Palliative Care Network

Specialist Palliative Care: Health Services Planning

Full Report - Approach, Findings and Recommendations

Palliative Care Network

May 2025

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EXECUTIVE SUMMARY

Purpose and Approach

Palliative care is the active holistic care for people of all ages with serious life-limiting illnesses, from diagnosis to the end-of-life. It aims to improve the quality of life of patients, chosen families, and caregivers, and includes the prevention, early identification and comprehensive assessment and management of physical symptoms, such as pain and fatigue, as well as psychological distress, spiritual and social needs, advanced care planning, and grief and bereavement supports. Specialist palliative care providers most commonly include a palliative medicine physician, palliative care consult nurse, and social worker. Care is provided in palliative care units (PCUs), inpatient settings, the community and home, and work collaboratively together and with other health care providers to address the unique needs and preferences of each patient and family to live life to their fullest.

In 2023, health services planning was identified as a priority area of focus by the Palliative Care Network Council, to provide more consistencies, opportunities, and efficiencies within service delivery across the province. Building on previous work, the Palliative Care Network, in collaboration with zone administrative palliative care leaders, palliative medicine physicians, and partners, began a population, needs-based health services planning process focused on specialist palliative care. Key deliverables included the:

- Development of a provincial care delivery model.
- Development of a provincial service delivery framework.
- Development definitions and associated service delivery components for PCUs, palliative approach to care beds, palliative care inpatient consult teams, and palliative care community teams.
- Identification of workforce metrics for PCUs, palliative care inpatient consult teams, and palliative care community teams.
- Identification and prioritization of key elements of a provincial service delivery framework (e.g., common referral, triage, discharge criteria, etc.).

Planning was supported by a thorough review of the evidence. Palliative care service and population level data from across the province was reviewed and validated. Environmental scans, service mapping, and a gap analysis were conducted for each zone.

Key Findings

- Nova Scotia has the third oldest population in Canada (Statistics Canada, 2024b) and people aged 55-74 constitute the largest age group (28%) (Nova Scotia Health Performance and Analytics, 2024), a group who are more likely to receive palliative care. The population over the age of 75 is expected to almost double over the next 15 years (Nova Scotia Health Performance and Analytics, 2024). Additionally, the majority (55.3%) of Nova Scotians die in our hospitals (Statistics Canada, 2024a), and the last year of life is often the most expensive in terms of health care costs (Tanuseputro et al., 2015). Palliative medicine physician planned retirements will likely lead to a 30% decline in FTEs with as much as 50% attrition in some areas.

- Considerable variability exists in structure, process, and outcomes of specialist palliative care services across the province. This variability was identified in approaches to care delivery (i.e., shared care, takeover, and consult), available team roles (i.e. dedicated triage role), service availability (i.e., after-hours access), population served, waitlist management, qualifications of specialist team members, and service delivery criteria and processes (i.e., referral, triage and discharge criteria). These variations informed several key themes for deliverables to guide ongoing planning.

- The **Consultation-Shared Care-Takeover Model** (Pereira et al., 2024) (see Figure 3) was selected as the provincial conceptual care model for specialist palliative care. It articulates three levels of care, from consultation at one end, shared care in the center and takeover at the other end. All approaches are applicable, however, the shared care approach is preferred, as this supports collaboration between non-specialist and specialist palliative care providers and builds competencies in non-specialist palliative care providers to integrate a palliative approach to care within practice.

- The **palliative care service delivery framework** (see Figure 4) articulates the ideal state of palliative care service provision, from patient diagnosis, through to post-death supports. While many aspects of the framework are in place today, there is room to work towards standardization of processes and criteria to provide equitable and timely care regardless of location.

- **Palliative care service delivery model definitions and service delivery components** for PCUs, palliative approach to care beds, inpatient consult teams, and community-based teams were developed. Key service delivery components include details such as location, staffing, scope of service, physical space, and health care provider qualifications.

- **Specialist palliative care workforce** metrics recommendations for palliative medicine physicians, nursing, and social work were underpinned by a shared care, needs and population-based approach, and developed by a separate working group (including palliative care network, zone palliative care leadership, palliative medicine physician leadership, medical affairs, Interprofessional Practice and Learning (IPPL)/workforce development, and Department of Health and Wellness (DHW)).
    - **Palliative care unit metrics** were based on the Canadian Society of Palliative Medicine (CSPM) guidelines (Henderson et al., 2019) and incorporated the number of beds within the unit and nursing hours per patient day (NHPPD).
    - **Inpatient consult team metrics** were based on the adapted Australian Palliative Care guidelines (Palliative care Australia, 2018) and incorporated the number of inpatient medical, surgical, ALC, and transitional care beds within the hospitals served by the teams.
    - **Community team metrics** were informed by the CSPM guidelines (Henderson et al., 2019) and were based on the number of deaths per annum and the assumption that 63-75% of total deaths could benefit from specialist palliative care at some point in their illness trajectory. An age and socioeconomic adjustment factor previously applied by DHW for primary health care planning was applied to community metrics calculations to account for impacts associated with care provision with these populations.

Key Recommendations

The health services planning approach identified several theme areas for priority action, which included:

Service Delivery

- Develop a standardized provincial referral form and explore opportunities to centralize referral receipt at the zone level.
- Develop care pathways for patients without a primary care provider.
- Develop care pathways for existing patients for after-hours care.
- Compile patient and family resources in serious illness, self-management support.
- Establish centralized zone triage.
- Standardize triage criteria.
- Standardize discharge criteria.
- Develop a siting process for zone leadership to determine palliative care service delivery requirements.

- Develop and implement a palliative approach to care framework that can be spread and scaled across the province in applicable service areas.

Workforce Planning

- Develop workforce metrics template for use by zone leadership to aid in health human resource planning.
- Develop common job descriptions for specialist palliative care providers.
- Work towards the realization of a shared care approach, as defined by the Consultation, Shared Care, Takeover Model.
- Support future business cases based on workforce metrics recommendations

Capacity Building

- Establish Learning Essential Approaches to Palliative Care (LEAP) education plan for health care providers providing a palliative approach to care.
- Determine educational requirements for specialist palliative care providers beyond nursing and physicians (i.e., social work).
- Develop transition-to-practice plans and ongoing practice development with IPPL.
- Develop a palliative care practice support program.
- Enhance education for referrers and the public regarding a palliative approach to care, and when to refer to specialist palliative care.

BACKGROUND/CONTEXT

- Nova Scotia Health (NSH) specialist palliative care services include health care providers (HCPs) who work across settings of care, including palliative care units (PCUs), inpatient consult services, ambulatory clinics, and community-based care. The most common interprofessional team members who comprise specialist palliative care teams across the province include palliative medicine physicians, registered nurses (RNs), and social workers. In addition to these roles, many other HCPs play an important role in supporting specialty palliative care (e.g., occupational therapist, physiotherapist, etc.). These roles possess and/or require specialized education and training in palliative care.
- In 2014, the Department of Health Wellness released the Integrated Palliative Care Strategy (Nova Scotia Government, 2014). In 2014, DHW released the Palliative Care Progress Report (Nova Scotia Government, 2015) that outlined progress made to move recommendations forward.
- In 2015, the Nova Scotia Health Authority was established, which paved the way for strengthened provincial collaboration, consistency, and efficiency in palliative care service delivery.
- In 2017, work began to outline a provincial model of care that articulated the service delivery components and workforce planning required to provide high quality, sustainable specialist palliative care.
- In 2021, there was organizational restructuring at NSH, and the Palliative Care Network (PCN) was established. The network has a provincial scope and mandate to recommend strategy, and improvement plans to drive the achievement of targeted, measurable and sustainable clinical and operational improvements in palliative care delivery.
- In September 2023, engagement occurred with Palliative Care Network council members to update the NSH PCN Strategic Priorities (Appendix A). Health services planning was identified as a priority area of focus. Health services planning is a process that appraises the overall health needs of a geographic area or population and determines how these needs can be met in the most effective manner through the allocation of existing and anticipated future resources. It is a future oriented process, and considers health improvements for targeted populations, changing demands for health services, new policy directions, and emerging trends to support improved health service delivery (Deloitte & NS Department of Health &Wellness, n.d.). The Nova Scotia Framework for Clinical Services Planning articulates the various levels of health services planning (Figure 1). The **Care Delivery Model** describes the

overall framework for the health care system and examines the patient's journey through the health care system. The **Service Delivery Model** describes where health services should be located (siting) and the resource required to provide the care (sizing) based on the needs of the population. This level of planning focuses on understanding the roles and responsibilities of health care providers. At the most granular level is the **Operational Model,** which describes the details of service delivery, including how HCPs provide care to the population they serve (Deloitte & NS Department of Health &Wellness, n.d.).

- In October 2023, the PCN, in collaboration with palliative care zone administrative leadership (directors and managers), physician leaders, and system partners began health services planning, drawing upon previous work, as well as the *NSH Integrated Health Services Framework (2022),* and associated toolkits which informed a population, needs-based planning process.
- A provincial planning approach was taken to enable consistency, while also ensuring local population health needs and data was considered in all stages of the planning process. Appendix D outlines data that were reviewed as part of the health services planning approach.
- The initial stage of health services planning was on **specialist palliative care** to support and enable coordinated and consistent pathways with primary care providers, other specialty teams, and system partners to meet the needs of patients and their families living with life limiting conditions. Later phases will explore strategies of an integrated **palliative approach to care** across care settings (empowering non-palliative care-specialists to provide primary palliative care to their patients and families).
- A project charter (Appendix B) and meeting structures were established to enable the work to occur in a collaborative and efficient way.
    - Deliverables identified as being in scope were the:
        - Development of a provincial care delivery model.
        - Development of a provincial service delivery framework.
        - Identification of workforce metrics for specialist palliative care community, palliative care unit (PCU), and inpatient consult services.
        - Identification and prioritization of key elements of a provincial service delivery framework (i.e., common referral, triage, discharge criteria).
    - Deliverables identified as being out of scope were:
        - The development of local zone operational plans.
        - Hospice care (separate structures were established to action this work).

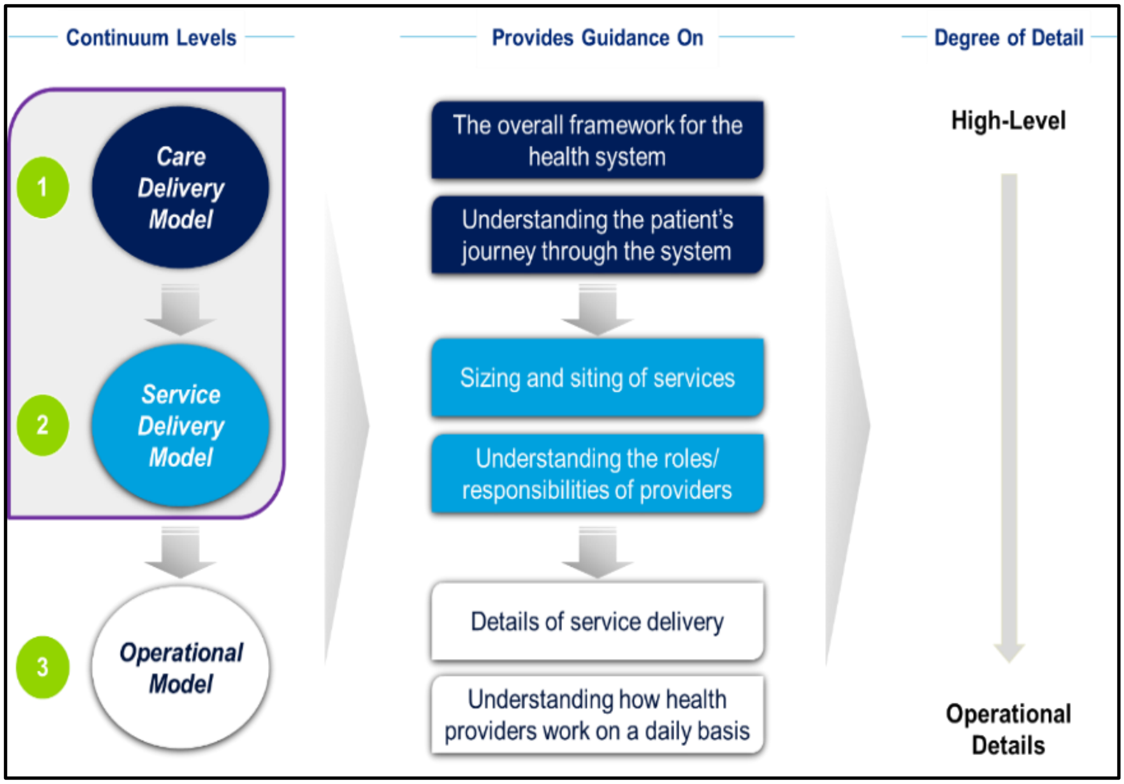


Figure 1 – Nova Scotia Framework for Clinical Services Planning (Deloitte & NS Department of Health & Wellness, n.d.)

