Hospice Palliative Care

Public Awareness Raising Framework

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EXECUTIVE SUMMARY

Goal

The goal of this communications framework is to enhance the ability of organizations working in the area of Hospice Palliative Care to increase target audiences awareness about Hospice Palliative Care options that are available to them. The target audiences are key segments of the Canadian population—older 'Baby Boomers', seniors and women—and health care providers.

Background

This communications framework has been produced for the Secretariat on Palliative and End-of-Life Care at Health Canada as the third phase of an initiative of the Public Information and Awareness Working Group; following the first phase which reviewed successful national and international social marketing initiatives, and second phase which identified opportunities and challenges to leverage existing efforts to enhance the community's public awareness activities.

Currently, over three million Canadians care for a loved one with a life-threatening illness and 90 per cent will die of a protracted life-threatening illness each year. Death and dying are a part of life and it is important that Canadians plan for this as they do other parts of their life.

A Two-Pronged Approach

Following the completion of research and analysis, the strategy is based on a two-pronged approach to communications to meet the needs of:

- Canadians who require "just-in-time" information when facing a life-threatening health crisis; and,
- Canadians who should consider their options in advance of need.

This approach supports the current situation where information is provided by health care providers when a health crisis is unfolding, as well as creating the opportunity to raise awareness of the importance of consideration in advance of need. The result is two distinct audiences that communications efforts will be directed towards: health care providers and Canadians.

Target Audiences

While health care providers represent a focused target audience of approximately 600,000 individuals, the Canadian population should be further segmented based on their potential for being caregivers and/or care receivers in the near future. The rationale for sub-segmenting the target audience is to enable delivery of finely-tuned messages and to increase media–buying efficiencies. Resulting audience sub-segments are 50-64 year-old Canadians in their pre-retirement or early retirement years, 65+ year-old Canadians and 35-49 year-old Canadian women.

Messages and Media

Having determined what should be communicated—an overall messaging theme of "quality of life" and why it is important that care and genuine concern for the patient and close ones is provided to the end—the focus gets shifted on how and where to say it. There are key messages and communications vehicle recommendations for each target audience and sub-segment.

- '*Care for the dying is care for the living*' speaks to health care providers as they have a special role to play in the management of Hospice Palliative Care due to the relationships they share with patients and can help them make the transition with the continuing care of someone they trust and respect. This audience could be reached through advertising in specialized publications and web sites, brochures in association mail-outs, e-newsletters through associations and specialized television programming.

- *'Because everyone is touched by life-ending illness, Hospice Palliative Care touches everyone'* speaks to 50-64 year-old Canadians as they have higher risk of dying from a long term, life-threatening illness, or are more likely to care for a

close one, such as an elderly parent, who is dying. This audience could be reached through magazine and newspaper advertising, direct mail letters or op-ed articles.

- *'Make the most of living, right to the end'* speaks to 65+ year-old Canadians as the need for maintaining the best possible quality of life does not end when they or somebody close is diagnosed with a terminal or life-threatening disease. There remains the need to ensure the best possible quality of dying. This audience could be reached through magazine and newspaper advertising, direct mail letters or op-ed articles.
- *'There are many people who can help and many ways to provide comfort and support.'* speaks to 35-49 year-old Canadian women who may be untouched by illness but should talk about death as facing it without adequate planning will make the inevitable worse. They can learn about the options and how to plan for the best possible quality of life for them and their close ones. This audience could be reached through magazine and radio advertising and direct mail letters.

Framework Usage

This communications framework was created to be a practical guiding tool for organizations working in the Hospice Palliative Care field. However, it can easily be adapted to meet the specific needs of communities in the provinces and territories.

INTRODUCTION

Background

In June 2001, the Government of Canada formally demonstrated its support toward advancing palliative and end-of-life care for Canadians by establishing the Secretariat on Palliative and End-of-Life Care at Health Canada. The objective of the Secretariat is to facilitate collaboration and coordination of effort with other federal government departments and agencies, representatives of national associations, professional associations, universities, researchers, the community, and provincial and territorial governments.

In the fall of 2002, five working groups were established with the goal of advancing the community component of the Secretariat's mandate. The groups were organized to address issues in the areas of best practices and quality care, education for health care providers, public information and awareness, research, and surveillance. Members of the groups were selected from across Canada based on geographic location, expertise and involvement in palliative and end-of-life care.

