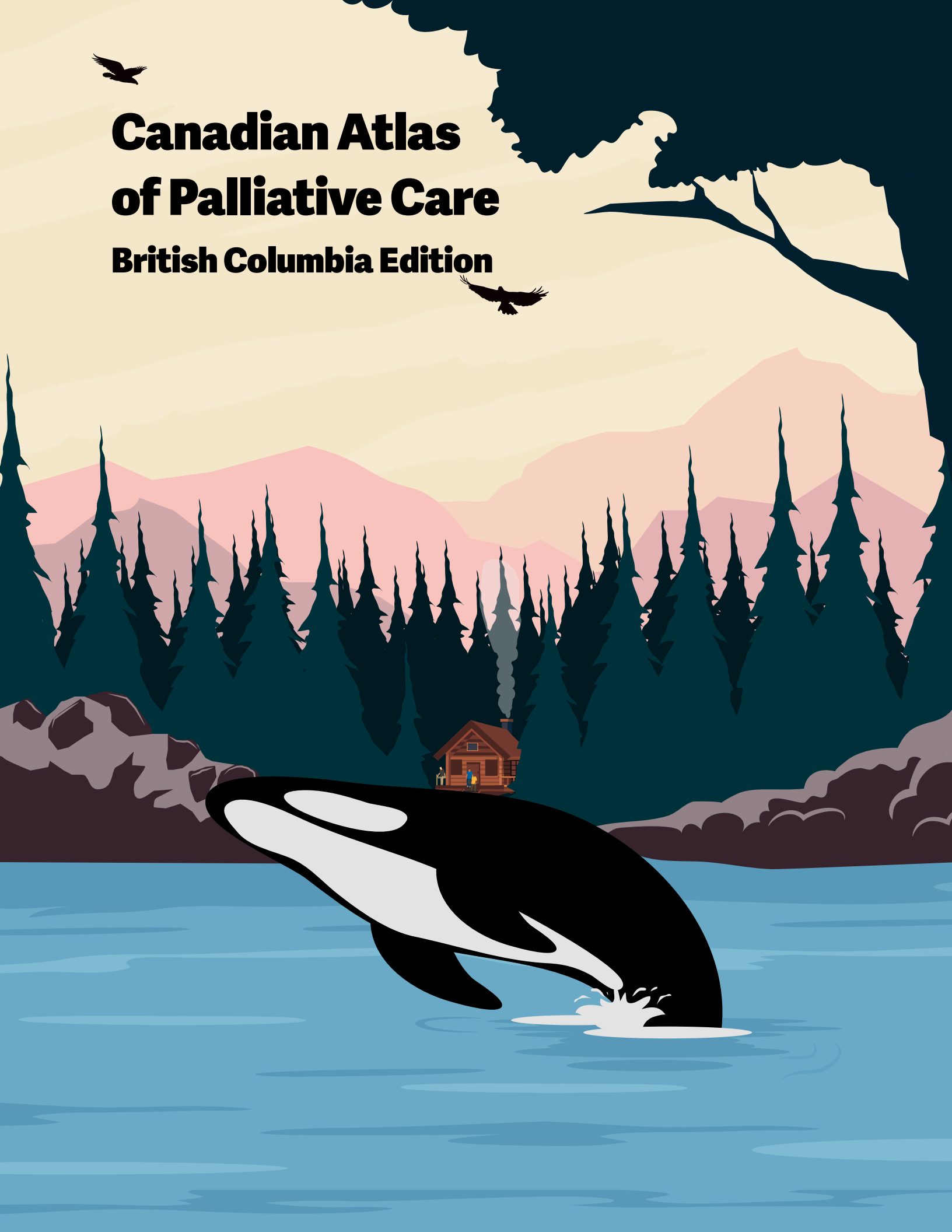
Canadian Atlas of Palliative Care

British Columbia Edition



Canadian Atlas of Palliative Care: British Columbia Edition

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McMaster University | Family Medicine, Division of Palliative Care

Pallium Canada

BC Centre for Palliative Care

Canadian Atlas of Palliative Care: British Columbia Edition

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CANADIAN ATLAS OF PALLIATIVE CARE PROJECT FOUNDING RESEARCH GROUP (2019)

In 2019, the Palliative Care Atlas of Canada Project was first initiated by Pallium Canada, in collaboration with the Dr. Joshua Shadd Pallium Canada Research Hub in the Division of Palliative Care at McMaster University. The founding research group was responsible for developing the preliminary research protocol.

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Pallium Canada

Pallium Canada commissioned, supported, and collaboratively led the development of the Canadian Atlas of Palliative Care, including this British Columbia edition, in partnership with key stakeholders

Pallium Canada is a national registered charitable organization founded in 2000 and focused on building professional and community capacity to help improve the quality and accessibility of palliative care in Canada.

BC Centre for Palliative Care

The BC Centre for Palliative Care (BCCPC) is a provincial organization dedicated to enhancing the quality of life and maintaining dignity for people in British Columbia (BC) who are living with serious illness, their families, and caregivers. Through collaboration with healthcare professionals, research institutions, community organizations, and the public, BCCPC drives the spread of best practices and innovations in palliative care and support to make it more accessible and culturally respectful.

Since its establishment in 2013, BCCPC has had a meaningful impact on the BC health system and society. The Centre has empowered thousands of healthcare professionals and students across disciplines to integrate a palliative approach into routine patient care, developed and shared resources that have significantly raised public awareness and encouraged advance care planning, and inspired hundreds of compassionate communities to support patients and families affected by serious illness.

Through partnerships with academic researchers and institutions nationwide, BCCPC continues to identify and promote best practices to improve the access and quality of palliative care and support across all settings.

Joshua Shadd Research Hub

The Joshua Shadd Pallium Research Hub represents a close collaboration between the Division of Palliative Care in the Department of Family Medicine at McMaster University and Pallium Canada. The Hub is an opportunity to undertake scholarship in several areas of mutual interest to the Division of Palliative Care and Pallium Canada. Both, for example, champion the role of primary- or generalist-level palliative care (also known as the palliative care approach) across different settings. Both champion interprofessional learning and collaboration and support a public health approach to palliative care.

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Lead Funder:

Sovereign Order Of
ST. JOHN OF JERUSALEM
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The Sovereign Order of St. John of Jerusalem, Knights Hospitaller, Vancouver

The Sovereign Order of St. John of Jerusalem, Knights Hospitaller, Vancouver has played a strong role in the funding and delivery of palliative care programs, hospices and other services in British Columbia.

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The Y. P. Heung Foundation's mission is to positively impact British Columbia by providing grants in the areas of Arts + Culture, Education, and Health.

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Saint Mary's Health Foundation of New Westminster

Saint Mary's Health Foundation of New Westminster supports health service delivery in the community and surrounding area formerly served by Saint Mary's Hospital.

Conconi Family
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The Conconi Family Foundation

The Conconi Family Foundation's mission is to improve the quality of life for communities across British Columbia, especially those most vulnerable.

HF
The Hamber Foundation
Bettering the lives of British Columbians

Hamber Foundation

The Hamber Foundation has been bettering the lives of British Columbians since 1965.

Foord Family
FOUNDATION

The Foord Family Foundation

The Foord Family Foundation's mission is to create a lasting positive impact in the Okanagan Valley and beyond.

LAND ACKNOWLEDGEMENT

Based at McMaster University, we recognize and acknowledge that we are currently on the traditional territory shared between the Haudenosaunee confederacy and the Anishinabe nations, which was acknowledged in the Dish with One Spoon Wampum belt. That wampum uses the symbolism of a dish to represent the territory, and one spoon to represent that the people are to share the resources of the land and only take what they need. We recognize that the land we call Ontario is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work and live on this land.

We also respectfully acknowledge the many traditional and unceded territories of Indigenous nations and peoples throughout British Columbia, the province studied in this Atlas, whose historical relationships with the land continue to this day.

RESEARCH ETHICS BOARD REVIEW AND APPROVAL

The Canadian Atlas of Palliative Care: British Columbia Edition was reviewed and approved by the Hamilton Research Ethics Board in Hamilton, Canada (REB # 16070, May 23, 2023).

CONTRIBUTORS: BRITISH COLUMBIA EDITION

The following individuals and organizations have contributed to this edition by participating in surveys, interviews, focus groups, or other data collection and verification activities. These persons represent front-line health care professionals, managers, directors, policymakers, educators, researchers and health care and community advocates. In addition to those who consented to be listed, the authors generously thank the many other individuals across the province who contributed to this Atlas.

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Executive Summary

BACKGROUND

Palliative Care Atlases map the status of palliative care in a country or jurisdiction across several domains and indicators. Several Palliative Care Atlases have previously been developed internationally at continent and country levels. Domains include Policy, Education, Professional Activities, Resources and Services in different populations and settings. Atlases are used to identify successes and gaps across these domains, including access to palliative care services, help guide policy development and planning, and facilitate the allocation of resources.

The Canadian Palliative Care Atlas is initially being done by provinces and their regions. The goal of this report is to summarize the findings of the British Columbia Edition of the Atlas.

METHODS

The domains and indicators used internationally were adapted to the Canadian context and guided data collection and reporting. We used mixed methods. Data collection was done in several sequential phases: 1) a search of public-facing information (such as web sites); 2) standardized online surveys (based on the domains and indicators) were completed by provincial and regional palliative care leaders and educators; 3) semi-structured interviews with provincial and regional palliative care leaders to clarify, expand and explain data collected from phases 1 and 2; 4) focus groups with leaders and front-line palliative care health care professionals to further confirm, expand and explain data from preceding phases; and 5) member checking with regional leaders for final input on results. Data is reported graphically, with tables, and additional text to provide context for some of the findings and to highlight special successes.

KEY FINDINGS

In the policy domain, the province established a centre of excellence for palliative and end-of-life care, the BC Centre for Palliative Care, responsible for accelerating and spreading best practices and innovations in palliative care across British Columbia. There is a provincial level strategic plan for end-of-life care from 2013. The province has a pharmacare benefit plan for palliative care that supports medication coverage, as well as some equipment and supplies, for people at the end-of-life.

Generally, across the province, there is a high level of access to specialist palliative care teams in hospitals, especially in medium to large-sized ones, with the exception of the Interior region. Specialist palliative care advice is also made available 24/7 through a provincial physician on call line. Integration of palliative care across various hospital inpatient and outpatient services is minimal to low overall, especially for non-cancer services. The BC Cancer Agency has embedded palliative care consultant support within their regional cancer centres. There are examples of excellence in some other specialty areas in different regions that can be spread more broadly.

Overall, there is an inadequate number of palliative care unit (PCU) beds for the province, relative to the population size. Two of the regions were found to have inadequate PCU beds for different reasons: one region (Interior) has no PCU beds and in another region (Island) these beds are primarily designated for use by palliative care rather than being dedicated to palliative care. Designated beds may not be available for patients with palliative care needs when admission is needed, and staff may not have adequate expertise in palliative care.

The number of hospice beds in the province is largely adequate when calculated using a conservative measure of the minimum recommended numbers. But, when combined with PCU beds for a total number of inpatient palliative care beds available, the number is inadequate, and more are needed to meet rising population needs. Hospices continue to play an important role in the provision of palliative care in the province and are publicly subsidized but generally require patients to pay a per diem payment at a fixed daily rate.

Across the province, there is a relatively high presence of specialist-level palliative care services (clinicians and/or teams) in the community, especially in medium to large urban centres, with the exception of the Interior Region which has lower access. Access is largely virtual in rural and remote regions. In many regions, especially rural and remote areas, after hours support relies on the provincial physician-led on call line. Most specialist palliative care teams in the community provide support through a *Consultation* model (sometimes with *Shared Care*).

There is significant variability across the province in the provision of primary palliative care by primary care clinics and services. In some communities, a high proportion of primary care clinicians provide a palliative care approach to their ambulatory patients, and there is evidence of upskilling on this approach by primary care professionals

through various continuing professional development programs available in the province. Fewer primary care teams/clinics provide home visits or after hours on call coverage for their patients with palliative care needs.

In long-term care (LTC), there is also considerable variability regarding the integration of palliative care. There is growing attention on palliative care in this setting, with examples from across the province's regions of increased efforts to integrate palliative care, supported by the BC Centre for Palliative Care's LTC Collaborative.

In the domain of education, palliative care training is reported in the University of British Columbia medical school curriculum and there are dedicated postgraduate residency programs for training specialist-level palliative care physicians through the College of Family Physician's Enhanced Skills program and the Royal College Subspecialty program for both Adult and Pediatric Palliative Medicine.

There is a robust program for pediatric palliative care through Canuck Place that provides both palliative care inpatient and outpatient services at two locations, including a community outreach team in the Vancouver area. The Canuck Place team provides virtual consultative support 24/7 for pediatric palliative needs across the province.

There are no specific province-wide strategic plans and initiatives to address the palliative care needs of populations such as 2SLGBTQI+ persons, homeless and marginally housed persons, incarcerated persons, and refugees and immigrants. There are isolated examples of excellence in the provision of palliative care to homeless and vulnerably housed populations.

There is strong community involvement across the province in palliative care, evidenced by many volunteer programs and over 120 compassionate community initiatives supported through a seed grant program through the BC Centre for Palliative Care. Hospice programs (residences and community programs) often serve as hubs for these activities.

This atlas explores each of British Columbia's five health regions in more detail across the domains and indicators, including providing maps and tables depicting the presence or absence of access to services. Readers are encouraged to read each of the region sections for details.

CONCLUSIONS

The Canadian Atlas of Palliative Care: British Columbia Edition provides a comprehensive view of palliative care as of 2024 in British Columbia. The Atlas outlines many examples of excellence throughout the province and shows opportunities for improvement and gaps in service. Overall, there are high levels of access to specialist-level palliative care services in hospital and community settings, with the exception of one region. There is significant variability across the province and within regions noted in some indicators, including the level of primary palliative care, integration of palliative care across different specialty services, in hospitals and in long-term care, and access to specialist palliative care support in rural and remote regions is largely virtual.

Introduction

Background

WHAT ARE PALLIATIVE CARE ATLASES AND THEIR ROLE?

Palliative care atlases are resources that provide easy-to-read graphical and text descriptions of the status of palliative care across several domains in a jurisdiction, usually at country and continental levels. They analyze and depict the state of palliative care in a country, region or jurisdiction at a given time (cross-sectional), highlighting successes and excellence, identifying gaps, and informing planners and policymakers with the goal of overall ongoing system quality improvement. Atlases are not minimum data sets or reports of minimal data sets.

The domains and indicators include policy, services, education, community engagement, and professional activities, among others. Refer to Appendix A for the details on the domains and indicators included within this Atlas.

Worldwide, atlases have become important tools and agents of change to inform continuous improvements in palliative care in a jurisdiction by highlighting strengths, identifying gaps, and prompting improvements across the jurisdictions studied.

Atlases also provide opportunities for comparative analyses across jurisdictions. Usually, for continent-level atlases, it allows for comparisons across countries. In the case of the Canadian Atlas (as with the Scottish Atlas), it also allows for comparisons between provinces and territories and their respective regions and subregions.

THE HISTORY OF PALLIATIVE CARE ATLASES

The evolution of palliative care atlases has recently been documented by the Atlantes Program of the Institute for Culture and Society (ICS) at the University of Navarra in Spain,[1] which has been a leader in the development of palliative care atlases internationally, following on initial pioneering work by the Lancaster End of Life Observatory in the United Kingdom.

One of the earliest palliative care atlases of seven European countries was published in 2000.[2] Since then, several international palliative care atlases have been developed, largely led by the Atlantes Program. These have included European editions (2013 and 2019) and editions for Africa (2017), the Middle East and North Africa (2017) and Latin America (2013 and 2021). Copies of these atlases can be accessed at the University of Navarra's Digital Repository.[3]

In 2019, led by the Atlantes Program, a large group of experts from across the world reviewed and updated the domains and indicators that are used for atlases; a consensus-based, Delphi-type approach was used for this.[4] The list includes 25 indicators across several domains. It was complemented by another study by Baur et al.[5]

The domains and indicators, study methods and methods of reporting, including cartography and infographic designs, undergo periodic updates and improvements as part of a continuous improvement strategy.

THE DIRECTION OF PALLIATIVE CARE IN CANADA

Access to palliative care is increasingly recognized as a human right;[6] providing palliative care for all citizens with life-threatening illnesses and their families is now recognized as a healthcare and social priority across the world. The World Health Assembly passed a resolution in 2014 calling on all member states to ensure access to palliative care for all its citizens, including different levels and services of palliative care and education.[7]

Over the past two decades, the Canadian federal government and several provincial and territorial governments have made significant improvements in palliative care. These successes are noteworthy and merit attention. However, ongoing gaps persist across the country and considerable variability exists across Canadian jurisdictions.

1 Tripodoro VA, Pons JJ, Bastos F, Garralda E, Montero Á, Béjar AC, et al. From static snapshots to dynamic panoramas: the evolution and future vision of palliative care atlas in cross-national perspectives. Research in Health Services & Regions. 2024 Apr 18;3(1).
2 Clark D, ten Have H, Janssens R. Common threads? Palliative care service developments in seven European countries. Palliative Medicine. 2000 Sep;14(6):479–90.
3 DADUN: Library - University of Navarra Home [Internet]. Unav.edu. 2024 [cited 2024 Dec 3]. Available from: https://dadun.unav.edu/home
4 Arias-Casais N, Garralda E, López-Fidalgo J, et al. Brief manual health indicators monitoring global palliative care development. Houston, TX: IAHPC Press; 2019.
5 Baur N, Centeno C, Garralda E, Connor S, Clark D. Recalibrating the "world map" of palliative care development. Wellcome Open Research. 2019 Aug 16;4:77.
6 Brennan F. Palliative Care as an International Human Right. Journal of Pain and Symptom Management. 2007 May;33(5):494–9.
7 World Health Organization. Sixty-Seventh World Health Assembly: Strengthening of palliative care as a component of comprehensive care throughout the life course [Internet]. Geneva: WHO; 2014 May. Available from: https://apps.who.int/gb/ebwha/pdf_files/wha67/a67_r19-en.pdf

In 2018, the federal government released a national *Framework on Palliative Care in Canada*.[8] It identified palliative care as a priority and called for, among other things, increased preparedness of the workforce on the palliative care approach and improved data collection on palliative care across Canada. It also called for the continued monitoring of the status of palliative care in the country. Subsequently, the *Action Plan on Palliative Care*[9] outlined aims to improve the quality of life for people living with life-limiting illnesses, families and caregivers, and to enhance access to and quality of care alongside health systems' performance.

The Canadian Institute for Health Information (CIHI), in its *Access to Palliative Care in Canada* 2018 report underscores the importance of undertaking a systematic process to understand the status of palliative care in the country, states that it is "... only when the state of publicly funded palliative care in Canada is understood can health system planners identify service gaps and develop strategies for improving care."[10]

HISTORY OF THE CANADIAN ATLAS OF PALLIATIVE CARE AND ITS PROVINCIAL AND TERRITORIAL EDITIONS

In response to the call by the federal *Framework on Palliative Care in Canada* to improve the assessment and monitoring of palliative care across Canada, and as a national leader in building palliative care capacity with an extensive network of partners across Canada, Pallium Canada decided in 2019 to develop the Canadian Atlas of Palliative Care, informed and guided by the international atlases developed at the University of Navarra.

An initial research team was formed and consisted of palliative care and primary care leaders, researchers, clinicians and educators from different organizations and provinces and included representation from the University of Navarra.

Through an iterative process by the research team, which also included consultations with key community organizations and institutions, the methodology and the international domains and indicators were adopted and adapted where necessary and then tested through a pilot study involving two Ontario regions that included urban and rural geographies and demographics. The experiences and learnings from the pilots informed additional modifications to the process, the domains and indicators, and the protocol used in this provincial atlas.

The ultimate vision is to have thirteen provincial and territorial editions, each with regional subsections, and a federal-level Atlas summarizing the status of palliative care at a country-wide level (to allow comparisons with other countries).

UPDATES

This British Columbia Edition of the Canadian Atlas of Palliative Care serves as a cross-sectional view of the status of palliative care in British Columbia, as of 2023 and 2024, providing a baseline going forward. Similar to other palliative care atlases, the goal is to update it every five years.

WHY THIS EDITION OF THE ATLAS DOES NOT INCLUDE PALLIATIVE CARE FOR INDIGENOUS POPULATIONS

This edition of the Canadian Atlas of Palliative Care does not seek to reflect palliative care services and programs of First Nations, Inuit, or Métis peoples in Canada. Instead, with humility and in the spirit of reconciliation, Pallium Canada is dedicated to collaborating in a distinct process, led and developed by Indigenous Peoples, to describe palliative care across Turtle Island provided by, with and for Indigenous peoples. Such mapping will adhere to the First Nations Principles of Ownership, Control, Access, and Possession (OCAP®)[11], Manitoba Métis principles of OCAS (Ownership, Control, Access and Stewardship)[12], and Inuit Qaujimajatuqangit.

8 Health Canada. Framework on Palliative Care in Canada [Internet]. Ottawa, ON: Health Canada; 2018. Available from: https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada/framework-palliative-care-canada.pdf

9 Health Canada. Action plan on palliative care. Ottawa, ON: Health Canada; 2019. Available from: https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care/action-plan-palliative-care-eng.pdf

10 Canadian Institute for Health Information. Access to Palliative Care in Canada. [Internet]. Ottawa, ON: CIHI; 2018. Available from: https://secure.cihi.ca/free_products/access-palliative-care-2018-en-web.pdf

11 Welcome to The Fundamentals of OCAP® - The First Nations Information Governance Centre [Internet]. The First Nations Information Governance Centre. 2023 [cited 2024 Nov 30]. Available from: https://fnigc.ca/ocap-training/take-the-course/

12 University of Manitoba. Framework for Research Engagement with First Nation, Metis, and Inuit Peoples [Internet]. Available from: https://umanitoba.ca/health-sciences/sites/health-sciences/files/2021-01/framework-research-report-fnmip.pdf

Overall Aims

The overall aims of the Canadian Atlas of Palliative Care: British Columbia Edition include raising awareness of the current state of palliative care in British Columbia; improving equitable and timely access to palliative care; identifying and spreading excellence; guiding and informing policymaking, planning and capacity building in the provision of palliative care; and enhancing the quality of palliative care in jurisdiction(s) across the province.

