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Item No. 12.1.4
Audit & Finance Standing Committee
December 3, 2018

TO: Chair and Members of Audit & Finance Standing Committee

Original Signed

SUBMITTED BY:

Jerry Blackwood, Acting Director of Finance & Asset Management/CFO

Original Signed

Jacques Dubé, Chief Administrative Officer

DATE: October 9, 2018

SUBJECT: **Funding Request - Hospice Society of Greater Halifax**

SUPPLEMENTARY REPORT

ORIGIN

October 2, 2018 – Amended motion approved that Halifax Regional Council approve a $250,000 capital contribution in 2018-19 [and] to provide a further $250,000 capital contribution to the Hospice Society of Greater Halifax in 2019-20 and request a staff report to identify the funding source and updated financials to be considered by the Audit & Finance Standing Committee and a recommendation to Halifax Regional Council.

LEGISLATIVE AUTHORITY

Administrative Order 1 Respecting Procedures of the Council.
Schedule 2. 4(f) Audit & Finance Standing Committee Terms of Reference.

Halifax Regional Municipality Charter ("HRM Charter"), S.N.S. 2008, c.39
79(1) The Council may expend money required by the Municipality for

…
(av) a grant or contribution to
…
(v) any charitable, nursing, medical, athletic, educational, environmental, cultural, community, fraternal, religious, sporting or social organization within the Province.
(vii) a registered Canadian charitable organization.

Administrative Order 2014-015-ADM Respecting Reserve Funding Strategies.
Reserve Business Case Q421 General Contingency Reserve

Recommendation on page 2

RECOMMENDATION

It is recommended that the Audit & Finance Standing Committee recommend that Halifax Regional Council:

1. Approve provision of a one-time capital grant to the Hospice Society of Greater Halifax in the amount of $500,000 towards the construction of a residential hospice facility at 618 Franklyn Street, Halifax to be funded as an unbudgeted withdrawal from the General Contingency Reserve Q421; and

2. Authorize the Chief Administrative Officer, or his designate, to negotiate, enter into and execute a Contribution Agreement on behalf of the Municipality with the Hospice Society of Greater Halifax, including the terms and conditions outlined in Table 1 of this report, and otherwise acceptable to the Chief Administrative Officer.

BACKGROUND

On February 21, 2018, the Hospice Society of Greater Halifax ("the Society") made a presentation to the Audit & Finance Standing Committee requesting $1,000,000 towards construction of a hospice facility in Halifax. Regional Council subsequently requested a staff report. Because the request for funding falls outside an existing municipal grant program, the staff report was tabled for debate at the September 19, 2018, meeting of the Audit & Finance Standing Committee. The staff recommendation to decline the request was overturned. In the alternative, the Standing Committee recommended that Regional Council approve an award in the amount of $250,000. The value of award was based on HRM's prior in-kind contribution to the establishment of a residential hospice through a less than market value sale of municipal property.

At their meeting of October 2, 2018, Regional Council approved a contribution of $250,000 in fiscal year 2018-19 but amended the motion to (i) add a further payment of $250,000 in fiscal year 2019-20, and (ii) requested additional financial information from the applicant. Further to Council's motion the Society was asked to provide the following:

- updated projected capital revenues (as of October 2018), including actual mortgage principal;
- actual and projected capital expenditures;
- projected operating revenue;
- projected operating costs with additional detail with respect to:
    - mortgage interest payment(s)
    - property taxes
    - any projected operating deficit in the first year of operation; and
- confirmation of the eligibility criteria to be used to determine the selection of hospice patients.

Questions of clarification were also communicated via email.

DISCUSSION

Proposed Financial Model: Revised Capital Budget

As of October 2018, the projected cost of a 10-bed residential hospice facility remains $6,774,000. To date, actual capital expenditures total $3,423,000 and the projected additional expenditures to completion are expected to be $3,351,000.

An update with respect to the total value of mortgage was provided by the Society as of October 18, 2018, which indicates that the approved mortgage is $4.2 million but will be increased to $6.2 million to provide maximum flexibility. The final documents are expected to be signed by November 30, 2018. In the interim, as of September 30, 2018, the Society has drawn $2.8 million on the mortgage. The completion date has been amended to early March of 2019, and the current plan is to receive patients in April of 2019. The pre-

opening period is funded in large part by the Province and there are sufficient funds on hand to cover pre-opening expenses.

