Referral to Palliative Care services in Champlain

The purpose of this tool is to help clinicians initiate a referral to the appropriate Palliative Care support service in the Champlain region, depending on the patient's needs, underlying illness and geographical location.

Select which description best applies to the patient you are hoping to connect with palliative care services:

1. **Patient with cancer who is actively followed by malignant hematology or a medical and/or radiation oncologist *and* is able to seek palliative care support in an outpatient setting**
2. **Patient with non-cancer illness who is able to seek palliative care support in an outpatient setting**
3. **Patient with any life-limiting illness and a poor prognosis who is not able to seek palliative care support in an outpatient setting but their care needs can still be met at home (including Retirement Homes or Long Term Care homes)**
4. **Patient with any life-limiting disease and poor prognosis who is not able to seek palliative care support in an outpatient setting and their care needs cannot be met at home**

*** Please note that most patients with a life-limiting illness who have symptom management and/or care needs would benefit from a referral to Ontario Health atHome for consideration of palliative nursing visits and/or other services.* The patient may first be admitted to a community caseload. If and when appropriate, the patient may then be transferred to the palliative care caseload to meet complex case management, complex symptom management and end of life care needs. *Referral form:* Ontario Health atHome

- **If the patient has a cancer diagnosis, is actively followed by malignant hematology or medical and/or radiation oncology, and is well enough to attend an outpatient clinic,** consider referral to:
    - The **Outpatient Supportive and Palliative Care Clinic** (located at The Ottawa Hospital Cancer Centre and Irving Greenberg Family Cancer Centre)
        - Clinic provides outpatient consultation and follow up for patients with complex symptoms related to their cancer (i.e. does not include pre-existing chronic pain or chronic symptoms/complications from previous treatments). Providers can also assist with advance care planning and goals of care conversations.
        - Contact information: 613-737-8899 x 75648
        - Referral should be completed through a generic faxed paper consultation (fax # # 613-739-6890) or via EPIC

- If the patient has a **life-limiting non-cancer diagnosis and is well enough to attend an outpatient clinic,** referral can be based on primary disease type:
    - *If end-stage liver disease* (and must be followed at The Ottawa Hospital (TOH) by a hepatologist or internist for their cirrhosis) **or** *end-stage kidney disease* (and receiving hemodialysis or peritoneal dialysis either in-center at TOH (General, Riverside or Civic campuses), Queensway Carleton Hospital, or at home), refer to:
        - **Palliative Support for Advanced Illnesses Clinics**
            - Clinic provides **outpatient** consultation and follow up support for patients with a life expectancy of approximately <18 months who require assistance with symptom management, and/or advance care planning/goals of care discussions
                - Please note that patients who are being considered for transplant can still be referred.
            - Contact information: 613-737-8899 x 77220
            - Referral should be completed through a generic faxed paper consultation (fax # 613-761-4520) or via EPIC
    - *If advanced cardiac disease,* refer to:
        - **Cardiac Supportive and Palliative Care Program**
            - Clinic provides outpatient consultation and follow up support for patients who require assistance with symptom management, and/or advance care planning/goals of care conversations
            - Contact information**:** 613-696-7414
            - Referral should be completed through: Referral form Cardiac Supportive and Palliative Care Program

- Completed form should be faxed to 613-696-7138 or emailed to supportivecare@ottawaheart.ca

- *If life-limiting neurologic condition/diagnosis, refer to:*
  - **Neuro Palliative Outpatient Consult Service**
    - Clinic provides outpatient consultation and follow up support to patients with any neurological life-limiting illnesses who require assistance with symptom management, advance care planning and/or access to other palliative care support services. The patient does not need to be followed by a TOH neurologist.
    - Referral should be completed through a generic faxed paper consultation (fax# 613-761-4520) or via EPIC
    - *Note - this team can see patients with limited mobility in their homes if needed

- **At this time, referral for patients with *end-stage respiratory disease* (e.g. COPD, pulmonary fibrosis) to an outpatient palliative care clinic (i.e. Palliative Support for Advanced Illnesses Clinic) can only be initiated by the TOH pulmonary rehab team.
  - If the patient is not followed by TOH pulmonary rehab, consider involvement of the Regional Palliative Consultation Team (RPCT) (see details below)

➢ If the patient does not fall into any of the above referral criteria, consider referral to the Regional Palliative Consultation Team (RPCT) for assistance with symptom management and/or advance care planning/goals of care discussions
- RPCT Referral form

