations, a competitive environment for health care delivery, insufficient funding, lack of trust and cooperation amongst providers and organizations. Most organizations stated they were not prepared to compromise their autonomy but were supportive of increased collaboration. While agencies recognized the need to develop a governance model for an integrated program, most stated that it would be challenging to identify the “lead organization”.

Additional comments by administrators and managers included:

- ✓ a desire to improve the quality/continuity of care for clients and families
- ✓ A desire to maintain organizational autonomy
- ✓ The program must include education, program evaluation and research functions
- ✓ a need to fund palliative care within their existing budget and other service obligations
- ✓ a need to build the new palliative care program on what exists, respecting existing organizational mandates
- ✓ the desire to develop a network rather than creating something new
- ✓ that competition for contracts with the CCAC is an obstacle to sharing information and collaboration
- ✓ That multiple points of entry for clients into the program are preferred (no “bottle neck” at intake)
- ✓ an integrated information system (data base) is very important (possibly web-based) and statistics must be collected
- ✓ there should be universal use of the In-home chart
- ✓ funding “silos” within the MOH may be an obstacle to collaborative program

development

- ✓ a common definition of palliative care must be developed
- ✓ the program must have a regional focus/mandate
- ✓ the program must be directly accountable to clients by giving them a strong voice in the governance.
- ✓ Long-term care facilities must be included in the “system”
- ✓ each home-care provider agency cannot support their own specialized interdisciplinary palliative care team due to insufficient human and financial resources. A palliative care team must be a shared resource.
- ✓ There needs to be early identification of patients into program

### **Regional Providers Perspective:**

Regional providers were unanimously in support of the development of an integrated palliative care program. They viewed the role as the following:

- ✓ Providing consultant/specialist support
- ✓ Providing education for health care providers
- ✓ Providing social support for families and palliative care providers
- ✓ Providing access to Thunder Bay palliative care services for regional clients.

Education of health care professionals delivered at home was identified as a need in regional communities. Half-day workshops on specific clinical topics could be brought to the region. Regular case conferences would be helpful, possibly using telemedicine to link regional providers with the Thunder Bay palliative care team. This would have both an educational and clinical value. In addition, palliative care specialists could make regular visits to the region for consultation.

Regional families require education and support regarding what to expect with a home death. The regional palliative care program could assist with the development of educational material for families at the time of a client’s discharge. Families and professionals also need access to specialist telephone consultation and support twenty-four hours a day, seven days a week.

Obstacles to palliative care exist such as medication not being available in rural communities and difficulties tracking clients. There is a shortage of resources and some clients

and families prefer to come to Thunder Bay for care. If this is their choice, the Thunder Bay program should be able to provide resources to assist them.

**Summary of Data:**

There is strong support amongst Thunder Bay providers, administrators and managers of health care organizations and regional providers for the development of an integrated, regional palliative care program. Models for integrated programs exist provincially and nationally and are being supported by provincial and federal governments.