Funding:	**Original Estimate**	**Revised**
Debt Financing	$4,200,000	$6,200,000[1]
Campaign Pledges	2,000,000	5,000,000[2]
In-Kind Donations (Corporate)	41,000	41,000
Total	**$6,241,000**	**$11,241,000**

1. The value of Housing Nova Scotia mortgage: the full value of mortgage financing might not be required depending on the success of an on-going capital campaign: denotes maximum borrowing capacity if applicable.
2. Pledges received and committed including $500,000 from HRM.

As presented, the provincial government is not providing a net cash contribution to construction of the facility. Rather, they have enabled the project through a Leasehold Mortgage. The initial term is 5 years with the option to renew. During the construction phase interest is calculated at a rate of 1.86% with a maximum payment of $78,000 up to completion of the building. Once the building is complete interest increases to 2.89% and principal payments commence. Hence, the society will need to generate annual revenues sufficient to sustain both partial operating costs and the payment of principal and interest due under the terms of the loan.

With pledges and access to the mortgage from Housing Nova Scotia the Society will have funds in excess of the projected $6,774,000 capital cost and as such a deficit is not anticipated. Capital costs can be fully covered and the facility construction completed. The full value of the mortgage may not be required but provides a substantial contingency.

Updated Fundraising Status

An update provided by the Society indicates that $2,260,000 has been received/committed in fundraising to date with pledges of $2,240,000 due to be collected by 2021.

Total Pledges to Date (as of September 30, 2018)	$2,260,000
Additional Verbal Pledges	$2,240,000
Total Pledges (as reported October 18, 2018)	**$4,500,000**

A projected total of $4.5 million excludes a contribution of $500,000 expected from the Municipality as per Regional Council's motion of October 2, 2018, which would bring total commitments to $5 million.

Revised Projected Operating Costs: Revenue and Expenditures (as of October 2018)

The Society has amended their fiscal year to April 1 to March 31 to align with government funding sources. The "pre-opening year" is April 1, 2018 to March 31, 2019. The projections below are for the first year of operation as a hospice for the period April 1, 2019 to March 31, 2020.

Revenue	**Original Estimate**	**Revised**
Donations	$250,000	$350,000
Fundraising Events	250,000	300,000
Grants	43,750	37,000
NSHA Funding	860,000	1,441,000
Social Enterprise	0	100,000
Total	**$1,403,750**	**$2,228,000**

The term "social enterprise" refers to a retail operation intended to generate net revenues to support the Society: a practice common to hospices. Planning is underway to develop an outlet for this purpose but it will not be located at the Franklyn Street location.

Any projected operating deficit will be covered from existing surplus funds and has been approved by the Province. As noted in the Society's updated submission "As the experience of hospices across the country indicates, we expect to see growth in revenue in excess of expenses as the community becomes familiar with the hospice facility"[1].

Expenses	**Original Estimate**	**Revised**
Salaries and Wages – Clinical	$1,049,487	$1,236,000
Operating: Facility/Society	527,612	439,000
Loan Interest	150,000	86,000
Capital Campaign/Fund Development	100,000	110,000
Total	**$1,827,099**	**$1,871,000**
(Deficit)/Surplus	**($423,349)**	**$357,000**

Property Tax Status: Updated

The Society has made initial inquiries to Property Valuation Services Corporation ("PVSC") with respect to an estimated assessed value (building and land lease). An estimate had not been received from PVSC as of this update but the Society have budgeted $10,250 for the first year of operation (fiscal year 2019-20) subject to the assessment notification and applicable municipal tax rates. It is anticipated that the facility's assessment classification may be 'split' based on use, for example to include both a Commercial (non-residential) and a Residential value (patient accommodations).

In 2018, the Society applied to the Municipality for tax relief but was declined because the property had not been assessed as taxable. The applicant was referred to the 2019 fiscal year program.

Financial Support Assessment

Public Benefit – According to the Society's web site, the hospice is expected to serve an estimated 150 to 200 patients a year[2]. Although this capacity is not expected to meet demand, the Society has stated that the Franklyn Street facility will not be expended. Rather, additional amenities would be developed in other locations. Community-based palliative care is expected to realize a saving in hospital costs: admission for end-of-life palliative acute care costs approximately $1,000 to $1,200 per day whereas hospice specialty care costs approximately $500 per day.

With respect to the criteria used to select patients for admission to the hospice, the Society has provided eligibility criteria which are included as Attachment 1 of this report.

Leverage Private Funds – The Society will invest considerable funds into construction of the facility including debt financing. To date, they have raised $2.2 million in commitments with pledges of $2.2 million, excluding municipal funding.