WHAT IS PALLIATIVE CARE?

All HCPs should have a basic understanding of the principles of palliative care and the competencies to meet the needs of their patients with a serious life limiting illness. The ability to meet patient needs may include providing care to the patient with existing service providers, as well as consultation and/or shared care with member(s) of a palliative care specialist team. A **palliative approach to care** is the application of palliative care knowledge and expertise into the delivery of care across different health care sectors and professions by healthcare professionals who do not specialize in palliative care. A palliative approach to care is particularly important to embed early when the prognosis of the patient is uncertain, and survivorship is a possibility (Health Canada, 2018). It takes the principles of palliative care and applies them to the care of people with chronic, life-limiting conditions by meeting their full range of needs at all stages of life, not only at end-of-life. This approach "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" (Seow, 2014).

Specialist palliative care services aim to improve the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of serious health-related suffering by means of early identification and impeccable assessment and treatment of pain and other complex physical, psychosocial, and spiritual concerns and problems (Sepúlveda et al., 2002). **Specialist palliative care teams** are **interprofessional** and include, at a minimum, access to physician, nursing, and social work support with specialist level training and certification. Team members each bring a unique expertise to the care of those with life limiting illnesses, which are outlined in the Nova Scotia Palliative Care Competency Framework (McCallum et al.,2018).

A referral to a specialist palliative care team can be made to access any combination of team members, based on the unmet needs identified, which include physical and psychosocial domains. Specialist palliative care teams also provide clinical support and guidance, education, and mentoring in palliative care to other members of the health care team. Teams work in a variety of care settings including providing care in the home, ambulatory clinics, hospital consult, and palliative care units.

Individuals can live with a life limiting illness for many years and can benefit from a palliative approach to care early in the disease trajectory, therefore previous definitions of palliative care that have focused on the last months and weeks of life need to be continuously challenged.

The International Association of Hospice and Palliative Care (IAHPC) definition (2023) defines palliative care as the active holistic care of individuals across all ages with serious health-related suffering due to severe illness, for those early in the disease trajectory and/or near the end of life. It aims to improve the quality of life of patients, their families, and their caregivers. Furthermore, palliative care (IAHPC, 2023):

- Includes, prevention, early identification, comprehensive assessment, and management of physical issues, such as pain and other distressing symptoms, psychological distress, spiritual and social needs.
- Supports patients to live as fully as possible until death, facilitating appropriate communication to help they and their families determine goals of care.
- Is applicable throughout the course of an illness and is aligned with a patient's needs.
- Is provided in conjunction with disease modifying treatments whenever needed.
- May positively influence the illness trajectory.
- Does not intend to hasten or postpone death, affirms life, and recognizes dying as a natural process.
- Supports families and caregivers during the patient's illness and following death.
- Recognizes and respects the cultural values and beliefs of the patient and their family.
- Is applicable in all health care settings (place of residence and institutions) and in all levels of care (primary to tertiary).
- A palliative approach to care can be provided by professionals with basic palliative care training.
- In complex cases, involves referrals to multidisciplinary specialist palliative care teams.

EVIDENCE REVIEW/LITERATURE

- In October 2023, the network conducted a rapid literature review of the specialist palliative care model of care to understand the best evidence and practices for planning specialist palliative care services. Three evidence snapshots were developed to inform health services planning:
    - Evidence Snapshot 1: Health Services Planning and Models of Care for Specialist Palliative Care - A Rapid Review
      This evidence snapshot found two care delivery models used in specialist palliative care service delivery - support, supplement and supplant model, and the consultation, shared care and takeover framework. The review concluded that the takeover model is inefficient while implementing the shared care requires education and capacity development for most responsible providers and ensuring patients' access to primary care providers.
    - Evidence Snapshot 2: Service Delivery Model and Settings for Specialist Palliative Care - A Rapid Review
      This evidence snapshot review explored the evidence on the structure of providing specialist palliative care. It identified different structures for specialist palliative care service delivery including hospital palliative care consult/advisory teams, inpatient palliative care units, outpatient clinics, community palliative care teams, specialist palliative care rounds in long term care, palliative day care, and virtual care. The review concluded that for all these models to meet palliative care needs adequately, the components and processes for the provision of out of hours specialist palliative care for ongoing support in the community is essential.
    - Evidence Snapshot 3: Human Resource Planning for Specialist Palliative Care - A Rapid Review
      This evidence snapshot highlighted the composition of the specialist palliative care team, differentiating core team and extended team members. The training requirements and scope of services were also identified. Six approaches to human resource planning for specialist palliative care were reported: (1) operations research modelling, (2) Canadian Society for Palliative Care Physicians recommendations, (3) Palliative Care Australia Framework for staffing, (4) nursing staffing framework, (5) use of exemplary model institutions, and (6) staffing based on typology of existing models.

HEALTH SERVICES PLANNING APPROACH

In October 2023, health services planning began. The workflow (see Figure 2) is described below:

- October-December 2023:
    - Three rapid reviews were completed, as listed above.
    - An environmental scan was conducted with zone health services managers of palliative care to understand the current state of palliative care services across the province. A summary of this environmental scan is included in Appendix E.
    - Palliative care service and population level data from across the province was reviewed and validated.
    - A visioning exercise was conducted to determine the preferred future state of palliative care service delivery.
    - A conceptual care delivery framework (see Figure 3) was identified and adopted as a guiding approach to describe, understand, assess, and monitor models being used by specialist palliative care teams in their interactions with primary care providers and other specialists.

- January 2024:
    - An industrial engineer from NSH met with health services managers across the province to understand key aspects of palliative care service delivery by zone.
    - A metrics working group was convened to focus on articulating specialist palliative care metrics. This included representation from Interprofessional Planning and Learning – Workforce Planning, Medical Affairs, Palliative Care Physician leadership, Department of Health and Wellness, PCN, and palliative care zone leadership. Key deliverables included:
        - Defining core team for specialist palliative care.
        - Development of workforce metrics planning assumptions/decision making factors
        - Metrics recommendations for community, palliative care unit (PCU), and hospital consult services.
        - Development of a HHR planning template with zone level data that can support zone health services planning and/or ongoing operational planning.

- February 2024:
    - The industrial engineer designed and administered a gap identification survey to health services managers in each zone, to determine gaps in the current state of palliative care service delivery.

  - Recommendations to align aspects of service delivery across the province were made based on the gaps identified.
  - A service delivery framework was developed based on the above work (see Figure 4).
  - Workforce metrics work continued, including feedback gathering from partners (i.e., palliative care physicians).

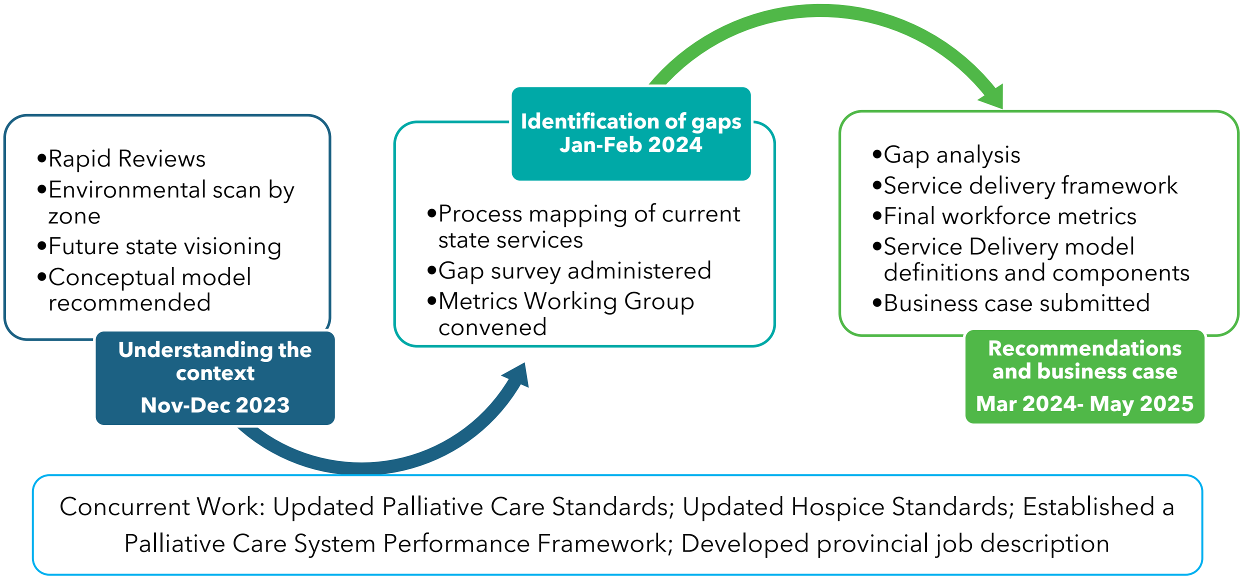
- July 2024:
  - Final metrics recommendations were completed.

- August 2024:
  - Using the workforce metrics recommendations as a basis, a business case was submitted to the Department of Health and Wellness, to garner additional resources in specialist palliative care FTEs (palliative care consult nurse, palliative medicine physician, social worker, and system support roles).
  - Engagement occurred to develop draft definitions and service components for PCU and palliative care beds.
  - Siting: The group mapped the current NSH sites with available palliative care services across the province (i.e., hospital consult, PCU, and community teams). Factors to consider when determining the siting of palliative care services, especially PCUs, were explored based on evidence and require a robust needs assessment (see Appendix F). This was informed by a methodology previously used by NSH Primary Health Care.
  - Sizing: As part of the specialist palliative care team metrics working group, a metrics template was developed to support operational leadership in ensuring needs and evidence-based sizing of specialist palliative care community, hospital consult, and inpatient unit teams.

- November 2023-April 2025:

  - Concurrent work was led by the PCN, which complemented and aligned with health services planning, included development of:
    - Standardized job description for community palliative care consult nurses
    - Revision and updates to palliative care standards and criteria
    - Development of a system performance framework for specialist palliative care that articulates system level key performance indicators (KPIs) and indicators, as well as a establishing a tableau dashboard
    - Review and revision of provincial Nova Scotia Hospice Standards

- Feb - May 2025
    - Refinement and further development of Specialist Palliative care service delivery model definitions and components (e.g., PCUs, Designated Palliative Approach Beds/Comfort Care Needs, Inpatient Consult Teams, Community Teams)



Understanding the context
Nov-Dec 2023

- Rapid Reviews
- Environmental scan by zone
- Future state visioning
- Conceptual model recommended

Identification of gaps
Jan-Feb 2024

- Process mapping of current state services
- Gap survey administered
- Metrics Working Group convened

Recommendations and business case
Mar 2024- May 2025

- Gap analysis
- Service delivery framework
- Final workforce metrics
- Service Delivery model definitions and components
- Business case submitted

Concurrent Work: Updated Palliative Care Standards; Updated Hospice Standards; Established a Palliative Care System Performance Framework; Developed provincial job description

Figure 2: Process for the Health Services Planning Project

SUMMARY OF KEY FINDINGS

- This iterative process involved a review of current demographic and palliative care service data, review of past background documents, initial environmental scan survey, literature reviews, service structure and process gap analysis by an industrial engineer, and engagement with palliative care clinicians and zone operational leaders. This highlighted various themes that underscore the need for a provincial, evidence, and needs-based approach to planning service delivery.