**Principles for the Regional Palliative Care Program**

Flexibility

Open Communications

Smooth Transitions

Timely Access to Services

Sufficient Range of Services Available

Alternative Settings for Care

Outreach and Support to Regional Communities

Education of Families and Professionals

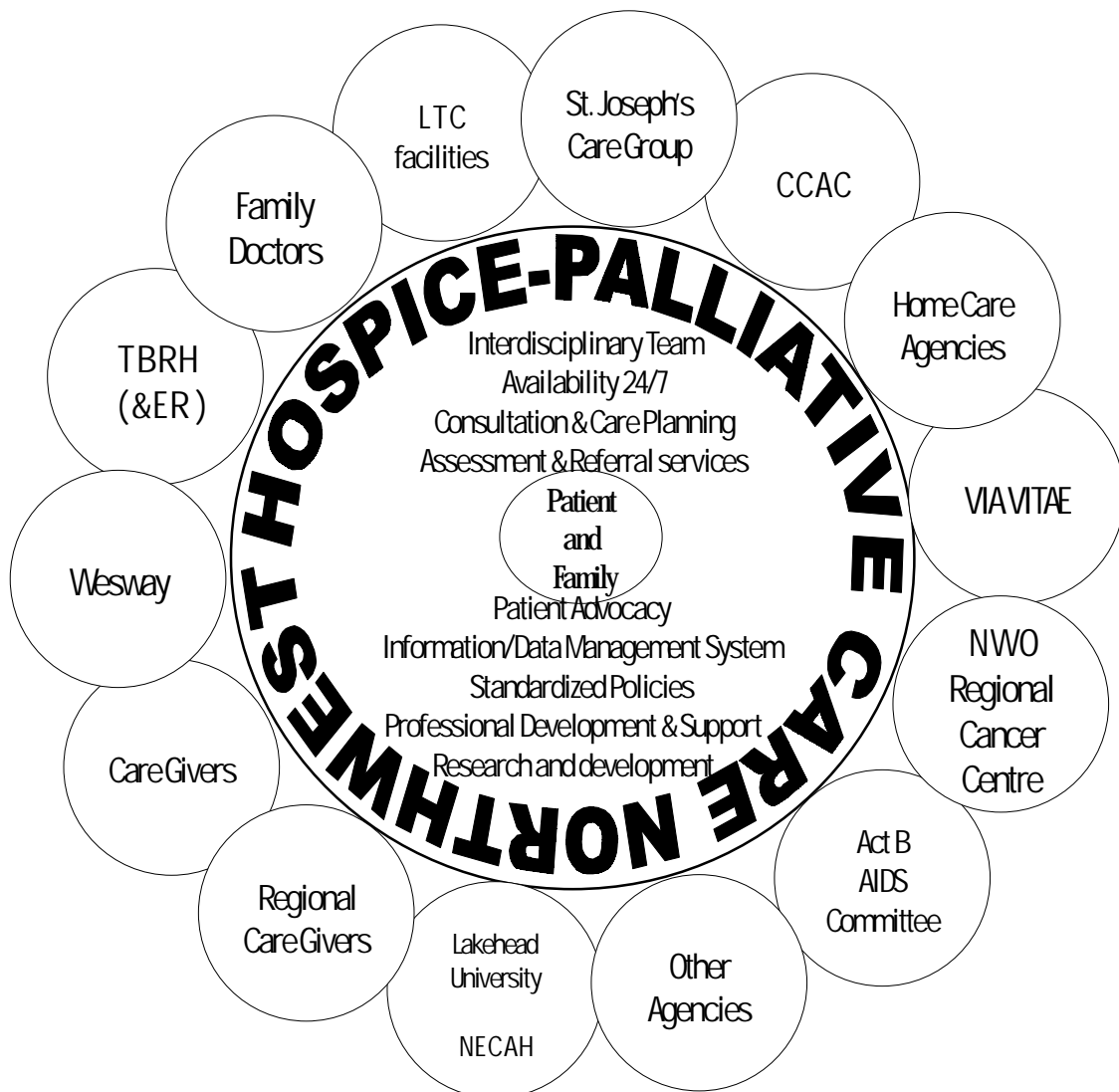
Research and Evaluation

Strong Regional and Provincial Linkages

**Proposed Model for Northwestern Ontario Palliative Care Program:**

***Hospice Palliative Care Northwest: an embassy for care of the terminally ill***

Using the principles of palliative care espoused by the primary care providers and the agencies, the working group has produced a model reflecting these values. This model has been called many things while in progress: the “Flower”, “Washing Machine”, or “Embassy”. Each of these analogies conjures up an image in the mind of the reader. We feel the metaphor of embassy best fits with our intent.



Please consider Hospice Palliative Care Northwest as the formal embassy, as one might find an embassy in a foreign country. This is a safe and comfortable place where a traveler may seek assistance from people able to meet his or her diverse needs. The patient and his or her family (here forth referred to collectively as “the client”) are in fact travelers, on the palliative journey. This is often an unfamiliar “country”, filled with many challenges.

The embassy has connections with the community and with all agencies and resources involved with the delivery of with palliative care. Health care organizations and community agencies that are partners in the palliative care program have service agreements with one another and the embassy. The connected outer circles represent these “connections”; the community agencies can be thought of as embassy consulates. In this model there is free communication between the connections, ensured by the service agreements.

A client may come to Hospice Palliative Care Northwest from any of these ”consulates”. That is, clients may enter the palliative care program from any partner agency. Information needed for a holistic interdisciplinary assessment is collected at intake and sent to the embassy. If necessary, the embassy staff can assist with the assessment. Often, the consulate is effective to meet the client’s care requirements. However, our traveler/ client may meet with the unexpected; perhaps this is a symptom that is not controlled or a concern that cannot be remedied. In this case, the embassy clinical staff and services will be activated on their behalf and become involved in direct care.

We hope each client can be integrated into the embassy system, thereby effectively receiving a “palliative care passport” that allows free, uninhibited flow through the embassy and consular system. In this way, the client receives the appropriate service from the most effective provider of that service. There may be several consulates and the embassy all working in unison to meet specific needs of each client.

