CARDUS — PALLIUM CANADA
PALLIATIVE CARE ROUNDTABLE

Fostering Palliative Care Compassionate Communities within the Canadian Context

AGENDA

Disclaimer: This document is a revised version of the Agenda used for the Cardus—Pallium Canada Roundtable held on April 27, 2016, in Ottawa, Canada. It is provided only to provide context for the roundtable summary document.

The agenda was originally developed as an internal document for prompting and discussion purposes only. It is a synopsis of materials from various sources, compiled by but not original to Cardus. Much is adapted from Pallium Canada materials, and we refer you to the wealth of resources available at pallium.ca.

Context and Objective

The objective for this roundtable is to use the insights of an interdisciplinary roundtable of experts to inform the development of a "palliative care ecosystem map" and a potential larger conference. This roundtable tests three convictions (each stated more starkly and without necessary nuance in order to illustrate the point – the nuance will follow below):

- The focus of existing medical models needs to be shifted (and broadened) from the individual person as the object of care to the person and natural caregivers[1], the palliative care model.
- Much of the well-intentioned effort within both the health and community sectors does not maximize synergy due to the "recruiting" of others to achieve the objectives of one's own discipline. Stated differently, a "public health" agenda may not be best achieved through the leadership of the health system but rather as part of a "flourishing" agenda in which the health system works in a complementary fashion with every other social sphere to achieve shared goals.
- Language is a significant challenge in achieving this objective. Jargon can also impede synergy. A significant part of our work needs to develop a shared vocabulary that transcends the particularities of any industry jargon.

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[1] By "natural caregiver," Cardus understands those people in your personal network whom you choose, and on whom you rely, for your intimate care and support. Examples might include: family members (immediate or extended), friends, community volunteers, church members, and, to a degree, people hired by you (whether from the community or from an organization).

Our hope is that after this roundtable we will be in a position to update the attached palliative care ecosystem map we have developed (Appendix A). Pending funding support, our intention is to transform this sketch into a website (applicable both nationally and as a template for local communities), and a national conference that would replicate the intentions of Pallium Canada's October 2015 Compassionate Communities conference with an attendance reflective of a complete cross-section of contributors. These collaborations will contribute to integration of effective palliative care into the current health and social care delivery system towards which Canadians aspire.

Definitions

The World Health Organization defines palliative care as: "an approach that improves the quality of life of patients and their families facing the problem 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."

www.who.int/cancer/palliative/definition/en/

The Canadian Hospice Palliative Care Association (2011) defines "hospice palliative care" as: "whole-person health care that aims to relieve suffering and improve the quality of living and dying." The purpose of hospice palliative care is to help patients and families: address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears; prepare for and manage the dying process; and cope with loss and grief during the illness and bereavement. "Hospice palliative care is appropriate for any patient and/or family living with, or at risk of developing, a life-limiting illness due to any diagnosis, with any prognosis, regardless of age, and at any time they 'have unmet expectations and/or needs, and are prepared to accept care."

www.chpca.net/media/7757/LTAHPC_Definition_of_HPC_from_the_Norms.pdf

Background

Please refer to pallium.ca for the full background of Pallium's work, vision, and momentum.

> *Pallium Canada has launched a revitalized focus on national and international community engagement to leverage and strengthen the community of clinicians, carers, educators, academics, administrators, volunteers, citizens and other partners who are working together to build palliative and end-of-life capacity as part of a sustainable health and social care system.*
>
> *— http://pallium.ca/phase-iii/*

Today, every area of health care has a public health agenda. That is, every area of health care except palliative care, though it would benefit from it. A public health approach takes the responsibility of palliative care from a few highly trained specialists to a community that considers it "everybody's business."

Pallium Canada is invested in helping Canada mobilize around palliative care as a public health issue, and in particular, to understand, adapt and adopt a Compassionate Communities paradigm. Through knowledge translation, education, project facilitation and leadership, Pallium Canada promotes this vital social transformation where death is re-normalized and broadly supported in community through social and health care vehicles.

Cardus and Pallium Canada are pleased to be working together towards this vision of integrating holistic palliative care in Canada by fostering dialogue, shared learning, and the co-creation of knowledge. In particular, the Palliative Care Roundtable seeks to leverage diverse expertise and experience with respect to a public health palliative care (PHPC) strategy. The roundtable seeks to better understand what this "palliative care ecosystem" encompasses through the eyes of our expert participants.

Question

For the benefits of the Compassionate Communities theory of practice to translate effectively from the European context to the North American one, we have to address the "translation" challenge. A disproportionate focus on the health care perspective, while crucial for funding, can be detrimental to the patient and especially to the patient's natural caregivers, let alone the bereaved. **What are the elements that a successful model incorporates to best place the patient and the caregiver and the bereaved at its centre, so as to take full advantage of all aspects of the community and the resources it can offer?** How do we spark and capitalize on synergies among stakeholders to entrench solid, comprehensive, enduring support?