- Population data suggest Nova Scotia has the third oldest population in Canada (Statistics Canada, 2024b). People aged 55 to 74 years constitute the largest age group (about 28%) in Nova Scotia (NSH Performance and Analytics, 2024). This group has been shown to be more likely to receive palliative care and the current population is also rapidly aging with population aged over 75 years expected to almost double over the next 15 years across the province (NSH Performance and Analytics, 2024). In addition, the majority (55%) of Nova Scotians are dying within hospitals (Statistics Canada, 2024a). A survey of Nova Scotia specialist palliative care physicians found planned attrition, due to retirement, will lead to 17% and 30% decline in palliative medicine physician FTEs provincially over the next 5 and 10 years respectively, with as much as 50% loss to planned attrition in some zones.

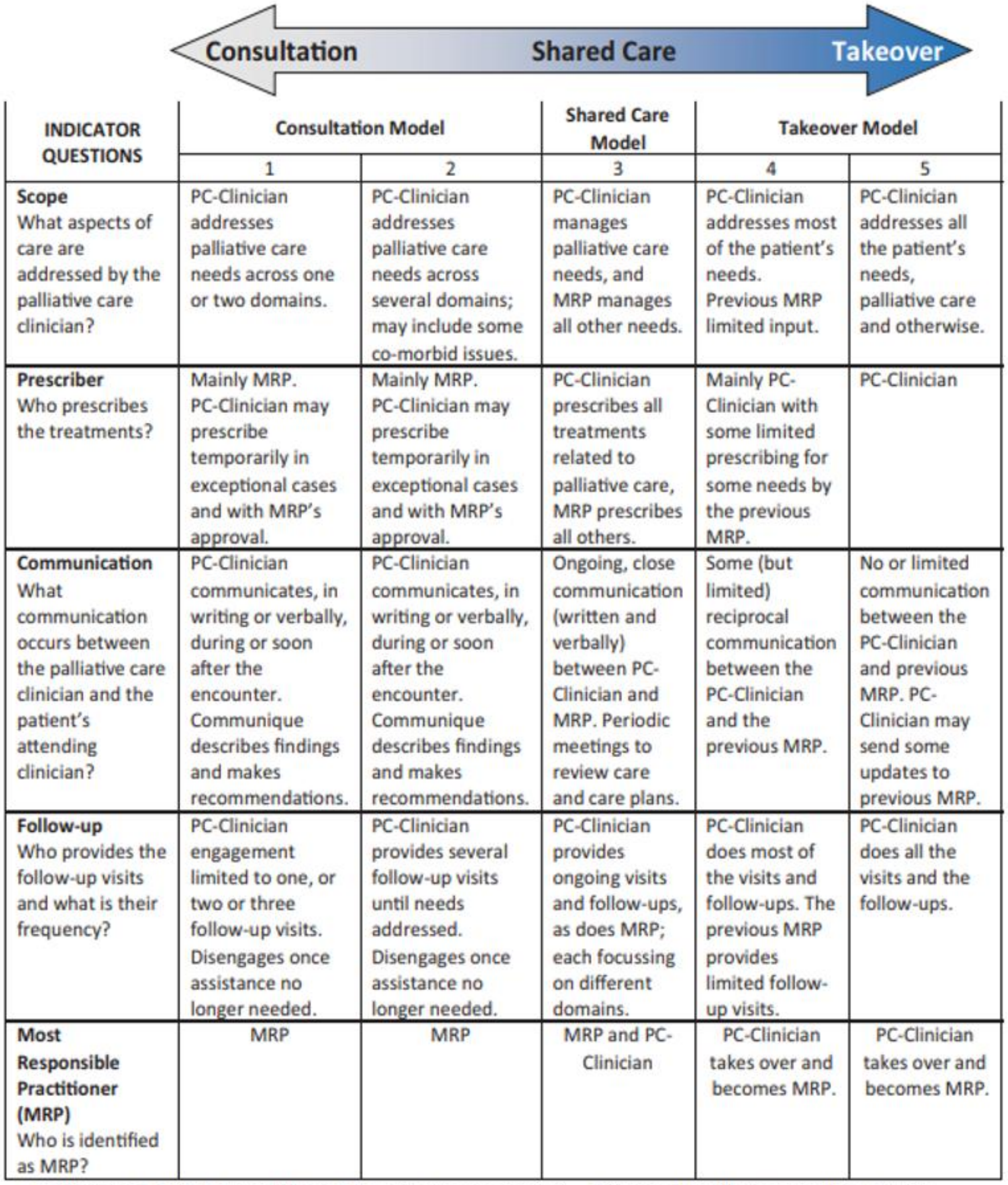
- Different recommendations proposed in the previous health services planning work that are fundamental to equitable service delivery were still outstanding (i.e., the development of a provincial referral and discharge criteria, provincial intake and triage system, standardizing the meaning of access to care, gap analysis of resource need versus availability).

- From the initial environmental scan and the gap analysis by the industrial engineer, considerable variability exists in structure, process, and outcomes of palliative care services delivery across the different zones. This included variability in the specialist palliative care staffing models and resource (e.g. dedicated triage role and clinical nurse lead role) and services available (e.g. after hour access) across the province as different services have evolved separately. There was also variability in care coordination, service response times, and in the model of care with some services predominantly using a takeover model or consult or shared care in other zones. Other areas of variability included the use of waitlists, length of wait times and the qualifications of specialist palliative care providers. This underscored variations across zones and equity considerations for access to specialist palliative care across the province and informed the identification of core themes for deliverables to guide ongoing planning. There is also no palliative care specific patient experience survey. For further details on the gap analysis results, see Appendix C.

- Findings from the literature review highlighted new evidence and opportunities to improve different areas of specialist palliative care health services planning (see Evidence Review/Literature section).
- Recent turnover in zone operational leaders highlighted opportunities to engage in aligning provincial priorities for specialist palliative care service delivery. This engagement demonstrated willingness and motivation to collaborate in identifying provincial priorities through a need and evidence-based health services planning process.
- An environmental scan was conducted with zone health services managers of palliative care to understand the current state of palliative care services across the province. A summary of this environmental scan is included in Appendix E.

CONCEPTUAL CARE MODEL: CONSULTATION-SHARED CARE-TAKEOVER MODEL

The **Consultation-Shared-Care-Takeover model** (Pereira et al., 2021) was chosen to articulate the preferred provincial palliative care conceptual model (see Figure 3). This framework describes a spectrum of care provision with *Consultation* at one end, *Takeover* at the other end, and *Shared Care* in the center. Five domains describe aspects of care provision that differentiate one approach from the other. All categories of care are relevant to palliative care delivery in Nova Scotia; however, the shared care approach is preferred as this supports a collaborative approach between specialist and non-specialist palliative care providers and builds competencies in non-specialist palliative care providers to integrate a palliative approach to care within their practice. Each category has its advantages, limitations, uses, and roles.



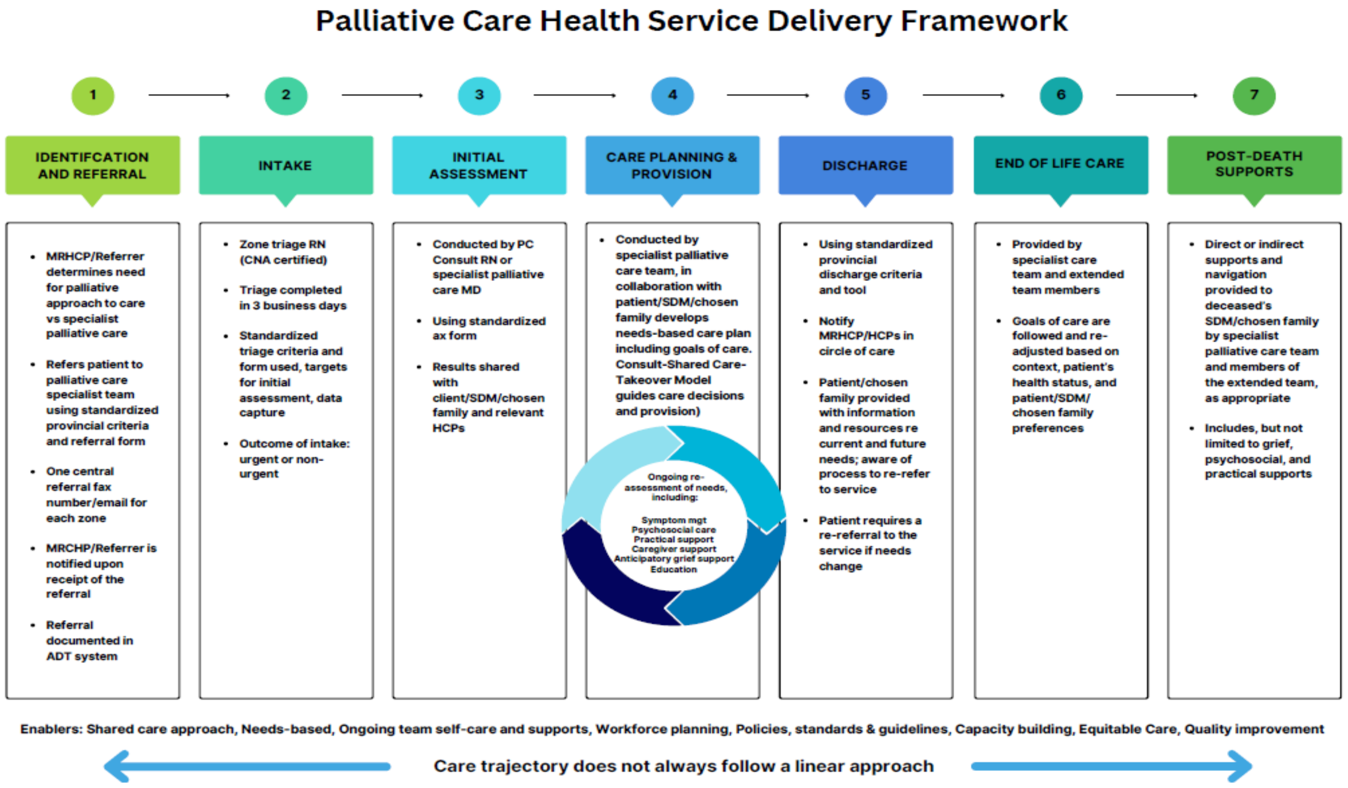
INDICATOR QUESTIONS	Consultation Model		Shared Care Model	Takeover Model	
	1	2	3	4	5
Scope What aspects of care are addressed by the palliative care clinician?	PC-Clinician addresses palliative care needs across one or two domains.	PC-Clinician addresses palliative care needs across several domains; may include some co-morbid issues.	PC-Clinician manages palliative care needs, and MRP manages all other needs.	PC-Clinician addresses most of the patient's needs. Previous MRP limited input.	PC-Clinician addresses all the patient's needs, palliative care and otherwise.
Prescriber Who prescribes the treatments?	Mainly MRP. PC-Clinician may prescribe temporarily in exceptional cases and with MRP's approval.	Mainly MRP. PC-Clinician may prescribe temporarily in exceptional cases and with MRP's approval.	PC-Clinician prescribes all treatments related to palliative care, MRP prescribes all others.	Mainly PC-Clinician with some limited prescribing for some needs by the previous MRP.	PC-Clinician
Communication What communication occurs between the palliative care clinician and the patient's attending clinician?	PC-Clinician communicates, in writing or verbally, during or soon after the encounter. Communique describes findings and makes recommendations.	PC-Clinician communicates, in writing or verbally, during or soon after the encounter. Communique describes findings and makes recommendations.	Ongoing, close communication (written and verbally) between PC-Clinician and MRP. Periodic meetings to review care and care plans.	Some (but limited) reciprocal communication between the PC-Clinician and the previous MRP.	No or limited communication between the PC-Clinician and previous MRP. PC-Clinician may send some updates to previous MRP.
Follow-up Who provides the follow-up visits and what is their frequency?	PC-Clinician engagement limited to one, or two or three follow-up visits. Disengages once assistance no longer needed.	PC-Clinician provides several follow-up visits until needs addressed. Disengages once assistance no longer needed.	PC-Clinician provides ongoing visits and follow-ups, as does MRP; each focussing on different domains.	PC-Clinician does most of the visits and follow-ups. The previous MRP provides limited follow-up visits.	PC-Clinician does all the visits and the follow-ups.
Most Responsible Practitioner (MRP) Who is identified as MRP?	MRP	MRP	MRP and PC-Clinician	PC-Clinician takes over and becomes MRP.	PC-Clinician takes over and becomes MRP.