SPECIFIC OBJECTIVES

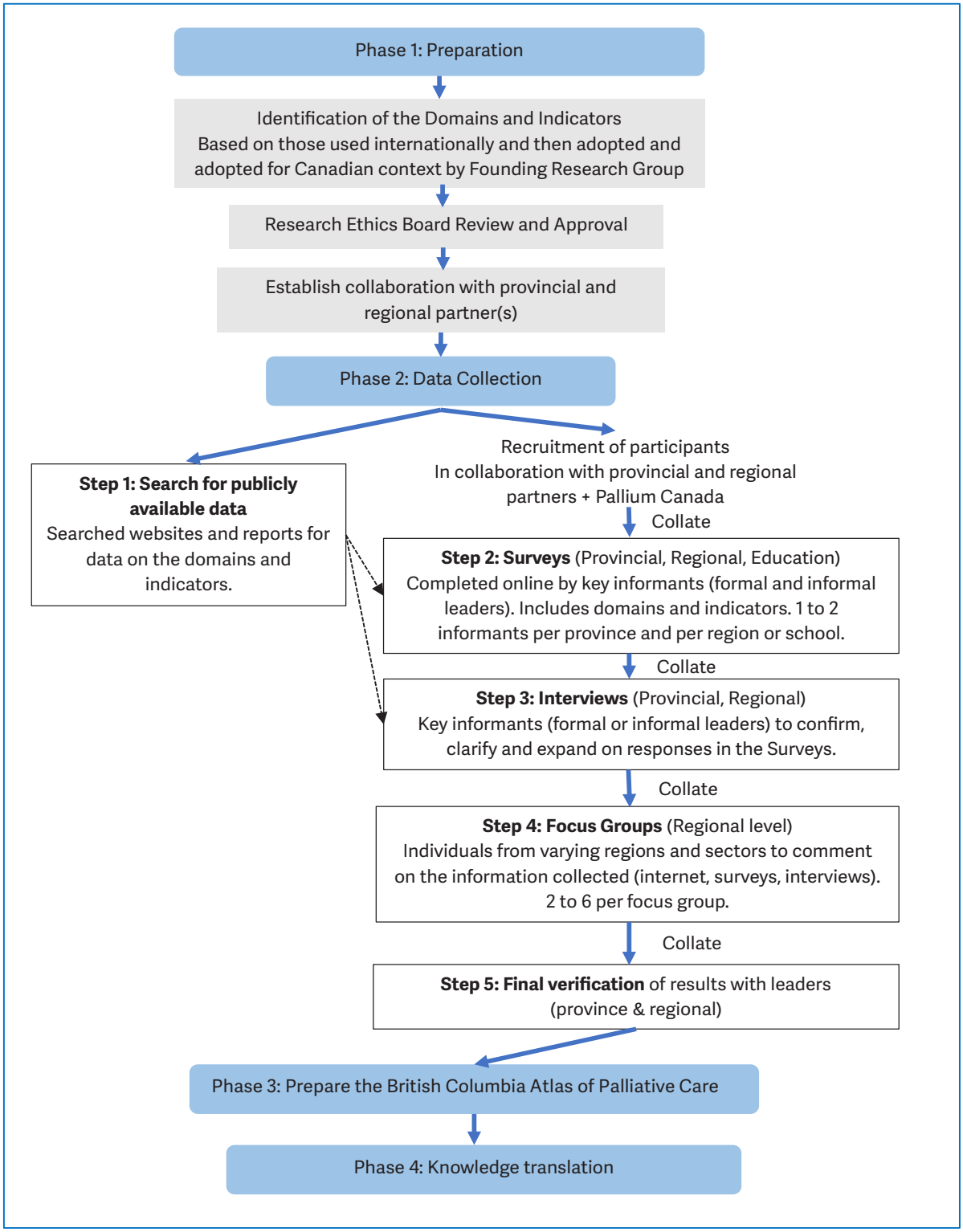
The Canadian Atlas of Palliative Care: British Columbia Edition, will:

- Describe the current state of palliative care across several domains and indicators in British Columbia and across Canada (federal, provincial and territorial, and regional levels).
- Identify and highlight areas of strengths and successes with the goal of scale and spread.
- Identify areas for improvement.
- Raise awareness of the status of palliative care for populations that require special attention, including children, 2SLGBTQI+ populations, incarcerated persons, recent immigrants and refugees, and homeless and marginally housed.
- Inform ongoing health system changes and improvements in palliative care to ensure equitable and timely access for all who need it.

Methods

Methods

A multi-phased, mixed-method approach was used – see Figure 1 and Appendix B for additional details of data collection and validation process. Methods were mainly adopted from the international atlases previously developed. However, Step 4 was added to obtain perspectives from font-line professionals and is unique to this project.



REPORTING OF DOMAINS AND INDICATORS

Overall, the reporting of results of indicators presented in this Atlas falls into one of the following categories:

1. **Objective results:** These indicators are relatively straightforward to identify and measure, such as the presence or absence of a policy or law, or the presence of a palliative care unit or hospice residence. These are reported as existing or not (YES/NO). In some cases, they exist but partially (e.g., coverage of palliative care medications or supplies in a home setting). In these cases, we have reported them as "Partial."

2. **Global impression:** Some indicators are challenging to measure accurately and across the whole province. The level of integration of palliative care across all hospital services and across all communities is not feasible given the resources available, availability of data and the significant variability that often exists across communities and regions. For these, a global judgment, based on the multi-source input received, is made. Some parameters and ranges have been used to guide the input received through surveys, interviews and focus groups. For example, minimal integration, partial integration, or full integration. The presence of some indicators, such as access to specialist palliative care teams in hospitals or communities, is reported as "Minimal or Absent," "Partial Low," "Partial High" or "Full," depending on the analyses undertaken. The results reported therefore reflect the judgments of individuals who participated in data collection and the research team's analysis. Refer to the Limitations section for more detail.

3. **Using an established standard:** This is possible in the case of the presence of inpatient palliative care beds in a region and province or territory. For this purpose, what is referred to as "The Catalonia formula"[1] has been used. This formula calls for at least 10 beds for every 100,000 population, with two or three of these beds being allocated to palliative care units (PCU) and seven to eight being hospice or palliative care continuing care type beds. This Atlas uses the standard for three palliative care unit beds and seven hospice beds. Based on this formula, a region is rated as having an adequate or inadequate number of beds. For the purposes of this Atlas, beds were deemed adequate if the number of beds was within 10% of the target number based on the Catalonia formula. The conservative number of two per 100,000 was used to determine adequacy for PCU beds.

When there is variability in the domains and indicators across a region, where possible, this Atlas provides some contextual information collated from the multi-source input in the form of Context text boxes. Some tabulated results are also further explained and contextualized through footnotes to the tables.

LIMITATIONS OF THE DATA

To obtain the best possible representation of the status across the different indicators and to explore some of the context, and to reduce the risk of potential biases or inaccurate impressions of both informants and researchers, this study has used a mixed method, multi-phase, multi-source, and multi-informant approach.

In some cases, specific data is not available or would require large-scale studies requiring significant resources and time to collect, both of which fell outside the resources and scope of this Atlas study. The indicators related to the integration of palliative care across different hospital services across a region's hospitals and the provision of primary palliative care by primary care professionals are examples. In these cases, the study relies on a general global impression inferred from the multi-source data and informants. In some cases, despite some reminders and outreaches to some informants (as described in the study protocol approved by the research ethics board), information was not forthcoming.

It must be noted that the study occurred following the end phases of the COVID-19 pandemic, and some potential informants were either redeployed or given added responsibilities related to health system recovery.

We aimed to mitigate any biases or limitations of individual participants' knowledge and experience by developing consensus through multiple stakeholder iterative reviews, ensuring input from different perspectives, and multiple information sources, including health system leaders and frontline clinicians.

Participant recruitment posed some challenges, resulting in certain regions and/or professions being more prominently represented in the dataset than others.

1 Gómez-Batiste X, Porta J, Tuca A, Stjernswärd J. Organización de Servicios y Programas de Cuidados Paliativos. 1st ed. Madrid, Spain: Arán Ediciones, S.L.; 2005.

How is the Atlas Organized?

The provincial edition of the Atlas is divided in two parts. Part A reports at a provincial level and Part B at a regional level. The latter is further divided into five sub-sections, each one corresponding to one of the five Regional Health Authorities in British Columbia. The different domains and indicators are reported in both parts A and B to allow comparison across the regions and to provide more detail given the large and varied geographics and demographics that make up British Columbia.

HOW IS THE INFORMATION REPORTED AND DISPLAYED (CONVENTION)?

DATA DICTIONARY, GLOSSARY AND DEFINITIONS

The Data Dictionary (refer to Appendix C) provides more information on specific terms, definitions, and standards for the benchmarking of palliative care services used in this atlas.

CONVENTION		EXPLANATIONS			
Maps	The extent to which the services or resources are present or absent in a region. The colours correspond to levels of presence or availability.	**Minimal/ Absent**	**Partial Low** 	**Partial High** 	**Full** 
Dashboard	The extent to which a service or resource is available or integrated. The more circles coloured, the higher the level of presence or access.	Minimal/Absent 			
		Partial Low 			
		Partial High 			
		Full 			
	Indicates a region is mostly as depicted; however, some areas may be higher or lower	Variable **V**			
Highlights	A unique innovation, program, or strategy in the region to improve palliative care delivery.				

Results Part A: Provincial Level

Results: Context

HEALTH SERVICES ORGANIZATION

FUNDING AND OVERSIGHT

In Canada, each province or territory is responsible for overseeing its own healthcare delivery. However, they must adhere to the federal Canada Health Act, enacted in 1984. This act ensures that all Canadian residents have access to medically necessary hospital and physician services without direct charges.

The Canada Health Act sets out the primary principles of public administration, comprehensiveness, universality, portability, and accessibility, which provinces and territories must adhere to in order to receive federal health transfer payments. Each province and territory then determines its service delivery model given its context, priorities and realities. The Canada Health Act does not list palliative care or home care as essential services, and therefore, whether palliative care is funded and to what extent varies from province to province and across the territories.

In British Columbia, healthcare funding comes from both the provincial and federal governments, with the majority (about 70%) coming from the province. British Columbia has a provincial health insurance program, the Medical Services Plan (MSP) that covers medically necessary healthcare services for residents of British Columbia. The MSP covers medically required services from physicians, midwives and diagnostic services. The Ministry of Health provides funding through Regional Health Authorities for hospital programs, mental health and addiction services, and residential/assisted living.

Prescription medications, medical supplies and pharmacy services are covered for certain populations through BC PharmaCare plans, including residents of long-term care, those with low incomes, and some with palliative care needs (known as Plan P). Plan P covers palliative care benefits for those at end-of-life who want to receive palliative care at home. It provides full coverage for approved medications, as well as equipment and supplies through the regional health authority. Home and community care services are available either through private pay professionals or publicly subsidized through the Regional Health Authorities. Hospices are publicly subsidized and require user payment at a fixed daily rate (currently $46.59), which may be reduced for those with low income.

ORGANIZATION OF HEALTH CARE AND PALLIATIVE CARE

The Ministry of Health (MoH) works together with a provincial health authority, five regional health authorities, and a First Nations health authority to provide health services.

The Provincial Health Services Authority (PHSA) operates a number of provincial agencies and specialized services that intersect with palliative care, including the ***BC Cancer Agency, BC Children's Hospital, BC Emergency Health Services, BC Renal Agency and Cardiac Services BC***. The primary role of the PHSA is to ensure BC residents have access to a coordinated network of high-quality specialized health services.

The ***First Nations Health Authority*** represents a new relationship between BC First Nations, the province and the federal government, and is responsible for health services previously provided by Health Canada's First Nations and Inuit Health Branch. This Atlas does not address palliative care provided by the First Nations Health Authority.

The five ***Regional Health Authorities*** (RHAs) govern, plan and deliver health services to meet the needs of the population within their respective geographic areas. Each RHA reports to and collaborates with the MoH and also collaborates with the PHSA.

Each RHA has its own leadership structure and service plan in accordance with their annual mandate letter from the MoH. Each RHA is organized into subregions known as health service delivery areas that further organize and deliver services within local health units and community services. Palliative care services vary according to the service plan and strategic priorities of each RHA.

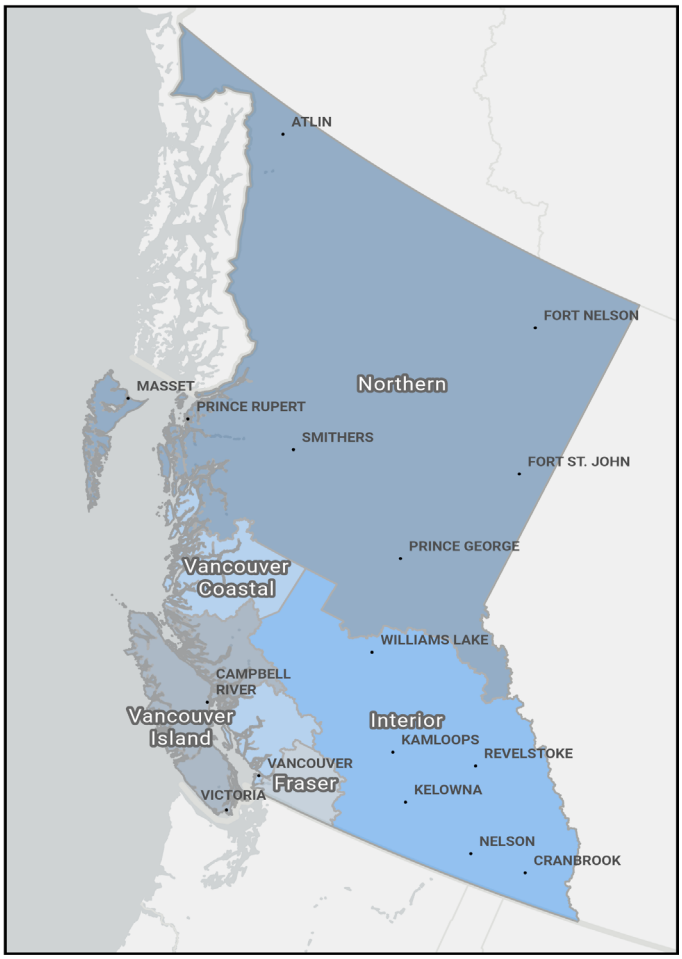
The MoH established an End-of-Life Care Action Plan for British Columbia in March 2013. To support implementation of this plan, the MoH committed funds to establish a centre of excellence for end-of-life care and, in June 2013, the BC Centre for Palliative Care (BCCPC). The BCCPC is a provincially funded organization aimed to accelerate and spread best practices and innovations in palliative care. The BCCPC works with partners across the BC health system, community sector and research institutions to improve access to high quality palliative care supports in all care settings and throughout illness.

COMMUNITY ENGAGEMENT AND INVOLVEMENT

Community participation and volunteerism, as in the rest of Canada, play an important role in British Columbia, contributing significantly to the social, economic, and health sectors, including palliative care. Volunteers provide companionship, emotional support, respite care for families, and practical assistance to patients and their families, including assistance with daily activities. In British Columbia, volunteerism has played a key role in establishing hospices and providing support in communities and hospice services.

In 2016, the BCCPC helped to launch the Compassionate Communities movement in British Columbia, establishing seed grants and providing tools, training, and coaching to community organizations to launch compassionate community initiatives that help care for persons with advanced illnesses and their families. To date, over 120 compassionate community initiatives have been supported across the province.

Regional Health Authority Regions



Legend

- Major Cities
- Fraser
- Interior
- Northern
- Vancouver Coastal
- Vancouver Island

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

PROVINCIAL POPULATION AND DEMOGRAPHICS

Population: 5,000,879
Population density: 5.4 people per sq km
Total provincial area: 920,686.55 km²
GDP for province: $304 billion
Life expectancy: Males: 79; Females: 84

AGE RANGE	POPULATION SIZE*	PERCENTAGE
0-19	970,590	19%
20-64	3,013,930	60%
65-74	591,770	12%
75+	424,595	9%

* Data taken from the 2021 Canadian Census

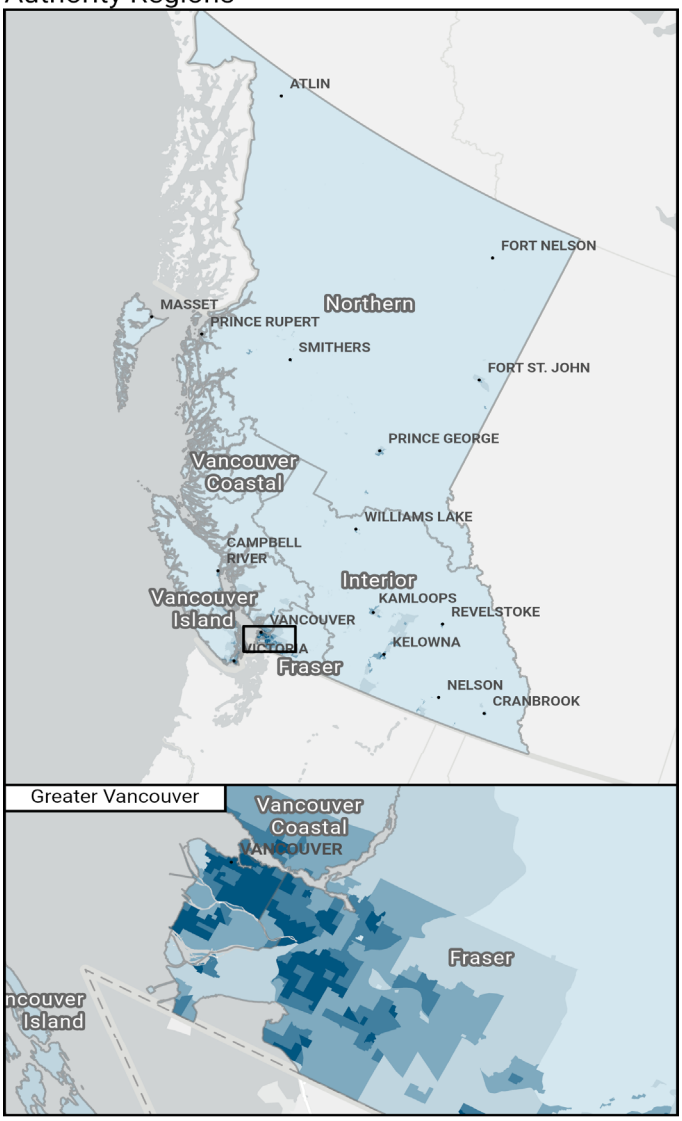
REGION	POPULATION SIZE*	POPULATION DENSITY PER KM²
Vancouver Coastal	1,198,017	23.0
Island	840,284	15.4
Interior	809,734	3.9
Fraser	1,872,476	125.0
Northern	280,368	0.5
TOTAL:	5,000,879	5.4

* Data taken from the 2021 Canadian Census

CAUSE OF DEATH	NUMBER OF DEATHS*	PERCENTAGE
Accidents/ Unintentional Injuries	3,361	8%
Cancer	11,069	25%
Cardiovascular	8,196	18%
Dementia/Alzheimer Disease	1,103	3%
Lung and Respiratory Diseases	1,510	3%
Other (including renal, neurological, etc.)	19,362	43%

* Data taken from Statistics Canada (Table 13-10-0801-01)

Population Density Across Regional Health Authority Regions



Legend

- Major Cities
- Health Authority Regions

Population Density, people/km2

- 0.00 - 10.59
- 10.60 - 144.49
- 144.50 - 1,478.44
- 1,478.45 - 3,270.57
- 3,270.58 - 77,545.30

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

Results Part A: Provincial Level

POLICY

POLICIES, STRUCTURES AND LAWS	PRESENCE
Designated office, secretariat or program responsible for palliative care	YES
A formal palliative care strategic plan, policy or framework	YES[1]
Law to ensure palliative care access	NO
Standards and norms for palliative care	YES
Designated palliative care leads	YES
Law related to advanced care planning	YES[2]
Compassionate care benefits	YES[3]

FORMAL STRATEGIES	PRESENCE
Home and community care	YES
Inpatient and outpatient hospital services (cancer and non-cancer)	YES
Long-term care facilities	YES
Rural and remote	NO
Paramedic/emergency services	YES

GOVERNMENT FUNDING	PRESENCE
Palliative care home service	PARTIAL[4]
Hospice residences	PARTIAL[5]
Community hospice services	PARTIAL
Medications: In hospital	FULL
Medications: Out of hospital	PARTIAL[3]
Supplies and equipment: In hospital	FULL
Supplies and equipment: Out of hospital	PARTIAL[3]
Continuing palliative care education in various settings	PARTIAL

Context:

[1]Provincial Plan (End-of-Life Care Action Plan for British Columbia, 2013).

[2]Provincial legislation.

[3]Federal program

[4]British Columbia has provincial palliative care benefits (Plan P), which patients are eligible for with a prognosis of 6 months or less (including home care). Some items may not be covered, so alternate practices (e.g., special requests) are submitted. People in long-term care are eligible for Plan B.

[5]Patients are required to pay a daily rate (even if on Plan P), unless approved for subsidy, which is often covered by the Regional Health Authorities.

SERVICES

PALLIATIVE CARE AND HOSPICE BEDS IN THE PROVINCE

	TYPES OF BEDS	NUMBER	ADEQUACY*	% OF TARGET BEDS
	Palliative Care Units (PCUs)	10		
	Palliative Care Unit beds	76[1]	Inadequate	50.7%
	Other palliative care beds	0		
	Hospice Residences	v		
	Hospice beds in residences[2]	318[2]	Adequate[3]	91.4%
	Other hospice beds[2]	2		
	Total number of inpatient palliative care beds (PCU and Hospice combined)	396[1]	Inadequate	79.2%

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

Context:

[1]The province has both dedicated and designated palliative care beds; however, this total only includes *dedicated* beds. *Dedicated* beds refer to beds that are allocated only for palliative care patients with staff dedicated to palliative care. *Designated* beds may be occupied by patients with other needs, such as internal medicine. *Designated* beds may therefore not necessarily be available to patients with palliative care needs should admission be required and staff may not have adequate expertise in palliative care. Two of the five regions in BC do not have Palliative Care Units (PCU). In general, the PCUs are end-of-life or acute care units.

[2]The province has both dedicated and designated hospice beds. Hospice beds are found in hospice residences (stand-alone or co-located in hospitals and long-term care homes) and designated hospice beds are in hospitals and long-term care homes.

[3]This is within 10% of the target beds, which, for the purpose of this Atlas, is deemed Adequate. However, if the population is to increase and age, this would be Inadequate.

SETTING: ACUTE CARE

HOSPITALS

Access to specialist-level palliative care teams in hospitals	●●●○ V
Funding models for palliative care physicians	MOSTLY BY SERVICE CONTRACTS

Context:

All physicians and nurse practitioners in British Columbia have access to a provincial physician-led provincial call line, which is staffed by specialist-level palliative care physicians for virtual support. Some regions have additional regional palliative care physicians and teams to provide in-person consultations in hospitals.

INPATIENT UNITS AND OUTPATIENT CLINICS

Integration* in inpatient units	●○○○ [1]
Integration* in outpatient clinics – Cancer	●●○○ V[2]
Integration* in outpatient clinics – Other**	●○○○ [3]

*Integration includes clinicians and staff with the core palliative care competencies to provide a palliative care approach; early activation of a palliative care approach; timely referral to specialist teams when needed; and collaboration with palliative care teams.

**Cardiology, respirology, nephrology, neurology.

Context:

[1]Integration is minimal across the majority of non-cancer inpatient units. There are isolated examples of integration in some centres.

[2]Integration is variable. Clinics run by the BC Cancer Agency have higher levels of integration compared to clinics run by Regional Health Authorities.