Viability – The Society estimates the facility will not operate at a deficit but has not made provisions to repay the mortgage principal during the first year of operation which will decrease pressure on cash-flow during the start-up phase. It has no substantive record in owning and operating a residential hospice facility. However, the Leasehold Mortgage is held by the provincial government

[1] Correspondence from Hospice Halifax to HRM staff dated October 18, 2018.

[2] www.hospicehalifax.ca/faq/

(Housing Nova Scotia) and in the event of default, dissolution of the non-profit society/charity, or any other action on the part of the Hospice Society of Greater Halifax whereby title, occupancy or interest is relinquished, ownership of the facility reverts to the provincial government or their respective successor or assignee. The provincial government's interest is further protected by a General Assignment of Rents and Leases Agreement whereby the Society assigns its right, title and interest in the leases and rents to the provincial government as security for payment of the principal, interest and other monies secured by the Leasehold Mortgage. Hence, in the immediate the facility would remain in the public domain and – with respect to HRM's contribution - access to a residential hospice maintained unless the provincial government elects otherwise.

In terms of operating costs independent of those covered by provincial operating assistance, the Society has realized annual growth in fundraising and the term "fund development" includes plans to generate operating revenues through fundraising and the establishment of a retail outlet.

Incrementality - Evidently the hospice facility will be complete and operational by early 2019 by virtue of provincial financing. Hence, the facility will be built regardless of whether HRM provides a contribution. The Society has commenced recruitment of clinical and non-clinical staff. However, higher debt financing could exert pressure on operating and cash flow if the capital campaign slows or stalls.

Proposed Contribution Agreement: Key Terms and Conditions

Table 1. Proposed Contribution Agreement: Key Terms and Conditions

HRM's contribution to the Hospice Society of Greater Halifax will be $500,000 to be used by the Society solely for the payment of capital costs directly incurred in the construction of a hospice facility located at 618 Franklyn Street, Halifax. For the purpose of this contribution a hospice is defined as a residence that provides care in the last weeks of life for those who cannot or choose not to die at home.

a. the contribution amount is a fixed contribution, and HRM is not liable for any of the Society's costs for the construction or operation of the Facility, nor is HRM a guarantor of the Society or the Facility;
b. the contribution amount represents HRM's complete financial commitment to the capital project;
c. there shall be no supplemental or incremental funds available to the Hospice Society of Greater Halifax;
d. the Hospice Society of Greater Halifax will indemnify HRM.

Payment of the Municipality's capital contribution shall be issued in two installments:

a. the first payment of $250,000 shall be paid in fiscal year 2018-19 towards completion of the Facility capital construction costs, possession and registration of the Society's ownership interest;
b. the second and final installment shall be paid in fiscal year 2019-20 towards indebtedness for principal and interest due under the Leasehold Mortgage dated August 31, 2017, payable to Housing Nova Scotia;
c. no portion of HRM's contribution shall be used for operating expenses associated with the subject property, the society, or any other party;
d. the Society shall commit to continued registration of both a Land Lease Agreement with the Atlantic School of Theology dated March 12, 2017, and the General Assignment of Rents and Leases Agreement with Housing Nova Scotia dated August 3, 2017.

HRM's contribution shall be contingent upon the execution of a signed Contribution Agreement
Funding shall be contingent on Regional Council's approval of the expenditures in the applicable fiscal year budget.
HRM's financial contribution shall be recognized by the Hospice Society of Greater Halifax commensurate with the level of investment in *Hospice Halifax*.

FINANCIAL IMPLICATIONS

Established municipal grant programs do not have the capacity to fund a capital request of this scale and the Community and Events Reserve Q621 does not have sufficient balance. Options for payment of the first installment, due to be issued in fiscal year 2018-19 include (i) re-directing funds from the 2018-19 capital budget or (ii) a withdrawal from the General Contingency Reserve Q421.

Budget Summary – Risk Reserve: General Contingency Reserve Q421

Budget Summary, General Contingency Reserve, Q421	
Balance in reserve, October 31, 2018	$11,677,539
Projected revenue to March 31, 2019	$ 62,802
Commitments to March 31, 2018	$(4,267,922)*
Projected net available balance to March 31, 2019, as at Oct 31	$ 7,472,419
Pending reports to Audit & Finance/adjustments of commitments:	
Reduce commitment for YMCA, included in above commitments to $1m	$ 500,000
The LINK Performing Arts	$(1,000,000)
Senior snow & ice program	$(200,000)
Purchase of fire boat	$ (1,300,000)
Purchase of land	$(4,275,000)
Revised projected net available balance, March 31, 2019	$ 1,197,419
*Commitments include $500k for Hospice Grant request, per recommendation	

*The first installment falls within the 2018-19 fiscal year. The second installment is to be paid in fiscal year 2019-20 as per the motion of Regional Council, October 2, 2018. The full $500,000 is to be committed in fiscal year 2018-19 if Council approves the staff the recommendation.