Phase I of the Hospice, Palliative Care Public Awareness Raising Framework was the completion of a review and evaluation of successful national and international initiatives designed to change public attitudes and behaviours—a social marketing approach. It proposed recommendations for next steps based on findings.

Phase II identified current Canadian palliative and end-of-life care public education and information raising and related initiatives, and explored various challenges and opportunities to leverage existing efforts to enhance the community's public awareness raising initiatives. In the absence of large scale funding, the report highlighted the importance of integrating consistent messaging throughout the year. Recognizing the variation in service provision across the country, the report also recommended a flexible awareness approach be developed.

Phase III, the subject of this report, is the development of a communications framework to help increase target audience awareness regarding Hospice Palliative Care. Members of the Quality End-of-Life Care Coalition of Canada (QELCCC) and members of all the working groups under the Canadian Strategy on Palliative and End-of-Life Care were consulted during the development of the framework and provided comments on the drafts before finalizing the communications framework.

Many Canadians receive information about Hospice Palliative Care during their greatest time of need—a "just-in-time" approach. Canadians can also benefit from understanding the choices available to them related to Hospice Palliative Care in advance of need. Providing organizations working in the area of Hospice Palliative Care with communications tools can assist in the process of generating discussion and lead to improved access of Hospice Palliative Care in their communities. Organizations can take from this framework what is most useful to them: messaging, process, approach and/or communications vehicles.

This framework attempts to stimulate interest and motivate target audiences to seek out information through a user-friendly format and content, clarify existing terms to ensure a common, unified definition and act as a tool for community groups to use to raise awareness, to empower intermediaries and to assist in disseminating communications. For the framework to add value, generalizations in key messaging must be avoided and we must recognize that we are always working with limited communications funding.

Our Methodology

As a subject that is avoided until it must be faced, dying and death are culturally complex and sensitive issues. Developing a communications framework can be informed by the application of a social marketing approach and behavioural change theories. Several models attempt to explain and plan behaviour. This framework is based on Prochaska and DiClemente's model that breaks down behavioural change into the following stages:

Stages	Description
Awareness Stages	o Precontemplation: Consumers really are not thinking about the behaviour as being appropriate for them at this point in their lives. o Contemplation: Consumers are actually thinking about and evaluating recommended behaviours.
Mobilization Stages	o Preparation: Consumers have decided to act and are trying to put in place whatever is needed to carry out the behaviour. o Action: Consumers are participating in the behaviour for the first time—or first several times.
Consolidation Stages	o Maintenance: Consumers are committed to the behaviour and have no desire or intention to return to earlier behaviour. o Relapse: Consumers sometimes resume their old habits. o Termination: Consumers have definitively adopted the new behaviour.

The process of raising awareness, changing attitudes and ultimately affecting behaviour takes time, perseverance as well as flawlessly crafted messages and well-executed communications. Many major social issues over the past 50 years, such as smoking cessation, have migrated through this staged continuum. Each of these stages requires a distinct approach.

During the awareness stages of "Precontemplation" and "Contemplation" the target audiences include "influencers" who can spread the messages with credibility and change norms. Messages are factual in nature or cerebral "head messages". In the mobilization stages of "Preparation" and "Action", the target audience is the general public and messages become emotional—aimed at the heart. Finally, in the consolidation stages of "Maintenance" and "Relapse", the messages are designed to reinforce positive behaviour and address specific issues that have led to relapse. Presently, Hospice Palliative Care is in the awareness stage of the social marketing continuum.

Implications for this Hospice Palliative Care Communications Framework

This framework presents messages for each stage of the social marketing continuum. In stage one the cold hard facts should be presented to stimulate interest and ensure that opinion leaders are on-side. In stage two mobilization emotional "heart" issues are the centrepiece of communications and the general public is usually the audience. In stage three the emphasis is on repetition and reinforcement to prevent relapses in behaviour.

How to Use this Communications Framework

This framework exists to be useful and practical. It is meant to address the needs of organizations working in the area of Hospice Palliative Care across Canada with an overarching, umbrella tool. Recognizing the variations in needs across provinces, territories and communities, this 'one size fits all' approach has its limitations which is why it is best considered as a guiding tool. Its structure walks the reader through the process of development, to provide the thinking, the rationale and the background material. In practice, the user might want to obtain the main contents of messaging and media vehicles. In this case, a good place to start is the Roadmap, beginning on page 24, which offers a snapshot regarding the main elements and issues.