Introductions

- Ray Pennings, Cardus' Executive Vice President and roundtable moderator: Cardus, context, and roundtable objectives.
- Dr. Kathryn Downer, Pallium's Executive Director: Pallium Canada.
- Participants' introductory statements describing their background and perspective as well as any key questions they believe essential to achieving the day's objective.

Session 1: Broadening our Perspectives

Community-Based Palliative Health Care Models and Compassionate Communities. Understanding Key Themes, Commonalities, Differences, and Tensions

The holistic palliative care philosophy moves us from disease or condition-specific care to person-centered care and recognizes that the psychosocial and spiritual dimensions have profound impact upon health and well-being. Palliative care strategies are patient-centered, family-focused, and community-based, providing for a sustainable person- and family-preferred model of care..

Canada falls short of quality end-of-life care for all, with only 16-30% of those who need palliative care receiving it. Demographic and fiscal pressures are only increasing the need for to address this gap

Various jurisdictions outside of Canada as well as within have responded to these pressures by introducing Public Health Palliative Care (PHPC) strategies. A public health approach to palliative care develops a wider community context in which palliative care services can make their contributions and takes the responsibility of palliative care from a few highly trained specialists to a community. The underlying philosophy behind PHPC is the international charter for public health, known as the **Ottawa Charter for Health Promotion** (http://www.who.int/healthpromotion/conferences/previous/ottawa/en/) . The Ottawa Charter was established in 1986 and is based on 5 core principles:

- Building public policies that support health
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

The **Compassionate Communities** paradigm is a leading example of a PHPC strategy, widely used in jurisdictions around the world. In many of these jurisdictions, the Compassionate Cities/Communities thoery of practice as developed and published by Dr. Alan Kellehear and colleagues is the actual model being used. Based heavily on the success of the WHO Healthy Cities model, Compassionate Communities treat palliative and end-of-life care as a community responsibility and creates partnerships between the community and services. The goal is to bridge gaps in the community, especially those involving social care. These gaps include inadequate and inequitable access to care, inadequate support for caregivers, lack of clear accountability for this care across systems of care, and lack of real integration of care.

For more information on the Compassionate Communities theory of practice, we refer you to Dr. Denise Marshall's presentation at the Pallium Canada, Compassionate Communities Symposium, held in Ottawa on October 2015, and entitled "Palliative Care as Public Health: Bringing the International Compassionate Communities Model to Canada." The report can be found on the Pallium website or online at: http://pallium.ca/wp-content/uploads/2015/11/Palliative-Care-as-Public-Health-Bringing-the-International-Compassionate-Communities-Model-to-Canada-Dr.-Denise-Marshall.pdf

The Canadian policy context presents a unique set of challenges and opportunities for PHPC strategies, yet policy experts, practitioners, and researchers are in a fortunate position to be able to learn from a growing number of community-based health-care policy innovations. A few examples here include Healthy Communities, Healthy Cities, Vital Signs, Thriving Cities, and in the palliative health-care field specifically, the BC Centre for Palliative Health (led by Roundtable participant Dr. Doris Barwich) and Pallium Canada. Finally, the Public Health Palliative Care International association seeks to develop compassionate communities and communicate the importance of public health ideas and approaches in palliative care at a global level. We include links for each of these here as well as introductory summaries in Appendix B. We also include a model developed on the research another roundtable participant, Mary Lou Kelley.

- *Health Communities* - http://www.ohcc-ccso.ca/en/what-makes-a-healthy-community
- *Healthy Cities* - http://www.euro.who.int/en/health-topics/environment-and-health/urbanhealth/activities/healthy-cities
- *Vital Signs* - http://www.vitalsignscanada.ca
- *Thriving Cities* – www.thrivingcities.com
- *BC Centre for Palliative Health* - www.bc-cpc.ca/cpc/
- *Pallium Canada* – www.pallium.ca
- *Public Health Palliative Care International* - www.phpci.info
- *Process of Palliative Care Program Development* - http://eolfn.lakeheadu.ca/wp-content/uploads/2015/07/Palliative-Care-Workbook-Final-December-17.pdf

We also want to consider lessons to be gained from outside of the health sector, where complex problems of a different nature similarly manifest within the community and rest upon outdated institutional and funding mechanisms. These conditions result in the same need for policy innovation and community capacity-building.

A comparative approach that seeks to understand best practices, as well as the tensions and synergies that lie across these various divides, is therefore highly constructive in our efforts to understand and enhance palliative care strategies.

The session seeks to foster this comparative understanding by leveraging the insights and expertise of a diverse set of roundtable participants. In our discussions of Compassionate Communities alongside other models and policy innovations, we seek to understand key themes, differences, commonalities, and tensions, mindful always of these aspects and applications within a Canadian context.