Risk Reserve – General Contingency Reserve Q421 is to receive the annual operating surplus of the Municipality as prescribed by the Provincial Financial Accounting and Reporting Manual and can be used to fund operating costs, offset deficits, or fund new operating and/or capital expenditures. This is an unbudgeted withdrawal from the reserve.

RISK CONSIDERATION

There are no significant risks associated with the funding recommendation other than reputational. The latter refers to non-profit organizations unaware of access to funding consideration outside an established municipal grant program.

To reach this conclusion, consideration was given to operational and financial risks. These are reduced or mitigated through a Contribution Agreement that forms a legal contract to ensure that funding is used only for the purpose outlined in the Agreement, including indemnification, and HRM achieves the public benefit as described.

COMMUNITY ENGAGEMENT

The Audit & Finance Standing Committee meetings are open to the public, a live broadcast of the meeting is provided, and members of the public may address the committee for up to 5 minutes at the end of each meeting during the Public participation portion of the agenda. The agenda, reports, minutes, and meeting video are posted online at Halifax.ca.

ENVIRONMENTAL IMPLICATIONS

Not applicable.

ALTERNATIVES

The Audit & Finance Standing Committee could recommend amendment(s) to the proposed terms and conditions of the Contribution Agreement.

ATTACHMENTS

1. Hospice Halifax: Eligibility and Requests for Assessment (October 2018).

A copy of this report can be obtained online at halifax.ca or by contacting the Office of the Municipal Clerk at 902.490.4210.

Report Prepared by: Peta-Jane Temple, Team Lead Grants & Contributions, Finance & Asset Management 902.490.5469

HOSPICE HALIFAX

ATTACHMENT 1

Hospice Halifax

Eligibility and Requests for Assessment

Last Update: October 2018

TITLE:	Hospice Eligibility and Requests for Assessment	NUMBER:	CL-HOS-001
Sponsor:	Director of Palliative Care Integration	Page:	1 of 10
Approved by:	Hospice Halifax Board of Directors	Approval Date: Effective Date:	October 16,2018 October 16,2018
Applies To:	Hospice Residences		

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PREAMBLE

1. Hospice residences are home-like community settings where palliative care is provided for eligible individuals.
2. It is important to have clear eligibility criteria for hospices to provide safe, equitable, sustainable, high-quality hospice-level care for those with limited life-expectancy.

3. All hospice residence policies are guided by the Nova Scotia Community Hospice Residence Standards.

1. HOSPICE HALIFAX ELIGIBILITY

1.1. POLICY STATEMENTS:

1.1.1. In order to be **eligible for hospice**, patients must:

- Have a predicted life expectancy of 3 months or less.
- Have a Palliative Performance Scale (PPS) score of 50% or less (See Palliative Performance Scale Version 2 (PPSv2))
- Be 16 years of age or older. Younger patients may be considered on a case-by-case basis with the IWK Hospital to determine if the setting is appropriate to meet the care needs of the child.

1.1.2. Patients or their Substitute Decision Maker (SDM) must:

- Be aware of the patient's diagnosis and life-expectancy, with no further plans for diagnostic tests or monitoring.
- Confirm their understanding that resuscitation and other life-prolonging interventions are not provided in hospice.
- Have explored all appropriate and available community supports but can no longer be supported at home, or have confirmed that a home death is not desirable.
- Agree to a transfer of care if the patient no longer meets the eligibility criteria described in this policy.

1.2. GUIDELINES:

Specific Eligibility Considerations

1.2.1. Hospice Care is not appropriate for:

- Mobile patients with wandering or aggressive behaviors that threaten their safety or the safety of other patients and staff.
- Patients with stable frailty who meet the eligibility criteria for long-term care.
- Patients who wish to come to hospice for the sole purpose of receiving Medical Assistance in Dying (MAiD).
- Patients who are actively dying and are admitted in another care facility (death is anticipated within 24 hours.)
- Patients who require planned and regularly scheduled transportation to off-site medical appointments.