PC-Clinician = Palliative Care Clinician (or palliative care service). Referrer = Usually the attending clinician.
MRP = Most Responsible Practitioner (physician, nurse practitioners) who is patient's attending clinician and responsible for overseeing all aspects of care (usually referrer to palliative care service).

Figure 3: The CST Conceptual Framework. C-S-T, Consultation-Shared Care-Takeover

SERVICE DELIVERY FRAMEWORK

A future state service delivery framework was developed by drawing upon the literature, best practices, expert opinion, and the key findings listed above. There are many aspects of the framework that are in place across Nova Scotia today. However, there are aspects that can be strengthened, including standardization of processes and criteria to reduce variation in service delivery to ensure all Nova Scotians have access to high quality palliative care, regardless of where they live.



Palliative Care Health Service Delivery Framework

1 IDENTIFCATION AND REFERRAL
- MRHCP/Referrer determines need for palliative approach to care vs specialist palliative care
- Refers patient to palliative care specialist team using standardized provincial criteria and referral form
- One central referral fax number/email for each zone
- MRCHP/Referrer is notified upon receipt of the referral
- Referral documented in ADT system

2 INTAKE
- Zone triage RN (CNA certified)
- Triage completed in 3 business days
- Standardized triage criteria and form used, targets for initial assessment, data capture
- Outcome of intake: urgent or non-urgent

3 INITIAL ASSESSMENT
- Conducted by PC Consult RN or specialist palliative care MD
- Using standardized ax form
- Results shared with client/SDM/chosen family and relevant HCPs

4 CARE PLANNING & PROVISION
- Conducted by specialist palliative care team, in collaboration with patient/SDM/chosen family develops needs-based care plan including goals of care. Consult-Shared Care-Takeover Model guides care decisions and provision)

Ongoing re-assessment of needs, including:

Symptom mgt
Psychosocial care
Practical support
Caregiver support
Anticipatory grief support
Education

5 DISCHARGE
- Using standardized provincial discharge criteria and tool
- Notify MRHCP/HCPs in circle of care
- Patient/chosen family provided with information and resources re current and future needs; aware of process to re-refer to service
- Patient requires a re-referral to the service if needs change

6 END OF LIFE CARE
- Provided by specialist care team and extended team members
- Goals of care are followed and re-adjusted based on context, patient's health status, and patient/SDM/ chosen family preferences

7 POST-DEATH SUPPORTS
- Direct or indirect supports and navigation provided to deceased's SDM/chosen family by specialist palliative care team and members of the extended team, as appropriate
- Includes, but not limited to grief, psychosocial, and practical supports

Enablers: Shared care approach, Needs-based, Ongoing team self-care and supports, Workforce planning, Policies, standards & guidelines, Capacity building, Equitable Care, Quality improvement

Care trajectory does not always follow a linear approach

Figure 4: Palliative Care Health Service Delivery Framework

WORKFORCE METRICS RECOMMENDATIONS

Effective workforce planning is crucial for achieving strategic goals, enhancing high quality healthcare, and ensuring patients' and healthcare providers' satisfaction. As part of the health service planning process, a working group was established with a deliverable to identify a health human resource workforce plan that would support a sustainable specialist palliative care delivery model, now and into the future.

The gap analysis, as well as a review of local data, suggest a gap in required resources that impact the ability of specialist palliative care providers to consistently meet the full spectrum of the demands of their role. For instance, a survey of Nova Scotia palliative medicine physicians found planned attrition due to retirement will lead to 17% and 30% decline in palliative care physicians FTEs in the province over the next 5 and 10 years respectively. This impact varies by province and could lead to as much as 50% loss to planned attrition in some zones.

The workforce metrics working group consisted of the PCN, zone palliative care leadership, palliative medicine physician leadership, medical affairs, Interprofessional Practice and Learning (IPPL)/workforce development, and DHW. The group developed health human resource planning metrics through a process of rigorous analysis of the population-based needs for specialist palliative care and the best evidence from the literature and consideration of other organizational work (e.g., application of nursing hours per patient day (NHPPD) staffing metrics led by NSH IPPL). The evidence informing the metrics was drawn from two models - the Canadian model recommended by the Canadian Society for Palliative Medicine and Australian model from Palliative Care Australia. The process for development of the specialist palliative care workforce metrics is highlighted in Figure 5.

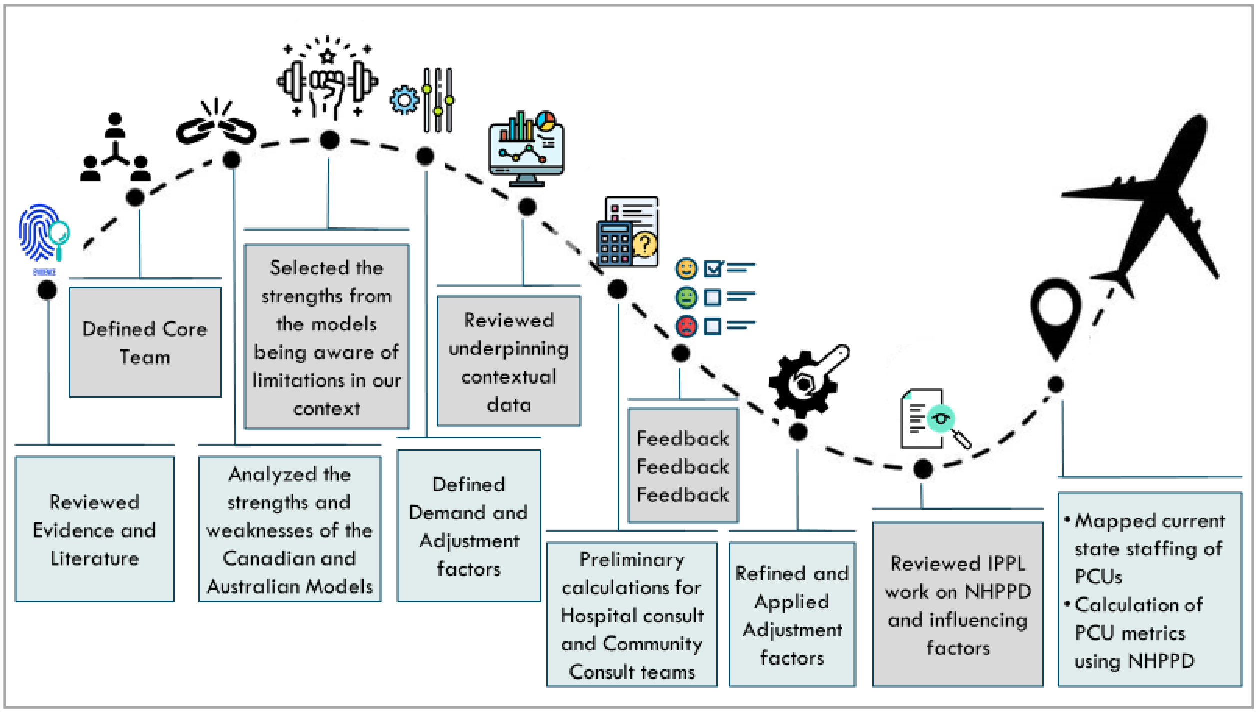


Figure 5: Process for Developing the Workforce Metrics Recommendations

The group proposed recommendations to expand and strengthen specialist palliative care teams: nursing (RNs, LPNs), physicians, and social workers within PCUs, palliative care hospital consult teams, and palliative care community teams. This aligned with Consult-Shared Care-Takeover model, and service delivery framework designed through the health services planning process.

The Workforce Metrics Working Group agreed to the following planning assumptions:

- Metrics are underpinned by a needs and population-based approach.
- The model of care to underpin the metrics is based on a shared care approach, where most patients are managed by the primary care provider, with core competencies in a palliative care approach (primary palliative care).
- The specialist palliative care team is made up of a core and extended team. Core team was defined as the minimum standard of professional disciplines required to provide interprofessional palliative care. This includes physicians, nurses, and social workers.
- Demand and adjustment factors were determined based on the evidence. Demand factors are the main determining factors that contribute to the need for a service and reflect the capacity of the population to benefit from that service. Adjustment factors are other factors that also influence the demand for a service or the ability to supply a service.
- Demand factors for estimating required human resource included:

  - For specialist community palliative care team: the number of deaths per annum.
  - For specialist Hospital Consult teams: the number of acute care beds in hospital.
  - For PCUs: Nursing Hour Per Patient Day (NHPPD) calculation for nursing staffing.
- The agreed upon adjustment factor for finetuning the estimates based on contextual realities was the age and socioeconomic status distribution factor, which was developed by DHW and has been previously successfully used in developing primary healthcare workforce metrics planning. Other potential adjustment factors, such as kilometrage claims data for specialist palliative care and Need a Family Practice Registry data, will be reassessed for ability to apply to future iterations.
  - The adjustment factor of age and socioeconomic status is applied to the demand factor rather than to the final FTE calculations.

Specialist Community Palliative Care Team metrics are based on the adapted recommendations from the Canadian Society of Palliative Care Physicians guidelines (CSPCP, 2019), and include:

- 63-75% of total deaths could benefit from specialist palliative care at some point in their illness trajectory (Gómez-Batiste et al., 2012; Murtagh et al., 2014).
- Each 1.0 FTE PCN can carry a caseload of 25 patients over 3 months equivalent to 100 patients/year.
- 1 palliative medicine physician is required for 4 PCN's each carrying a caseload of 25 patients resulting in a caseload of approximately 100 patients over 3 months equivalent to 400 patients/year.
- For every 6 PCN's (150 patients), the program requires 1.0 FTE social worker.
- For each 1.0 FTE physician, 30% dedicated time goes to non-clinical responsibilities (e.g., education, mentorship, etc.), 8% (4 weeks) vacation and 2 weeks CPD (4%).
- 10% PCN and social work time is dedicated to non-clinical responsibilities such as education/admin/research, 8% vacation.
- The community calculations for PCNs were adjusted by deducting the hospital consult team totals to arrive at the total FTE for the specialist community PC consult nurses.

Specialist Hospital Consult Team metrics are based on the adapted Australian guidelines (Palliative Care Australia, 2018):

- Based on a demand factor of number of inpatient medical, surgical, ALC and transitional care-related beds within hospitals served by the team.
- Per every 125 hospital beds, the specialist palliative care workforce required will be 0.75 FTE palliative medicine physician, 0.75 FTE palliative care consult nurse, and 0.25 FTE social worker.

Inpatient PCU metrics are based on the Canadian Society of Palliative Care Physicians guidelines (CSPCP, 2019):

- Number of beds within the unit.
- Per 10 PCU beds (Non tertiary), a recommendation of 0.7 FTE palliative medicine physician and a minimum of 3 regulated HCPs (RN and LPN) 24/7; NHPPD=7.92 to 8.8 (aligned with IPPL and workforce planning methodology).
- Per 5-6 PCU beds (Tertiary), a recommendation of 1.0 FTE physician and a minimum of 2 regulated HCPs (RN and LPN) 24/7; NHPPD=7.92 to 8.8 (aligned with IPPL and workforce planning methodology).

SERVICE DELIVERY MODEL DEFINITIONS AND COMPONENTS

Service delivery model definitions and details regarding service components for PCUs, palliative approach to care beds, palliative care consult teams, and palliative care community teams were developed and are listed below.

Palliative Care Unit (PCU)

Definition

The PCU definition is based on the European Association for Hospice and Palliative Care Definition (Payne et al, 2022) and is as follows:

- Part of a hospital that provides specialist inpatient care with the primary aim at crisis intervention and medical stabilization.
- Essential services should be available 24 hours per day and seven days per week.
- Integrated Palliative Care Units require a highly qualified, interprofessional team. Staff members in palliative care units should have specialist training.

Location

- Tertiary or regional hospitals.

Physical Space

- The physical space is designed to respect the needs, privacy, confidentiality, and dignity of patients, chosen families, and caregivers.

Scope of Service:

- Management of complex symptoms including pain, dyspnea, delirium, psychosocial issues, and end-of-life care. Site access to support services/equipment (e.g., MRI, CT scan, high-flow O2, CADD pump).