The Roundtable's broad intent is to allow for natural synergies and the opportunity for a spectrum of experts to share and learn from one another. We **propose four general themes**, representing key aspects of PHPC strategies, to spark thought and help frame dialogue:

- ***Holistic Health Care***

  A system of comprehensive or total patient care that includes not only the physical needs but also the emotional, social, spiritual, and economic needs of the person.

- ***Includes Natural Caregiver and the Family Context***

  A system that understands, values, and supports the integral role of natural caregivers and the family context.

- ***Community-Based***

  A system that seeks to move health care into the wider community and social context by mobilizing local assets, capacities, and relationships.

- ***Integrated and Coordinated Continuum of Care***

  A system where the delivery of care is not seen as a series of alternatives to be chosen between, but rather as a continuum of care in which there is a seamless continuity of end-of-life care supports and settings. This involves the integration of not only services, but also our systems of policy development, legislation, and regulation.

Discussion Questions:

From your experience and knowledge of various community-based initiatives:

- Are there important differences and tensions in terms of how these key aspects are addressed or reflected?
- Despite the palliative care model placing natural caregivers at its centre along with patients, the health care system tends to treat natural caregivers merely as part of the support system for patients. What is the impact of this difference?
- Beyond the themes noted above, are there further synergies and commonalities among these models?
- Is there particular language used in some of these models that communicates especially well across sectors? Is there particular language that creates confusion?
- What might these differences, commonalities, and tensions, suggest for efforts to mobilize a Public Health Palliative-Care Strategy?

Session 2: Deepening our Lens

The Community Context

"Home, family and the community are too fundamental to the identity of the person to be ignored in the basic care of the chronically ill or dying person."
(2011 Parliamentary Committee – "Not to be Forgotten").

PHPC strategies move beyond medical care to a community-based model of care that is better able to provide for a continuum of holistic supports. This coincides with an understanding that these strategies depend upon a complex and require a coordinated, multi-sectoral, and integrated response that is adapted to the particularities of the local community. A community-capacity approach is therefore necessary that seeks to bridge gaps in care by creating the necessary conditions and building the necessary partnerships. In this context, levels of social capital, which can be understood to include trust, empathy, and cooperation, as well as culture and education, become important considerations.

"The design of systemic end of life care involves the creation of relationships."
(National Council for Palliative Care, UK)

While federal and provincial governance institutions can play an important role in PHPC policy innovations, mobilizing around these approaches depends upon its flexible adaptation to the particular conditions of the community. These policy innovations, therefore, give rise to a host of important questions around the need to better understand the relevant aspects, barriers, and opportunities within the particular community context.

Recognizing that Canadian communities are diverse and varied in a number of important ways, we offer a preliminary list of these "contextual variations" as follows:

- **Geographical Considerations** – relating to whether the community is urban or rural, its size, remoteness, etc.

"A significant number of Canadians, close to seven million people, live in rural areas and communities of only a few thousand people. If there is a form of "two-tiered" health care in Canada it would be the distinction between urban and rural areas in terms of health care delivery. Canada's health policy has emphasized urban centers, attempting to adopt urban models of health care to rural health care delivery. Certainly as vast an area as Canada, with a widely dispersed population, makes it extremely challenging to deliver health-care to rural and remote areas."

(2011 Parliamentary Committee, "Not To Be Forgotten")

- **Governance Mechanisms,** funding and accountability structures, regional health structures, and local stakeholders;
- **Social Capital and Trust**;
- **Health Care Services**, including availability, access supports, informational supports, caregiver supports, etc.;
- **Culture and Diversity,** particularly as this applies to First Nations and immigrants;
- **Personal Level Attributes** that may affect access or pathways of care, including income, education, language capacity, caregiver supports, transportation, etc.

Again, these considerations are offered only to spark dialogue around the important aspects to consider when mobilizing around PHPC strategies.

Discussion Questions

Reflecting on your experience and knowledge of various community-based initiatives:

- How might variations across communities serve to influence and shape efforts to create Public Health Palliative Care strategies within the Canadian context?
- What key aspects and enabling conditions are needed within the community in order to build, operationalize, and maintain Public Health Palliative Care Strategies?
- What structures and processes are needed for people from diverse groups to come together to work out decisions about the community?

- What promising practices exist about mechanisms for networking, communication and cooperation among those within the community?
- What are the conditions that support wider and deeper networks for caring in community? Are these consistent across communities?

Session 3: Looking Ahead

General discussion about logical next steps and objectives

How might our previous discussions and learning impact on our understanding of the "palliative care ecosystem map" (Appendix A)?

Our hope is that a broad understanding of the map better reflects palliative care strategies, which place both the patient and caregiver at its centre. Pending funding support, our intention is to use this map as an online framework to help guide the efforts of various stakeholders both nationally and at the community level. We are hopeful of further convening of meetings, whether a national conference or local roundtables, that include a representative cross-section of all relevant stakeholders, allowing for further conversations

Specifically, how might the conversational tool in Appendix A be amended to help us consider:

- who needs to be invited into the national conversation?
- why do they need to be included?
- how do we find a vocabulary for this that transcends disciplinary jargon and is therefore broadly accessible to all participants?