1.2.2. Also, some patients require interventions or management strategies that are **not** provided in hospice. Examples include, but are not limited to:

- Patients who are ventilator-dependent.
- Patients receiving dialysis.

- Patients requiring ongoing platelet or whole blood transfusions.
- Patients requiring or requesting the ongoing use of intravenous lines (peripheral or central) for any medications (including chemotherapy, antibiotics) or fluid.
- Patients with active, infectious diarrhea (eg. Clostridium difficile).
- Patients with active airborne disease (eg. measles, tuberculosis, herpes disseminated zoster).
- Patients with active Implanted Cardiac Defibrillators (ICDs).
    - Deactivation prior to admission (or a plan to deactivate it as soon as possible after admission) is required.

1.2.3. Certain interventions or devices will not necessarily exclude a patient from hospice, but do require discussion with the hospice care team to determine if the patient's needs can be safely met. Examples include, but are not limited to:

- High-flow oxygen (more than 15L/min)
- Negative pressure wound therapy (NPWT)
- Bi-Level Positive Airway Pressure (BiPAP) or Continuous Positive Airway Pressure (CPAP)
- Enteral feeding
- Antineoplastic therapies including hormonal/oral agents
    - A discussion with the treating specialist about stopping oral agents is recommended prior to admission.
- Procedures for symptom management that require ongoing transportation to an acute-care facility (eg. thoracentesis, paracentesis, palliative radiation therapy)
- Peripherally inserted central catheters (PICCs) or central venous catheters (CVCs)
    - PICCs and CVCs are removed before or shortly after admission to hospice.
    - If they cannot be removed, PICCs and CVCs will not be used or maintained in hospice. Dressings will be changed according to local protocols.

2. REQUESTS FOR ASSESSMENT

2.1. **POLICY STATEMENTS:**

2.1.1. If the patient's **most responsible healthcare professional** believes that the patient is appropriate for hospice based on the eligibility criteria outlined above, a request for assessment for hospice is made. Any special care needs or circumstances such as those listed in section 1.2.3 above must be discussed with the hospice at this time.

- Requests must come from the patient's most responsible healthcare professional.
- If the professional making the request is not the patient's **primary care provider**, the person or team making the request must inform them that it has been made.

- Requests are not accepted directly from patients or family members.

2.2. **GUIDELINES:**

2.2.1. *Requests* are reviewed and prioritized by the hospice assessor or their delegate according to the identified care needs and acuity of the patients.

2.2.2. *Admission priorities* are determined by the individual hospice Medical Directors and/or Nurse Managers through a collaborative triage process with care partners; eligible patients' care needs and acuity will be the primary factors in considering priority for admission.

2.2.3. Admission decisions will also be guided by patients' place of care. People living at home or those who are precariously housed, whose care needs exceed what they can manage safely or comfortably with the resources available to them, will receive first priority. People accessing care in a hospital or other care institution will receive next priority.

Admission to hospice is not considered emergent, and patients are not generally accepted in direct transfer from emergency departments or other facilities without an in-person assessment.

2.3. **PROCESS:**

2.3.1. If appropriate, based on the information provided in the request for assessment, it is the responsibility of the hospice team or its delegate to complete an in-person standardized assessment of the patient.

At their discretion, the hospice may waive the in-person assessment when it is clear from consultation with the requesting party that the patient meets the eligibility criteria.

2.3.2. Based on the information received in the request for assessment and/or from the in-person assessment, if a patient does not meet the eligibility criteria, the hospice communicates the reason(s) for not admitting the patient to the requesting party.

- This decision is clearly documented.
- It is the responsibility of the requesting party to inform the patient/family of the decision.

2.3.3. Based on the in-person assessment, at the discretion of the hospice, if a patient is a) predicted to meet the eligibility criteria in the near future, or b) meets the criteria but is not ready for admission, the hospice keeps the patient information accessible for a period of 3 months.

- Within 3 months, the requesting party must initiate contact with the hospice for the patient to be considered again for hospice and must send any new pertinent information to the hospice.
- After 3 months, a new request must be made.

2.3.4. It is the responsibility of the hospice assessor or their delegate to include in their in-person assessment, as appropriate, the following:

- A standardized assessment, and/or a review of the content of the request for assessment, and any supporting information as required.
- An explanation and review of the hospice philosophy of care and the hospice's admission agreement (if applicable) with the patient or substitute decision maker.
    - Once the patient or SDM has a chance to review the hospice's admission agreement, they are asked to sign it.
- A description of the hospice facility and its amenities.