The embassy houses a paid group of consultants who will work directly with a client if requested or who can assist the other community agency staff in dealing with clinical, psychosocial or spiritual issues. The functions of the Hospice Palliative Care Network are to house an interdisciplinary team that is paid to provide clinical consultation, direct service, care planning and education to clients and professionals. The team includes palliative care

physicians, nurse practitioners, pharmacists, social workers, spiritual advisors, physiotherapists, nurses, occupational therapists, nutritionists, volunteers and complementary therapists. Some team members may be employed by other organizations and have their time donated or purchased for the palliative care program. Team members are available twenty-four hours a day, seven days a week for telephone consultation or home visits via an on-call roster. If needed, the team will advocate for clients throughout the health care system. The physical location of the Hospice Palliative Care Northwest program has little impact on its function. It is essentially a “virtual organization” with offices and a communication center.

The team, on behalf of the program and in consultation with community partners, develops standardized policies, protocols and care plans to assist with consistency of service provision. Team members provide professional development and support to health care professionals delivering palliative care. The program houses an information and data system, which tracks each client with their consent. The program also maintains an integrated health care record for each client that can be accessed by providers involved in their care. This could be web-based or computer-based. The program ensures that consents are obtained to share information and that health care directives are in place. Continuity of care for clients is promoted through service agreements amongst provider agencies. Finally, the program has an active program of research and evaluation.

The model of Hospice Palliative Care Northwest was developed around existing human resources and other resources. The “core” of the embassy staff is the present Pain and Symptom Management Team Coordinator, the nurse practitioner and the program administrative assistant. The budget of the PSMT would be reallocated to Hospice Palliative Care Northwest. Additional funding will be needed to pay physicians (alternate payment plan) and pay interdisciplinary team members for their work on the palliative care program. We now have four physicians in Thunder Bay committed to providing palliative care. We have a well-established interdisciplinary team to draw from for the new program. Plans have already been initiated to obtain alternative payment arrangement and “on call” payment for palliative care physicians. It is possible that “in kind” arrangements could be made with local health care organizations to contribute some staff hours to the program as support for the interdisciplinary team. A proposal will need to be made to the Ontario Ministry of Health for a budget enhancement to expand the staff complement of the palliative care program. In addition to clinical staff, the program requires some additional human resources for information management, maintaining health records, research, education and administrative coordination.

In the longer term, additional programs are needed for the region, which would then become partners in Hospice Palliative Care Northwest. Some of these include: respite services; long-term care hospice beds; chronic care hospice beds; a day hospice; a free-standing hospice; a bereavement and grief counseling program; an in-home medication program. All of these new programs would require additional resources.

**Vision for Governance of Hospice Palliative Care Northwest:**

The Working Group discussed the governance needs for Hospice Palliative Care Northwest and identified the desirable organizational qualities of the sponsoring organization. These qualities are offered to PCNN as potential criteria against which to judge the governance alternatives presented in this report. No effort has been made to prioritize these qualities; we felt they must be considered holistically. It is also clearly recognized by the working group that no one sponsoring organization can bring all of these qualities to Hospice Palliative Care Northwest; each option offers advantages and disadvantages, which must be weighed relative to the others.

Potential Criteria for Evaluating Governance Options of Hospice Palliative Care Northwest:

- ✓ Program autonomy provided for Hospice Palliative Care Northwest
- ✓ Organization strongly committed to making palliative care a priority service
- ✓ Organization committed to the goal, activities and outcomes of the HPC Northwest
- ✓ Organization mandated to treat palliative clients with any disease
- ✓ Incorporated to receive government funding
- ✓ Strongly committed to program evaluation and research
- ✓ Strongly committed to education for staff and clients
- ✓ Mandated or willing to provide regional service
- ✓ Credible to the professional community and clients
- ✓ Highly visible in the city and region
- ✓ Flexible in their approach to service delivery and client service
- ✓ Minimal bureaucracy in operations
- ✓ Possesses the political skills to advocate effectively for program and client needs
- ✓ Good morale amongst staff
- ✓ Professional and clinical support available to program staff
- ✓ Strong vision for palliative care and future program development
- ✓ Commitment of financial support or in-kind support
- ✓ Solid professional linkages within the city and region
- ✓ No union obstacles to effective program functioning

### **Governance Options for Northwestern Ontario Palliative Care Program:**

The working group examined the current service delivery system resources and offers five governance options for the consideration of PCNN. No effort has been made to prioritize them; all have something valuable to offer.