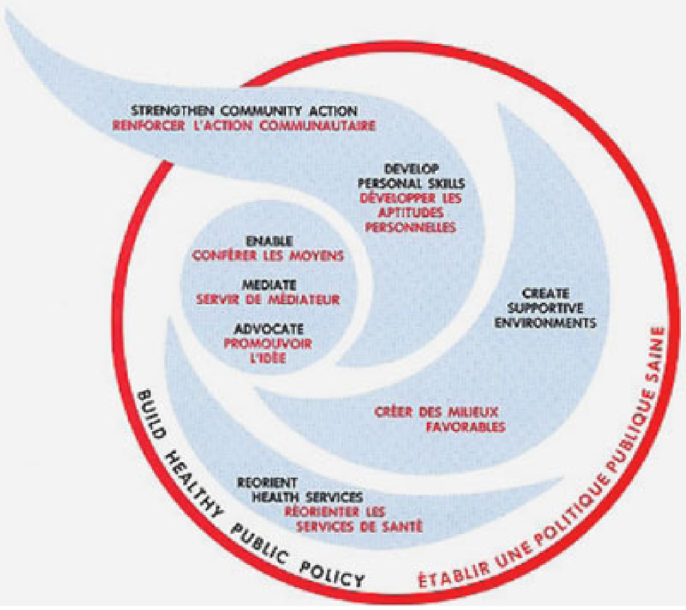
APPENDIX ‘A’:
A Conversational Tool towards a “Palliative Care Ecosystem Map”

The underlying philosophy behind Public Health Palliative Care (PHPC) is the international charter for public health, known as the Ottawa Charter for Health Promotion. The Ottawa Charter was established in 1986 and is based on five core principles:

- Building public policies that support health
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

Using the themes above, we offer (on the next page) a first draft of a Canadian “palliative care ecosystem map.” It provides a conversational tool to consider:

- who needs to be invited into the national conversation?
- why do they need to be included?
- how do we find a vocabulary for this that transcends disciplinary jargon and therefore broadly accessible to all participants?



OTTAWA CHARTER DIAGRAM from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index4.html page 5]

Almost every example we provide in the map fits in more than one category. The purpose is to ensure that all partners are eventually on the map, without great concern about where they fall. If we are to take the health charter seriously, we need to see that all the partners are included.

The map features at its centre a slightly modified version of the Auditor General of Ontario’s 2014 “Palliative-care Continuum,” which they adapted from information from the Canadian Hospice Palliative Care Association. For the roundtable’s internal use only, the map is provided exclusively to further our collaborative learnings and is not for broader distribution or publication.

Develop Personal Skills

Anything that helps patients or natural caregivers be more informed of their options or acquire the necessary skills to provide care.

EXAMPLES:

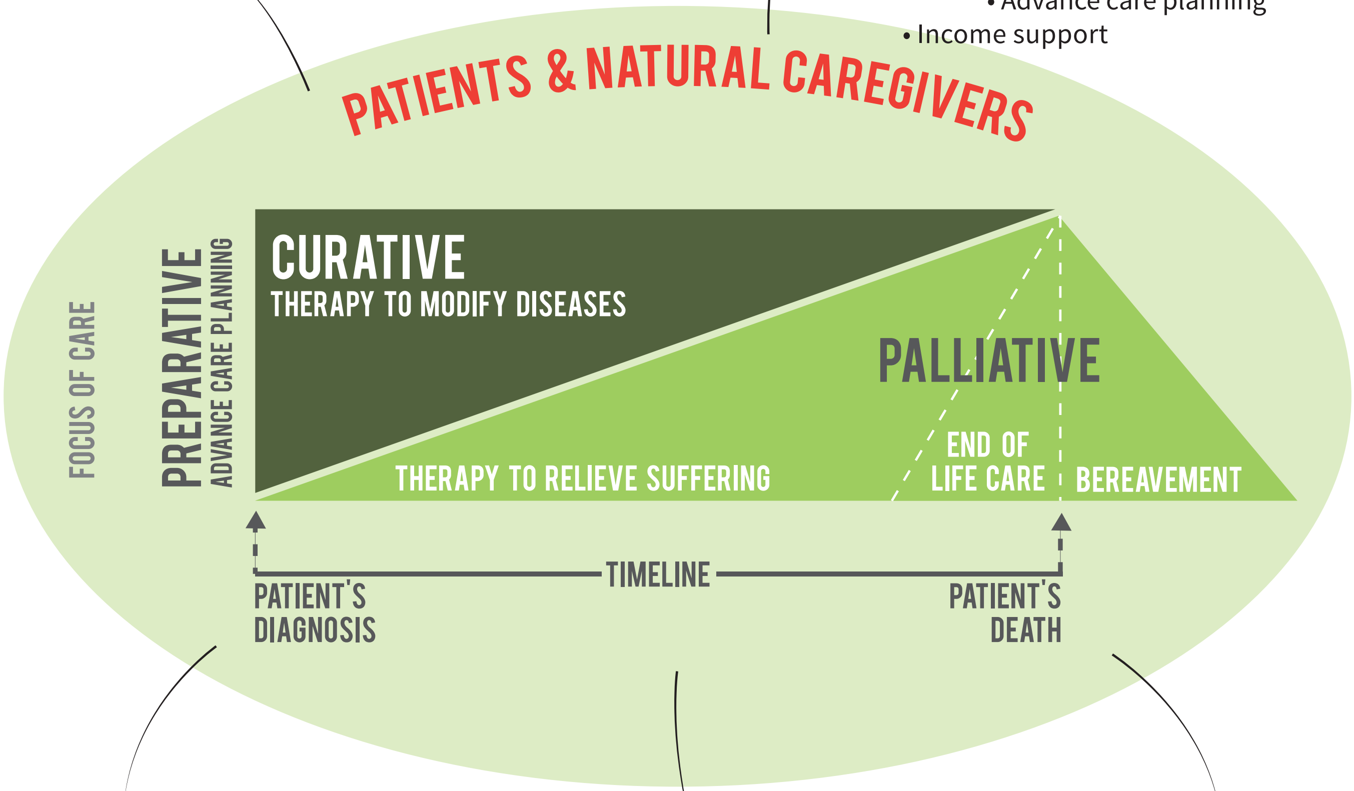
- Canadian Virtual Hospice
- Nurse Navigator
- The palliative care equivalent of pre-natal education