2.3.5. It is the responsibility of the hospice assessor or their delegate to confirm that the patient has a signed Do-Not-Resuscitate/Allow a Natural Death document.

2.3.6. Once all of the above are confirmed by the hospice assessor or their delegate, the patient is placed on the list for admission to hospice.

3. ONGOING ELIGIBILITY

3.1. **POLICY STATEMENTS**

3.1.1. It is the responsibility of the interdisciplinary hospice care team members to assess a patient's continued appropriateness for hospice on an ongoing basis as part of their regular assessment.

3.1.2. Based on this ongoing assessment and discussion with the patient/substitute decision maker, the most appropriate place of future care is determined.

3.1.3. Patients are discharged when:

- They and their families express the wish to return home, or
- It has been determined that the course of the illness and/or goals of care have changed and would be more appropriately addressed in either an acute care or long term care setting.

3.1.4. The attending hospice physician makes decisions about discharge in consultation with the hospice care team, patient, and family.

3.1.5. Each hospice site will have a discharge process or policy based on local resources and patient flow procedures.

4. REFERENCES

LEGISLATIVE ACTS/REFERENCES

"Policy framework for the establishment of Hospice as a setting of care in Nova Scotia." Nova Scotia Department of Health and Wellness. March 2017.

"An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)". Government of Canada. (S.C. 2016, c. 3). Accessed on February 21, 2018. http://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html

OTHER

Nova Scotia Community Hospice Residence Standards. Nova Scotia Health Authority. March 2017.

"Personal Directives Act – Information for Health Care Providers." https://novascotia.ca/just/pda/_docs/PDA_Web_Info_Health%20Care%20providers.pdf

5. RELATED DOCUMENTS

POLICIES

Medical Assistance in Dying (MAiD) – NSHA policy pending

Nova Scotia Department of Health and Wellness, Service Eligibility Policy, effective February 28, 2015: https://novascotia.ca/dhw/ccs/policies/policyManual/Service_Eligibility_Policy.pdf

6. DEFINITIONS

Frailty	Frailty is a stage of life that is the result of the cumulative effects of health and functional deficits over the life course. When this accumulation of deficits depletes the physiologic reserve to the point that day-to-day activity is affected, a person is said to be "frail".
Hospice	A term that encompasses both a *setting* of care and a *type* of care for those near the end of life, focused on comfort rather than acute care. Hospice as a *setting* can include stand-alone facilities or designated hospice beds in other locations. In this policy, "hospice" will refer to a Hospice Residence.
Hospice delegate (for assessment purposes)	A healthcare professional with training in hospice palliative care whos is authorized by hospice leadership to assess patients for admission.
Hospice-level care:	Care provided in the last weeks of life for those who cannot or do not wish to die at home. Hospice is for those who are relatively stable but require monitoring and interventions that are unavailable in their home setting for a variety of reasons.

Medical Assistance in Dying	In accordance with federal legislation, medical assistance in dying includes circumstances where a medical practitioner or nurse practitioner, at an individual's request: administers a substance that causes an individual's death; or prescribes a substance for an individual to self-administer to cause their own death.
Most responsible healthcare professional	The healthcare professional who has the overall responsibility for directing and coordinating the care and management of a patient *at a specific point in time***.**
Palliative Care	Care that improves the quality of life of patients/families facing life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual. Includes *end of life care* offered to dying persons and a *palliative approach* to care integrating key aspects at appropriate times for those with advanced illness at *increased risk of dying.*
Palliative Performance Scale	The Victoria Hospice Palliative Performance Scale (PPS, version 2) is an 11-point scale designed to measure patients' performance status in 10% decrements from 100% (healthy) to 0% (death) based on five observable parameters: ambulation, ability to do activities, self-care, food/fluid intake, and consciousness level. It is designed to provide a snapshot of functional assessment at the time of assessment.
Personal Directive	A legal document that allows a person to name a substitute decision maker to make health and personal care decisions on behalf of the individual, if they are not mentally capable. A Personal Directive includes decisions about health care, nutrition and hydration; where the person would like to live and die and comfort measures; it needs to be written, dated, signed by the person and witnessed by an adult.
Primary Care	The day-to-day healthcare usually provided by a family physician or a Nurse Practitioner. Typically, primary care providers act as the first contact and principal point of care for patients within a healthcare system, and they facilitate access to other specialist care that a patient may need.

Substitute Decision Maker (SDM): The person named in a Personal Directive to make decisions on behalf of the author of the directive when that person can no longer speak for themselves, also called a delegate or substitute decision maker.