[3]Integration in non-cancer outpatient clinics is minimal, but efforts to improve integration are underway. BC Renal, for example, has a provincial Palliative Care Committee, resources and an Integrative Palliative Nephrology Resource Guide, which builds on the End-of-Life Framework (2009).

SETTING: COMMUNITY

COMMUNITY

Access to community specialist care teams	●●●○ V[1]
Communities with 24/7 access to specialist palliative care teams	●●●○ V[2]

Context:

[1]Access to specialist palliative care clinicians in the community is variable; 100% in some communities to less than 10% in very rural areas. Some regions have hospital-based teams that provide some in-person community coverage. Community specialist teams largely provide *Consultative* care across the province with some doing *Shared Care*. There are gaps in palliative care provision for patients who do not have a primary care physician or other clinician.

[2]Most access is provided virtually by regional teams or through the provincial physician-led on call line. Patients, families and nurses have access to a provincial nursing-led palliative care call line for 24/7 support.

PALLIATIVE HOME CARE

Access to palliative home care services	●●●○ V[1]
Availability of 24/7 access	●●○○ V[2]

Context:

[1] Palliative home care is often provided by generalist home care staff and not specialist palliative home care.

[2]24/7 access is variable; some areas have coverage, while others have limited after-hours access. In many rural locations, after hours support is primarily virtual (by phone).

PRIMARY CARE

Overall provision of primary palliative care	●●○○ V
Providing palliative care to ambulatory patients	●●●○ [1]
Providing palliative care home visits	●○○○ V
Clinics providing 24/7 on-call coverage	●○○○ V
Standards/indicators for overall provision of primary palliative care	NO
Training for primary care professionals on the palliative care approach available	YES[2]

Context:

[1]Overall, the provision of primary palliative care by primary care professionals is variable across the province.

Most family physicians and primary care clinics provide primary palliative care to their ambulatory patients in the clinic. Home visits and after-hours care are less common, except in smaller communities. Gaps in palliative care provision also exist for patients unattached to a primary care professional.

[2]Palliative care training programs, such as the BC Centre for Palliative Care's online modules and Pallium Canada's Learning Essential Approaches to Palliative Care (LEAP) courses, are readily available, with evidence indicating that primary care physicians and nurse practitioners across the province are undertaking LEAP training.

RURAL AND REMOTE AREAS

Access to specialist palliative teams	●●○○ V[1]
Strategic plan to build primary palliative care capacity	NO
Standards/indicators for access to primary palliative care	NO
Funding for education on the palliative care approach	YES
Training of primary care professionals on the palliative care approach available	YES

Context:

[1]In-person access to specialist palliative care teams varies significantly, ranging from minimal availability to 30%. Some very rural areas have no physicians or access to community teams due to challenges with geographical access and staffing. Rural physicians and nurse practitioners can access specialist palliative care teams through the provincial physician-led on call line.

HOSPICE SERVICES

Standards/indicators for hospice residences	NO
Hospice residences	31
Community hospice organizations*	77[1]

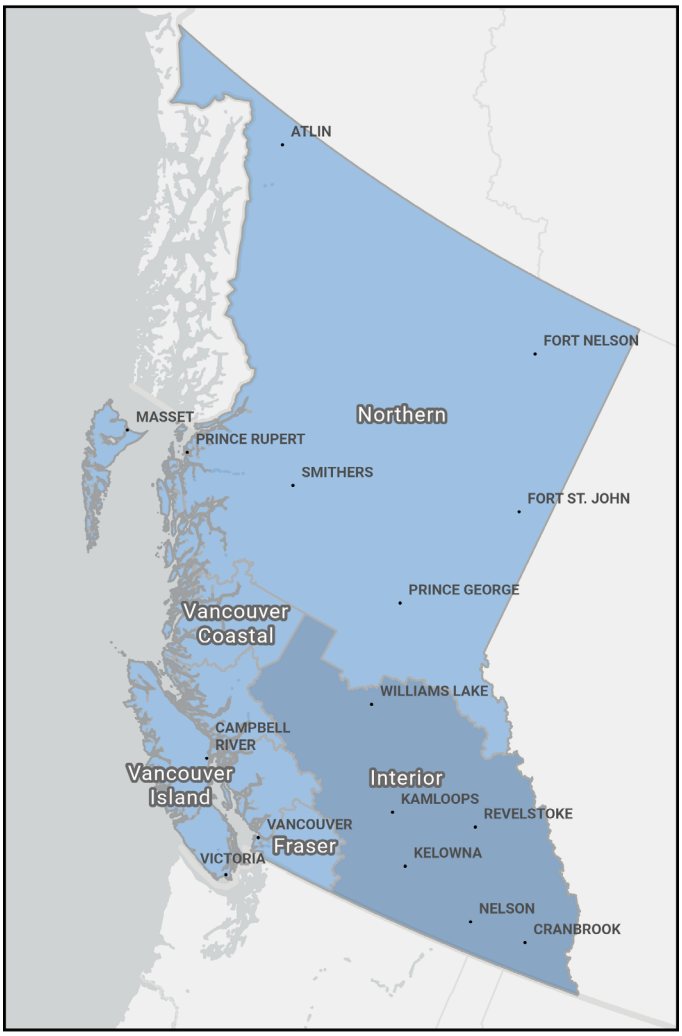
*Due to data collection methods and the wide range of organizations that may provide hospice services, this may be an underrepresentation.

Context:

[1]Community hospice organizations may operate a hospice residence, but most do not. They provide direct and indirect care to patients and support for families.

MAPS

Access to Palliative Home Care Services

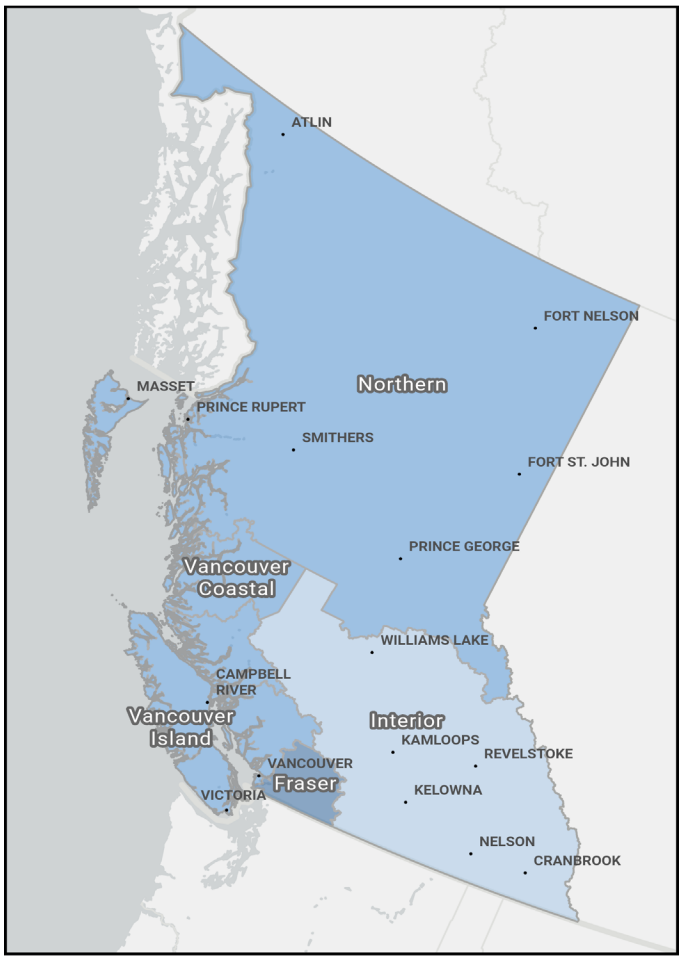


Legend

- Major Cities
- Full
- Partial High

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

Access to Specialist Level Care Support Teams in Hospital

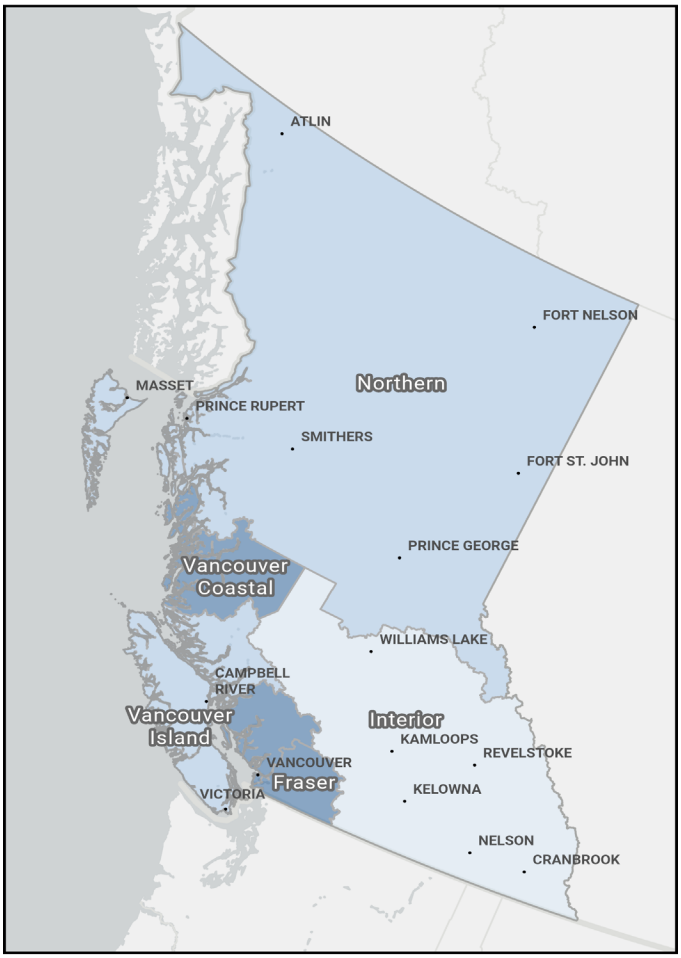


Legend

- Major Cities
- Full
- Partial High
- Partial Low

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

Access to Specialist Level Care Support Teams in the Community

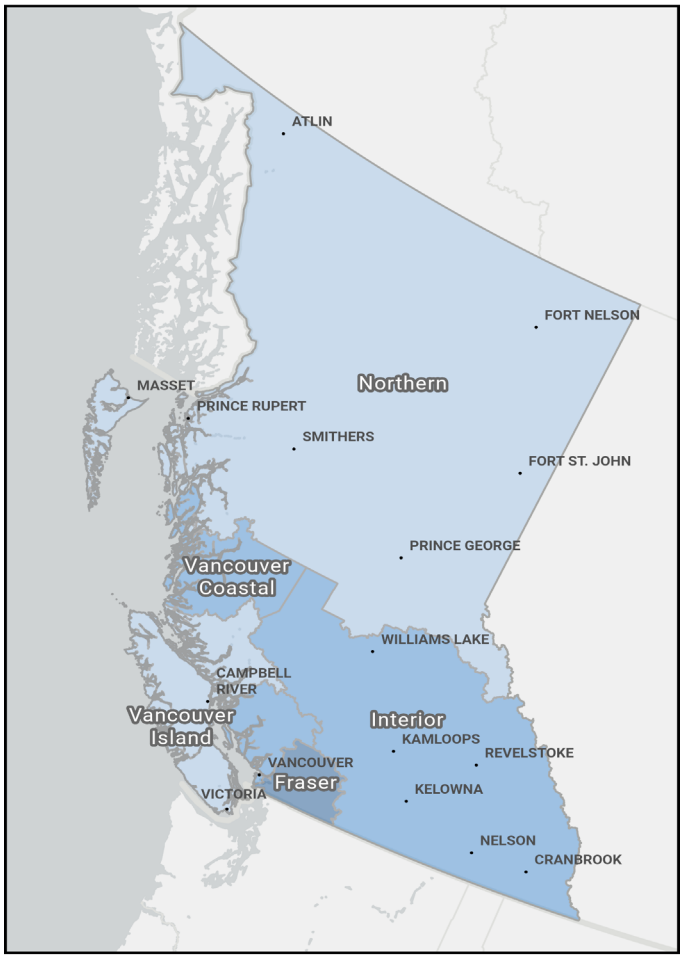


Legend

- Major Cities
- Full
- Partial Low
- Minimal/Absent

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

Access to Specialist Level Care Support Teams in Long-term Care Homes



Legend

- Major Cities
- Full
- Partial High
- Partial Low

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

LONG-TERM CARE (LTC)

Access to specialist palliative care services	●●●○ V[1]
Integration of palliative care approach	●●○○ V
Standards/indicators for providing palliative care	NO
Formal standards of training on palliative care approach	NO
Training programs on the palliative care approach available	NO
Funding for education on the palliative care approach	NO

Context:

[1]Physicians can access the provincial physician-led palliative care call line. Nurses can access the provincial nursing-led call line if no regional level support exist or are available.

Across the province, the BC Centre for Palliative Care is leading the "Strengthening a Palliative Approach in Long-Term Care Initiative," to enhance current strategies and create new integration strategies.

PARAMEDIC EMERGENCY SERVICES

Training paramedics in palliative care	YES[1]

Context:

[1]BC Emergency Health Services (BCEHS) has a provincial palliative model called ASTaR (Assess, See, Treat and Refer), which supports paramedics to deliver enhanced care to palliative patients in their homes and refer them to the Health Authority teams. In rural and remote areas, community paramedics see patients regularly (e.g., weekly) and are often the main contact for palliative care patients, who may be referred to them from home health services. Pallium's LEAP Paramedic course is utilized and available for free by BCEHS to all staff. Over 50% of the workforce has completed it and new members are encouraged to complete it within the first six months of onboarding. Actual implementation in each region varies.

PALLIATIVE CARE RESOURCES

Advance Care Planning resources/programs	YES[1]
Palliative care competencies elaborated for different professions and levels*	YES[2]

Context:

[1]Resources are available online through the government website and community organizations.

[2]BC Interprofessional Palliative Care Competency Framework and Discipline-specific Palliative Care Competency Frameworks (plus COVID-19 pandemic specific palliative competencies).

Highlight:

The BC Centre for Palliative Care supports essential conversations with healthy adults and their families, people with serious illness, and health care providers. BCCPC offers training and resources for two types of workshops: volunteer-led Advance Care Planning for the public, and Serious Illness Conversations for health care students and providers.

SYSTEM PERFORMANCE

Each Health Authority has a "Health Care Report Card." These are published multiple times a year on key priority areas for the Ministry of Health and the Health Authorities. Some system performance indicators for British Columbia and its health regions have been reported by the Canadian Institute for Health Information (CIHI) 2023 Palliative Care Report and by the Canadian Partnership Against Cancer (CPAC) in 2017.

EDUCATION

MEDICAL AND NURSING SCHOOLS*

Medical schools	1[1,2,3]
Nursing schools (LPN, RN, graduate, post-graduate programs)	21[3]

POSTGRADUATE EDUCATION AND CERTIFICATION

Physician Education	
Palliative care residency programs:	
College of Family Physicians of Canada Certificate of Added Competence in Palliative Care and Residency program	YES
Royal College of Physicians and Surgeons of Canada Subspecialty in Palliative Medicine and Residency program	YES – ADULT AND PEDIATRIC
Nursing Education	
Nursing specialization or certification in palliative care**	YES

*See the Regional reports for the extent to which palliative care appears in undergraduate and postgraduate curricula

**Nursing specialization is achieved through CHPC(N) national certification

Context:

[1]There is one medical school in British Columbia, the University of British Columbia (UBC). It has 5 campuses and teaching sites across the province. Palliative care education varies between sites. Campuses are located in UBC Vancouver (Vancouver Coastal Health Authority), UBC Okanagan (Interior Health Authority), UBC Northern British Columbia (Northern Health Authority), University of Victoria (Island Health Authority) and Surrey (Fraser Health Authority).

Palliative care residents for the College of Family Physicians program and the Royal College of Physicians and Surgeons programs rotate across the sites. Residents across different specialty areas are also allocated to the different sites.

[2]Simon Fraser University is opening a new medical school in 2026.

[3]The Serious Illness Conversation course is required for all fourth-year medical students. The course is also required in 7 out of 13 Registered Nursing programs at the time of data collection.

PROFESSIONAL ACTIVITIES

Palliative care association or organization	YES[1]
Existence of palliative care directory of services	YES
Dedicated resources to organize palliative care continuing professional development	YES[2]
Palliative care conference/symposia provincially	YES[3]
Research activities	YES[4]
Palliative care quality improvement initiatives	YES

Context:

[1]The British Columbia Hospice Palliative Care Association and the BC Centre for Palliative Care.

[2]BC Centre for Palliative Care provides training and education opportunities, such as online palliative care modules and continuous learning opportunities through Pallium Canada's Palliative Care ECHO Project.

[3]The British Columbia Centre for Palliative Care hosts a conference.

[4]There is significant palliative care scholarship undertaken by groups in British Columbia. Research projects across the province are led by researchers in UBC, University of Victoria, Trinity Western University, BCCPC, Canuck Place Research Initiative, BC Cancer, and BC Children's Hospital Research Institute, among others. Themes include equity in palliative care access (ePAC led by Kelli Stajduhar), patient centered-decision making (Richard Sawatzky), volunteer navigation (Nav-CARE led by Barb Pesut), improving pediatric palliative care and understanding children with serious illness/medical complexity (Hal Siden).

Sample Publications:

Stajduhar KI, Giesbrecht M, Mollison A, Dosani N, McNeil R. Caregiving at the margins: An ethnographic exploration of family caregivers experiences providing care for structurally vulnerable populations at the end-of-life. Palliative Medicine. 2020;34(7):946-953. doi:10.1177/0269216320917875

Sawatzky, R., Porterfield, P., Donald, E., Tayler, C., Stajduhar, K., & Thorne, S. (2023). Voices lost: where is the person in evaluating a palliative approach to care? Palliative care and social practice, 17, 26323524231193041. https://doi.org/10.1177/26323524231193041

Pesut B, Duggleby W, Warner G, et al. Scaling out a palliative compassionate community innovation: Nav-CARE. Palliative Care and Social Practice. 2022;16. doi:10.1177/26323524221095102

Noriega, E. C., Siden, H., & Lavergne, M. R. (2023). Infants, children, youth and young adults with a serious illness in British Columbia: a population-based analysis using linked administrative data. CMAJ open, 11(6), E1118–E1124. https://doi.org/10.9778/cmajo.20220181

Belayneh M, Fainsinger R, Nekolaichuk C, Muller V, Bouchard S, Downar J, Galloway L, Ghosh S, Hawley P, Herx L, Kmet A, Lawlor P. Edmonton Classification System for Cancer Pain: Comparison of Pain Classification Features and Pain Intensity across Diverse Palliative Care Settings in Canada. J Palliat Med. 2023 Mar;26(3):366-375.

Hawley P, Chow L, Fyles G, Shokoohi A, O'Leary MJ, Mittelstadt M. Clinical Outcomes of Start-Low, Go-Slow Methadone Initiation for Cancer-Related Pain: What's the Hurry? J Palliat Med. 2017 Nov;20(11):1244-1251.

Boen C, Ridley J, Hawley P. Methadone for Pain Management in Chemotherapy-Induced Peripheral Neuropathy: A Retrospective Review. J Pain Palliat Care Pharmacother. 2024 Jul 30:1-10.

FOCUSED POPULATIONS

PEDIATRIC PALLIATIVE CARE

Formal strategy for pediatric palliative care	NO
Pediatric hospice residence(s)	YES[1]
Outpatient palliative care programs for pediatric populations	YES
Respite pediatric palliative care (hospice or hospital setting)	YES
Pediatric palliative care consultation team(s)	YES
24/7 access to specialist pediatric palliative care consult team(s)	YES
Education program(s) for pediatric palliative care	YES

Context:

[1]Canuck Place Children's Hospice provides 24/7 specialized pediatric palliative care at two free-standing residences in Fraser Health Authority and Vancouver Coastal. In addition, they provide 24/7 virtual support for children with palliative care needs across BC and the Yukon, including consultation to communities, hospices, and hospitals. Canuck Place works with Child Health BC to develop a pediatric palliative care Tiers of Service Framework which guides service delivery planning. Training and education are available for health care professionals through the UBC Pediatric Palliative Care Rotation, Serious Illness Conversation Guide - Pediatrics Training, and other initiatives.

OTHER FOCUSED POPULATIONS

POPULATION	FORMAL STRATEGY	PROGRAM/INITIATIVE
2SLGBTQI+*	NO	NO
Homeless and marginally housed	NO	NO
Incarcerated people (correctional facilities)	NO	NO
Recent immigrants and refugees	NO	NO

*Refers to Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex and additional people

Context:

There are no existing strategies or provincial wide programs for these populations. There are some isolated but noteworthy initiatives in some of the Regional Health Authorities, especially with respect to palliative care for homeless and marginally housed persons and for recent immigrants and refugees. See each Health Authority for more information.

COMMUNITY ENGAGEMENT

VOLUNTEERS

Formal strategy for palliative care volunteers	YES[1]
Programs or initiatives for volunteers	YES
Training programs for volunteers	YES

COMMUNITY RESOURCES

Compassionate Community activities and other community engagement activities/ resources*	YES[2]
Grief and bereavement services	YES
Formal strategy for support of informal caregivers	NO
Programs or initiatives for informal caregivers	YES[3]

*e.g., death cafes, visiting programs, support groups

Context:

[1]There are provincial volunteer standards for hospice palliative care through the British Columbia Hospice Palliative Care Association.

[2]There are yearly grant opportunities within the province to provide funding for compassionate communities supporting in-person and virtual initiatives, including a Seed Grant through BCCPC.

[3]The Family Caregivers of BC (FCBC) is a provincial not-for-profit organization that provides education, advocacy, and support for caregivers across the province through a call centre, one-on-one and group-based interventions, education and informational resources, a directory of services, and referrals to local assistance. The option of referring caregivers to FCBC for support has now been included as an item that must be completed in hospital discharge summaries.

Overall, hospices and community organizations provide a large majority of grief and bereavement support throughout the region, in addition to other support services. The Patient Voices Network, a provincial wide organization, is actively working to improve patient care across BC, ensuring that patient perspectives are incorporated into palliative care initiatives.

Results Part B: Regions

Fraser Health

DEMOGRAPHICS

Fraser Health Authority is one of five Regional Health Authorities in British Columbia that govern, plan and deliver health-care services within their geographic areas. It is the most populated region in British Columbia and mostly urban.

Area	11,323 KM²
Population	1,872,476
Population density/km²	167.8 PERSONS/KM²

POLICY

POLICIES, STRUCTURES AND LAWS	PRESENCE
Designated office, secretariat or program responsible for palliative care	YES
A formal palliative care strategic plan, policy or framework	YES[1]
Standards and norms for palliative care	YES
Designated palliative care leads	YES

FORMAL STRATEGIES	PRESENCE
Home and community care	YES
Inpatient and outpatient hospital services (cancer and non-cancer)	YES
Long-term care facilities	YES
Rural and remote	YES
Paramedic/emergency services	YES

GOVERNMENT FUNDING	PRESENCE
Palliative home care services	PARTIAL[2]
Medications: In hospital	FULL[3]
Medications: Out of hospital	PARTIAL[3]
Supplies and equipment: In hospital	FULL
Supplies and equipment: Out of hospital	PARTIAL[3]
Continuing palliative care education in various settings	PARTIAL

Context:

[1]Regional strategy as well as provincial level strategy.