Build Healthy Public Policy

Any initiative that makes the "palliatively" healthier choice the easier choice for policymakers and the public.

EXAMPLES:

- Palliative care as public health
- Palliative literacy
    - Public education
    - Advance care planning
- Income support



Create Supportive Environments

Anything that provides a broader awareness or policies of accommodation and/or support for patients and natural caregivers.

EXAMPLES:

- Employment policies
- Financial policies
    - Income Support Policies
    - Taxation Policies
- Alternative living support
- "Bucket list" support
- Public education
    - Normalization of Death("Die-alogues")
- Bereavement/grief support
- Neighbourhood/religious/ethnic supportive communities
- Coordinating bodies
- Peer support groups

Reorient Health Services

Any action undertaken that impacts the funding, training, credentialing, or resourcing the systems which impact the palliative care continuum.

EXAMPLES:

- Funding
    - Models
    - Access
- Medical records
    - Access
    - Interoperability
    - Websharing
- Clinical support
    - Training (original or continuing)
    - Curriculum

Strengthen Community Action

Anyone whom patients or natural caregivers would be inclined to call directly for help, who provide a tangible direct help to the patients or natural caregivers.

EXAMPLES:

- Neighbourhood/religious/Ethnic action communities
    - Meals on Wheels
    - A church's Aging Support team
    - Community-based hospices

APPENDIX B
PUBLIC HEALTH REFERENCES AND INNOVATIONS
Brief Summaries

OTTAWA CHARTER FOR HEALTH PROMOTION

www.phac-aspc.gc.ca/ph-sp/docs/charter-chartre/index-eng.php

The first International Conference on Health Promotion met in Ottawa in 1986. The conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on inter-sectoral action for health.

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

The Ottawa Charter for Health Promotion established 5 core principles as follows:
- Building public policies that support health
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

COMPASSIONATE CITIES CHARTER

www.phpci.info/#!resources/c52k

Professor Allan Kellehear and Dr Julian Abel have developed the Compassionate Cities Charter. The Charter outlines 13 social changes to be delivered with regard to death, dying, loss and care that can be driven through the Mayor's Office.

People who live with life-threatening or life-limiting illness, their caregivers, and the bereaved are segmented social groups, forced to experience lifestyles that are commonly socially hidden and disenfranchised from the wider society. Outside of the health services that deal specifically with their immediate problems, these populations suffer from a range of other troubles that are separate but linked to their health conditions or social circumstances – loneliness, isolation, job loss, stigma, depression, anxiety and fear, or even suicide. These populations also suffer from a range of other debilitating health problems often caused by their social and psychological troubles - insomnia, cardiac arrhythmias, chronic fatigue and headaches, hypertension, and gastric-intestinal disorders.

Compassionate Cities are communities that publicly recognize these populations, and these needs and troubles, and seek to enlist all the major sectors of a community to help support them and reduce the negative social, psychological and medical impact of serious illness, care-giving, and bereavement. A compassionate city is a community that recognizes that care for one another at times of health crisis and personal loss is not simply a task solely for health and social services but is everyone's responsibility.