The Northwestern Ontario Cancer Centre was not included as a governance option as its mandate is exclusively the treatment of patients with Cancer and its organizational structure will not permit autonomous functioning for a regional, community-focused palliative care program. Since the majority of clients who currently receive palliative care are suffering from Cancer and the Cancer Centre has skilled clinicians in many disciplines, the Cancer Centre will be a critically important partner in Hospice Palliative Care Northwest. Dr. Dahliwal, Executive Director of the Cancer Centre, clearly stated his commitment to the vision of an integrated palliative care program and indicated his organization's willingness to participate and provide resources to such a program.

Regardless of the governance model selected, it is the opinion of the working group the PCNN should continue to plan an active advisory role in the new palliative care program. The exact nature of the role may vary according to the governance model.

#### **✓ St. Joseph's Care Group:**

This option would place the new palliative care program as a community program of St. Joseph's Care Group, possibly situated at the Westmount site or in the new long-term care facility being constructed. This model would offer the clinical staff of the palliative care program ready access to the expertise and support of the interdisciplinary palliative team on the hospice unit. Given the shortage of skilled palliative care clinicians, the potential exists for some sharing of staff between the hospice unit and Hospice Palliative Care Northwest. This model could also offer patients easier transition from community care to hospital-based hospice care in the event that this is required.

#### **✓ Community Care Access Centre**

The mission of the Community Care Access Centre is to provide a single point of access for individuals to community care, including information and referral, eligibility determination for in-home services, case management, coordinated service planning and assessment for eligibility into long-term care facilities. CCAC's mandate for assessment and

referral already includes clients needing palliative care at home and they have organizational approaches to do this. CCAC has service contracts with home care provider agencies that employ experienced and skilled palliative care clinicians on their staffs. Many of these clinicians collaborate with the Pain and Symptom Management Team. Having hosted the PSMT since fall of 2000, CCAC has worked to enhance their palliative care program and plan to hire a palliative care coordinator next year. The Ministry of Health is funding a palliative care pilot project with the Toronto CCAC that appears to be successful. CCAC has a mandate for providing service in the District of Thunder Bay, but not within the Kenora-Rainy River District.

✓ **Via Vitae:**

Via Vitae is the only incorporated organization in Thunder Bay whose sole mandate is the provision of palliative care services. The mandate of Via Vitae could be expanded to include governance of the new palliative care program. Additional services such as a bereavement program could be added in the future. This governance option would provide an independent incorporated organization to manage the palliative program without creating a new organization. This would bring two important palliative care services together in single governance, allowing for easier coordination and possible increased financial efficiency through the sharing of staff or services. This option would also address the expressed desire of Via Vitae to have their organization better integrated into the care delivery system; they currently feel that their volunteers are underutilized.

✓ **Independent Incorporated Agency:**

This option has similarities to the governance model of the Thunder Bay Placement Coordination before it was amalgamated into the Community Care Access Centre. It also has similarities to the Canadian Cancer Care Ontario Regional (CCOR) board. In this option, a new incorporated organization would need to be established. The organization would have a “stakeholder board” with representation from each organization involved in the delivery of palliative care. The board, through consensus, would establish program standards, policies and procedures, and care protocols. These standards would be used to manage the operation of the palliative care program. Health care organizations could join the palliative care program and in doing so would agree to deliver their palliative care services in a manner consistent with the program standards.

✓ **Lakehead University, Palliative Care Centre of Excellence**

This option would integrate the Ontario Ministry of Health’s Pain and Symptom Management Team Initiative with the Physician and Interdisciplinary Community Education Initiatives under the governance of Lakehead University. Lakehead University has sponsored

the two palliative care education initiatives since 1993. Integration of the three initiatives would provide the foundation to establish a new Palliative Care Centre of Excellence at Lakehead University. This university Centre could have strong linkages with the new Thunder Bay Regional Hospital, the new Northwestern Ontario Medical School and Lakehead University's Department of Psychology and the Schools of Nursing and Social Work. Current linkages would be maintained with the Northern Educational Centre for Aging and Health (NECAH), the Centre for Rural and Northern Health Research (CRaNH) and Health Sciences North at Lakehead University. This option would enhance the coordination between the service, education and research functions of Hospice Palliative Care Northwest and would especially serve to strengthen the education and research functions. Lakehead University has a long history of collaboration with the Northwestern Ontario Regional Cancer Centre in the area of research and development and this partnership would strengthen the Palliative Care Centre of Excellence at Lakehead University.