[2]Fraser Health provides short-term end-of-life home support. Home support hours are available at no charge for clients with a prognosis of less than 6 months and a functional status decline that requires personal assistance.

[3]British Columbia has provincial palliative care benefits (Plan P), which patients are eligible for with a prognosis of 6 months or less (including home care). Some items may not be covered, so alternate practices (e.g., special requests) are submitted. People in long-term care are eligible for Plan B. Fraser Health Authority covers equipment and supplies according to BC palliative benefits.

SERVICES

SETTING: ACUTE CARE

Hospitals

Access to specialist-level palliative care support teams	●●●●
Access to specialist-level palliative care support teams 24/7	●●●●
Funding models for palliative care physicians	SERVICE CONTRACTS

Context:

All hospitals within Fraser Health have full access to at least one palliative care team for support. Larger hospitals are equipped with dedicated palliative care teams, while smaller hospitals share teams that provide coverage across multiple facilities.

Palliative physicians covering the PCUs, hospitals and community are paid through service contracts, nursing and allied professionals through local operational budgets, and nurse practitioners through the regional budget.

Inpatient Units and Outpatient Clinics

Integration* in inpatient units	●○○○
Integration* in outpatient clinics—Cancer	●●●●
Integration* in outpatient clinics—Other**	●●○○ V

*Integration means services with core palliative care competencies providing primary or generalist level palliative care and collaborating closely with and referring to specialist palliative care teams when needed and in a timely manner.

**Cardiology, respirology, nephrology, and neurology.

Context:

There is very good integration in cancer and renal Clinics. Most of the cancer clinics are run by BC Cancer. The palliative care teams may provide care to oncology patients if needed. Palliative care education is available for cardiology, nephrology, and neurology as well as urgent care.

Palliative Care Units (PCUs)

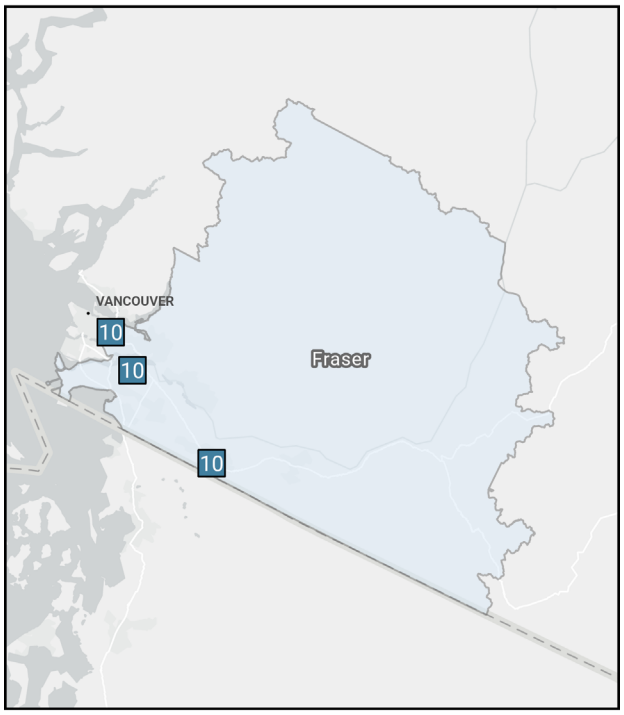
		NUMBER	ADEQUACY*	% OF TARGET BEDS
	Palliative care units (PCUs)	3		
	Palliative care unit beds	30	INADEQUATE	52.6%
	Other palliative care beds	0		
	Total palliative care beds	30	INADEQUATE	53.4%

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

Context:

The PCUs are all acute care.

Palliative Care Units in Fraser Region



Legend

- Major Cities

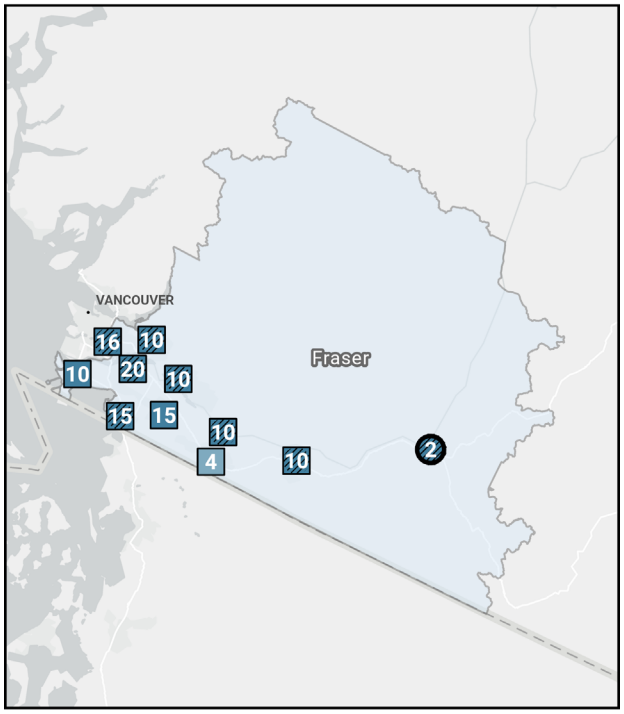
Facility, Type

- PCU, Acute
- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

Hospices in Fraser Region



Legend

- Major Cities

Facility, Patients, Location-type

- Hospice Residence, Adult, Stand-alone
- Hospice Residence, Adult, Co-located
- Hospice Residence, Pediatric, Stand-alone
- Other Hospice Beds, Adult, Co-located
- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

SETTING: COMMUNITY

Hospice Residences and Services

		RESPONSES	ADEQUACY*	% OF TARGET BEDS
	Hospice residences	10		
	Hospice beds in residences	120		
	Other hospice beds	2		
	Total hospice beds	122	ADEQUATE[1]	93.1%
	Standards/indicators for hospice residences	YES		
	Community hospice organizations**	12		

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

**This may not include all community organizations that provide hospice or palliative care-related services and support.

Context:

[1]The number of beds is technically below the 7 beds per 100,000 but we have considered it adequate for our study purposes.

A majority of the hospice residences are co-located, and the region has one pediatric hospice.

Total Number of Palliative Care Beds:

The total number of palliative care beds in the region (in hospitals and hospices) is 152, which is inadequate (80%) based on Fraser Health's total population.

COMMUNITY

Access to community specialist care teams	●●●●
Communities with 24/7 access to specialist palliative care teams	●●●●
Standards/indicators for access to community palliative care teams	YES
Models of practice of specialist palliative care teams	CONSULTATION/ SHARED CARE

Context:

The consult team of physicians and nurse practitioners is available 24/7 for other professionals, while the nurse clinicians (with palliative care certification or equivalent) provide 7-day/week daytime support in almost all communities. The rest of the consult team is available office hours on weekdays.

The provincial palliative care nurse-led phone line (housed within Fraser Health) is available after hours for patients, families and nurses. Physicians also have access to a specialist palliative care physician via a provincial on call support line. The palliative team may take over care if the patient is unattached.

Palliative Home Care

Availability of palliative home care nursing	●●●○[1]
Availability of 24/7 access	●○○○V[1]
Restrictions on coverage	YES[2]
Training of staff in palliative care approach available	YES

Context:

[1]Some restrictions apply, largely due to resource availability.

[2]In accordance with the regional palliative benefits plan (Plan P).

Palliative home care is provided through a generalist model in which general home care nursing teams provide palliative care with the support of specialist-level palliative care clinicians when needed.

There is variability across the region. Some communities have increased the number of community health nurses and allied health staff to provide more availability in the evenings and on weekends.

Primary Care

Overall provision of primary palliative care	●●●○V
Providing palliative care to ambulatory patients	●●●○
Providing palliative care home visits	●○○○
Clinics providing 24/7 on-call palliative care coverage	●○○○
Standards/indicators for overall provision of primary palliative care	NO
Training for primary care professionals on the palliative care approach available	YES

Context:

Primary care physicians across the region are expected to offer primary palliative care to their clinic patients. The palliative consult teams provide monthly education sessions for primary care professionals as needed.

Community health nurses are the patients' first point of contact. They are attached to three or four family physicians whose patients they are responsible for and can contact the family physician when needed. They are attached to family physician groups whose patients they are responsible for and they can contact the family physician as needed. They also provide virtual support and remote monitoring. The palliative consult team is contacted if the primary care physician cannot be reached, if the care exceeds the capacity of the physician, or through referrals to the consult team.

Home care and primary care professionals have in-person and virtual access to palliative care physicians/nurse practitioners and virtual access overnight/weekends (after hours availability is 5 p.m. to 8 a.m. daily).

The provincial palliative care nurse-led phone line is available after-hours for patients, families and nurses.

Rural and Remote Areas

Access to specialist palliative care teams	●●●●
Standards/indicators for access to primary palliative care	YES
Funding for education on the palliative care approach	YES
Training of physicians and primary care professionals on palliative care approach available	YES

Context:

There are no specific rural and remote care strategies. See Community and Rural and Primary Care for more information.

Paramedic Emergency Services

Training of paramedics in palliative care	PARTIAL - V

Context:

BC Emergency Health Services in the region have educated paramedics who can support palliative patients in their homes without transporting them to the ER (treat and release). Training includes using the patient's "green sleeve" health record, which contains the Advance Care Planning (ACP) details. Implementation can vary.

Long-Term Care (LTC)

Access to specialist palliative care services	●●●●
Integration of palliative care approach	●●●○ V
Standards and/or indicators for providing palliative care	YES[1]
Standards for training of staff on palliative care approach	YES
Training programs for staff on palliative care approach available	YES
Funding to provide palliative care education for staff	NO

Context:

[1]Regional level standards/indicators.

The Strengthening a Palliative Approach in Long-Term Care initiative is underway in partnership with the BCCPC.

Each LTC home is responsible for supporting the standards of care for patients and training staff under the direction of the regional Long-Term Care Network. All LTC homes in the region have access to the Palliative Consult Team.

ADVANCE CARE PLANNING

Advance Care Planning resources	YES

Context:

The Fraser Health Authority website contains resources such as workbooks, videos, conversation tips, information on legal options, responsibilities, life support interventions, and applicable medical orders. The provincial "Pathways" platform provides Advanced Care Planning resources for health care professionals.

SYSTEM PERFORMANCE

Each Health Authority has a "Health Care Report Card." These are published multiple times a year on key priority areas for the Ministry of Health and the Health Authorities. Some system performance indicators for British Columba and its health regions have been reported by the Canadian Institute for Health Information (CIHI) 2023 Palliative Care Report and by the Canadian Partnership Against Cancer (CPAC) in 2017.

EDUCATION

MEDICAL SCHOOLS

	UNIVERSITY OF BRITISH COLUMBIA (UBC): VANCOUVER-FRASER MEDICAL PROGRAM*
UNDERGRADUATE EDUCATION	
Inclusion of palliative care in undergraduate curriculum	CLASSROOM LEARNING: OPTIONAL CLINICAL ROTATION: OPTIONAL
POSTGRADUATE EDUCATION	
Palliative Care Residency Training Programs	
Royal College Subspecialty Certification in Palliative Medicine	YES – ADULT/PEDIATRICS
College of Family Physicians Certificate of Added Competence in Palliative Care	YES
OTHER SPECIALTY RESIDENCY TRAINING PROGRAMS	**PALLIATIVE CARE EDUCATION/EXPERIENCES**
Anesthesia	OPTIONAL: CLINICAL ROTATION
Cardiology	OPTIONAL: CLINICAL ROTATION
Critical care	OPTIONAL: CLINICAL ROTATION
Emergency medicine	OPTIONAL: CLINICAL ROTATION
Family medicine	MANDATORY: CLINICAL ROTATION
Geriatrics	OPTIONAL: CLINICAL ROTATION
Internal medicine	OPTIONAL: CLINICAL ROTATION
Neurology	OPTIONAL: CLINICAL ROTATION
Radiation oncology	OPTIONAL: CLINICAL ROTATION
Medical oncology	OPTIONAL: CLINICAL ROTATION
Psychiatry	OPTIONAL: CLINICAL ROTATION
Respirology	OPTIONAL: CLINICAL ROTATION
Surgery	OPTIONAL: CLINICAL ROTATION

*No information provided on classroom learning for palliative care in any of the Specialty Residency Training Programs

Context:

The University of British Columbia (UBC) has an academic campus in the Fraser Health Authority. Residents are distributed across all UBC academic sites and rotate across the sites. Residents across different specialty areas are also allocated to the different sites and may rotate across these. Recently, there has been an increase in the number of residency spots for the College of Family Physicians certificate of Added Competence specific to the region.

NURSING SCHOOLS

SCHOOLS	INCLUSION OF PALLIATIVE CARE IN UNDERGRADUATE PROGRAM (DIPLOMA/DEGREE PROGRAMS*)
British Columbia Institute of Technology (BCIT)	CLASSROOM LEARNING: OPTIONAL
Douglas College	INFORMATION NOT PROVIDED
Kwantleen Polytechnic U	INFORMATION NOT PROVIDED
Trinity Western U	INFORMATION NOT PROVIDED
University of Fraser Valley	CLASSROOM LEARNING: MANDATORY

*Refers to classroom learning; however, it does not address adequacy (number of hours or clinical versus classroom learning).

Context:

Across British Columbia, all undergraduate nurses are required to do mandatory palliative training as part of the nursing curriculum.

PROFESSIONAL ACTIVITIES

Existence of palliative care directory of services	YES
Dedicated resources to organize palliative care continuing professional development	YES
Palliative care conference/symposia regionally	YES
Active palliative care research	YES
Palliative care quality improvement initiatives	YES

Context:

Fraser Health organizes training and education sessions for nurses, physicians, and primary care professionals, including Pallium Canada's Palliative Care ECHO Project sessions, Pallium Canada's LEAP courses, huddles and journal clubs. There is a regional education day and a hospice education day. They have a very strong and robust quality improvement activities and agenda.

FOCUSED POPULATIONS

PEDIATRIC PALLIATIVE CARE

Formal strategy for pediatric palliative care	NO
Pediatric hospice residence(s)	YES
Outpatient palliative care program(s) for pediatric populations	YES
Respite pediatric palliative care (hospice or hospital setting)	YES
24/7 access to specialist pediatric palliative care team(s)	YES
Education program(s) for pediatric palliative care	NO

Context:

Access to pediatric palliative care is available through BC Children's Hospital and/or Canuck Place, a pediatric hospice in Abbottsford. See *Provincial Results* for more information.

OTHER FOCUSED POPULATIONS

POPULATION	FORMAL STRATEGY	PROGRAMS AND/OR INITIATIVES
2SLGBTQI+*	NO	NO
Homeless and marginally housed	NO	YES[1]
Incarcerated people (correctional facilities)	NO	NO[2]
Recent immigrants and refugees	NO	NO[3]

*Refers to Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex and additional people

Context:

[1]The palliative care team works collaboratively with the Fraser Health Integrated Homelessness Action Response Team (IHART).

[2]Access to palliative care is provided on an individual case-by-case basis to incarcerated people.

[3]All patients can access palliative care, regardless of immigration status.

COMMUNITY ENGAGEMENT

VOLUNTEERS

Formal strategy related to incorporating and/supporting volunteers	YES
Volunteer opportunities in palliative care	YES
Volunteer training activities in palliative care available	YES

COMMUNITY RESOURCES

Compassionate Community activities and other community engagement activities/ resources*	YES
Grief and bereavement services	YES
Formal strategy for support of informal caregivers	YES
Programs or initiatives for informal caregivers	YES

*e.g., death cafes, visiting programs, and support groups.

Context:

Hospice programs and community organizations in the region offer volunteer programs, volunteer training, grief and bereavement services and support for informal caregivers. Fraser Health provides each hospice society funding to help employ a volunteer coordinator who supports the recruitment, training and retention of volunteers.

Interior Health

DEMOGRAPHICS

Interior Health is one of five Regional Health Authorities in British Columbia that govern, plan and deliver health-care services within their geographic areas. The geography of this region includes large and small cities and many rural and remote communities.

Area	215, 422 KM²
Population	809,734
Population density/km²	3.8 PERSONS/KM²

POLICY

POLICIES, STRUCTURES AND LAWS	PRESENCE
Designated office, secretariat or program responsible for palliative care	YES
A formal palliative care strategic plan, policy or framework	YES[1]
Standards and norms for palliative care	YES
Designated palliative care leads	YES

FORMAL STRATEGIES	PRESENCE
Home and community care	YES
Inpatient and outpatient hospital services (cancer and non-cancer)	YES
Long-term care facilities	YES[1]
Rural and remote	NO
Paramedic/emergency services	YES[1]

GOVERNMENT FUNDING	PRESENCE
Palliative home care services	PARTIAL[2]
Medications: In hospital	FULL
Medications: Out of hospital	PARTIAL[2]
Supplies and equipment: In hospital	FULL
Supplies and equipment: Out of hospital	PARTIAL[2]
Continuing palliative care education in various settings	PARTIAL[3]

Context:

[1]Apply the provincial palliative care policies or strategies.

[2]British Columbia has provincial palliative care benefits (Plan P), which patients with a life-limiting condition are eligible for if they have a life expectancy of up to 6 months. Plan P provides 100% coverage of prescription and over-the-counter palliative medications on the Plan P formulary (some medications are not covered and special requests may be submitted) and coverage for some supplies and equipment. People in long-term care are eligible for Plan B.

[3]A legacy fund available for physicians in rural areas only.

SERVICES

SETTING: ACUTE CARE

Hospitals

Access to specialist-level palliative care support teams	●●○○
Access to specialist-level palliative care support teams 24/7	●●○○
Funding models for palliative care physicians	SERVICE CONTRACT

Context:

There are no specialist palliative care teams in the region's hospitals, except for in the regional cancer centre in Kelowna with one part-time physician. There is access to virtual consultation as needed, provided by two sessional groups of family physicians (not specialist level) and a provincial-led palliative care physician line for virtual consults 24/7. There are also two palliative care nurse specialists available for consultations during weekday office hours only.

Inpatient Units and Outpatient Clinics

Integration* in inpatient units	●○○○
Integration* in outpatient clinics—Cancer	●●○○[1]
Integration* in outpatient clinics—Other**	●○○○

*Integration means services with core palliative care competencies providing primary or generalist level palliative care and collaborating closely with and referring to specialist palliative care teams when needed and in a timely manner.

**Cardiology, respirology, nephrology, neurology.

Context:

[1]A palliative care specialist physician and two palliative care specialist nurses are available (part-time) at the regional cancer centre for consultations.

Overall, integration is absent or in the early stages of development.

Highlight:

There are some clinics that provide palliative care or have integrated palliative care as well. These include a specialist palliative care consultation in the Pain and Symptom Management Clinic at the Kelowna Cancer Center, a primary palliative care respiratory clinic, and the Pain and Symptom Clinic in Kamloops for non-malignant diseases. But these are limited to only one urban centre in the region.

Palliative Care Units (PCUs)

		NUMBER	ADEQUACY*	% OF TARGET BEDS
	Palliative care units (PCUs)	0		
	Palliative care unit beds	0	INADEQUATE	0%
	Other palliative care beds	0		
	Total palliative care beds	0		

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

Context:

There are no palliative care units.

Palliative Care Units in Interior Region

Legend

- Major Cities

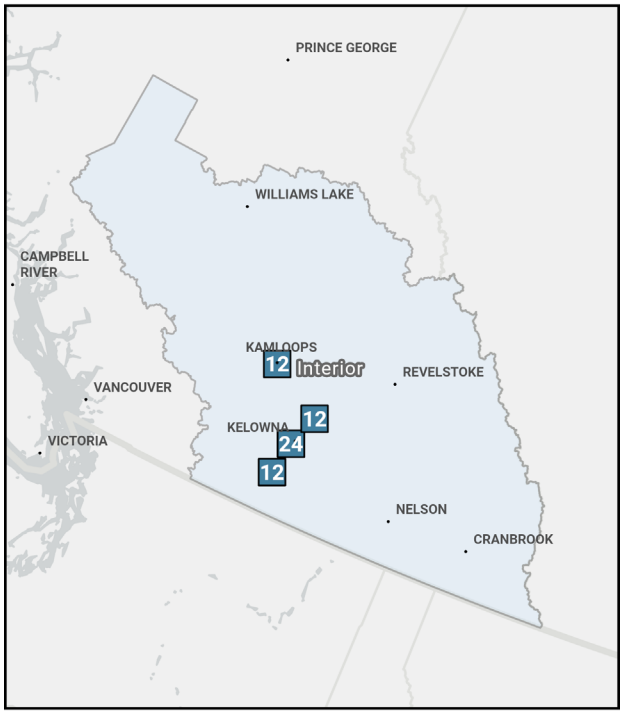
Facility, Type

- PCU, Acute
- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

Hospices in Interior Region



Legend

- Major Cities

Facility, Patients, Location-type

- Hospice Residence, Adult, Stand-alone
- Hospice Residence, Adult, Co-located
- Hospice Residence, Pediatric, Stand-alone
- Other Hospice Beds, Adult, Co-located
- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

SETTING: COMMUNITY

Hospice Residences and Services

		RESPONSES	ADEQUACY*	% OF TARGET BEDS
	Hospice residences	4		
	Hospice beds in residences	60	ADEQUATE[1]	
	Other hospice beds	19[2]		
	Total hospice beds	79		
	Standards/indicators for hospice residences	YES		
	Community hospice organizations**	28		

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

**This may not include all community organizations that provide hospice or palliative care-related services and support.

Context:

[2]There are 19 designated hospice beds located within long-term care homes, which were closed during the COVD-19 pandemic and have not been reinstated. Designated beds can be used for other purposes and admission for palliative care is not guaranteed.

Not all hospices are owned and operated by the Health Authority. All hospices are free-standing residences.

Total Palliative Care Beds:

In total, there are 79 palliative care beds (PCU or hospice); however, only 60 beds are dedicated. Therefore, the number of beds in inadequate (74.1%) for Interior's population.

Community

Access to community specialist care teams	●●○○
Communities with 24/7 access to specialist palliative care teams	●●○○
Standards/indicators for access to community palliative care teams	NO
Models of practice of specialist palliative care teams	CONSULTATIONS

Context:

Virtual consultation support is provided by two groups of family physicians with palliative care experience (one group in Kamloops and another group in Kelowna, not specialist level) who provide 24/7 consults to hospital- and community-based clinicians in their respective regions.

Specialist support is available through the provincial, physician-led palliative care call (24/7). Patients, families and other health care professionals have access to a provincial, nurse-led palliative care call line.

Palliative Home Care

Availability of palliative home care nursing	●●●○[1]
Availability of 24/7 access	●●○○[1]
Restrictions on coverage	YES[2]
Training of staff in palliative care approach available	YES[3]

Context:

[1]Access is more challenging in rural and remote regions where access, geography, critical mass and workforce shortages are barriers. Access 24/7 is challenging across the region.