Compassionate Cities are communities that publicly encourage, facilitate, support and celebrate care for one another during life's most testing moments and experiences, especially those pertaining to life-threatening and life-limiting illness, chronic disability, frail ageing and dementia, grief and bereavement, and the trials and burdens of long term care. Though local government strives to maintain and strengthen quality services for the most fragile and vulnerable in our midst, those persons are not the limits of our experience of fragility and vulnerability. Serious personal crises of illness, dying, death and loss may visit any us, at any time during the normal course our lives. A compassionate city is a community that squarely recognizes and addresses this social fact.

Through auspices of the Mayor's office a compassionate city will - by public marketing and advertising, by use of the cities network and influences, by dint of collaboration and co-operation, in partnership with social media and its own offices – develop and support the following 13 social changes to the cities key institutions and activities.

- Our schools will have annually reviewed policies or guidance documents for dying, death, loss and care
- Our workplaces will have annually reviewed policies or guidance documents for dying, death, loss and care

- Our trade unions will have annually reviewed policies or guidance documents for dying, death, loss and care
- Our churches and temples will have at least one dedicated group for end of life care support
- Our city's hospices and nursing homes will have a community development program involving local area citizens in end of life care activities and programs
- Our city's major museums and art galleries will hold annual exhibitions on the experiences of ageing, dying, death, loss or care
- Our city will host an annual peacetime memorial parade representing the major sectors of human loss outside military campaigns – cancer, motor neuron disease, AIDS, child loss, suicide survivors, animal companion loss, widowhood, industrial and vehicle accidents, the loss of emergency workers and all end of life care personnel, etc.
- Our city will create an incentives scheme to celebrate and highlight the most creative compassionate organization, event, and individual/s. The scheme will take the form of an annual award administered by a committee drawn from the end of life care sector. A 'Mayors Prize' will recognize individual/s for that year those who most exemplify the city's values of compassionate care.
- Our city will publicly showcase, in print and in social media, our local government policies, services, funding opportunities, partnerships, and public events that address 'our compassionate concerns' with living with ageing, life-threatening and life-limiting illness, loss and bereavement, and long term caring. All end of life care-related services within the city limits will be encouraged to distribute this material or these web links including veterinarians and funeral organizations
- Our city will work with local social or print media to encourage an annual city-wide short story or art competition that helps raise awareness of ageing, dying, death, loss, or caring.
- All our compassionate policies and services, and in the policies and practices of our official compassionate partners and alliances, will demonstrate an understanding of how diversity shapes the experience of ageing, dying, death, loss and care – through ethnic, religious, gendered, and sexual identity and through the social experiences of poverty, inequality, and disenfranchisement.
- We will seek to encourage and to invite evidence that institutions for the homeless and the imprisoned have support plans in place for end of life care and loss and bereavement.
- Our city will establish and review these targets and goals in the first two years and thereafter will add one more sector annually to our action plans for a compassionate city – e.g. hospitals, further & higher education, charities, community & voluntary organizations, police & emergency services, and so on.

This charter represents a commitment by the city to embrace a view of health and wellbeing that embraces community empathy, directly supporting its inhabitants to address the negative health impacts of social inequality and marginalization attributable to dying, death and loss.

A city is not merely a place to work and access services but equally a place to enjoy support in the safety and protection of each other's company, in schools, workplaces, places of worship and recreation, in cultural forums and social networks anywhere within the city's influence, even to the end of our days.

For more information on the Compassionate Communities model, we refer you to Dr. Denise Marshall's presentation at the Pallium Canada Compassionate Communities Symposium, held in Ottawa on October 2015, entitled "Palliative Care as Public Health: Bringing the International Compassionate Communities Model to Canada."

The report can be found at:
pallium.ca/wp-content/uploads/2015/11/Palliative-Care-as-Public-Health-Bringing-the-International-Compassionate-Communities-Model-to-Canada-Dr.-Denise-Marshall.pdf
You can also go to to pallium.ca/compassionate-communities-2/symposium-recap-mobilizing-your-compassionate-community/ and find the link if the above takes too long to load.

BC CENTRE FOR PALLIATIVE CARE

www.bc-cpc.ca/cpc/

The BC Centre for Palliative Care is comprised of health care experts providing leadership for best practice research and education in palliative care, advance care planning and building compassionate communities.

The Centre is committed to enabling excellence in care for all British Columbians living with serious illness. As a provincial organization, the Centre collaborates with members of the public, policy makers, regional health authorities, professional bodies and community organizations from across BC to:

- Improve access to Advance Care Planning and palliative care supports for patients and families
- Increase access to quality education, practice support, and resources for health care providers to integrate a palliative approach to care
- Engage citizens and mobilize partnerships across BC to create Compassionate Communities that provide practical support, compassion and care to patients and their families.

Established in 2013 in support of the Ministry of Health's Provincial End of Life Action Plan, and funded through the Institute for Health System Transformation and Sustainability (IHSTS), the Centre's focus is to convene and establish provincial networks and community partnerships by drawing together patients, families, care givers, clinicians, health administrators, researchers and community organizations.