Please note that informal caregivers are frequently referred to as 'caregivers', and formal care providers or professionals as 'health care providers' or 'care providers'.

MAIN DEFINITIONS

Hospice Palliative Care	Canadian Hospice Palliative Care Association[i]	World Health Organization[ii]
Definitions	o Aims to relieve suffering and improve the quality of living and dying. o Strives to help patients and families address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears. o Strives to help patients and families prepare for and manage self-determined life closure and the dying process. o Strives to help patients and families cope with loss and grief during the illness and bereavement. o Aims to treat all active issue, prevent new issues from occurring, and promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization. o Appropriate for any patient and/or family living with, or at risk of developing, a life-threatening 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. o May complement and enhance disease modifying therapy or it may become the total focus of care. o Most effectively delivered by an interdisciplinary team of healthcare providers who are both knowledgeable and skilled in all aspects of the caring process related to their discipline of practice.	o 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. o Provides relief from pain and other distressing symptoms. o Affirms life and regards dying as a normal process. o Intends neither to hasten nor postpone death. o Integrates the psychological and spiritual aspects of patient care. o Offers a support system to help patients live as actively as possible until death. o Offers a support system to help the family cope during the patients' illness and in their own bereavement. o Uses a team approach to address the needs of patients and their families, including bereavement counseling. o Will enhance quality of life, and may also positively influence the course of illness. o Applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes investigations needed to better understand and manage distressing clinical complications.

STRENGTHS, WEAKNESSES, OPPORTUNITIES, THREATS — SWOT ANALYSIS

Strengths are elements that work in your favour and can be controlled.
Weaknesses are elements that require improvements and are within your control.
Opportunities are elements out of your control that could yield positive results in the future.
Threats are elements out of your control that act as barriers to possible success.

The following analysis summarizes important findings from Stages I and II reports and their messaging implications.

Strengths	Weaknesses / Barriers	Opportunities	Threats
450 organizations operating in this realm.	Negative perceptions, stigma associated with dying and death.	Knowledge of advanced care options has been increasing in the past decade, death stigma starting to decrease Majority of people have not had dialogue regarding advanced care instructions/plans.	Negative connotations.
Many existing services and educational efforts provide platforms upon which to build.	Currently there are a number of terms and definitions attached to Hospice Palliative Care resulting in lowered impact and effectiveness of current messaging and brand value being eroded.	Canadians have high demand for health care information, opportunity to build a central, national information source.	Jurisdictional issues as it is the responsibility of provinces and territories to administer and fund initiatives which results in a wide range of service offerings depending on geographic location.
Communities are ready to build on existing communications and/or services success that have occurred.	“Death denial and death defiance” is a feature of health care system and Canadian attitudes.	Emotional and rational value in planning for the future.	Asking health care providers to do “one more thing” when they have reached their capacity.
Strong empathy that is universal amongst us all—our humanity.	Subjectivity—individual stories, associations points-of-view.	Changing demographics towards an aging population resulting in increased demand.	Overload of health information and conflicting messages.
	Western thinking, English-centric, cultural needs diversity due to different value systems and beliefs.	Demographic shift from “do-as-you’re-told” generation to empowered generation.	Primary health care system stretching its capacity, can not effectively respond to emerging issues.
	Multi-cultural traditions are not fully considered, understood or respected.	Layers of opportunities: o Political o Canadians/consumer o Provider/system	Gap between information needs and services to meet the needs.
	Fragmentation in communications.	Internet is the most trusted source of health information.	Continued political and systemic will to take care of

Strengths	Weaknesses / Barriers	Opportunities	Threats
			“the land of the living”.
		This is not a silo project as there is the common goal of improving individual projects that will result a stronger overall system.	Difficult to sort through all of the information on the Internet and determine what is factual or useful, and what is not.
		Many access points to triage and guide to different services (Telehealth, Primary Health Network).	Information and training may not be consistent across all access points.

KEY ISSUES

The issues outlined below were drawn out of the research that was completed in the development of the framework. They have been used to provide direction in the creation of messaging and communications tactics to reach the desired target audiences.