### **Outstanding Issues:**

There are a number of outstanding issues that need to be discussed by PCNN in relation to the proposed Hospice Palliative Care Northwest.

#### Definition of Palliative Care:

It will be necessary to revisit the definition of palliative care used by the program and to ensure that there is common agreement amongst all partner organizations and health care professionals. The definition selected will influence both the diseases treated and when clients are referred to the palliative care program.

#### Criteria for admission to the program:

One critical decision will be when patients and families should be referred to the palliative care program. There are alternative perspectives on the onset of the dying process. Does dying begin when a health care team has obtained and analysed enough information to make the judgment that the person is dying? Does dying begin when the facts are communicated to the patient by the health care team, that is, when the patient is aware that he/she is dying? Does dying begin when the patient and family realize or accept the fact of the terminal illness? Does dying begin when nothing more can be done to preserve life? There was a general view amongst providers that clients would generally benefit by being identified as palliative sooner in order that more services and supports can be put in place. The conceptual framework used in the Palliative

Care Institute may be useful to discuss here. Should the client be referred to the Palliative Care Program during the Initial Phase (Breaking the Bad News), Ongoing Phase (Supporting the Struggle) or the Ending Phase (Weaving Life with Death)? The screening questions used in the HPCNet project may be useful here. It may also be necessary to develop different sets of protocols and care plans appropriate for each of the three phases of palliation and the bereavement phase.

#### Development of Common Standards, Protocols or Care Plan:

This will be essential to ensure consistency of care. The new CPCA guidelines are near completion and can provide a framework for regional standards, protocols and care plans. The Pain and Symptom Management Team has already begun this process by involvement with the Registered Nurses Association of Ontario, on the “best practice guidelines” for pain management.

#### Governance:

Issues of governance will need to be decided. Almost all providers and administrators interviewed in conjunction with the strategic planning emphasized that it would be difficult to determine a governance model for Hospice Palliative Care Northwest. Some people even suggested that it would be impossible to establish this integrated program unless the Ministry of Health mandated it. The working group is optimistic that providers and organizations have sufficient commitment to the goal of the new palliative care program that a decision on an acceptable can be achieved.

#### Budget and Proposal Development:

A proposal and business plan for Hospice Palliative Care Northwest will need to be developed. It is expected that new funding for palliative care will be announced by Health Canada the end of June 2001. It would increase our region’s chances of accessing funding from this source if the proposal and business plan could be ready by that date.

#### **Conclusion:**

It has been a rewarding experience to participate in the strategic planning working group. There is a strong recognition throughout the region that palliative care services need to be enhanced and that services for clients need better integration and coordination. The working

group believes that the model proposed in this document for Hospice Palliative Care Northwest accomplishes these ends.

Overall, providers and administrators strongly support PCNN's initiative to develop an integrated, regional palliative care program. There are, however, some challenges to be overcome related to negotiating issues of governance and resources. The existing resources of the PSMT, presently hosted by the CCAC, will need to be reallocated to Hospice Palliative Care Northwest. Additional resources will also be needed to expand the current functions and staff complement of the PSMT. Timing for this strategic planning process is opportune in that Senator Sharon Carstairs, head of the Canadian Senate with special responsibility for palliative care, stated that \$800 million dedicated to palliative care will be announced by Health Canada the end of June 2001. The funding will be allocated through each province's Ministry of Health.

The working group hopes that this report is helpful to PCNN when discussing the structure and function of the integrated, regional palliative care program. As of submission of this report, the strategic planning working group has completed its task. We wish PCNN and the Service Committee well in taking the strategic planning process to the proposal stage.

Appendix 1:

## Members of Hospice Palliative Care Network Northwest

- Alzheimer Day Centre
- Alzheimer Society of Thunder Bay
- AIDS Thunder Bay
- Bereaved Families of Ontario
- Central Park Lodge
- Comcare
- Community Care Access Centre
- Consumer
- Gentiva Olsten
- Lakehead Psychiatric Hospital
- Lakehead University
- L'Accueil Francophone
- Northern Educational Centre for Aging and Health
- Northwestern Ontario Regional Cancer Centre
- Pain & Symptom Management Team
- Pinewood Court
- Regional Representation - Terrace Bay & Geraldton  
(multi faith association)
- Saint Elizabeth's Health Care
- St. Joseph's Hospice
- Thunder Bay Regional Hospital - Port Arthur &  
McKellar Site
- Versa Care Centre
- Via Vitae Palliative Care Volunteers
- Victorian Order of Nurses