Admission Criteria

- For patients with complex to fluctuating complexity. The Consult-Shared Care-Takeover Model will be used to determine needs of all patients admitted with a palliative care referral. Criteria include:

- Intended for patients who have been referred to the specialist palliative care team.
- Goals of care and levels of intervention (LOI) align with palliative care patients' needs, which includes C1, C2, S2*.

  **On a case-by-case basis, S1 may be accepted with appropriate escalation procedures. Exceptions will be at the discretion of the palliative care physician.*

- The unit is not intended for patients with an LOI of F.
- Palliative Care Units should not have palliative care patients in a non-traditional treatment space (i.e., hallway, family room) during periods of overcrowding. Doubling up rooms should be avoided as much as possible.

Medical Oversight

- Most Responsible Provider can be the hospitalist with core competencies in palliative care, with consultative access to specialist palliative medicine physicians.

Nursing Coverage

- A minimum of 3 regulated health care providers 24-7 for 9-10 beds and 2 regulated health care providers 24-7 for 6-7 beds. NHPPD=7.92 to 8.8**

Clinical Supervision & Specialist Qualifications:

- Every palliative care unit should have a clinical lead who is a specialist palliative medicine physician with appropriate certifications (e.g., CCFP(PC) or FRCP (PM))
- 50-75% of RNs should have completed CHPCN certification. All disciplines working on the unit will have a transition to practice plan, which identifies the required education and competency requirements. Training would be obtained over a defined timeline according to operational requirements.
- Unit manager(s) should have some training in palliative care, per Nova Scotia Palliative Care Competency Framework.

Designated Palliative Approach Beds (Comfort Care)

Definition

These are inpatient beds located in private rooms that are not dedicated solely for palliative care but used on an as-needed basis. These rooms have received special funding from community hospice societies, foundations and other sources to make them comfortable and improve the experience for patients at the end of life and their families.

Location

- Tertiary, Regional Hospitals, or Community Hospitals

Physical Space

- Rooms are private, and more comfortable for patient and family.

Admission Criteria

- Designated (not dedicated) for palliative patients who are actively dying*.
- The patient's level of intervention is normally C2 and occasionally C1.

**In some cases, and depending on patient's needs, access to palliative care services, and competencies of the staff, patients may be admitted who require non-complex symptom or psychosocial supports.*

Clinical Supports & Qualifications:

- Formal links with a specialist palliative care provider for purposes of referral, consultation, and access to specialist care where clinically appropriate/required
- Key staff who frequently care for patients with life-limiting conditions or who provide care for patients admitted to comfort care rooms/beds should possess competency in generalist palliative care skills. Training (e.g., LEAP) would be obtained over a defined timeline according to operational requirements.

Palliative Care Hospital Consult Team

Definition

An interprofessional team who provide specialist palliative care consultation, advice, and support to other clinical staff and provide care for patients with life-limiting illnesses (including those that are potentially curable) and their families with complex palliative care needs.

Scope of Services

The specialist palliative care consultation team should:

- Provide patients with symptom management, emotional support, support for decision making, and support for end-of-life problems, as well as support for the families and health care professionals.

- Carry out a comprehensive assessment of patients and their families based on information from referring staff, physical examinations of patients, discussions with the family, medical charts, and the results of other examinations and provide recommendations and direct care.

- Provides formal and informal education and capability building to other healthcare providers providing a palliative approach to care.

- Liaise with other services both within and outside the hospital to support the planning of care options.

- Hold collaborative meetings with the referring health care professionals if needed.

- May operate specialist palliative care outpatient clinics for ongoing follow-up if needed.

Team Composition

- The primary team members include specialist palliative medicine physicians and palliative care consult nurses with specialist-level training and certification in palliative care, a social worker with palliative care competencies, and administrative staff. Training would be obtained over a defined timeline according to operational requirements and identified through a transition to practice plan.
- The team should have access to other professionals working in liaison with them, including grief specialists, chaplains, dietitians, rehabilitation therapists (i.e., physiotherapists, occupational therapists, speech and language therapists), pharmacists, psychologists, and other medical specialists (e.g., oncologists, psychiatrists, internal medicine).

Access

- Referrals from physicians and nurse practitioners

Setting of Care

- Inpatient Hospital Settings
- Outpatient clinics

Space

The team should have access to a room for staff meetings, space for administrative support, as well as clinical space for confidential conversations and clinical examinations for patients.

This does not have to be located in the hospital where care is provided (recognizing that many teams cover multiple hospitals).

Palliative Care Community Team

Definition

An interprofessional team that provides specialist palliative care consultation, advice, and support to other healthcare providers and home-based care for patients with life-limiting illnesses (including those that are potentially curable) and their chosen families with complex palliative care needs.

Scope of Services

Common roles of the specialist palliative care community team include:

- Most often, the specialist palliative care community team has an advisory and mentoring function and offers expertise in pain therapy, symptom control, palliative care, and psychosocial support.
- These teams work in conjunction with primary care providers and home care service providers, including nurses and personal support workers, to provide integrated palliative care in patients' homes.
- Provides advice to patients on the management of pain and other symptoms that may be of the most concern.
- Discusses physical, emotional, spiritual and social needs and support decision making and planning for future care by means of advanced care planning.
- Provide direction to other appropriate health and social care services required such as grief and bereavement support, complementary therapies, living well services, hospice, etc.

Levels of Care

Palliative care community teams may:

- Consult: Involves no direct contact with the patient. It may involve a professional consultation between the referrer and the community specialist palliative care team on matters of addressing complex symptoms and needs, and options of care.

- Shared care: Care involves an assessment visit to a patient to provide added support to the professional, following which the patient is discharged or short, planned episodes of care offered to the patient and family according to need.
- Take over: Care is offered on a longer-term basis where there are ongoing complex needs.

Setting of Care

- Home
- Community-Based Facilities i.e. Long-Term Care

Team Composition

- The primary team members include specialty palliative medicine physicians and RNs with specialist-level training and certification in palliative care, a social worker with palliative care competencies, and administrative staff. Training would be obtained over a defined timeline according to operational requirements and identified through a transition to practice plan.
- The team should have access to other professionals working in liaison with them, including grief specialists, chaplains, dietitians, rehabilitation therapists (e.g., physiotherapists, occupational therapists, speech and language therapists), pharmacists, psychologists, and other medical specialists (i.e., oncologists, psychiatrists, internal medicine).

Access

- Referrals from physicians and nurse practitioners*.

  *In exceptional circumstances, self-referral from patients may be accepted. Exceptional circumstances include when the primary care provider is not available or the MRP is unwilling

Physical Space

- The team should have access to a room for staff meetings, space for administrative support, clinical space for confidential conversations and clinical examination for patients, and a storage area for medical equipment.

MOVING FORWARD – RECOMMENDATIONS FOR PRIORITY ACTION

Based on the findings following the health services planning process, priority areas for action were identified and are arranged by three themed areas.

Service Delivery

The following table highlights the palliative care service level gaps as defined from the gap analysis and recommendations to address the gaps as proposed by the working group.

Gap-Lack of Standardized	Recommendation
Provincial Referral Form	Develop a standardized provincial referral form
Referral Receipt Process	Centralize referral receipt process at the zone level
Self-Referral/Navigation Function	Develop a pathway to support patients who do not have a primary care provider. Develop processes for existing patients to access care after hours. Compile resources to support people to manage their illness in their home/community.
Triage Criteria	Central triage RN within each zone Develop standardized triage criteria and tool
Discharge	Develop standardized discharge criteria and tool
Data Integrity	Ensure data collection at the service level is done in a consistent and reliable way. PCN to support development and monitoring of provincial indicators. Zone leadership to work with clinicians and administrative staff to ensure data collection processes are developed, utilized, and monitored.

Key Actions from the Recommendations

1. Provincial Referral Form

- Enact working group of operational palliative care leaders to develop common referral form and use existing meeting structures within the Palliative Care Network to gather feedback from leaders, physicians, and staff. Gather feedback from system partners including Continuing Care, Primary Health Care, Cancer Care, etc.

- Develop and implement a communications plan to promote and socialize use of new referral form.

2. Referral Receipt Process

- Explore potential approaches and pros and cons of centralizing referral at the zone level.
- Centralized referral may require additional resources and may impact existing referral contact/fax numbers.
- Explore opportunities to align with e-Referrals work done organizationally (referrals from across province are coordinated through a central office).

3. Self-Referral/Navigation Function

- Develop processes to support patients without a primary care provider to enable access to palliative care services, where appropriate.
- Compile a list of provincial resources /supports for patients/chosen families to help them to manage a life limiting illness in their home/community.
- Develop processes to support patients and their existing families who are attached to a palliative care service after regular hours.
- Develop and implement communications to relevant partners about these processes.

4. Triage Criteria

- Explore pros and cons of centralizing triage at the zone level (where it does not currently exist (i.e., EZ and NZ) (may require additional resources).
- Based on past work, review, and update triage criteria.
- Develop a triage tool.

5. Discharge Criteria:

- Determine common discharge criteria.
- Determine standardized waitlist criteria and caseload management guidelines.
- Create a discharge tool/form.
- Establishing consistencies and standardization, where appropriate, will prepare the palliative care system for the transition to the new provincial clinical information system (CIS). As work is completed (i.e., referral form), communication with the One Patient One Record (OPOR) team will occur to ensure new documentation and processes are integrated into the new CIS.

Other actions identified under the theme of **service delivery** include:

- Develop a siting process to support zone leaders to determine palliative care service delivery requirements based on evidence, data, contextual factors, and experience.
- Design and implement a plan to prototype a model to enable a palliative approach to care and explore spread and scale of this prototype in all zones.
- Invite opportunities for engagement, participation and/or feedback from Mi'kmaw and Indigenous people with future actions associated with health services planning through established partnerships with Tajikeimɨk.

Workforce Planning

- Drawing upon the established team metrics, support the development of business cases into the future.
- Provide palliative care zone leadership with a workforce metrics template to support zone planning that is updated on regular basis (annual or biannual) based on updated population and service level data, including the impact of HCP attrition.
- Collaboratively with IPPL, People Services, zone operations and network, support the development of common job descriptions where appropriate.
- Support the realization of a shared care approach to palliative care, as defined by the Consultation, Shared Care, Takeover Model.

Capacity Building

- Establish a Learning Essential Approaches to Palliative Care (LEAP) education plan for HCPs who provide a palliative approach to care for patient's receiving care in designated palliative care beds.
- Determine educational needs for members of the specialist palliative care team beyond nursing and physicians (i.e., social work, managers), including transition to practice plans.
- Work collaboratively with IPPL to identify needs and deliver palliative care education to specialist and non-specialist palliative care providers.
- Establish a palliative care practice support program framework and approach.
- Information, education and support for referrers and the public should be provided so that access to palliative care is clearly understood.

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APPENDIX A: PALLIATIVE CARE NETWORK STRATEGIC PRIORITIES

The NSH Palliative Care Network is a multidisciplinary group who work collaboratively to design and recommend strategy and improvement plans in palliative care across Nova Scotia. The document outlines a framework for enhancing palliative care in Nova Scotia. Priorities are focused on improving access to care, supporting individualized and needs based care, building provider and volunteer capacity, and strengthening palliative care enablers.

Palliative Care Defined

- Palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness, for those early in the disease trajectory, and/or near the end of life. Its goal is to improve the quality of life of patients, their families, and their caregivers" (adapted from the International Association of Hospice and Palliative Care, 2023).

Aim

- Nova Scotians of all ages with a life limiting illness, including the people who support them, are supported to live well, die well, and grieve well.

Priorities

- **Providing Quality Palliative Care**: Palliative care is integrated and accessible to patients with a life limiting illness. That is, care is timely, equitable, appropriate, coordinated, and embedded early in the illness trajectory across care settings. It involves collaboration between interprofessional teams, enhancing availability of a palliative approach to care as well as specialist palliative care, and coordination of care.
- **Supporting Individualized, Needs-Based Care**: Patients, chosen families, and caregivers are supported to actively participate in their care based on their own values, preferences, expressed needs and goals. It emphasizes providing knowledge, support for managing illness, and grief services.
- **Building Provider and Volunteer Capacity**: Ensures health care providers and volunteers have the knowledge, skills, and supports to deliver high-quality palliative care through training, education, and wellness programs.