The role of the BC Centre for Palliative Care is to collaborate, coordinate and catalyze effective conversations at all levels to create capacity and enable change in the way people live and die in British Columbia. A palliative approach to care focuses on the person and their family, their needs and their goals of care from time of diagnosis. The Centre's goal is to support early integration of this approach in every setting of care in BC.

The Centre's inaugural Executive Director, Dr. Doris Barwich, has established the Centre's strategic focus and mobilized provincial networks and partnerships. Prior to joining the Centre in 2013, Dr. Barwich co-led Fraser Health's End of Life Care program with several nationally and internationally recognized leading practices in Advance Care Planning, population health and program delivery.

PALLIUM CANADA

http://pallium.ca/compassionate-communities-2/

Pallium is a pan-Canadian, not-for-profit organization mandated to improve Palliative Care across Canada through education and community-building with health professionals and carers. ***Our Vision 2020 is that every Canadian who requires palliative care will receive it early, effectively and compassionately.***

Since Pallium's 2001 launch, hundreds of courses have been delivered across Canada in English and French and thousands of health professionals across different disciplines have been trained. A robust network of palliative care and community leaders and organizations (from academic institutions to clinical services) works collaboratively with Pallium to develop and deliver palliative care training, resources and clinical support tools (Pallium Palliative Pocketbook [English, French, paper and electronic], the Pallium Resource App, LEAP courses customized to care settings, online modules, and teaching videos) to bring best practices to the bedside. Pallium supports the continuum of care to ensure that at each transition the best care is consistently provided.

Pallium mobilizes the best minds in the country to advance interprofessional palliative care education at the "essentials" level. Aboriginal leaders and people are engaged to illuminate culturally respectful sensitivity as exampled by our First Nations, Metis and Inuit peoples' learnings within the LEAP courseware. We are conducting early development work to launch Compassionate Schools, Companies and Neighbourhood Programs.

Pallium's 2020 Strategic Plan calls for action across four goals:

- EDUCATION- Educate health professionals and carers across home care, community care and institutional care settings.
- COMPASSIONATE COMMUNITIES - Empower Canadian communities to care for ailing persons and mobilize social, education and business sectors.
- INTEGRATION OF PALLIATIVE CARE IN HEALTH AND SOCIAL SERVICES- Recognize service excellence (e.g. provide a biannual report on the level of integration of palliative care services across regions in Canada), and
- SUSTAINABILITY- Build long term viability, quality and efficient processes.

Pallium is well positioned to leverage its past successes and current infrastructure renewal to provide national leadership through its collaborative pan-Canadian network and partnerships to mobilize positive systemic change.

Nothing impacts us and our families more intimately than the death of a loved one.

WHO - HEALTHY CITIES

www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities

The WHO Healthy Cities project is a global movement. It engages local governments in health development through a process of political commitment, institutional change, capacity-building, partnership-based planning and innovative projects. Nearly 100 cities are members of the WHO European Healthy Cities Network, and 30 national Healthy Cities networks across the WHO European Region have more than 1400 cities and towns as members.

The primary goal of the WHO European Healthy Cities Network is to put health high on the social, economic and political agenda of city governments. Health is the business of all sectors, and local governments are in a unique leadership position, with power to protect and promote their citizens' health and well-being.

The Healthy Cities movement promotes comprehensive and systematic policy and planning for health and emphasizes:

- the need to address inequality in health and urban poverty
- the needs of vulnerable groups
- participatory governance
- the social, economic and environmental determinants of health.

This is not about the health sector only. It includes health considerations in economic, regeneration and urban development efforts.

HEALTHY COMMUNITIES

www.ohcc-ccso.ca/en/what-makes-a-healthy-community
Also see: Healthy Communities Orientation Slides www.ohcc-ccso.ca/en/webfm_send/618

The Ontario Healthy Communities Initiative (OHCC) - Healthy Communities/Healthy Cities (HC) is an international movement that involves thousands of HC projects, initiatives and networks world-wide. HC takes a holistic view of communities, recognizing that “everything is connected to everything” and “the whole is more than the sum of its parts”. Healthy Communities initiatives are multi-sectoral collaborations that integrate social, economic and environmental goals to benefit the whole community and strengthen community capacity to promote and sustain health.

The OHCC promotes healthy community principles across all sectors, providing support, facilitation, resources and tools to communities that are pursuing local Healthy Communities goals.

Healthy Communities are based on the following principles:

- Health is a state of complete physical, mental and social well-being.
- Social, environmental and economic factors are important determinants of human health and are inter-related.
- People cannot achieve their fullest potential unless they are able to take control of those things which determine their well-being.
- All sectors of the community are inter-related; sectors need to share their knowledge, expertise and perspectives and work together to create a healthy community.