➢ If the patient requires **palliation/end of life care at home (including retirement home):**

- **STEP 1** - Refer to Ontario Health atHome
  - Ontario Health atHome will add the patient to the appropriate caseload and initiate palliative nursing visits and/or other services based on the patient's needs
  - Ontario Health atHome referral form
  - *Please note – if the patient is from LTC, you do not need to refer to Ontario Health atHome. Instead, proceed to STEP 2 for a patient residing in LTC.*

- **STEP 2** - Refer to the appropriate clinician:

A. If the patient **does <u>not</u>** have a primary care provider (family physician or NP), refer to a specialist community palliative care group according to the patient's address
   - Use the following link to determine which group to refer to depending on the patient's geographic location: Community Palliative Care physician map
   - Referrals can be made by completing paper/online PDF of referral form for each group or through Ocean (search "Palliative Community Physician")
   - ***Each group has specific referral criteria, but most groups generally require PPS 50% or less and/or complex symptom needs
   - ***If a referral is urgent, contact the appropriate Palliative Care group by phone to discuss with the accepting physician

B. If the patient has a primary care provider (family physician or NP), call the Regional Palliative Consultation Team (RPCT) at 1-800-651-1139 to determine if RPCT has previously worked with the patient's primary care provider

   - If RPCT confirms that the patient's primary care provider is able to provide palliative care support at home, refer to RPCT. RPCT will then discuss directly with the patient's primary care provider to plan next steps.
     - RPCT referral form

- If RPCT confirms that the patient's primary care provider does ***not*** provide palliative care support at home, refer to a specialist community palliative care group according to the patient's address (as in step A above)

- If RPCT does not know if the patient's primary care provider can support palliative care at home and the referral is *not* urgent, refer to RPCT. RPCT will work to get in touch with the primary care provider and determine next steps.

- If RPCT does not know if the patient's primary care provider can support palliative care at home and the referral *is* urgent, refer to a community palliative care team (as in step A above).

- **STEP 3 -** Consider need for injectable medications in the home
  - If the patient will require injectable medications, request a Symptom Response Kit (SRK)
  - It is recommended that there is direct communication with the physician accepting care of patient in the community to determine whether they agree that an SRK is needed and to confirm who will order the SRK (i.e. order at time of discharge or wait until seen by community palliative care clinician).

A note about LTC:

- Residents from LTC generally return to their LTC home from hospital and can remain at their LTC home for end-of-life care.
  - Admissions to The William and Maureen Shenkman Palliative Care Unit at Saint-Vincent Hospital for LTC patients are considered on a case-by-case basis, usually for patients with very complex symptom burden.
- LTC homes are able to provide all injectable medications *without* sending a SRK but the discharging physician needs to indicate on the discharge prescription what injectable medications should be given and when.
- You can refer to the Regional Palliative Consultation Team (RPCT) for patients requiring extra palliative care support in LTC

- If the patient requires **admission to hospice/Palliative Care unit for symptom management and/or end of life care:**
    - If patient located in Ottawa:
        - Initiate Social Work consult and submit a referral to:
            - The William and Maureen Shenkman Palliative Care Unit (PCU) at Bruyere Health Saint-Vincent Hospital or Hospice Care Ottawa/la Maison de l'Est
                - Please see PCU and hospice eligibility criteria Palliative Care referral information
                - Referral form can be found on Ocean (type "Hospice-Palliative Care" near "Ottawa" in the search bars) – note that this form is often filled out by social work, but can be completed and faxed by any healthcare provider
            - Diane Morrison Hospice @ Ottawa Mission for people experiencing homelessness or structural vulnerability.
                - Contact number 613-234-1144.

    - If patient is located outside of central Ottawa, consider referral for admission to the following, depending on patient's location:
        - Renfrew: Hospice Renfrew
        - Cornwall: Carefor Hospice Cornwall – For admission information contact the Intake Coordinator at 613 938 2763, ex 4131 and 4135
        - Madawaska: Madawaska Valley Hospice
        - Pembroke: Hospice Palliative Care Unit - Marianhill
        - Wakefield: La Maison des Collines

    - If patient is from the Gatineau area - Maison Mathieu Froment Savoie | Services for patients (mmfs.org)

    - Note - if a patient who lives outside of Ottawa is admitted to hospital, can also consider repatriation back to their community hospital for end-of-life care closer to home.