- **Strengthening the Palliative Care Enablers**: Enablers are in place to support the provision of standardized high-quality palliative care. It involves establishing performance indicators, improving quality through continuous improvement, developing supportive policies, and integrating research into practice.

Core Principles

- Person-centered care
- Integrated, coordinated systems
- Evidence-driven approaches
- Open communication and collaboration
- Equity and inclusivity
- Sustainability of practice

APPENDIX B: PROJECT CHARTER – HEALTH SERVICES PLANNING

1. Project Identification

Project Name	**Health Services Planning – Palliative Care**
Project Sponsor	Dr. Nicole Boutilier
Project Lead	Shannon Ryan Carson and Dr Dave Henderson

2. PROJECT SUMMARY

2.1 Purpose / Business Reason

Building upon past work, a provincial care delivery and service delivery model will be developed to describe the delivery of palliative care specialist services across the continuum of care and illness trajectory. It will outline best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place (Government of Western Australia, Department of Health, 2012).

Development of a provincial care model will enable the delivery of services that are high-quality, and informed by best practice, evidence, and experience across the province. It will allow us to identify/validate areas of strengths and gaps, enable efficient use of resources and provide a strengthened and unified approach to ongoing health services and business case planning.

2.2 Project Objectives

1. Development of a provincial *care delivery model* (what, why, and *big* how) for specialist palliative care services
2. Development of a provincial *service delivery framework/model for* specialist palliative care services (where and at what level, i.e. siting and sizing of services, understanding the roles and responsibilities of providers, identification of tools to support standardized approach to care where appropriate)
3. Development of strategies to support a palliative approach to care across settings (e.g., cancer care, renal, etc.)

2.3 Project Scope

In Scope:

- Development of recommendations for a provincial care delivery model for palliative care specialty services
- Development of current and future state data elements
- Development of recommendations for a provincial service delivery framework for palliative care specialty services
- Recommendations for team metrics that can inform business plan (i.e., FTEs)
- Engagement with identified partners
- Identification and prioritization of key components to support of a provincial service delivery framework

Out of Scope:

- Local zone operational plans
- Hospice care

3. Schedule

Key Deliverables / Milestones	Lead	Due Date
1. Project charter approved	Shannon	Mid November 2023
2. Identify groups/structures to support the work	Shannon	November 2023
3. Rapid review: Care and service delivery models	Dayo	October 2023
4. Current state assessment – data to support the planning: Environmental scan (internal and key external partners) Identification of strengths and gaps	Sarah Dayo PC Managers	October-December 2023
5. Care Delivery Model development (what is included, why is it included, and at a high level, how is it delivered)	Project Team	October-December 2023
6. Service Delivery Framework development (includes siting - equity, diversity and inclusion and sizing – staff/team metrics, roles/responsibilities)	Project Team	January-September 2024
7. HHR Planning/Metrics	Shannon/Dave/Project Team	January-September 2024
8. Develop a common health services planning template	Shannon/Sarah/Project team	January-September 2024
9. Potential Business Case Submission for PC teams/Project Closure	Shannon/Sarah Project Team	September 2024
10. Explore strategies to support palliative care approach across care settings (cancer care, renal, etc.)	Network and Zones	January 2025+

Project Organization

Role	Name/Title
Project Sponsor	Dr. Nicole Boutilier
Project Lead	Shannon Ryan Carson and Dave Henderson
Project Team Members (i.e. Communications Lead, IPPL Rep., Health Services Manager, Industrial Engineer, FMS, Finance Lead, Health Services, PFA, Mi'kmaq Representative, Implementation Scientist, Admin. etc.) Phased Planning Approach (draft) • Phase 1 – Identify scope, planning approach, data requirements, environmental scan, needs/gaps • Phase 2 – Conceptual model identification • Phase 3 – Identify service delivery framework • Phase 4 – Explore strategies to enable an integrated palliative approach to care across care setting	**Network Leader** **Network Senior Analyst** **Zone Directors** **Zone Managers** IPPL Professional Practice Leader Performance and Analytics PFAs First Nations Consultant Palliative Care Clinicians (physicians, nurses, social workers) Health System Partners (ie oncology, PHC, Continuing Care, EHS) Palliative Care Network Admin Asst Note: initial project group will include those in **bold print**. Will determine strategies for engaging others identified on this list through a phased planning approach)

4. Project Assumptions / RISKS

- Project is endorsed and jointly led by zone and network leaders
- Resources for this phase of the work are in-kind
- Palliative Care is a shared responsibility across the health system
- Much work has already occurred – build on this work rather than start fresh

5. Critical Success Factors/KEY PERFORMANCE INDICATORS (KPI)

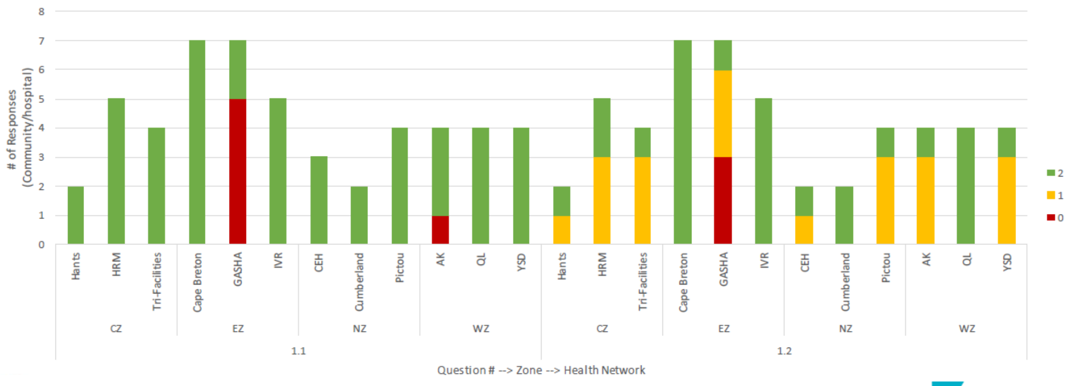
- Zone and Network alignment on purpose and priority of the work
- Zone and Network communication and collaboration structures are well defined and known
- Roles and responsibilities of the project team are outlined and agreed upon to execute deliverables
- Project Management support to stay on track of deliverables
- Change management approach is taken throughout the project development and carried through to health services planning/business case development
- Key stakeholders are engaged throughout the different phases of work
- Zones use the model of care to support health service planning and business case development
- The palliative care systems is appropriately resourced to provide high-quality care
- Indicators of success are identified (i.e. waitlist reductions, patient/family satisfaction, high quality care)

APPENDIX C: ZONE GAP IDENTIFICATION SURVEY RESULTS

The gap analysis and survey results are presented below. Questions were developed based on a set of palliative care standards which were developed as part of the NSH Integrated Health Services Planning work done in 2021-22.

Nova Scotians have information and education about palliative care, including available resources and supports, throughout the illness trajectory that meets their identified needs.

- 1.1 Do patient/family/care givers have access to information and education about palliative care, throughout the illness trajectory that meets their identified needs? (Y/N)
- 1.2 How often are patient/family/care givers adequately informed of those education resources? (1-Never; 2-Rarely; 3-Sometimes; 4-Often; 5-Always)



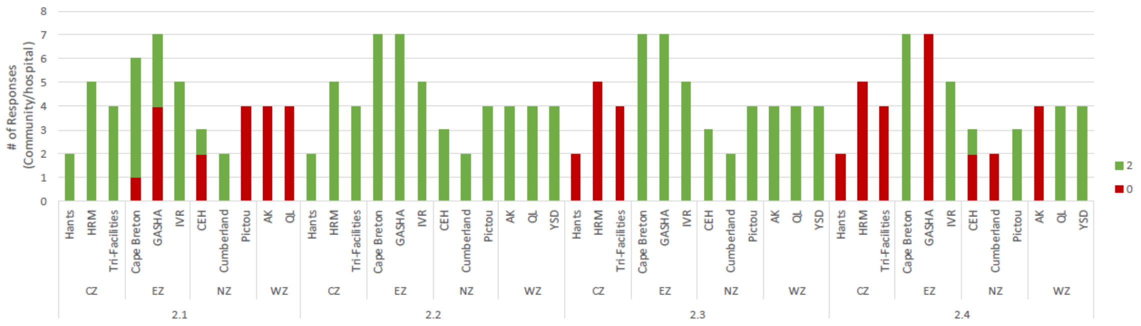
Nova Scotians are identified early in the illness trajectory by a member of their existing care team (ie: primary care, disease specialist, emergency etc.) and have access to a palliative approach in all settings of care.

2.1 Are patients identified in a timely manner in the illness trajectory by a member of their existing care team (i.e. primary care, disease specialist, emergency etc.)?

2.2 Do patients/family/care giver have access to a specialist palliative care?

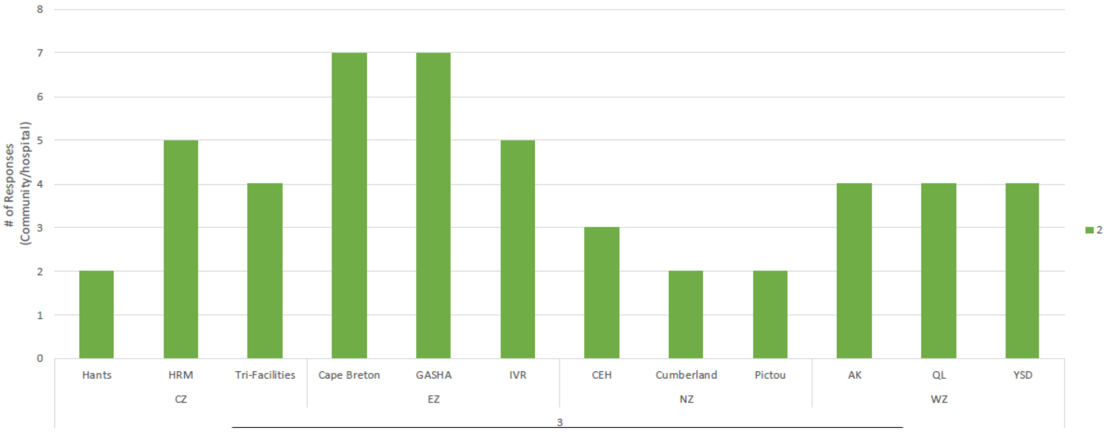
2.3 Does the Specialist Palliative Care (SPC) Team have documented screening and referral criteria?

2.4 Is this screening and referral criteria clearly communicated to MRHCPs and referring partners?



Nova Scotians receiving a palliative approach and their family/caregivers have their needs identified through a comprehensive holistic evidence-based assessment by their interdisciplinary team, with support from palliative care specialists if required.

3.1 Do patients receiving SPC and their family/caregivers have their needs identified through a comprehensive holistic evidence-based assessment?



Nova Scotians receiving a palliative approach are reassessed regularly by a member of the care team, reviewing goals of care and effectiveness of treatment to address ongoing needs in all settings of care.