[2]Can be activated at 6 months prior to death in accordance with the regional palliative benefits plan (Plan P).

[3]There are continuing education programs for home care professionals. Examples include Pallium Canada's LEAP courses, Palliative Education for Health Care Assistants (acute, community, long-term care, etc.), and the Serious Illness Conversation Guide.

Primary Care

Overall provision of primary palliative care	●●●○ V
Providing palliative care to ambulatory patients	●●●○[1]
Providing palliative care home visits	INFORMATION NOT PROVIDED
Clinics providing 24/7 on-call palliative care coverage	INFORMATION NOT PROVIDED
Standards/indicators for overall provision of primary palliative care	NO
Training for primary care professionals on the palliative care approach available	PARTIAL[2]

Context:

[1]Many primary care professionals in the region, particularly in small towns, offer home visits to their own patients, have call groups, and may provide 24/7 service; however, the extents of these services are unknown. The region has many unattached patients.

[2]There are palliative care education/training programs for primary care health care professionals. Training may be covered for physicians if located in a rural area.

Rural and Remote Areas

Access to specialist palliative care teams	●●○○[1]
Standards/indicators for access to primary palliative care	NO
Funding for education on the palliative care approach	YES
Training of physicians and primary care professionals on palliative care approach available	YES

Context:

[1]There is virtual access to palliative care support through two groups of family physicians and the nursing consultation line, as well as the provincial physician-led palliative care line (see prior section related to access to specialist palliative care services in the community).

Initiative underway to address palliative care delivery in remote areas. There is a legacy fund available for physicians in rural areas for education.

Long-Term Care (LTC)

Access to specialist palliative care services	●●○○[1]
Integration of palliative care approach	●●○○
Standards and/or indicators for providing palliative care	YES
Standards for training of staff on palliative care approach	YES
Training programs for staff on palliative care approach available	YES
Funding to provide palliative care education for staff	NO

Context:

[1]All LTC facilities have 24/7 in-person access to family doctors who may have basic knowledge of palliative care, two clinical nurse specialists who are available in the daytime for phone consultations, and after-hours nursing support is available through the provincial palliative care nursing line. Though, these services are not widely accessed. Funding for palliative care education is available.

Paramedic Emergency Services

Training of paramedics in palliative care	PARTIAL - V

Context:

There is no regional level training. The BC Emergency Health Services has the ASTaR project provides advanced paramedic care for palliative patients through 911 calls. Within Interior Health, home care identifies palliative clients and links them with community paramedics in rural and remote places. Implementation varies across the region. Community paramedics participate in the Interior Palliative Care rounds (see *Other Activities*).

Advance Care Planning

Advance Care Planning resources	YES

Context:

Resources are available for staff and the public, including a locally developed Advance Care Planning document, My Advance Care Plan.

SYSTEM PERFORMANCE

Each Health Authority has a "Health Care Report Card." These are published multiple times a year on key priority areas for the Ministry of Health and the Health Authorities. Some system performance indicators for British Columba and its health regions have been reported by the Canadian Institute for Health Information (CIHI) 2023 Palliative Care Report and by the Canadian Partnership Against Cancer (CPAC) in 2017.

EDUCATION

MEDICAL SCHOOLS

	THE UNIVERSITY OF BRITISH COLUMBIA - SOUTHERN MEDICAL PROGRAM
UNDERGRADUATE EDUCATION	
Inclusion of palliative care in undergraduate curriculum	CLASSROOM LEARNING: OPTIONAL CLINICAL ROTATION: OPTIONAL
POSTGRADUATE EDUCATION	
Palliative Care Residency Training Programs	
Royal College Subspecialty Certification in Palliative Medicine	NO PROGRAM
College of Family Physicians Certificate of Added Competence in Palliative Care	NO PROGRAM

OTHER SPECIALTY RESIDENCY TRAINING PROGRAMS	PALLIATIVE CARE EDUCATION/EXPERIENCES
Anesthesia	NOT APPLICABLE
Cardiology	NOT APPLICABLE
Critical care	NOT APPLICABLE
Emergency medicine	NOT APPLICABLE
Family medicine	NOT APPLICABLE
Geriatrics	NOT APPLICABLE
Internal medicine	NOT APPLICABLE
Neurology	NOT APPLICABLE
Radiation oncology	NOT APPLICABLE
Medical oncology	NOT APPLICABLE
Psychiatry	NOT APPLICABLE
Respirology	NOT APPLICABLE
Surgery	NOT APPLICABLE

NURSING SCHOOLS

SCHOOLS	INCLUSION OF PALLIATIVE CARE IN UNDERGRADUATE PROGRAM (DIPLOMA/DEGREE PROGRAMS*)
University of British Columbia Okanagan	MANDATORY
College of the Rockies	NO INFORMATION PROVIDED
Selkirk College	NO INFORMATION PROVIDED
Thompson Rivers University	NO INFORMATION PROVIDED
Okanagan College	NO INFORMATION PROVIDED

*Refers to classroom learning; however, it does not address adequacy (number of hours or clinical versus classroom learning).

PROFESSIONAL ACTIVITIES

Existence of palliative care directory of services	YES
Dedicated resources to organize palliative care continuing professional development	YES[1]
Palliative care conference/symposia regionally	NO[2]
Active palliative care research	YES
Palliative care quality improvement initiatives	YES

Context:

[1]Throughout Interior Health, there are regular regional clinical palliative care rounds. See Other Activities for more information.

[2]A provincial level conference available to staff.

FOCUSED POPULATIONS

PEDIATRIC PALLIATIVE CARE

Formal strategy for pediatric palliative care	NO
Pediatric hospice residence(s)	NO
Outpatient palliative care program(s) for pediatric populations	NO
Respite pediatric palliative care (hospice or hospital setting)	NO
24/7 access to specialist pediatric palliative care team(s)	YES
Education program(s) for pediatric palliative care	YES

Context:

Access to virtual pediatric palliative care support is available through the BC Children's Hospital/Canuck Place Consult Team if needed. See *Provincial Results* for more information.

OTHER FOCUSED POPULATIONS

POPULATION	FORMAL STRATEGY	PROGRAMS AND/OR INITIATIVES
2SLGBTQI+*	NO	NO
Homeless and marginally housed	NO	NO
Incarcerated people (correctional facilities)	NO	NOT APPLICABLE
Recent immigrants and refugees	NO	NO

*Refers to Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex and additional people.

COMMUNITY ENGAGEMENT

VOLUNTEERS

Formal strategy related to incorporating and/supporting volunteers	NO
Volunteer opportunities in palliative care	YES[1]
Volunteer training activities in palliative care available	YES[1]

COMMUNITY RESOURCES

Compassionate Community activities and other community engagement activities/ resources*	YES[2]
Grief and bereavement services	YES
Formal strategy for support of informal caregivers	NO
Programs or initiatives for informal caregivers	YES[3]

*e.g., death cafes, visiting programs, and support groups.

Context:

[1]There are provincial volunteer standards for hospice palliative care.

[2]Through hospices and community organizations or provincial organizations.

[3]Programs and education for informal caregivers are offered through community or provincial organizations.

OTHER ACTIVITIES

Highlight:

There are Whole Community Palliative Care Rounds held weekly across Interior Health, based on a hub and multiple spokes model. The team consists of home health, long-term care, acute care, all disciplines, physicians, community paramedics, hospice societies, hospice volunteers, and palliative clinical nurse specialists. A local facilitator(s) leads the discussion of a palliative care case. The Health Authority has developed guidelines to facilitate these rounds.

Island Health

DEMOGRAPHICS

Island Health Authority is responsible for delivering health and care services across Vancouver Island, a large island located off the west coast of Canada with about 100 communities. These communities are urban, rural and remote communities.

Area	54,564 KM²
Population	840,284
Population density/km²	15.4 PERSONS/KM²

POLICY

POLICIES, STRUCTURES AND LAWS	PRESENCE
Designated office, secretariat or program responsible for palliative care	YES
A formal palliative care strategic plan, policy or framework	YES[1]
Standards and norms for palliative care	YES
Designated palliative care leads	YES

FORMAL STRATEGIES	PRESENCE
Home and community care	YES
Inpatient and outpatient hospital services (cancer and non-cancer)	NO[2]
Long-term care facilities	YES
Rural and remote	NO[2]
Paramedic/emergency services	YES

GOVERNMENT FUNDING	PRESENCE
Palliative home care services	PARTIAL[3]
Medications: In hospital	FULL
Medications: Out of hospital	PARTIAL[3]
Supplies and equipment: In hospital	FULL
Supplies and equipment: Out of hospital	PARTIAL[3]
Continuing palliative care education in various settings	PARTIAL[4]

Context:

[1]Island Health Authority plan as well as applying the provincial palliative care policy.

[2]New strategic plan in development.

[3]British Columbia has provincial palliative care benefits (Plan P), which patients are eligible for with a prognosis of 6 months or less (including home care). Some things may not be covered so alternate practices (e.g., special requests) are submitted. People in long-term care are eligible for Plan B.

[4]Island Health has an education framework and offers educational opportunities to staff in all care settings. The health authority also provides funding to hospices who provide education.

SERVICES

SETTING: ACUTE CARE

Hospitals

Access to specialist-level palliative care support teams	●●●○
Access to specialist-level palliative care support teams 24/7	●●●○
Funding models for palliative care physicians	SERVICE CONTRACTS

Context:

Most hospitals have access to specialist palliative care teams. There are access gaps in some rural and remote regions. Physicians and nurse practitioners also have access to the provincial physician-led palliative care call line.

Inpatient Units and Outpatient Clinics

Integration* in inpatient units	●○○○
Integration* in outpatient clinics—Cancer	●○○○
Integration* in outpatient clinics—Other**	●○○○

*Integration means services with core palliative care competencies providing primary or generalist level palliative care and collaborating closely with and referring to specialist palliative care teams when needed and in a timely manner.

**Cardiology, respirology, nephrology, and neurology.

Context:

There is little integration of palliative care into inpatient and outpatient clinics in this region.

Palliative Care Units (PCUs)

		NUMBER	ADEQUACY*	% OF TARGET BEDS
	Palliative care units (PCUs)	3		
	Palliative care unit beds	0	INADEQUATE	0%
	Other palliative care beds	37 - V		
	Total palliative care beds	37 - V		

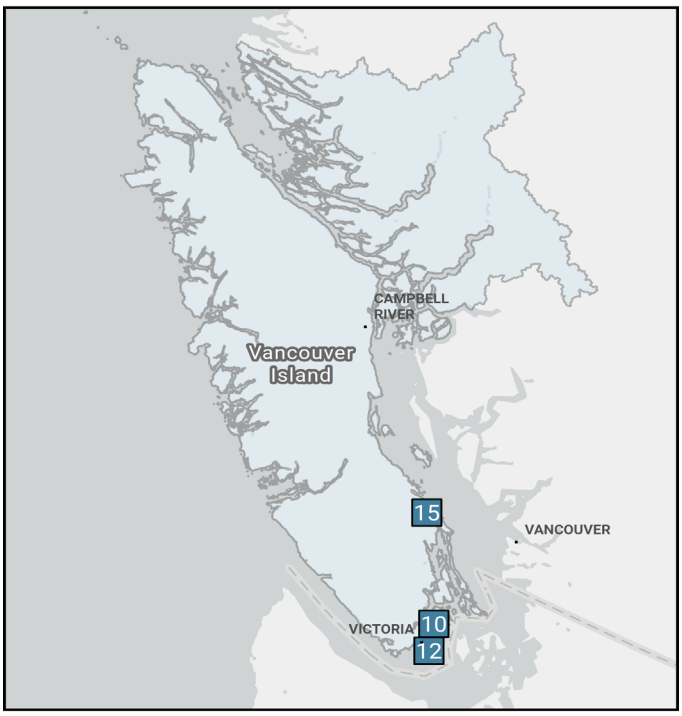
*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

Context:

All PCUs are end-of-life, and none of them are dedicated beds, meaning hospitals can use the beds as they see fit, including redeploying staff as needed. Palliative care admissions must be negotiated with management, and it can be difficult to retain staff with palliative care expertise. The number of beds available for palliative care admissions is therefore Variable and overall inadequate for population needs. Only 34 are publicly funded.

Based on the population size of Island Health, there should be at least 25 dedicated PCU beds.

Palliative Care Units in Island Region



Legend

- Major Cities

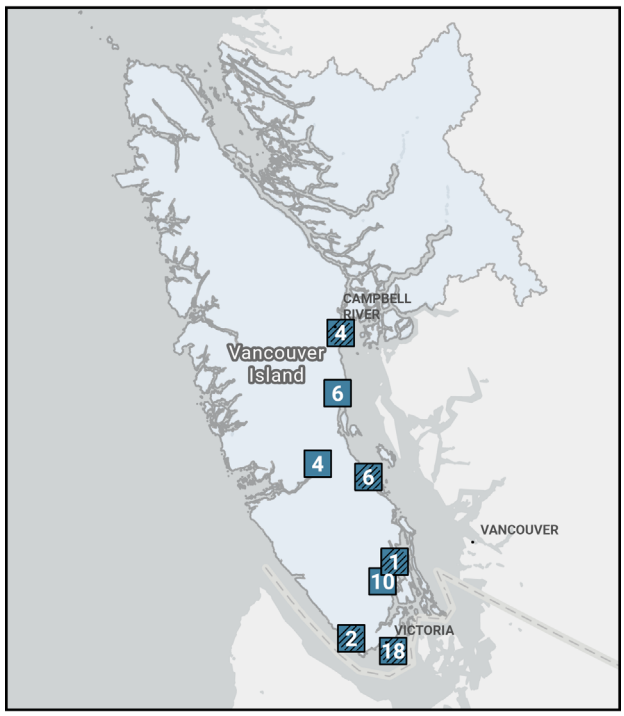
Facility, Type

- PCU, Acute
- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

Hospices in Island Region



Legend

- Major Cities

Facility, Patients, Location-type

- Hospice Residence, Adult, Stand-alone
- Hospice Residence, Adult, Co-located
- Hospice Residence, Pediatric, Stand-alone
- Other Hospice Beds, Adult, Co-located
- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

SETTING: COMMUNITY

Hospice Residences and Services

		RESPONSES	ADEQUACY*	% OF TARGET BEDS
	Hospice residences	8		
	Hospice beds in residences	51		
	Other hospice beds	0		
	Total hospice beds	51	INADEQUATE	86.7%
	Standards/indicators for hospice residences	YES		
	Community hospice organizations**	12		

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

**This may not include all community organizations that provide hospice or palliative care-related services and support.

Context:

The region has established hospice bed criteria and access guidelines. Some hospice residences are stand alone and others are co-located with long-term care. All hospices are for adults.

Total Palliative Care Beds:

The total number of palliative care beds (PCU and hospice beds) for the region is 88; however, only 51 of those beds are dedicated. Therefore, the palliative care beds are inadequate (60.7%) for the region's population.

Community

Access to community specialist care teams	●●●○[1]
Communities with 24/7 access to specialist palliative care teams	●●○○[2]
Standards/indicators for access to community palliative care teams	NO
Models of practice of specialist palliative care teams	CONSULTATION[3]/SHARED CARE

Context:

[1]All communities have virtual access to a specialist palliative care team (includes a physician, nurse, or social worker) through a regional phone support line. A nurse consultant and physician are accessible between 8 a.m. and 10 p.m.

[2]One community has a hospice palliative response team that is available 24/7. Outside of that community, physicians and nurses in other communities can access the provincial physician-led palliative care call line.

[3]A palliative care physician may manage the patient's care (take over) if the patient is house bound and does not have a primary care physician.

Palliative Home Care

Availability of palliative home care nursing	●●●○[1]
Availability of 24/7 access	●○○○
Restrictions on coverage	YES[2]
Training of staff in palliative care approach available	YES[3]

Context:

[1]Can be activated up to 6 months prior to death in accordance with the provincial palliative benefits plan (Plan P).

[2]There are logistic challenges with reaching rural and remote communities to provide home care services and consultations are usually virtual. Almost none of the region has access to 24/7 home care. One area provides increased overnight nursing services for patients in the last 3 months of life.

[3]All home care staff receive training as part of their orientation.

Primary Care

Overall provision of primary palliative care	●○○○V
Providing palliative care to ambulatory patients	●●○○
Providing palliative care home visits	●○○○
Clinics providing 24/7 on-call palliative care coverage	●○○○
Standards/indicators for overall provision of primary palliative care	NO
Training for primary care professionals on the palliative care approach available	YES[1]

Context:

[1]Island Health has an education framework and offers educational opportunities to staff in all care settings; however, the frequency of the offers varies from year to year.

Family physicians and nurse practitioners have access to a physician-led provincial consultation line. Most patients who have a primary care physician or nurse practitioner will have primary palliative care provided to them by this clinician. However, gaps exist for patients who do not have a primary care physician or nurse practitioner.

Rural and Remote Areas

Access to specialist palliative care teams	●●●○[1]
Standards/indicators for access to primary palliative care	NO
Funding for education on the palliative care approach	NO
Training of physicians and primary care professionals on palliative care approach available	YES[2]

Context:

[1]Access to specialist palliative care is mostly virtual, but some areas have in-person access.

[2]Island Health has an education framework and offers educational opportunities to staff in all care settings, with variable spread at this time.

Long-Term Care (LTC)

Access to specialist palliative care services	●●○○
Integration of palliative care approach	●●○○
Standards and/or indicators for providing palliative care	YES
Standards for training of staff on palliative care approach	PARTIAL
Training programs for staff on palliative care approach available	PARTIAL[1]
Funding to provide palliative care education for staff	NO

Context:

[1]Island Health has an education framework and offers educational opportunities to staff in all Island Health care settings. Privately operated LTC is not included in this.

Island Health has an Integration of a Palliative Care Approach strategy. LTC has daytime access to palliative consultation teams in their communities. There has been a decline in the integration of palliative care into LTC homes post-COVID, and work is ongoing to address this.

Paramedic Emergency Services

Training of paramedics in palliative care	NO

Context:

BC Emergency Health Services has offered training to paramedics to support palliative patients in their homes without transporting them to the ER (treat and release). The uptake of this has been low in this region.

Advance Care Planning

Advance Care Planning resources	YES

Context:

The provincial "Pathways" platform provides Advanced Care Planning resources for health care professionals.

SYSTEM PERFORMANCE

Each Health Authority has a "Health Care Report Card." These are published multiple times a year on key priority areas for the Ministry of Health and the Health Authorities. Some system performance indicators for British Columba and its health regions have been reported by the Canadian Institute for Health Information (CIHI) 2023 Palliative Care Report and by the Canadian Partnership Against Cancer (CPAC) in 2017.

EDUCATION

MEDICAL SCHOOLS

	UNIVERSITY OF BRITISH COLUMBIA (UBC): ISLAND MEDICAL PROGRAM
UNDERGRADUATE EDUCATION	
Inclusion of palliative care in undergraduate curriculum	MANDATORY: CLASSROOM LEARNING
POSTGRADUATE EDUCATION	
Palliative Care Residency Training Programs	
Royal College Subspecialty Certification in Palliative Medicine	THROUGH THE UBC PROGRAM. RESIDENTS MAY DO ROTATIONS IN VICTORIA.
College of Family Physicians Certificate of Added Competence in Palliative Care	SAME AS ABOVE

OTHER SPECIALTY RESIDENCY TRAINING PROGRAMS	PALLIATIVE CARE EDUCATION/EXPERIENCES
Anesthesia	NOT APPLICABLE
Cardiology	NOT APPLICABLE
Critical care	NOT APPLICABLE
Emergency medicine	OPTIONAL: CLINICAL ROTATION
Family medicine	MANDATORY: CLINICAL ROTATION
Geriatrics	NOT APPLICABLE
Internal medicine	OPTIONAL: CLINICAL ROTATION
Neurology	NOT APPLICABLE
Radiation oncology	MANDATORY: CLINICAL ROTATION
Medical oncology	NOT APPLICABLE
Psychiatry	NOT APPLICABLE
Respirology	NOT APPLICABLE
Surgery	NOT APPLICABLE

NURSING SCHOOLS

SCHOOLS	INCLUSION OF PALLIATIVE CARE IN UNDERGRADUATE PROGRAM (DIPLOMA/ DEGREE PROGRAMS*)
University of Victoria/Camosun College	OPTIONAL: CLASSROOM LEARNING
Vancouver Island University	NO INFORMATION PROVIDED
North Island College	NO INFORMATION PROVIDED

*Refers to classroom learning; however, it does not address adequacy (number of hours or clinical versus classroom learning).

PROFESSIONAL ACTIVITIES

Existence of palliative care directory of services	NO
Dedicated resources to organize palliative care continuing professional development	YES
Palliative care conference/symposia regionally	YES
Active palliative care research	YES
Palliative care quality improvement initiatives	YES

FOCUSED POPULATIONS

PEDIATRIC PALLIATIVE CARE

Formal strategy for pediatric palliative care	NO[1]
Pediatric hospice residence(s)	NO
Outpatient palliative care program(s) for pediatric populations	PARTIAL[2]
Respite pediatric palliative care (hospice or hospital setting)	NO
24/7 access to specialist pediatric palliative care team(s)	YES
Education program(s) for pediatric palliative care	NO

Context:

[1]A formal strategy and pathway for pediatric palliative care is in development.

[2]Adult palliative care teams and community health nurses will see children as needed

Access to virtual pediatric palliative care support is available through the BC Children's Hospital/Canuck Place Consult Team if needed. Pediatric patients can receive hospice and respite care at Canuck Place. See *Provincial Results* for more information.

OTHER FOCUSED POPULATIONS

POPULATION	FORMAL STRATEGY	PROGRAMS AND/OR INITIATIVES
2SLGBTQI+*	NO	NO
Homeless and marginally housed	NO	YES[1]
Incarcerated people (correctional facilities)	NO	YES
Recent immigrants and refugees	NO	NO[2]

*Refers to Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex and additional people

Context:

[1]The Palliative Outreach Resource Team (PORT) is a service of the ePAC (Equity in Palliative Approaches to Care - a collaboration of Island Health, the University of Victoria, and Victoria Cool Aid Society) for people who may have difficulty accessing palliative support and services because of poverty, homelessness, lack of social support, racialization, stigma and discrimination; and are living in the Victoria area.

[2]Programs, education and support for informal caregivers offered through the health authority via a virtual caregiver support program as well as other community or provincial organizations.

Highlight:

The work with the structurally vulnerable and marginalized populations through the PORT team is an example of excellence in Island Health, and the region aims to spread similar participatory actions and community engagement across the island to develop a network of services within various communities that provide palliative care support.

COMMUNITY ENGAGEMENT

VOLUNTEERS

Formal strategy related to incorporating and/supporting volunteers	YES
Volunteer opportunities in palliative care	YES
Volunteer training activities in palliative care available	YES[1]

COMMUNITY RESOURCES

Compassionate Community activities and other community engagement activities/ resources*	YES
Grief and bereavement services	YES
Formal strategy for support of informal caregivers	YES
Programs or initiatives for informal caregivers	YES[2]

*e.g., death cafes, visiting programs, and support groups.