Issues	Implications
No cohesive, integrated model: o Unclear definitions. o Fragmented services. o Federal/provincial/territorial variations in service levels.	o Build a user-friendly definition (centred on "palliative") based on consensus building efforts. o Communicate on a high-level "umbrella" basis so our messages are relevant regardless of province or territory.
Acceptance of death: o Avoidance and denial—death-defying and death-denying culture. o Aversion to discussing topic. o Feelings of guilt when asking for help. o Difficult to modify existing behaviours and systems.	o Move in stages. o Develop messaging. o Promote discussion. o Recognize humanity associated with delivery of messages.
Communications not reinforced by behaviour: o Different learning patterns and communications skills between health care professionals, results in inconsistent delivery of messages. o Gap between information needs and availability/provision of information/services by health care providers.	o Diversify communications. o Communicate to health care providers and consider timing of communications and other tactics. o Begin to change the hierarchical nature of seeking out information: nurses, social workers, case managers in addition to physicians, provide information.

HOSPICE PALLIATIVE CARE CONTINUUM

The social marketing model presents an approach to framing communications related to major social issues. It is recognized that comprehension, awareness and ultimately behaviour change related to social issues take many years to accomplish. An individual usually goes through a process of becoming aware of an issue, being interested in the issue, and desiring to change, followed by a mobilization period when the time is right to actually begin to change behaviour. Sustaining this requires a period of consolidation when reinforcement of the change in behaviour occurs. Different messages are needed for each stage of the process to achieve the desired action.

Awareness of Hospice Palliative Care in the Canadian public is still very low. Communications messages need to draw the attention of the public to the availability and existence of hospice palliative care. This is an important task that requires taking into consideration the clutter of other health and social information that target the general public every year.

To make Hospice Palliative Care relevant to the audience, providing more information to the public about the "benefits" of Hospice Palliative Care is important. Benefits relate to the range of services and the scope of providers. They also relate to benefits to health care providers, caregivers and to care receivers and their close ones. Discussion of death and dying is one action that people can take with their close ones to share the type of quality of life they wish to have.

Most communities will find that they are in the first stage of the awareness-building continuum. Others may find that they have already engaged their audience about Hospice Palliative Care and are examining the activities to increase understanding and encourage specific behaviour. The main use of the continuum becomes moving target audiences through the phases, while providing the flexibility to address the changing landscape of Hospice Palliative Care delivery and awareness across the country.

With sustained efforts and time, a deeper understanding of the issues surrounding Hospice Palliative Care provides opportunities for more targeted communications. While it is too early to anticipate at this time the type of messages to deliver in a few years, the approach acknowledges the need to refine and expand the message and show that there's more to Hospice Palliative Care. It also assumes that more people will know about it.

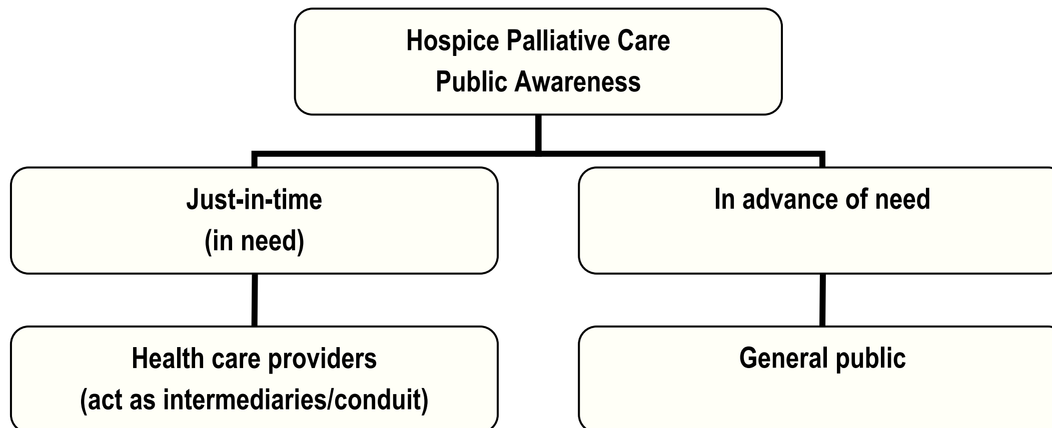
HOSPICE PALLIATIVE CARE CONTINUUM MATRIX

	Awareness (Stage One)	Mobilization (Stage Two)	Consolidation (Stage Three)
Current situation	Negative associations, low information levels.	Denial and avoidance of tackling issues head-on, attitudes may be starting to change, but not widespread behaviour.	Geographic discrepancies and cultural variances.
Objective	Raise awareness levels. Change negative associations. Communicate the facts.	Convert attitudes to actions in advance of need. Overcome denial.	Address relevance. Reinforce positioning.
Strategy	Establish importance and relevance to audience. Provide a common definition.	Communicate the variety of care services. Create opportunities for open discussions.	Communicate types of decisions and choices applicable to sub-groups situation.
Challenges	Stigma – "It's about death, loneliness, loss and losing hope".	Postponement, denial – "Let's not talk about it."	Culturally appropriate – "How do I reach all of Canada's diverse audiences?"
Tasks	Show why it's important.	Show what care options are available and what planning can accomplish.	Show how it can be applied to specific situations to be identified.