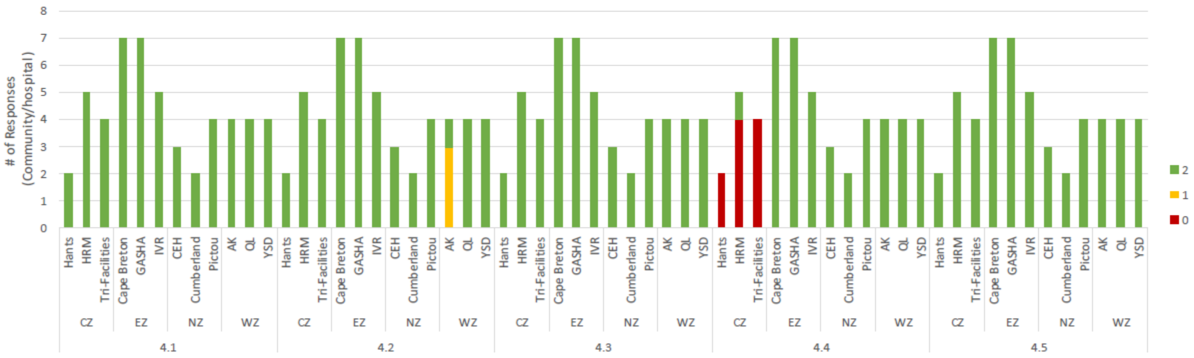
4.1 At episodes of significant progression/exacerbation of disease

4.2 A significant change in the patient's family/social support

4.3 A significant change in functional status

4.4 patient or family request

4.5 At end of life.

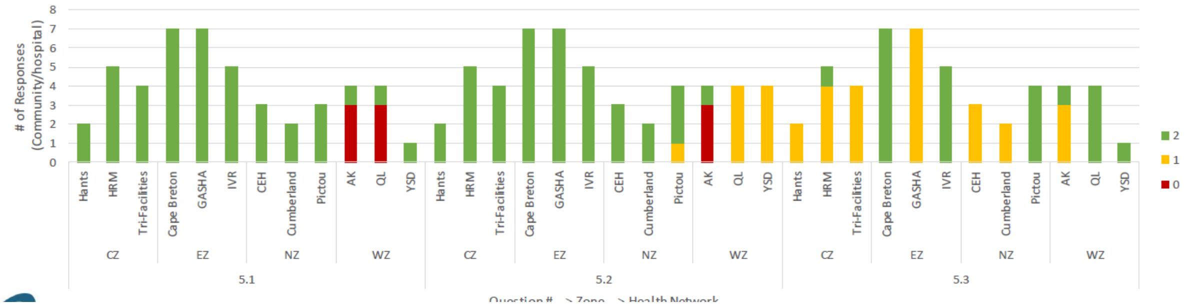


Nova Scotians have a culturally safe individualized care plan developed collaboratively with the care team that is respected, reviewed and updated regularly that includes goals, preferred setting of care, and preferred place of death.

5.1 Patients have an individualized care plan developed collaboratively with the care team that includes goals, preferred setting of care, and preferred place of death? (Y/N)

5.2 Is that plan reviewed and updated regularly? (1-Never; 2-Rarely; 3-Sometimes; 4-Often; 5-Always)

5.3 If yes, do you have strategies in place to ensure those plans are culturally safe? (1-Strongly Disagree; 2-Disagree; 3-Uncertain; 4-Agree; 5-Strongly Agree)

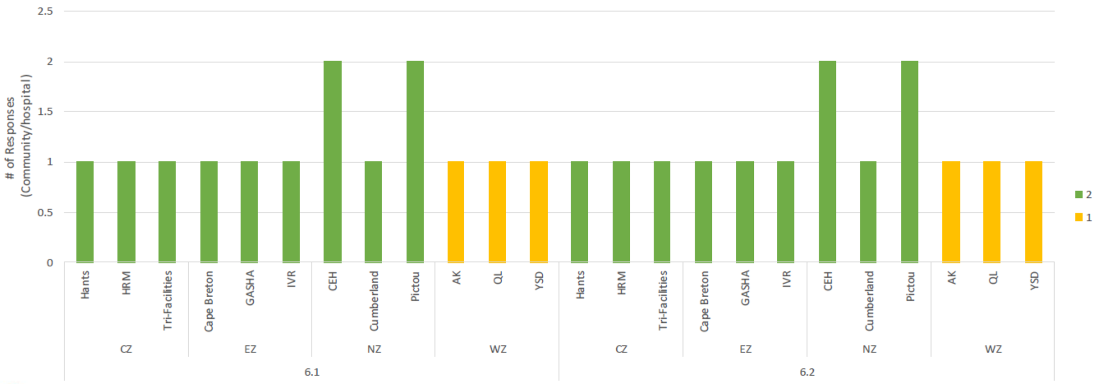


Nova Scotians have access to palliative care resources to appropriately meet their needs at home and to support them to die in the location of their choice

6.1 Patients have access to palliative care resources to appropriately meet their needs at home?

6.2 Patients have access to palliative care resources to support them to die in the location of their choice.

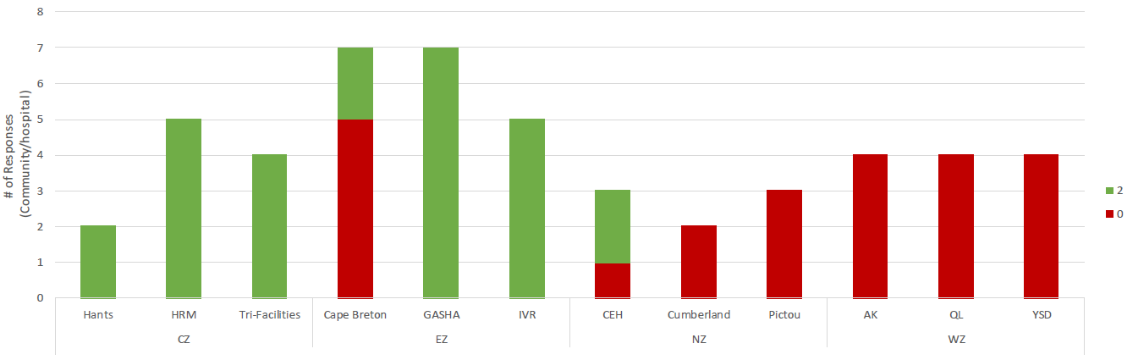
(1-Never; 2-Rarely; 3-Sometimes; 4-Often; 5-Always)



Nova Scotians receiving a palliative approach to care have an identified member of the interdisciplinary team responsible for coordinating and communicating the care plan to ensure seamless transitions and transfers in care.

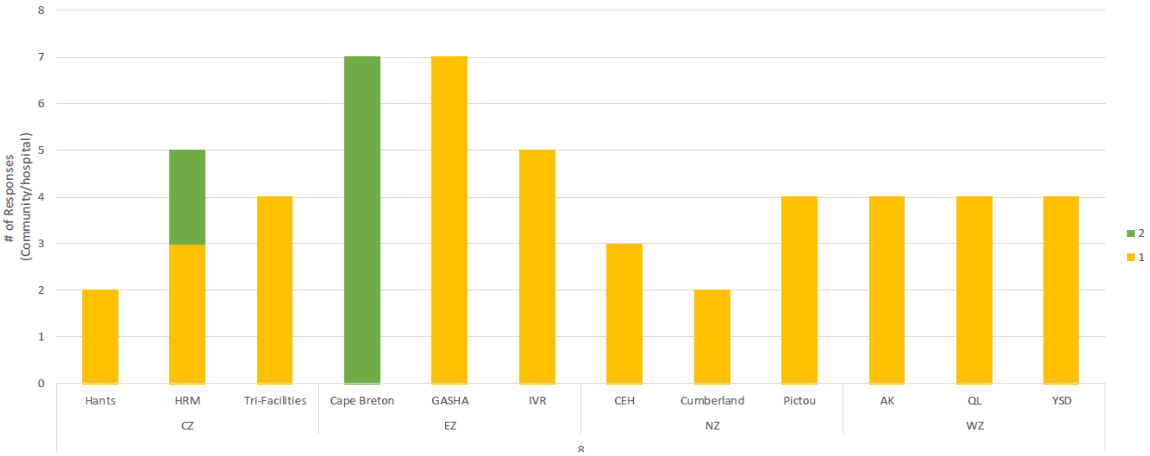
7. Is there an identified member of the SPC Team responsible for coordinating and communicating the care plan to ensure seamless transitions and transfers in care?

NOTE: where applicable RN indicated for all locations, with one exception of an LPN in this role.



Nova Scotians with palliative care needs and their family have 24/7 access to support and resources to manage symptoms arising in all settings of care.

8. Select which option best describes <u>**PATIENT**</u> access to SPC Teams:
Full 🟩; Partial 🟨; Minimal 🟥; None 🟥

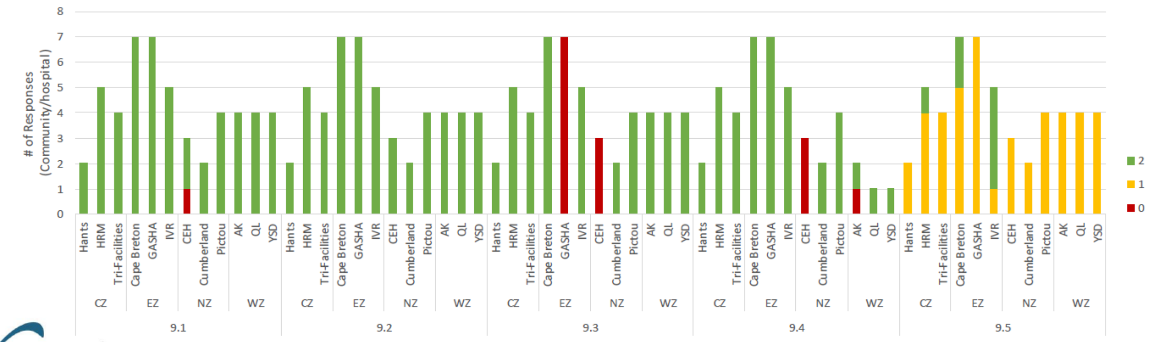


Nova Scotians receiving a palliative approach to care, and their family/caregivers, have access to support that addresses their mental, emotional, social, practical, cultural and spiritual needs in a culturally safe manner.

Patients receiving a palliative approach to care, and their family/caregivers, have access to support that addresses the following needs:

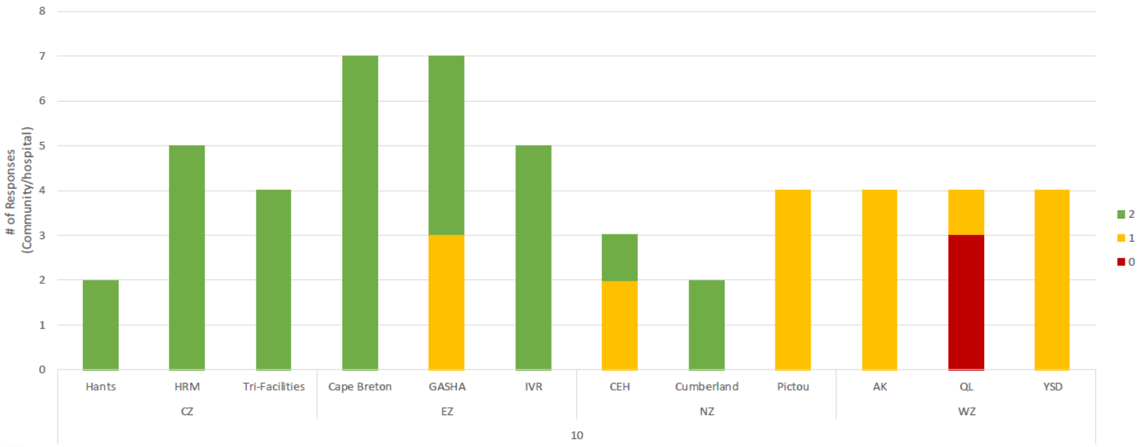
9.1 Mental and Emotional; 9.2 Social and Practical; 9.3 Cultural; 9.4 Spiritual

9.5 Do you have strategies in place to ensure those supports are provided in culturally safe manner? (1-Strongly Disagree; 2-Disagree; 3-Uncertain; 4-Agree; 5-Strongly Agree)



Nova Scotians have access to grief (including anticipatory grief) and bereavement support that meets their needs, both for expected and unexpected deaths.

10. Family/Care Givers have access to grief (including anticipatory grief) and bereavement support that meets their needs, both for expected and unexpected deaths.

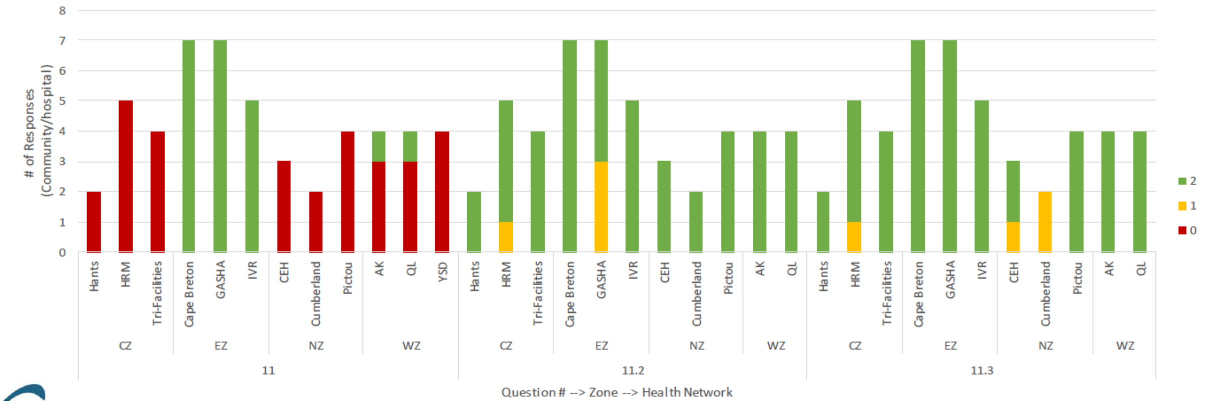


The specialist palliative care team is available and adequately resourced to support the interdisciplinary team to deliver high quality care at any point in the illness trajectory based on identified needs.