Context:

[1]Vancouver Island Federation of Hospices (VIFOH) facilitates the training of volunteers with integration in all care settings.

[2]Programs, education and support for informal caregivers are offered through the health authority via a virtual caregiver support program as well as other community or provincial organizations.

Northern Health

DEMOGRAPHICS

Northern Health is one of five Regional Health Authorities in British Columbia that govern, plan and deliver health-care services within their geographic areas. It is the largest health authority in physical size. Due to its size, the region has a large number of rural and remote communities, and one large urban community. The communities range from a few hundred people to about 80,000 people in the largest community (i.e., Prince George).

Area	560,736 KM²
Population	280,368
Population density/km²	0.5 PERSONS/KM²

POLICY

POLICIES, STRUCTURES AND LAWS	PRESENCE
Designated office, secretariat or program responsible for palliative care	YES
A formal palliative care strategic plan, policy or framework	YES[1]
Standards and norms for palliative care	YES
Designated palliative care leads	YES

FORMAL STRATEGIES	PRESENCE
Home and community care	YES
Inpatient and outpatient hospital services (cancer and non-cancer)	YES
Long-term care facilities	YES
Rural and remote	YES
Paramedic/emergency services	YES

GOVERNMENT FUNDING	PRESENCE
Palliative home care services	PARTIAL[2]
Medications: In hospital	FULL
Medications: Out of hospital	PARTIAL[2]
Supplies and equipment: In hospital	FULL
Supplies and equipment: Out of hospital	PARTIAL[2]
Continuing palliative care education in various settings	PARTIAL

Context:

[1]Northern Health Plan as well as applying the provincial palliative care policy.

[2]British Columbia has provincial palliative care benefits (Plan P), which patients are eligible for with a prognosis of 6 months or less (including home care). Some things may not be covered so alternate practices (e.g., special requests) are submitted. People in long-term care are eligible for Plan B.

SERVICES

SETTING: ACUTE CARE

Hospitals

Access to specialist-level palliative care support teams	●●●○[1]
Access to specialist-level palliative care support teams 24/7	●●●○[1]
Funding models for palliative care physicians	MEDICAL ON CALL AVAILABILITY PROGRAM[2]

Context:

[1]There is a Palliative Care Consultation Team (physicians, a pharmacist, and nurse consultants) who provide virtual support throughout the region (and in-person support in one community). The on-call physician is available 24/7 to support physicians and nurse practitioners. The nurse consultants and the pharmacist are available to nurses, social workers, and other community members during the day on weekdays. Physicians and nurse practitioners also have access to the provincial physician-led palliative care call line.

[2]The Palliative Care Consultation Teams are funded by the health authority through the Medical on Call Availability Program and sessional contracts for consultation time.

Inpatient Units and Outpatient Clinics

Integration* in inpatient units	●○○○
Integration* in outpatient clinics—Cancer	●○○○
Integration* in outpatient clinics—Other**	●○○○

*Integration means services with core palliative care competencies providing primary or generalist level palliative care and collaborating closely with and referring to specialist palliative care teams when needed and in a timely manner.

**Cardiology, respirology, nephrology, and neurology.

Context:

The BC Cancer Centre clinic in the region has higher levels of integration than the regional clinics.

Palliative Care Units (PCUs)

		NUMBER	ADEQUACY*	% OF TARGET BEDS
	Palliative care units (PCUs)	0		
	Palliative care unit beds	0	INADEQUATE	0%
	Other palliative care beds	13		
	Total palliative care beds	13		

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

Context:

Northern Health does not have a palliative care unit, only designated palliative care beds within hospitals (13 beds in 11 hospitals). Designated beds can be used for other purposes and admission for palliative care is not guaranteed.

Palliative Care Units in Northern Region

Legend

- Major Cities

Facility, Type

- PCU, Acute
- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

Hospices in Northern Region

Legend

- Major Cities

Facility, Patients, Location-type

- Hospice Residence, Adult, Stand-alone
- Hospice Residence, Adult, Co-located
- Hospice Residence, Pediatric, Stand-alone
- Other Hospice Beds, Adult, Co-located
- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

SETTING: COMMUNITY

Hospice Residences and Services

		RESPONSES	ADEQUACY*	% OF TARGET BEDS
	Hospice residences	1		
	Hospice beds in residences	10	INADEQUATE	51.0%
	Other hospice beds	12 – V		
	Total hospice beds	22 - V		
	Standards/indicators for hospice residences	NO		
	Community hospice organizations**	9		

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

**This may not include all community organizations that provide hospice or palliative care-related services and support.

Context:

Six long-term care homes have designated hospice beds (up to 12 beds total), which are available to both people admitted into the long-term care home requiring hospice care and community admissions hospice care. Designated beds can be used for other purposes and admission for palliative care is not guaranteed.

Due to the population distribution of the region, distributing hospice beds across the region is more useful than having standalone hospice residences.

Total Palliative Care Beds:

In total, there are 35 palliative care beds (PCU and hospice); however, only 10 of those beds are dedicated. Therefore, for the region's population, the number of beds is inadequate (35.7%).

Community

Access to community specialist care teams	●●○○ V[1]
Communities with 24/7 access to specialist palliative care teams	●●○○ V[1]
Standards/indicators for access to community palliative care teams	YES
Models of practice of specialist palliative care teams	CONSULTATION[2]

Context:

[1]The Palliative Care Consultation Team (physicians, a pharmacist, and nurse consultants) provides virtual support throughout the region (and in-person support in one community). The on-call physician is available 24/7 on-call support to physicians and nurse practitioners. The nurse consultants and pharmacist are available to nurses, social workers, and other community members during the day on weekdays. Physicians and nurse practitioners also have access to the provincial physician-led palliative care call line. One community (the main urban centre) has in-person support but only part-time.

[2]Very rarely the Takeover model is used.

Palliative Home Care

Availability of palliative home care nursing	●●●○ V[1]
Availability of 24/7 access	●●○○ [2]
Restrictions on coverage	YES[1]
Training of staff in palliative care approach available	YES[3]

Context:

[1]Can be activated 6 months prior to death in accordance with the regional palliative benefits plan (Plan P). Mostly daytime availability, however, some regions only have access a couple days a week per week. The provincial palliative care nurse-led phone line is available after hours for patients, families and nurses.

[2]Limited by large rural and remote geography and sparse population dispersion.

[3]Pallium Canada's LEAP courses, Kath Murray's Life and Death Matters, and Pallium Canada's Palliative Care ECHO Project offerings are provided to staff.

Primary Care

Overall provision of primary palliative care	●●●○ V
Providing palliative care to ambulatory patients	●●●○
Providing palliative care home visits	●●○○ V
Clinics providing 24/7 on-call palliative care coverage	●●○○
Standards/indicators for overall provision of primary palliative care	YES
Training for primary care professionals on the palliative care approach available	NO

Context:

Some primary care clinics provide on-call coverage, especially in smaller communities. Patients are encouraged to call the provincial nurse-led palliative care call line first.

Rural and Remote Areas

Access to specialist palliative care teams	●●●○
Standards/indicators for access to primary palliative care	YES[1]
Funding for education on the palliative care approach	NO
Training of physicians and primary care professionals on palliative care approach available	YES

Context:

[1]Northern Health specific standards and indicators.

Long-Term Care (LTC)

Access to specialist palliative care services	●●○○
Integration of palliative care approach	●○○○
Standards and/or indicators for providing palliative care	YES[1]
Standards for training of staff on palliative care approach	YES[2]
Training programs for staff on palliative care approach available	YES
Funding to provide palliative care education for staff	YES

Context:

[1]The Northern Health Authority has a regional specific standards/indicator for palliative care in LTC.

[2]Pallium Canada's LEAP courses, Kath Murray's Life and Death Matters, and Pallium Canada's Palliative Care ECHO Project offerings are provided to staff.

Paramedic Emergency Services

Training of paramedics in palliative care	PARTIAL - V

Context:

There is no regional level training. The BC Emergency Health Services has the ASTaR project provides advanced paramedic care for palliative patients through 911 calls. Implementation varies across the region.

Advance Care Planning

Advance Care Planning resources	YES

Context:

The provincial "Pathways" platform provides Advanced Care Planning resources for health care professionals.

SYSTEM PERFORMANCE

Each Health Authority has a "Health Care Report Card." These are published multiple times a year on key priority areas for the Ministry of Health and the Health Authorities. Some system performance indicators for British Columba and its health regions have been reported by the Canadian Institute for Health Information (CIHI) 2023 Palliative Care Report and by the Canadian Partnership Against Cancer (CPAC) in 2017.

EDUCATION

MEDICAL SCHOOLS

	UNIVERSITY OF BRITISH COLUMBIA - NORTHERN MEDICAL PROGRAM
UNDERGRADUATE EDUCATION	
Inclusion of palliative care in undergraduate curriculum	NOT APPLICABLE
POSTGRADUATE EDUCATION	
Palliative Care Residency Training Programs	
Royal College Subspecialty Certification in Palliative Medicine	NOT APPLICABLE
College of Family Physicians Certificate of Added Competence in Palliative Care	NOT APPLICABLE

OTHER SPECIALTY RESIDENCY TRAINING PROGRAMS	PALLIATIVE CARE EDUCATION/EXPERIENCES
Anesthesia	NOT APPLICABLE
Cardiology	NOT APPLICABLE
Critical Care	NOT APPLICABLE
Emergency medicine	NOT APPLICABLE
Family medicine	EXPERIENTIAL: LONGITUDINAL EXPOSURE THROUGH RESIDENCY
Geriatrics	NOT APPLICABLE
Internal medicine	NOT APPLICABLE
Neurology	NOT APPLICABLE
Radiation oncology	NOT APPLICABLE
Medical oncology	NOT APPLICABLE
Psychiatry	NOT APPLICABLE
Respirology	NOT APPLICABLE
Surgery	NOT APPLICABLE

Context:

The Northern Medical Program does not have residency spots within Northern Health, except for family medicine.

NURSING SCHOOLS

SCHOOLS	INCLUSION OF PALLIATIVE CARE IN UNDERGRADUATE PROGRAM (DIPLOMA/DEGREE PROGRAMS*)
University of Northern British Columbia	OPTIONAL: CLASSROOM LEARNING
College of New Caledonia	INFORMATION NOT PROVIDED
Coast Mountain College	INFORMATION NOT PROVIDED
Northern Lights College	INFORMATION NOT PROVIDED

*Refers to classroom learning; however, it does not address adequacy (number of hours or clinical versus classroom learning).

PROFESSIONAL ACTIVITIES

Existence of palliative care directory of services	YES
Dedicated resources to organize palliative care continuing professional development	YES
Palliative care conference/symposia regionally	NO
Active palliative care research	YES
Palliative care quality improvement initiatives	YES

FOCUSED POPULATIONS

PEDIATRIC PALLIATIVE CARE

Formal strategy for pediatric palliative care	NO
Pediatric hospice residence(s)	NO
Outpatient palliative care program(s) for pediatric populations	NO
Respite pediatric palliative care (hospice or hospital setting)	NO
24/7 access to specialist pediatric palliative care team(s)	YES
Education program(s) for pediatric palliative care	NO

Context:

Access to virtual pediatric palliative care support is available through the BC Children's Hospital/Canuck Place consult team if needed. See *Provincial Results* for more information.

OTHER FOCUSED POPULATIONS

POPULATION	FORMAL STRATEGY	PROGRAMS AND/OR INITIATIVES
2SLGBTQI+*	NO	NO
Homeless and marginally housed	NO	NO
Incarcerated people (correctional facilities)	NO	NO
Recent immigrants and refugees	NO	NO

*Refers to Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex and additional people

Context:

At the time of data collection, Northern Health is updating their strategic plan, which will include 2SLGBTQI+, homeless and marginally housed, and recent immigrants and refugees.

COMMUNITY ENGAGEMENT

VOLUNTEERS

Formal strategy related to incorporating and/supporting volunteers	NO
Volunteer opportunities in palliative care	YES[1]
Volunteer training activities in palliative care available	YES[1]

COMMUNITY RESOURCES

Compassionate Community activities and other community engagement activities/ resources*	YES[2]
Grief and bereavement services	YES
Formal strategy for support of informal caregivers	NO
Programs or initiatives for informal caregivers	YES[3]

*e.g., death cafes, visiting programs, and support groups.

Context:

[1]There are provincial volunteer standards for hospice palliative care.

[2]Through hospice and community organizations or provincial organizations.

[3]Programs and education for informal caregivers offered through community or provincial organizations.

Vancouver Coastal Health

DEMOGRAPHICS

Vancouver Coastal Health is the second most populated Regional Health Authority in British Columbia and includes British Columbia's largest city, Vancouver. The health authority is divided into two subregions along the west coast of Canada. These subregions are unconnected (divided by the mainland portion of the Vancouver Island Health Region) and each includes urban, semi-urban and rural communities. The southern subregion is the most populated and includes the large city of Vancouver, with 720 000 inhabitants, the city of Richmond (population 220 000), and surrounding urban communities.

Area	58,440 KM²
Population	1,198,017
Population density/km²	20.5 PERSONS/KM²

POLICY

POLICIES, STRUCTURES AND LAWS	PRESENCE
Designated office, secretariat or program responsible for palliative care	YES
A formal palliative care strategic plan, policy or framework	YES[1]
Standards and norms for palliative care	YES
Designated palliative care leads	YES

FORMAL STRATEGIES	PRESENCE
Home and community care	YES
Inpatient and outpatient hospital services (cancer and non-cancer)	YES
Long-term care facilities	YES
Rural and remote	YES
Paramedic/emergency services	YES[1]

GOVERNMENT FUNDING	PRESENCE
Palliative home care services	PARTIAL
Medications: In hospital	FULL
Medications: Out of hospital	PARTIAL[2]
Supplies and equipment: In hospital	FULL
Supplies and equipment: Out of hospital	PARTIAL[2]
Continuing palliative care education in various settings	PARTIAL[3]

Context:

[1]Provincial initiative.

[2]British Columbia has provincial palliative care benefits (Plan P), which covers some palliative care medications and home care for 6 months (usually for patients at the end of life). Some aspects of supplies and medications may not be covered but special requests, referred to as "alternate practices," may be submitted. People in long-term care are eligible for Plan B.

[3]Funding for palliative care education is limited to the programs selected by Vancouver Coastal Health's specific education initiatives.

SERVICES

SETTING: ACUTE CARE

Hospitals

Access to specialist-level palliative care support teams	●●●○ V
Access to specialist-level palliative care support teams 24/7	●●●○ V
Funding models for palliative care physicians	MIXED[1]

Context:

[1]In some cases, through hospital budgets and others through fee-for-service models.

Physicians and nurse practitioners in hospitals, primary care and other care settings have access to a provincial physician-led palliative care call line staffed 24/7, which is staffed by Vancouver Coastal physicians.

The region has formal standards and indicators related to access to specialist palliative care consultation/support clinicians/teams in acute care hospitals.

Inpatient Units and Outpatient Clinics

Integration* in inpatient units	●●●○
Integration* in outpatient clinics—Cancer	●●●○
Integration* in outpatient units—Renal	●●●○
Integration* in outpatient clinics—Other**	INFORMATION NOT PROVIDED

*Integration means services with core palliative care competencies providing primary or generalist level palliative care and collaborating closely with and referring to specialist palliative care teams when needed and in a timely manner.

**Cardiology, respirology, and neurology.

Context:

Cancer clinics (run by BC Cancer and regionally) and renal clinics have a good integration of a palliative approach to care.

Palliative Care Units (PCUs)

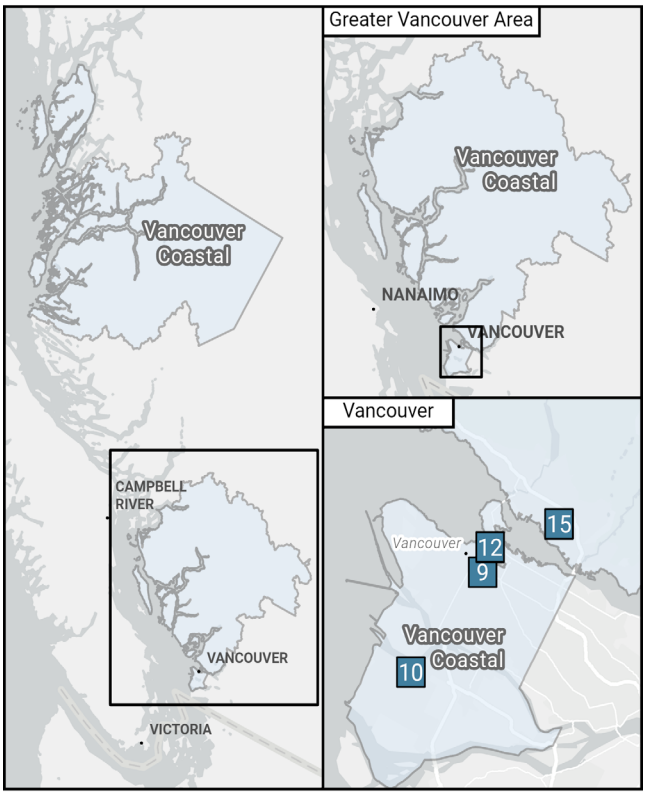
		NUMBER	ADEQUACY*	% OF TARGET BEDS
	Palliative care units (PCUs)	4		
	Palliative care unit beds	46	ADEQUATE	
	Other palliative care beds	0		
	Total palliative care beds	46		

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

Context:

The four PCUs are mainly "acute palliative care units" and are all dedicated palliative care beds.

Palliative Care Units in Coastal Region



Legend

- Major Cities

Facility, Type

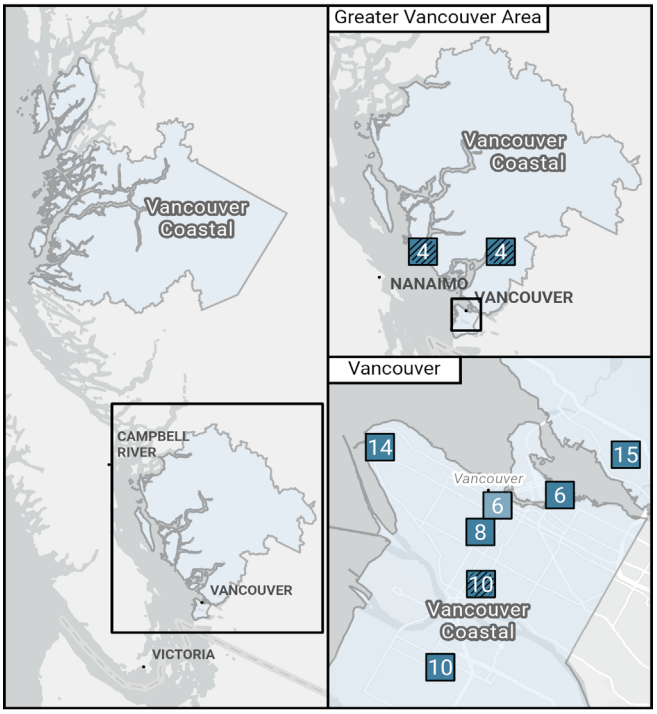
- PCU, Acute

- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

Hospices in Coastal Region



Legend

- Major Cities

Hospice

Facility, Patients, Location-type

- Hospice Residence, Adult, Stand-alone
- Hospice Residence, Adult, Co-located
- Hospice Residence, Pediatric, Stand-alone
- Other Hospice Beds, Adult, Co-located

- Health Authority Regions

Facility labels report number of beds available.

References: 1) ESRI Light Gray Basemap (arcgis.com); 2) Regional Health Authority Boundaries (BC Map Hub); Major Cities (The Atlas of Canada Base Maps of BC).

SETTING: COMMUNITY

Hospice Residences and Services

		RESPONSES	ADEQUACY*	% OF TARGET BEDS
	Hospice residences	9		
	Hospice beds in residences	77		
	Other hospice beds	0		
	Total hospice beds	77	ADEQUATE	91.8%
	Standards/indicators for hospice residences	YES		
	Community hospice organizations**	27		

*Catalonia formula (10 beds per 100 000 population of which 3 are PCU beds, and 7 are hospice or continuing care type beds). Only dedicated beds are included.

**This may not include all community organizations that provide hospice or palliative care-related services and support.

Context:

The total number of hospice beds includes a pediatric hospice with 6 beds (Canuck Place). The majority are stand-alone hospice residences. Patients are required to pay a fixed daily rate for hospice residences.

Total Palliative Care Beds:

In total, Vancouver Coastal has 123 inpatient palliative care beds (PCU and hospice beds), all of which are dedicated to palliative care use. This is considered Adequate based on the region's population.

Community

Access to community specialist care teams	●●●●
Communities with 24/7 access to specialist palliative care teams	●●●○
Standards/indicators for access to community palliative care teams	YES
Models of practice of specialist palliative care teams	CONSULTATION

Context:

Access to specialist palliative care teams in the community is high for in-person support weekdays during daytime hours. Some areas have evening access. All overnight access is virtually provided through a regional help line for health care professionals, which is staffed by palliative care nurses.

Palliative Home Care

Availability of palliative home care nursing	●●●●
Availability of 24/7 access	●●●○ [1,2]
Restrictions on coverage	YES[1,2]
Training of staff in palliative care approach available	YES[3]

Context:

[1]Rural areas may experience service gaps in the evenings. Some areas have evening and weekend shifts. Overnight access is limited to virtual support.

[2]In accordance with the provincial palliative benefits plan (Plan P).

[3]Home care professionals have multiple palliative care education programs available to them, including Pallium Canada's LEAP courses. There is evidence from Pallium Canada of some primary care professionals in this region taking LEAP training.

Patients, families and nurses have access to a provincial nursing-led phone line for support.

Primary Care

Overall provision of primary palliative care	INFORMATION NOT PROVIDED
Providing palliative care to ambulatory patients	INFORMATION NOT PROVIDED
Providing palliative care home visits	INFORMATION NOT PROVIDED
Clinics providing 24/7 on-call palliative care coverage	INFORMATION NOT PROVIDED
Standards/indicators for overall provision of primary palliative care	YES[1]
Training for primary care professionals on the palliative care approach available	●●●○ [2]

Context:

[1]The region has standards and indicators and further supports primary care through education and guideline development.

[2]Vancouver Coastal Health supports some education, such as Pallium Canada's LEAP courses that are delivered virtually or by a hybrid model.

The provincial palliative care nurse-led phone line is available after hours for patients, families and nurses.

Most palliative care specialist teams in the community follow a *Consultation* and *Shared Care* model. In this region, primary care is supported through education and guideline development, with evidence from Pallium Canada showing strong engagement of primary care professionals in LEAP training. This suggests that primary care professionals are taking on the role of primary palliative care provision.