A Healthy Communities process involves:

- Equitable community engagement
- Intersectoral partnerships
- Political commitment
- Healthy public policy
- Asset-based community development

Qualities of a Healthy Community include:

- Clean and safe physical environment
- Peace, equity and social justice
- Adequate access to food, water, shelter, income, safety, work and recreation for all
- Adequate access to health care services
- Opportunities for learning and skill development

- Strong, mutually supportive relationships and networks
- Workplaces that are supportive of individual and family well-being
- Wide participation of residents in decision-making
- Strong local cultural and spiritual heritage
- Diverse and vital economy
- Protection of the natural environment
- Responsible use of resources to ensure long term sustainability

These principles have been adapted from the work of Trevor Hancock and Leonard Duhl. They are discussed in more detail, with references to earlier documents, in a report Dr. Hancock prepared for the Senate Subcommittee on Population Health in March 2009 entitled Act Locally: Community-based population health promotion.

The report can be found at: www.parl.gc.ca/Content/SEN/Committee/402/popu/rep/appendixBjun09-e.pdf

VITAL SIGNS

www.vitalsignscanada.ca

Vital Signs is a national program led by community foundations and coordinated by Community Foundations of Canada that leverages local knowledge to measure the vitality of our communities and support action towards improving our collective quality of life.

More than 65 communities in Canada and around the world are using Vital Signs to mobilize the power of community knowledge for greater local impact.

Vital Signs uses community knowledge to measure the vitality of our communities - gathering data and publishing reports on significant social and economic trends to tell the story of how Canadian communities are faring in key quality-of-life areas.

Vital Signs connects the dots between existing data to dive deep on issues such as poverty, food insecurity and youth unemployment. Community foundations use Vital Signs to start conversations and identify trends to help communities act on local priorities and opportunities.

Vital Signs was first started by the Toronto Foundation in 2001, after a group of civic leaders came up with a new way to engage their community in understanding and monitoring the health and vitality of Toronto. Vital Signs became a national program in 2006 and continues to grow each year across Canada and internationally.

Community foundations use Vital Signs as a catalyst to involve their community and develop a picture of quality-of-life using a wide range of national data and local research. This community knowledge helps foundations decide where to focus their attention and resources to have the greatest impact.

Community Foundations of Canada releases a national Vital Signs report each year to engage Canadians in a deeper discussion about national trends and to explore issues that are key to our shared success in the future. This year's 2015 national Vital Signs report explores the importance of "belonging" in Canadian communities.

The report can be found at: www.vitalsignscanada.ca/en/page-45-2015-belonging

THRIVING CITIES

www.thrivingcities.com

An initiative of the Institute for Advanced Studies in Culture at the University of Virginia, Thriving Cities offers important insights for scholars, practitioners, and citizens in evaluating the well-being of their communities. Thriving Cities is committed to turning those insights into action-oriented tools that will empower key stakeholders—including foundations, city officials, city planners, religious leaders, politicians, educators, business people, academics, non-profits, and residents—to ask and answer the question: what does it mean and take to thrive in my city and how can I contribute?

What is Thriving Cities? Thriving Cities is developing a new paradigm for urban analysis, community assessment, and civic engagement based on a holistic framework of community wealth and well-being. An initiative of the Institute for Advanced Studies in Culture at the University of Virginia, Thriving Cities is committed to turning research-based insights into action-oriented tools that will empower key stakeholders—including foundations, city officials, city planners, religious leaders, politicians, educators, business people, academics, non-profits, and residents—to ask and answer the question: What does it mean and take to thrive in my city, and how can I contribute?

The Thriving Cities paradigm builds upon a “human ecology” framework. Human ecology stresses the fact that cities are neither collections of autonomous individual or discrete problem areas, each hermetically sealed from one another; nor do cities behave like mechanical systems that can be managed and controlled by rational experts from on high. A human ecology approach sees cities as complex, asymmetric, and dynamic social systems that both empower and constrain the ways of life and life chances of their residents.

RECENT JOURNAL ARTICLES

Abel. J., Walter, T., Carey, L., Rosenberg, J., Noonan, K., Horsfall, D. et al. (2013). Circles of care: Should community development redefine the practice of palliative care? BMJ Supportive & Palliative Care 3: (4) 436-443.

Abel, J., Bowra, J., Walter, T. and Howarth, G. (2011). Compassionate community networks: supporting home dying. BMJ Supportive & Palliative Care 1 (2), pp. 129-133.

Kellehear, A. (2013). Compassionate communities: End of life care as everyone's responsibility. Quarterly Journal of Medicine (UK) 106, 12, pp 1071-1076.

Rumbold, B., Aoun, S. (2014). Bereavement and palliative care: A public health perspective. Progress in Palliative Care 22(3), 131-135.

Sallnow, L. and Paul, S. (2014) Understanding community engagement in end of life care: developing conceptual clarity. Critical Public Health.

ABOUT CARDUS

Cardus is a think tank dedicated to the renewal of North American social architecture. Headquartered in Hamilton, ON, Cardus has a track record of delivering original research, quality events, and thoughtful publications which explore the complex and complementary relationships between virtues, social structures, education, markets, and a strong society. Cardus is a registered charity.

www.cardus.ca