11.1 Do you have defined triage criteria to assign levels with target dates for initial consult? (Y/N)

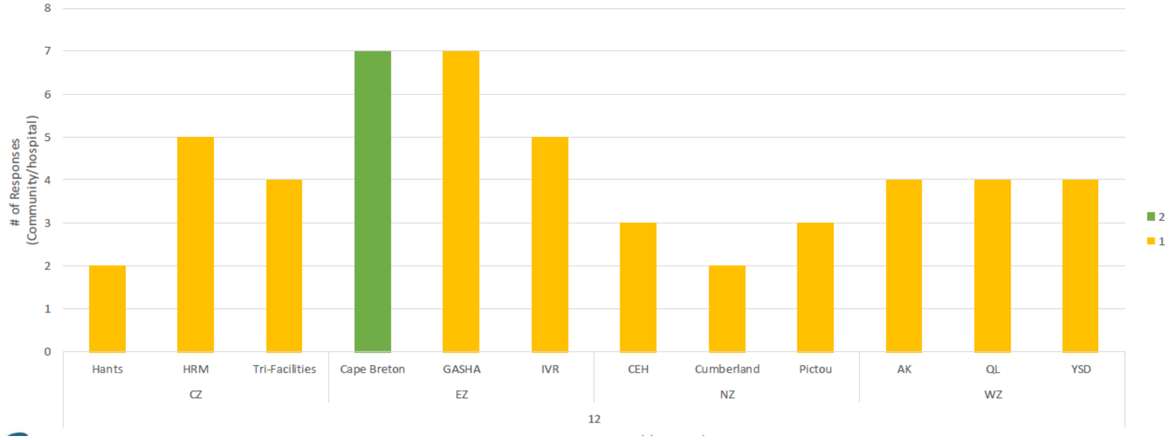
11.2 Please rate how well targets are met for urgent consults? (1-Never; 2-Rarely; 3-Sometimes; 4-Often; 5-Always)

11.3 Please rate how well targets are met for all other consults?



Virtual/phone palliative care advice is available to care teams 24/7 in all settings of care by providers with the required competencies to respond to symptom management issues.

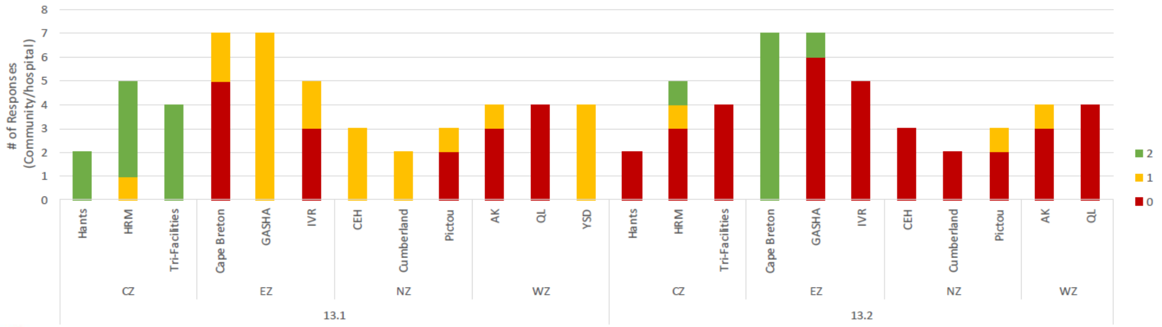
12. Select which option best describes access to SPC Team availability to **OTHER CARE TEAMS** (e.g. primary care, continuing care, oncology, etc): **Full** 🟩; **Partial** 🟨; **Minimal** 🟥; **None** 🟥



Nova Scotians can expect to receive care from health care providers and volunteers who have the competencies and support to deliver high-quality palliative care within the scope of their role, in all settings of care, with access to ongoing education, training and evidence-based tools.

13.1 How well does the SPC Team provide non specialist palliative care providers access to ongoing education, training and evidence-based tools? (1-Never; 2-Rarely; 3-Sometimes; 4-Often; 5-Always)

13.2 How well does the SPC Team provide volunteers access to ongoing education, training and evidence-based tools?



APPENDIX D: DATA SOURCES

Health services planning was driven by up-to-date provincial data to inform a population and needs based planning approach. The Nova Scotia Health Analytics Tableau Dashboard (Nova Scotia Health) housed the majority of the data listed below.

- Population projections and change (provincial, zone, county) (Nova Scotia Government).
- Community cluster profiles (health status, non-medical determinants of health, health system performance, and community and health system characteristics) (Data sources include Canadian Community Health Survey, Census, Statistics Canada, MSI Billing, Vital Statistics, Nova Scotia Atlee Perinatal Database, Nova Scotia Cancer Registry, and the Canadian Chronic Disease Surveillance System).
- Nova Scotia death, birth, and natural increase rates by county (Service Nova Scotia).
- Palliative care patient and family experience surveys (Nova Scotia Health).
- Nova Scotia health services maps, showing where palliative and hospice services are available in Nova Scotia (Nova Scotia Health).
- Palliative Care Database (Western, Northern, and Eastern Zone) and Ccasper Palliative Care Database (Central Zone) service-level data. Including:
    - Referrals to palliative care
    - Referral location and source
    - Palliative care patient population details (top diagnoses, age)
    - Live discharges and deaths
    - Death location
    - Total and average length of stay in days
- Need a Family Practice Registry numbers (numbers of Nova Scotians without access to a primary care provider across the province).

APPENDIX E: ENVIRONMENTAL SCAN KEY THEMES

After conducting an environmental scan with each zone, key themes were identified based on similarities, differences, and challenges in palliative care service delivery. Below is a description of these key themes.

Areas of Similarities

- Admission/referral and discharge criteria are similar but not articulated similarly – no firm criteria, especially for discharge. Requires strong skills in clinical decision-making regarding patient appropriateness.
- Takeover model is only being used consistently on the PCU in Central Zone; otherwise, the care delivery model across province is most often shared care and/or consult.
- Primary care access challenges the shared care model, resulting in the takeover model happening in some areas of province and palliative medicine physicians providing more than palliative care.
- Each zone has a Clinical Nurse Educator (CNE).
- Specialist palliative care teams most often include palliative medicine physician, palliative care consult nurse (PCN), and social worker.

Areas of Differences

- Initial Assessments – the physician and RN see every community patient in the Halifax region. In other areas, the consult nurse sees the patient first, then determines need for physician involvement.
- Waitlists – Central Zone and Eastern Zone do not have waitlists whereas Northern Zone and Western Zone maintain waitlists – reasons for this include staffing vacancies, vast geography for staff to cover, and variance in access to primary health care.
- In Eastern Zone, and specifically with the Cape Breton palliative care program, PCNs are required to have their Hospice Palliative Care-Canadian Nurses Association certification to be employed.
- A dedicated role for triage exists in some areas of the province (Antigonish, Cape Breton, Annapolis Valley, South Shore, Southwest, and Pictou). In other areas this does not exist. The triage role varies by title across the zones (e.g., RN, CNL, access navigator, etc.). In all areas that employ this role, a nursing qualification is required.

- There is no provincial patient experience survey (most zones have implemented local patient experience surveys; however, this is not consistently administered across the province).
- A clinical nurse lead (CNL) role is present in the Eastern Zone (a 1.0 FTE supports the palliative care service in Guysborough, Antigonish, and Strait areas, and a 1.0 FTE supports the Cape Breton service). The CNL is a content expert and support for the nursing team. This role can coordinate discharges, bed utilization, implement and support the manager in quality initiatives. The CNL support the nurses in skills and policy. The CNL identify learning needs of staff and support this aspect as well. Given the demands on CNE's, this role has been beneficial to support teams with specialist palliative care education and support.

- Access to the specialist palliative care team after hours: Areas with PCUs, have mechanisms for existing patients/families to contact unit staff (with 24/7 access to a palliative medicine physician) them with questions, and for support (as their charts are available to the staff on these units). This includes patients followed by the teams who cover Halifax Regional Municipality and Cape Breton (Sydney and surrounding areas). Patients who reside in areas without PCUs typically have questions or concerns addressed during office hours, Monday-Friday. All PCN's work Monday to Friday from 8am-4pm and may flex their time outside these hours to meet patient care needs.

Challenges

- Staffing vacancies in some areas mean shifts in the care delivery model and care provision, towards takeover.
- Palliative care service level data is being collected differently across province and to varying degrees.
- HHR shortages and access challenges experienced by VON and Continuing Care can result in increased pressure on the palliative care team, and the need to provide care that is typically not part of their role.
- There is a lack of clarity on definitions for PCUs and palliative care beds across the province, which makes it challenging to ensure appropriate staffing complements, education, admission criteria, etc.

APPENDIX F: CONSIDERATIONS FOR SITING OF PALLIATIVE CARE UNITS

Palliative care units are an essential part of the acute care facility that supports the needs of patients living with serious life-limiting illness and their families who have complex medical needs, including physical symptoms and other psychosocial and spiritual concerns. Evidence suggests that adequate planning is required for the siting of palliative care units to ensure the beds meet existing needs.

Needs Assessment

A needs assessment study should be conducted, focusing on population needs, local priorities, models of care, and relationships with other agencies to inform a needs-based calculation of required beds(Doyle, 2021). According to Doyle (2021), the following questions should guide the needs assessment.

Population

- How many patients will likely benefit from the palliative care service at any one time?
- What is their age distribution?
- What is the prevalence of symptoms?
- What is the main cause of death in the area or region?
- What are thought to be the other unmet needs of these patients?
- What is the trajectory of death?
- What proportion is dying at home and in hospital?
- Which diseases in a defined community are likely to benefit from palliative care?

Priorities

- Is the service primarily to provide care in the home, or to train family members to care better?
- Is the service primarily to provide care or to educate and train local health care professionals to provide better care, in the home or in local hospitals?
- Is the goal to enable more people to remain at home for longer periods?
- Is the goal to enable more people to die at home? (as distinct from wanting to remain at home if possible)?

Care Models

- What are the obstacles to good palliation as perceived by health care workers in the area?
- Should the proposed service provide home care and /or inpatient care?
- Should there be a palliative care ward in the local hospital or a free-standing palliative care unit/hospice?
- Should a hospital palliative care service manage the patients or provide advice and support?
- Will education be provided and if so, which model of care provision will best facilitate it?

Relationships with Other Agencies

- What will be the relationship with any existing palliative care services?
- What will be the relationship with the local hospital?
- What will be the relationship with the local medical community?
- Who will prescribe and dispense medications and be responsible for opioid storage etc.?
- Will there be access to basic (non-sophisticated) diagnostic facilities and to case notes of all patients referred to the service?

In addition to these, NSH developed a Siting and Sizing criteria for care delivery models for health services planning in 2016 highlighted in the table below.

Siting and Sizing Methodology Criteria	
Category	**Criteria**
Population Need	Population and determinants of health data, including deprivation indices (e.g., Census data, income, education, language, etc.)
	Health status information (e.g., disease burden, prevalence)
	Historical service utilization data and projections
	Health equity lens
	Consultation and engagement data
Geography and Travel Distance	Application of geographic framework for planning (community clusters, networks, zones)
	Standards for access to services (time, distance), where applicable
	Travel patterns
	Accessibility / proximity to public transit, where applicable

Siting and Sizing Methodology Criteria	
Category	**Criteria**
Infrastructure / Resources	Available space
	Available support resources e.g. pharmacies
	Equipment and technology
	Interdependency of other services, academic and research partnerships
Resource Stewardship	Cost implications (of service locations and sizing requirements)
	Availability of human resources