Rural and Remote Areas

Access to specialist palliative care teams	●●●○ [1]
Standards/indicators for access to primary palliative care	YES
Funding for education on the palliative care approach	YES[2]
Training of physicians and primary care professionals on palliative care approach available	YES

Context:

[1]Access to palliative care help line is available 24/7 for all clinicians in the region.

[2]The RPACE (palliative education) team provides palliative approach to care education in rural areas of the region; online education is also available.

Long-Term Care (LTC)

Access to specialist palliative care services	●●●○
Integration of palliative care approach	●●●○
Standards and/or indicators for providing palliative care	YES[1]
Standards for training of staff on palliative care approach	NO
Training programs for staff on palliative care approach available	YES
Funding to provide palliative care education for staff	YES

Context:

[1]Regional level standards/indicators.

LTC homes can consult local palliative care physician services for consultation support. LTC nurses can access a provincial nursing-led palliative care phone line for support.

Within Vancouver, there is a 24/7 virtual call line, staffed by family physicians, that LTC staff can use to get support on general issues. However, the physicians may not be palliative care specialists or have palliative care training.

Paramedic Emergency Services

Training of paramedics in palliative care	PARTIAL - V

Context:

BC Emergency Health Services in the region have educated paramedics who can support palliative patients in their homes without transporting them to the ER (treat and release). Training includes using the patient's "green sleeve" health record, which contains the Advance Care Planning (ACP) details. Implementation can vary.

Advance Care Planning

Advance Care Planning resources	YES

Context:

The provincial "Pathways" platform provides ACP resources for health care professionals.

SYSTEM PERFORMANCE

Each Health Authority has a "Health Care Report Card." These are published multiple times a year on key priority areas for the Ministry of Health and the Health Authorities. Some system performance indicators for British Columba and its health regions have been reported by the Canadian Institute for Health Information (CIHI) 2023 Palliative Care Report and by the Canadian Partnership Against Cancer (CPAC) in 2017.

EDUCATION

MEDICAL SCHOOLS

	UNIVERSITY OF BRITISH COLUMBIA (UBC) VANCOUVER-FRASER MEDICAL PROGRAM
UNDERGRADUATE EDUCATION	
Inclusion of palliative care in undergraduate curriculum	OPTIONAL: CLASSROOM LEARNING OPTIONAL: CLINICAL ROTATION
POSTGRADUATE EDUCATION	
Palliative Care Residency Training Programs	
Royal College Subspecialty Certification in Palliative Medicine	YES – ADULT/PEDIATRICS[1]
College of Family Physicians Certificate of Added Competence in Palliative Care	YES[1]

OTHER SPECIALTY RESIDENCY TRAINING PROGRAMS	PALLIATIVE CARE EDUCATION/EXPERIENCES
Anesthesia	OPTIONAL: CLINICAL ROTATION
Cardiology	OPTIONAL: CLINICAL ROTATION
Critical Care	OPTIONAL: CLINICAL ROTATION
Emergency medicine	OPTIONAL: CLINICAL ROTATION
Family medicine	MANDATORY: CLINICAL ROTATION
Geriatrics	OPTIONAL: CLINICAL ROTATION
Internal medicine	OPTIONAL: CLINICAL ROTATION
Neurology	OPTIONAL: CLINICAL ROTATION
Radiation oncology	OPTIONAL: CLINICAL ROTATION
Medical oncology	OPTIONAL: CLINICAL ROTATION
Psychiatry	OPTIONAL: CLINICAL ROTATION
Respirology	OPTIONAL: CLINICAL ROTATION
Surgery	OPTIONAL: CLINICAL ROTATION

*No information provided on classroom learning for palliative care in any of the Specialty Residency Training Programs.

Context:

[1]Number of residency spots will vary yearly.

The University of British Columbia's (UBC) main academic campus is in Vancouver in the Coastal Health Authority. Residents are distributed across all UBC academic sites and rotate across the sites, which include campuses in the Interior Health region and the Vancouver Island Health region. Residents across different specialty areas are also allocated to the different sites and may rotate across these.

NURSING SCHOOLS

SCHOOLS	INCLUSION OF PALLIATIVE CARE IN UNDERGRADUATE PROGRAM (DIPLOMA/DEGREE PROGRAMS*)
Langara College	MANDATORY: CLASSROOM LEARNING
University of British Columbia (UBC)	MANDATORY: CLASSROOM LEARNING OPTIONAL: WORKSHOP
Vancouver Community College	MANDATORY: CLASSROOM LEARNING

*Refers to classroom learning; however, it does not address adequacy (number of hours or clinical versus classroom learning).

PROFESSIONAL ACTIVITIES

Existence of palliative care directory of services	YES
Dedicated resources to organize palliative care continuing professional development	NO
Palliative care conference/symposia regionally	YES
Active palliative care research	YES
Palliative care quality improvement initiatives	YES

Context:

Research is largely undertaken at the University of British Columbia with active research in the areas of pain management and symptom management.

FOCUSED POPULATIONS

PEDIATRIC PALLIATIVE CARE

Formal strategy for pediatric palliative care	YES
Pediatric hospice residence(s)	YES
Outpatient palliative care program(s) for pediatric populations	YES
Respite pediatric palliative care (hospice or hospital setting)	YES
24/7 access to specialist pediatric palliative care team(s)	YES
Education program(s) for pediatric palliative care	NO

Context:

Canuck Place Children's Hospice provides palliative care services to pediatric populations in British Columbia. It has two hospice locations, one of which is in the Vancouver Coastal region and the other in the Fraser Health region. The hospice provides 24/7 clinical care, including end-of-life care.

Highlight:

Canuck Place has been a Canadian and world leader in pediatric palliative care. The care provided includes counselling, family support, recreation therapy, music therapy, education, end-of-life care, and bereavement services.

OTHER FOCUSED POPULATIONS

POPULATION	FORMAL STRATEGY	PROGRAMS AND/OR INITIATIVES
2SLGBTQI+*	NO	INFORMATION NOT PROVIDED
Homeless and marginally housed	NO	YES[1]
Incarcerated people (correctional facilities)	NO	INFORMATION NOT PROVIDED
Recent immigrants and refugees	NO	YES[2]
Informal Caregivers	NO	YES

*Refers to Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex and additional people

Context:

[1]May's Place Hospice provides hospice services to individuals who are structurally vulnerable.

[2]Richmond has a Chinese advisory council. The council advises on regional initiatives, including palliative care. This includes the translation of documents and resources for patients.

The region supports an equity lens for the design and delivery of health care services and programs to embed cultural safety, anti-racism, and equity.

Highlight:

May's Place Hospice is a six-bed hospice with a home-like setting and 24/7 nursing care that provides integrated, trauma-informed end-of-life care for structurally vulnerable populations.

COMMUNITY ENGAGEMENT

VOLUNTEERS

Formal strategy related to incorporating and/supporting volunteers	YES
Volunteer opportunities in palliative care	YES
Volunteer training activities in palliative care available	YES

COMMUNITY RESOURCES

Compassionate Community activities and other community engagement activities/resources*	YES
Grief and bereavement services	YES
Formal strategy for support of informal caregivers	NO
Programs or initiatives for informal caregivers	YES

*e.g., death cafes, visiting programs, and support groups.

Context:

Programs, education and support for informal caregivers offered through the Health Authority via a virtual caregiver support program as well as other community or provincial organizations.

Community hospice organizations have volunteer opportunities. Many organizations offer training and education specifically for palliative care.

OTHER ACTIVITIES

Vancouver Coastal has implemented a "Palliative Care Flag" initiative. This allows patients to indicate in their charts their wish to receive a palliative care approach when receiving care.

Additionally, palliative care patients discharged from hospital to any community setting require a plan either with home care or a long-term care home to prepare for any unexpected changes in the patient's health.

Discussion and Conclusion

Discussion

Overall, palliative care is well established in many parts of British Columbia, especially in most urban centres. There is a long and active history of palliative care development and innovation in the province. However, access to various services is more challenging for rural and remote communities. Variability is noted across regions and subregions across several indicators. There are many examples of excellence across the province, across the domains and indicators.

In the policy domain, there are provincial-level and regional-level structures in place to oversee the ongoing development of palliative care and public funding to support many aspects of palliative care delivery. The provincial strategic plan for palliative care is older, from 2013. The changing demographics of the British Columbia population and their palliative care needs have evolved over the past 10 years, and the provincial plan may benefit from a reassessment, especially through the current lens of equity-oriented approaches to palliative care. The British Columbia Centre for Palliative Care has been a strong advocate and organizer of palliative care across the province since its inception, and is recognized as a national and international leader, especially for its position papers and clinical guidelines, which are widely accessed.

Generally, across the province, there is a high level of access to specialist palliative care teams in hospitals, especially in urban areas. However, considerable variability and some glaring gaps are noted. In the urban and semi-rural parts of the Fraser Health, Island Health and Coastal Health regions, there are high levels of access, including 24/7 access to palliative care teams in hospitals. Access seems limited in Interior Health. Across the province, access to 24/7 support in smaller hospitals is largely by virtual support from the provincial physician on call line, and in some cases, regional on call support is provided. The extent to which the provincial phone support lines are used was not explored.

There is variable integration across the province of palliative care across various hospital inpatient and outpatient services. It is recognized that the concept of "integration" is a complex construct with varying understandings and definitions. For the purposes of this study and report, optimal "integration" includes the following elements: a) the clinicians and staff of that service or team are equipped with core competencies to provide a palliative care approach; b) the service provides a palliative care approach itself, including identification of patients with palliative care needs earlier in the illness; c) patients are referred in a timely manner to a palliative care service when needed; and, in some cases, d) a palliative care clinician embedded in the service or palliative care clinics within that service. These concepts are, to varying degrees, described in the growing literature base on the constructs of the palliative care approach and integration of palliative care.[1, 2, 3, 4, 5, 6, 7] The elaboration by the BC Centre for Palliative Care of specialist-level as well as primary- and generalist-level palliative care competencies for different professions help inform further integration.

Integration appears greater in cancer centres and services than across non-cancer services, such as cardiology, nephrology, respirology, and neurology, including non-cancer hospital inpatient and outpatient services. There are, however, examples of excellence across the province. An in-depth exploration of the extent of these was outside the scope of this Atlas study but warrants attention in future studies. This phenomenon is not unique to British Columbia and has been noted in other provinces and jurisdictions as well, providing opportunities for improvement.[8, 9] With respect to cancer centres, some variability is described across these centres.

Overall, the number of palliative care unit (PCU) beds in the province appears inadequate as per the "Catalonia Formula" for inpatient palliative care beds, as first described by Xavier Gomez-Batiste et al.[10] Most units

1 Brazil K. A Call for Integrated and Coordinated Palliative Care. Journal of Palliative Medicine. 2018 Jan;21(S1):S-27-S-29.
2 Hui D, Bruera E. Integrating palliative care into the trajectory of cancer care. Nat Rev Clin Oncol. 2016.
3 Maciver J, Ross HJ. A palliative approach for heart failure end-of-life care. Current Opinion in Cardiology. 2018 Mar;33(2):202–7.
4 Pereira J, Chasen MR. Early palliative care: taking ownership and creating the conditions. Current Oncology. 2016 Dec 22;23(6):367.
5 Sawatzky R, Porterfield P, Lee J, Dixon D, Lounsbury K, Pesut B, et al. Conceptual foundations of a palliative approach: a knowledge synthesis. BMC Palliative Care. 2016 Jan 15;15(1).
6 Stajduhar KI, Tayler C. Helene Hudson Lecture: Taking an "upstream" approach in the care of dying cancer patients: The case for a palliative approach. Canadian Oncology Nursing Journal. 2014 Aug 5;24(3):144–8.
7 Touzel M, Shadd J. Content Validity of a Conceptual Model of a Palliative Approach. Journal of Palliative Medicine. 2018 Nov;21(11):1627–35.
8 Quinn KL, Stukel T, Stall NM, Huang A, Isenberg S, Tanuseputro P, et al. Association between palliative care and healthcare outcomes among adults with terminal non-cancer illness: population based matched cohort study. BMJ. 2020 Jul 6;m2257.
9 Tanuseputro P, Budhwani S, Bai YQ, Wodchis WP. Palliative care delivery across health sectors: A population-level observational study. Palliative Medicine. 2016 Jul 10;31(3):247–57.
10 Gómez-Batiste X, Porta J, Tuca A, Stjernswärd J. Organización de Servicios y Programas de Cuidados Paliativos. 1st ed. Madrid, Spain: Arán Ediciones, S.L.; 2005.

appear to be acute or end-of-life units. The exact number, however, is not clear, as some of the beds are designated rather than dedicated beds; in other words, they may be occupied by patients who do not require palliative care and may not be readily available when needed for a palliative care admission. The provincial ministry has identified standards related to the number of PCU beds in hospitals, but these numbers are not uniformly attained. There may also be a misdistribution of the PCUs and PCU beds. They are, for example, largely absent in northern cities and in the Interior region. This Atlas study used the definition of a PCU established by consensus by the 2015 study Ontario expert work group, a definition that was informed by Radbruch and Payne, von Gunten, and Elsayem et al. [11, 12, 13] A PCU was defined as a specialized, geographically defined hospital unit (or wing) dedicated to the management of patients with complex and/or acute palliative care needs across the illness trajectory. It is staffed by an experienced interprofessional palliative care team with specialist-level competencies in palliative care. "Floating" beds, where any bed in the hospital or in pre-assigned units can be designated as "palliative" if occupied by a patient with predominantly palliative care needs, are not included in the definition. The problem with these *floating* beds, and sometimes with designated beds that are often in mixed units (not only solely dedicated for palliative care patients), is that they may not necessarily be available when patients with palliative care needs require inpatient admission to them, and the staff often have no or minimal palliative care training (or palliative care focus) to care for these patients, especially if they have complex needs.

The number of hospice beds (hospice residences) is also deemed adequate by this study, but this is borderline. The number is actually just below the target by 10%, even when using a conservative target of 7 hospice beds per 100 000 population. This means that growth in the population and further aging of the population may render this number as inadequate. Collectively, when one adds all the PCU beds and hospice beds to assess the overall number of inpatient beds available, the number is not adequate.

Hospices continue to play an important role in the provision of palliative care in the province. Often, they also serve as hubs to mobilize communities in the form of volunteering opportunities and compassionate community initiatives. They are also often the main resource for grief and bereavement services in their communities. Notwithstanding their key roles, the care and services they provide are only partly funded by public funding and require a set daily rate to be paid by patients who are admitted. Most hospice residences in the province are free-standing homelike facilities.

This Atlas study found that generally, across the province, there is considerable variability in in-person access to specialist-level palliative care services (clinicians and/or teams) in the community. Access is higher in the larger urban centres (with some exceptions, including the Interior Region). Access to specialist palliative care support in smaller and rural communities is largely through virtual support from a provincial or regional support line. The extent to which this line is used and found to be useful warrants further study. The predominant practice model of community palliative care teams is *Consultation* and, to a lesser extent, *Shared Care*. The models and their respective roles, strengths and limitations are described elsewhere.[14, 15, 16, 17] *Consultation* and *Shared Care* models may better support and build primary and generalist palliative care than a *Takeover* model, but it requires ownership of palliative care by primary care professionals and services (as well as other specialty services).

Overall, there are variable levels of primary palliative care being provided by family physicians and primary care teams across the province, with a high proportion of primary care clinicians in some communities providing a palliative care approach to their ambulatory patients and fewer providing home visits or after hours on call support for patients with palliative care needs. There is evidence of upskilling on a palliative care approach by primary care professionals through the uptake of various continuing professional development programs available in the province.

A major strength in the province is the high level of palliative care training provided for paramedics. This has been an intentional and funded strategy for several years. On the ground implementation of palliative care supports provided by paramedics, such as the Assess, See, Treat and Refer initiative, varies in each region.

11 Radbruch L, Payne S. White Paper on standards and norms for hospice and palliative care in Europe. European Association for Palliative Care. European Journal of Palliative Care. 2010; 17(1), 22–33.

12 von Gunten CF. Secondary and Tertiary Palliative Care in US Hospitals. JAMA. 2002 Feb 20;287(7):875.

13 Elsayem A, Swint K, Fisch MJ, Palmer JL, Reddy S, Walker P, et al. Palliative Care Inpatient Service in a Comprehensive Cancer Center: Clinical and Financial Outcomes. Journal of Clinical Oncology. 2004 May 15;22(10):2008–14.

14 Pereira J, Klinger C, Seow H, Marshall D, Herx L. Are We Consulting, Sharing Care, or Taking Over? A Conceptual Framework. Palliative medicine reports [Internet]. 2024 Feb 1 [cited 2024 May 19];5(1):104–15.

15 Maybee A, Winemaker S, Howard M, Seow H, Farag A, Park HJ, et al. Palliative care physicians' motivations for models of practicing in the community: A qualitative descriptive study. Palliative Medicine. 2021 Dec 17;36(1):181–8.

16 Howard M, Shireen Fikree, Allice I, Farag A, Siu HYH, Baker A, et al. Family Physicians with Certificates of Added Competence in Palliative Care Contribute to Comprehensive Care in Their Communities: A Qualitative Descriptive Study. Palliative Medicine Reports. 2023 Feb 1;4(1):28–35

17 Brown CR, Hsu AT, Kendall C, Marshall D, Pereira J, Prentice M, et al. How are physicians delivering palliative care? A population-based retrospective cohort study describing the mix of generalist and specialist palliative care models in the last year of life. Palliative Medicine. 2018 Jun 11;32(8):1334–43.

In the long-term care (LTC) setting, there is considerable variability across the province with respect to the integration of palliative care. There is, however, growing attention in this area and a number of new initiatives being supported through the BCCPC LTC Collaborative, for example. The integration of palliative care across LTC facilities is an area for improvement. Training programs are available to support this, as well as access to local specialist palliative care teams who can provide education, coaching, mentoring and consultation to build capacity.

In the domain of education, palliative care training is reported in the curricula of the single medical school in the province. Information about the curricula in nursing schools was difficult to access. At the postgraduate education level, compulsory palliative care training is required within family medicine and oncology residency programs. There are examples of compulsory training in other residency programs, but detailed information across all residency programs was challenging to obtain. Palliative care training should be a priority across different specialty programs and across the health professions to equip physicians and other professionals entering practice with core palliative care skills to provide a palliative care approach for their patients with serious illness. There are dedicated palliative care residency programs across the province to train specialist-level palliative care physicians, including for both adult and pediatric palliative specialists. More detailed curriculum mapping work is needed to better map the presence of palliative care training across medical specialty residencies and undergraduate training in nursing and the other health professions.

While there is an exemplary pediatric palliative care program in the province provided through Canuck Place Children's Hospice, which provides both inpatient and outpatient pediatric palliative care programming across two sites, access across the province to pediatric palliative care is still not widespread, and is an area for improvement. The Canuck Place program does provide virtual support, including after-hours advice to clinicians across the province and even into the Yukon.

With respect to other focused populations, there are no provincial strategies or initiatives addressing the palliative care needs of homeless/marginally housed persons, incarcerated persons, 2SLGBTQI+ persons or recent immigrants and refugees. There are, however, examples of excellence in the provision of palliative care to homeless and vulnerably housed populations, notably the Palliative Outreach Resource Team (PORT) in Victoria. This program is a collaboration between the University of Victoria, Island Health, Victoria Cool Aid Society, and Victoria Hospice Society and should inspire spread across the province and to other special focus populations who require equity in palliative approaches to care.

There is considerable community involvement across the province in all regions and many subregions, with extensive uptake of compassionate communities initiatives, volunteer-based programs and supports for family caregivers.

Several limitations are identified in this study. These have been described in the Methods section previously. It is important to note what an Atlas is and what it is not. Atlases provide overviews, often global impressions, of the status of palliative care in a jurisdiction across several domains and indicators. There is a fine balance in these palliative care atlases between excessive generalization and too much granularity. They are not designed (and do not have the resources) for detailed explorations, such as surveys of all services in a jurisdiction – for example of primary care clinics, long-term care homes, and hospital units and services. They rely on input from key informants who may not necessarily have detailed knowledge across all care settings and subregions of a jurisdiction. The use of multiple sources of information and iterative processes is used to mitigate gaps and biases, and to get an overall sense of the presence of services and integration across a jurisdiction.

As highlighted in the Introduction section, the provision of palliative care to Indigenous populations – urban, rural or remote – was not studied. The goal is to undertake a distinct process, with humility and in the spirit of reconciliation, led and developed by Indigenous Peoples, to describe palliative care across Turtle Island provided by, with and for Indigenous peoples. Such mapping will adhere to the First Nations Principles of Ownership, Control, Access, and Possession (OCAP®).

Conclusion

This British Columbia Edition of the Canadian Palliative Care Atlas explores the presence and access to palliative care services, resources and infrastructure across British Columbia. It provides a cross-sectional snapshot across several domains and many indicators that serve to highlight many successes and examples of excellence across the province. There are strengths in palliative care across many of the indicators, especially with the presence of specialist teams in most urban hospitals and communities, and widespread community engagement and initiatives in palliative care. However, there is still considerable variability across many indicators with one region notably underserved across palliative care services, and there are many opportunities for improvement across the domains.

Appendices

Appendix A - Domains and Indicators

DOMAINS			INDICATORS	FEDERAL	PROVINCIAL/ TERRITORIAL	REGIONAL
Demographics (D)	D1	D1.1	Total area (km2)	F	PT	R
		D1.2	Urban, rural, and remote geographic areas Population and age distribution Population density	F	PT	R
		D1.2	Model of organization of health services (e.g., health authorities, regions)	F	PT	
	D2		Number of deaths per year and causes of death	F	PT	
Policy (P)	P1		Designated office, secretariat, and/or program responsible for palliative care	F	PT	R
	P2		Existence of a current palliative care plan, policy, framework, and/or strategy	F	PT	R
	P3		Existence of a specific palliative care law to ensure palliative care (PC) access	F	PT	
	P4		Policies/law regarding ACP	F	PT	
	P5		Existence of standards and norms for palliative care	F	PT	R
	P6		Compassionate care benefits	F	PT	
	P7		Designated government funding for:			
		P7.1	Palliative care home care services	F	PT	R
		P7.2	Hospice Residences	F	PT	
		P7.3	Community hospices	F	PT	
		P7.4	Palliative care medications and supplies/equipment:			
		P7.4.1	Medications: In-hospital care	F	PT	R
		P7.4.2	Medications: Out-of-hospital	F	PT	R
		P7.4.3	Supplies/Equipment: In-Hospital	F	PT	R
		P7.4.4	Supplies/Equipment Out-of-Hospital	F	PT	R
		P7.4.5	Education CPD (continuing professional development)	F	PT	R
	P8		Formal strategies in place to integrate palliative care into:			
		P8.1	Home and community care	F	PT	R
		P8.2	Inpatient and outpatient hospital services (including cancer and non-cancer illnesses)	F	PT	R
		P8.3	Long-term care facilities	F	PT	R
		P8.4	Rural and remote	F	PT	R
		P8.5	Paramedic and emergency services, etc.	F	PT	R
	P9		Designated palliative care leaders	F	PT	R

DOMAINS			INDICATORS	FEDERAL	PROVINCIAL/ TERRITORIAL	REGIONAL
Services (S)	S1		Acute Care Settings			
	S1.1		Palliative care units (PCUs)			
		S1.1.1	Number of PCUs and beds	F	PT	R
		S1.1.2	Location (geography and number of beds)			R
		S1.1.3	Describe the PCUs (e.g., type)			R
		S1.1.4	Adequacy of number of units and beds	F	PT	R
	S1.2		Specialist-level palliative care teams or access to such teams in hospitals (inpatient and outpatient)			
		S1.2.1	Extent of hospitals in region, with access to specialist-level palliative care team	F	PT	R
		S1.2.2	Funding models for professions		PT	R
	S1.3		Integration of palliative care approach in hospital inpatient services (cardiology, ED, ICU, medicine, nephrology, neurology, oncology, respirology, etc.) services			
		S1.3.1	Extent palliative care approach is integrated into acute care hospitals' services/units in region			R
		S1.3.2	Examples of excellence of integration in inpatient services			R
	S1.4		Integration of palliative care approach into outpatient clinics (cancer, heart, lung, renal, neuro, geriatrics, etc.)			
		S1.4.1	Extent palliative care approach is integrated in clinics across region			R
	S2		Community settings			
	S2.1		Specialist-level palliative care teams in the community			
		S2.1.1	Standards and/or indicators for access to community palliative care teams	F	PT	R
		S2.1.2	Access to community specialist palliative care teams	F	PT	R
		S2.1.3	Communities with 24/7 access		PT	R
		S2.1.4	Models of practice of specialist palliative care teams			R
	S2.2		Palliative home care services			
		S2.2.1	Access to palliative home care nursing	F	PT	R
		S2.2.2	Coverage 24/7 home care		PT	R
		S2.2.3	Restrictions on coverage			R
		S2.2.4	Training of staff in palliative care approach			R
	S2.3		Primary-level palliative care (family physicians and primary care clinics overall provision of primary palliative care)			
		S2.3.1	Standards and/or indicators for overall provision of primary palliative care	F	PT	R

DOMAINS			INDICATORS	FEDERAL	PROVINCIAL/ TERRITORIAL	REGIONAL
		S2.3.2	Extent primary care clinics provide palliative care to ambulatory patients	F	PT	R
		S2.3.3	Extent primary care clinics provide palliative care home visits	F	PT	R
		S2.3.4	Extent primary care clinics provide 24/7 on-call palliative care coverage	F	PT	R
		S2.3.5	Training for primary care professionals on the palliative care approach	F	PT	R
	S2.4		Hospices and hospice beds			
		S2.4.1	Standards and/or indicators	F	PT	R
		S2.4.2	Number of hospices, location, and beds	F	PT	R
		S2.4.3	Model: Standalone, local facility (e.g., LTC, local hospital)	F	PT	R
		S2.4.4	Adequacy of number of hospice beds	F	PT	R
	S2.5		Community hospice services (e.g., day programs)	F		
		S2.5.1	Presence of community hospice programs	F	PT	R
		S2.5.2	Location and number of community hospice programs	F	PT	
		S2.5.3	Grief and bereavement services			R
	S2.6		Palliative care in long-term care (LTC) facilities			
		S2.6.1	Standards and/or indicators for palliative care in LTC	F	PT	R
		S2.6.2	Formal standards of training of staff in LTC on palliative care approach	F	PT	R
		S2.6.3	Formal strategy for Integration of palliative care in LTC	F	PT	R
		S2.6.4	Training programs for LTC staff on palliative care approach	F	PT	R
		S2.6.5	Access to specialist palliative care service in LTC facilities	F	PT	R
		S2.6.6	Extent LTC facilities have integrated palliative care approach	F	PT	R
		S2.6.7	Funding to provide palliative care education for LTC staff	F	PT	R
	S2.7		Provision of palliative care by paramedic emergency medical services			
		S2.7.1	Formal strategy	F	PT	R
		S2.7.2	Training of paramedics in palliative care approach	F	PT	R
	S3		Rural/remote			
			Provision of palliative care in rural and remote areas			
		S3.1	Standards or indicators	F	PT	R
		S3.2	Strategic plan	F	PT	R
		S3.3	Access to specialist palliative care teams (%)	F	PT	R

DOMAINS			INDICATORS	FEDERAL	PROVINCIAL/ TERRITORIAL	REGIONAL
		S3.4	Funding for education on the palliative care approach	F	PT	R
		S3.5	Training of family physicians and primary care professionals on palliative care approach	F	PT	R
	S4		Resources			
		S4.1	Palliative care competencies elaborated for different professions and different levels	F	PT	
		S4.2	Advance Care Planning resources	F	PT	R
System Performance (SP)	SP1		Elements and indicators (process, structure, outcome) for palliative care Identified for jurisdictions (Atlas will summarize elements and/or indicators published by various organizations across Canada and summarize these in table format/ provide links → Leverage partner organizations	F	PT	R
Education (E)	E1		Physicians			
		E1.1	Recognition of palliative care specialization or sub-specialization/ certification	F	PT	
		E1.2	Number of palliative care residency positions (province/territory-wide and by medical school)	F	PT	R
		E1.3	Mandatory vs. optional or absent palliative care education in medical school (undergraduate) training	F	PT	R
		E1.4	Physician residency training on palliative care approach (post-graduate): anesthesia, cardiology, critical care, emergency medicine, family medicine, geriatrics, internal medicine, neurology, oncology, psychiatry, respirology, and surgery	F	PT	R
	E2		Nurses			
		E2.1	Recognition of nursing specialization/ certification in palliative care	F	PT	
		E2.2	Mandatory vs. optional or absent palliative care education in undergraduate nursing curriculum	F	PT	R
		E2.3	Mandatory vs. optional or absent palliative care education in graduate nursing curriculum	F	PT	R
Professional Activities (A)	A1		Existence of a palliative care association or organization	F	PT	
	A2		Existence of palliative care directory of services	F	PT	R
	A3		Dedicated resources to organize palliative care CPD (continuing professional development)	F	PT	R

DOMAINS			INDICATORS	FEDERAL	PROVINCIAL/ TERRITORIAL	REGIONAL
	A4	A4.1	Palliative care conference/symposia	F	PT	R
		A4.2	Evidence of palliative care research activities	F	PT	R
		A4.3	Evidence of palliative care quality improvement initiatives	F	PT	R
Focused populations (FP)	FP1		Pediatric palliative care			
		FP1.1	Formal strategy	F	PT	R
		FP1.2	Pediatric hospice residence(s)	F	PT	R
		FP1.3	Outpatient palliative care program(s) for pediatric populations	F	PT	R
		FP1.4	Respite pediatric palliative care (hospice or hospital setting)	F	PT	R
		FP1.5	Pediatric Palliative care consultation team(s)	F	PT	R
		FP1.6	24/7 access to specialist pediatric palliative care consult team	F	PT	R
		FP1.7	Education program(s) for pediatric palliative care	F	PT	R
	FP2		Palliative care needs of 2SLGBTQI+ persons:			
		FP2.1	Formal strategy	F	PT	R
		FP2.2	Programs and/or initiatives	F	PT	R
	FP3		Palliative care needs of homeless persons/the marginally housed:			
		FP3.1	Formal strategy	F	PT	R
		FP3.2	Programs and/or initiatives	F	PT	R
	FP4		Palliative care needs of persons in correctional facilities:			
		FP4.1	Formal strategy	F	PT	R
		FP4.2	Programs and/or initiatives	F	PT	R
	FP5		Palliative care needs of recent immigrants and refugees:			
		FP5.1	Formal strategy	F	PT	R
		FP5.2	Programs and/or initiatives	F	PT	R
	FP6		Palliative care needs of informal care-givers:			
		FP6.1	Formal strategy to support	F	PT	R
		FP6.2	Programs and/or initiatives	F	PT	R
		FP6.3	Education programs for informal caregivers	F	PT	R
Community engagement (C)	C1		Volunteers			
		C1.1	Formal strategy	F	PT	R
		C1.2	Programs and/or initiatives.	F	PT	R
		C1.3	Training programs for volunteers	F	PT	R

DOMAINS			INDICATORS	FEDERAL	PROVINCIAL/ TERRITORIAL	REGIONAL
	C2		Community engagement			
		C2.1	Compassionate Communities initiative underway	F	PT	R
		C2.2	Other community engagement activities/resources	F	PT	R
Other activities (O)	O1		Other resources and/or programs	F	PT	R

Appendix B: Method Details

Phase 1: Preparation

Identification of the domains and indicators: There are existing domains and indicators that are reported in international palliative care atlases; however, not all indicators are appropriate or relevant to the Canadian context. Therefore, the founding research group modified the list of indicators for this atlas. For example, given the well-documented availability of opioids in Canada, the indicator on availability of opioids was modified to include the funding (public) of palliative care medicines. Additional indicators have included exploration of access to palliative care for populations that are often disadvantaged (e.g., homeless and immigrant populations) in terms of accessing palliative care.

Establish collaboration with provincial and regional partners: In Canada, many of the provinces have provincial level organizations (who receive funding or are entirely funded by the provincial governments). They may provide guidelines, oversight, education, and more specific for palliative care. The authors created partnerships and connections with these groups. These partners advocated for the Atlas and its importance, and provided connections with regional level health care leaders knowledgeable in palliative care.

Phase 2: Data Collection

Step 1: Search for publicly available data: Search for organizations or information in each domain. A guiding document was used for each province and sub-region to ensure consistency during searches.

Step 2: Surveys: There were three different types of surveys: provincial, regional, and education. A link to an electronic survey was sent by email to potential participants. For the provincial and regional surveys, links were sent to our established contacts (from Phase 1). For education surveys, they were sent to administrators in nursing and medical education at all universities and colleges known to have nursing and medicine education programs (the list was established through Phase 2, Step 1). The surveys were organized by the domains and indicators. Participants had the option to skip any questions they did not want to or were unable to answer and upload relevant documentation, if desired. Follow-up emails were sent to non-responders. Purposeful sampling was used to send surveys to new participants when initial contacts did not respond.

Step 3: Interviews: Interviews were conducted with regional and provincial health care leaders and leaders of provincial organizations. The interviews were semi-structured, based on the domains and indicators and done using a video conference service. With permission, the interviews were audio recorded. The purpose of the interviews was to clarify information in the surveys and fill in any missing information. Interviews occurred with one person or more people depending on the participant's preferences. Snowball and purposeful sampling were used to try and connect with additional individuals if there was still missing data. Interview participants included health care leaders, administrators and health care professionals.

Step 4: Focus Groups: Focus groups were done only at a regional level. The focus groups were semi-structured, based on the domains and indicators and done using a video conference service. With permission, the focus groups were audio recorded. The purpose of the focus group was to verify the data collected to date and fill in any remaining gaps in the data. The moderator of the focus group presented the data on the region to participants and invited participants to provide feedback on the information. The focus groups included health care leaders, health care professionals, and others knowledgeable in palliative care in the specific region.

Step 5: Final Verification: Also known as member checking. A data summary was sent to interview or main regional contacts to provide comments, clarifications or provide any other information.

Appendix C: Data Dictionary, Glossary and Definitions

The following definitions, explanations and examples are the references being used for the Canadian Atlas of Palliative Care. The information provided here may differ from definitions used by others.

Acute Care Hospital: Facility that provides active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or major surgery. For the purposes of this Atlas, hospital size is defined as:

- Small hospital (often community hospital, secondary-level care): < 100 beds
- Medium size hospital (community or teaching hospital with secondary and tertiary level care): 100 to 200 beds. May provide teaching in the health professions.
- Large size hospital (usually offers tertiary and quaternary level care); > 200 beds. Often teaching hospitals for health profession learners.

Catalonia Formula for inpatient palliative care beds: A formula developed in Catalonia, Spain in 2005 that helps plan and assess the number of beds for palliative care inpatient care needed in a region. This formula has been used successfully applied internationally, and found to be valid, in Canadian jurisdictions such as Alberta and British Columbia, when these regions were planning their palliative care services 10 to 15 years ago. It has also been applied by the Ontario Hospice Palliative Care Association.

- For every 100 000 inhabitants, a region needs 10 palliative care inpatient beds. Of these, 2 to 3 should be acute palliative care, such as in a palliative care unit, and 7 to 8 should be hospice and/continuing care type beds. The original formula, in Spanish, spoke of the latter as "continuing care," but in essence, includes the type of care provided in hospices in jurisdictions such as Canada and the United Kingdom. For this Atlas we are using 3 palliative care beds and 7 hospice beds. [1]

Compassionate Communities: These are communities, and corresponding initiatives, that are compassionate in their support of people through the difficult times associated with serious illness, dying and bereavement. Compassionate community initiatives are varied and in addition to supporting care, they often also raise awareness of various aspects of palliative care and end of life care and bereavement.

Consultation, Shared Care, and Takeover Models[2]: Specialist palliative care teams, whether in hospitals, the community or long-term care facilities, use one of three models (or combinations) relative to the primary care professionals or other specialty professionals that refer to them:

- **Consultation model:** The palliative care clinician provides consultation support, usually in the form of recommendations or sometimes with direct order, and follows the patient as needed until the situation has resolved, at which time the palliative care team withdraws. Throughout, the patient's attending clinician remains the most responsible physician or practitioner (MRP). The palliative care service leaves once the situation has resolved (but is available for future consultation requests).
- **Shared care model:** The palliative care specialist is responsible for providing the palliative care aspects of care, while the patient's attending clinician (family physician, nurse practitioner or specialist in different fields) is responsible for all other aspects of care. In palliative care, given its holistic nature and approach, it is often difficult to separate the two and can cause confusion as to who is the most responsible clinician, increasing the risk of patients "falling through the cracks."
- **Takeover model:** The palliative care clinician assumes responsibility for all aspects of care and becomes the most responsible clinician. This is appropriate in the case of a patient with complex needs is admitted to a palliative care unit under the care of a palliative care clinician. It may also be appropriate in other settings if a patient's needs are complex and outside the expertise of their usual attending clinician.

Hospice: In the Canadian context, hospice care is a component of palliative care. It often, but not exclusively, provides palliative care support at the end of life (in the last days and weeks of life) in a community setting. Hospices can provide inpatient care, and/or day care and outpatient programs, and/or support in a patient's home. Hospice residences aim to provide a homelike environment to support patients and their loved ones. Some hospice organizations provide both residential care and outpatient programs, while others provide

1 Gómez-Batiste X, Porta J, Tuca A, Stjernswärd J. Organización de Servicios y Programas de Cuidados Paliativos. 1st ed. Madrid, Spain: Arán Ediciones, S.L.; 2005.

2 Pereira J, Klinger C, Seow H, Marshall D, Herx L. Are We Consulting, Sharing Care, or Taking Over? A Conceptual Framework. Palliative medicine reports [Internet]. 2024 Feb 1;5(1):104–15. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10898231/

only outpatient or home-based support. Hospices are often a nucleus for community-based compassionate community programs and volunteer training.

Hospice beds: Hospice beds are found in hospice residences. They usually are for short-stay care for patients who cannot be cared for at home (by preference or due to a lack of resources at home) but who do not need acute-high intensity care and resources that are mainly found in acute care hospital settings. While these beds are usually found in free-standing hospices (small buildings that mimic a home), they can also be hosted in long-term care facilities or continuing care facilities, or sometimes even in a wing of a small community hospital. The care they provide, notwithstanding the site, should be aligned with best practices of hospice inpatient care, including an interprofessional team, hospice level staffing, and a homelike environment as best as possible.

Hospice societies or organizations: Not-for-profit community organizations that deliver hospice palliative care (in the community or in a hospice), including bereavement services and programs. These organizations sometimes operate from a hospice residence.

Integration of palliative care in primary care: Refers to the extent to which primary care professionals such as family physicians, community nurses and primary care clinics provide a palliative care approach. It requires core palliative care skills. Primary palliative care includes providing a palliative care approach to ambulatory patients (who attend the primary care clinics) and availability to provide palliative care-related home visits and after-hours support, as well as timely referrals to specialist palliative care teams when patient needs warrant it. For the purposes of this Atlas, ***Full or high levels*** of integration means that the majority of primary care professionals and primary care clinics (70% or more) provide primary palliative care and are equipped with core palliative care competencies to provide a palliative care approach. *Partial High* levels of integration mean that a large number of family physicians and primary care clinics (50% to 70%) provide primary palliative care. *Partial Low* levels of integration means that 10% to 50% provide primary palliative care. ***Minimal*** integration means that <10% of primary care professionals and primary care clinics in a region do this. The level of integration or provision of primary palliative care is closely linked to the model of practise of the specialist palliative care team in the region (if there is one). In the case of high levels of integration, the palliative care service tends to practice a consultation model (with occasional sharing care and taking over as MRP in only select cases), whereas in the case of low levels of ;integration, the palliative care team tends to take over the provision of all palliative care, including primary-level and specialist-level.

Integration of palliative care in hospitals: Refers to the extent to which physicians and other health care professionals in hospital-related inpatient and outpatient services, across the different specialty areas (e.g., oncology, internal medicine, cardiology, respirology, and pediatrics), provide a palliative care approach to their own patients and refer to specialist palliative care teams when needed (e.g., when complex or to confirm care plans). This requires core palliative care competencies and includes identifying patients with palliative care needs early. Different models exist. Higher levels of integration typically mean palliative care clinicians are embedded in part of regular rounds in these services. Lower levels of integration typically involve referring to the specialist palliative care teams on an as-needed basis. Simply having an outpatient palliative care clinic does not represent an integration of the palliative care approach by these specialty clinics, especially if the specialist services do not provide a palliative care approach themselves.

Palliative care: Defined by the World Health Organization as "[A]n approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual."[3] Palliative care should be activated early in the illness and not only in the terminal phase of the illness, the last days or weeks of life. It is applicable for persons of all ages experiencing a serious progressive illness and those dying, whether from advanced cancer or non-cancer illnesses. It requires specialist-level as well as primary-level or generalist-level services as well as mobilizing of the community and other sectors (in addition to health care), such as social and education services.

Palliative care approach: Refers to core competencies (knowledge, attitudes and skills) that allow a health care professional to provide basic palliative care of a high quality (as opposed to specialist palliative care, which requires advanced competencies and experience in providing palliative care). The palliative care approach includes identifying patients with palliative care needs early on, undertaking advance care planning and other important conversations, such as goals of care discussions, identifying the needs of patients across different domains and initiating care plans to address these, connecting patients and families to resources, and engaging palliative care specialists when needed.

Primary palliative care: Palliative care (specifically a palliative care approach) provided by primary care professionals and emergency services when equipped with core competencies to provide a palliative care approach. The term in Canada has often been used to

3 World Health Organisation. WHO | WHO Definition of Palliative Care. Whoint [Internet]. 2012 Jan 28; Available from: https://www.who.int/cancer/palliative/definition/en/

also refer to a palliative care approach provided by health care professionals in other specialty areas, such as oncology, cardiology, respirology, nephrology, geriatrics, neurology, pediatrics, critical care, emergency medicine, amongst others. However, there is an international movement to reserve the term "primary palliative care" to refer to palliative care provided only by primary care professionals. The term "generalist palliative care" is increasingly touted to be used to refer to the palliative care approach provided by other specialists and specialty areas. Competencies for primary/generalist level palliative care across disciplines are established in the Canadian Interdisciplinary Palliative Care Framework[4].

Generalist palliative care: See "Primary palliative care" and the "Palliative care approach."

Specialist palliative care: Palliative care provided by health care professionals with advanced training, certification and experience in palliative care, who are able to provide advanced levels of palliative care for patients with the most complex needs. Specialists in palliative care have an important role in advancing the field through education, quality improvement, research and health services leadership. In Canada, specialist level competencies have been established for professionals in a variety of disciplines in the Canadian Interdisciplinary Palliative Care Competency Framework[4]. Specialist nursing certification in palliative care is available through the Canadian Nurses Association (CNA), and supported by the Canadian Palliative Care Nursing Association, as the CNA Hospice Palliative Care Nursing Certification with the designation "CHPC(N)". Specialist physician training and credentialing are available through two routes. The College of Family Physicians of Canada (CFPC) has a Certificate of Added Competency in Palliative Care and the Royal College of Physicians and Surgeons of Canada provides certification through the Subspecialty in Palliative Medicine, with designations "CAC-PC" and "FRCPC PM," respectively.

Palliative Care Unit (PCU): For the purposes of this Atlas, and aligned with definitions described in the literature and by the European Association for Palliative Care, "dedicated" means a unit with an interprofessional team that focuses entirely or predominantly on providing palliative care and staffed by physicians and other professionals with advanced skills, experience and/or training in palliative care. This does not include "floating" or "designated" beds across the hospital that are occasionally or temporarily designated as "palliative," in other words, to care for someone with palliative care needs. In the case of "floating beds," a hospital may temporarily designate a bed in one or other unit as being specifically to care for a patient with palliative care needs. There are no specific beds in the hospital for this purpose, but they are designated as palliative care when the need arises and where there is space or a bed available. In the case of "designated beds," one or more beds can be allotted to patients with palliative care needs in a specific unit (e.g., internal medicine unit). The challenge with floating and designated beds is that the staff working on the unit or during the shift that these beds are identified temporarily for palliative care may not have the required skills and experience to care for patients with complex palliative care needs and their focus may be understandably on what they are most used to or experienced in (such as an acute internal medicine patient or surgical patient), and admissions for the purposes of providing palliative care need to be negotiated with the operations team responsible for those beds.

While PCUs are usually hosted in acute care hospitals, they can sometimes in Canada also be hosted in continuing care facilities.

Four different profiles (or types) of PCUs are recognized, depending on the complexity and acuity of patients admitted, the length of stay, the alive discharge rate, and access to: sophisticated investigations and imaging such as CT scans and MRIs; treatments and interventions such as palliative care radiotherapy and chemotherapy, high flow oxygen and interventional radiology; and consultation support from specialists across different specialty areas.

Acute PCU: High complexity and acuity, high alive discharge rate (>30%), short length of stay (mean about 7 to 10 days or less).

End-of-life PCU: Mixed complexity, including patients with low to medium complexity, low alive discharge rate (<10-20%), short length of stay (mean about 7 to 10 days or less).

Continuing Care PCU: Mixed complexity, including patients with low to medium complexity, long length of stay (median of 10 to 20 days with a range of days to weeks and even months).

Mixed PCU: Includes a mixed profile of patients meeting criteria of an acute PCU, others an end-of-life PCU and/or continuing care PCU.

Rural Area: Any region with low population density (<400 persons per square kilometre) and usually consists of farms, open land and/forests, and often contains small population centres.

Remote Area: Area located far from population centres with isolated small population centres and small holdings and consists mainly or entirely of natural regions/wilderness fauna and flora. People in these regions generally receive most of their health care through a family physician or nurse practitioner.

4 Canadian Partnership Against Cancer & Health Canada. The Canadian Interdisciplinary Palliative Care Competency Framework. Toronto, ON: 2021. Available from: https://www.partnershipagainstcancer.ca/topics/palliative-care-competency-framework/