TARGET AUDIENCES

A two-pronged approach to communications is recommended to meet the needs of:

- Canadians who require "just-in-time" information when they are facing a life-threatening health crisis; and,
- Canadians who should consider their options in advance of need.



There are currently communications tools available, or in development, that provide "just-in-time" information to those in need. To reach people in need, a just-in-time approach is required as the communication needs to be frequently tailored and introduced with great care. Health care providers are conduits or intermediaries for the level and timing of information.

An additional approach is required to complement and support the "just-in-time" communications. In the second approach, audiences in advance of need within the Canadian population are targeted. Those audiences include potential caregivers and care receivers (up to five million), across all ethnic, geographic and religious affiliations. Segmenting the Canadian population by specific sub-group will aid in messaging effectiveness as the "shotgun approach" is minimized. This allows for the possibility of making a better connection with the target.

Reasons to Segment the Target Audience from the General Public to Sub-segments

Primary reasons for segmenting target audiences are to enable delivery of finely-tuned messages and to increase media–buying efficiencies. Segmenting of target audiences also reduces media expenditures and media mix from trying to reach all Canadians. Segmenting provides a deeper understanding of who is the current audience and who is the desired target audience. Therefore, segmenting reduces media expenditures and increases efficiency.

Target Audiences—Canadians

Sub-segments have been selected based on their potential for being caregivers and/or care receivers in the near future:

- 50-64 year-old Canadians in their pre-retirement or early retirement years
- Seniors, 65+ year-old Canadians
- Women, 35-49 year-old Canadians

These sub-segments are by no means exclusive. For example, other sub-groups can include Aboriginals or people with disabilities. It is the targeted approach that is illustrated here. Using the suggested sub-segments; however, will prove useful in generating a better understanding of their profile, needs, and reveal indications for the messaging.

50-64 year-old Canadians in their pre-retirement and early retirement years

Demographics:

- Over six million Canadians fit within this age group. There is close to a 50/50 split between men and women.[iii]
- "Older working-age" cohort that is expected to increase by 30 per cent from 7.1 to 9.5 million by 2011.[iv]
- Over 2.1 million Canadians within this age group have completed a college diploma and/or a university degree.[v]
- The language composition of this age group is: 4.3 million speak English, 884,000 speak French, 1.2 million speak both English and French and 101,000 speak neither official language.[vi]

Lifestyle:

- Over four million Canadians in this age group are married, and not separated.[vii]
- Approximately 169,000 Canadians in this age group are widowed.[viii]
- Labour force participation rate falls off after age 55. Still, about half the population aged 55 to 64 continues to be active in the labour market.

Health information:

- Over 1.3 million Canadians in this age group have already been diagnosed with heart disease, stroke or high blood pressure.[ix]
- Obesity is on the rise across many age groups; however, they are the highest in this one.[x]
- Compared to 10 years ago, the rates of obesity in this age group have soared by nearly 60 per cent; and 52 per cent are inactive. However, 80 per cent still think they will enjoy a longer life expectancy than previous generations.[xi]

Other "competing" health information:

- Maturing Baby Boomers are concerned with health management and in pursuit of physical fitness. They desire exercise programs that include 'joint-friendly' fitness equipment, low-impact aerobics, and gentle yoga classes.[xii]
- 58 per cent of Canadians in this age group think that their weight has little or no effect on their heart health.[xiii]

Other relevant communications considerations:

- Vast majority of "Baby Boomers" can speak at least one official language.
- According to a 1998 study, Baby Boomers can expect to live long enough to be a problem not only for their children, but their grandchildren and great-grandchildren too.[xiv]
- Baby Boomers are shaking up the traditional ideas of aging and marketers must understand that the 'old' marketing rules no longer apply.[xv]
- Canadians in this age group want incentives to support their making healthy lifestyle choices. Popular suggestions include more funding for projects that would encourage activity instead of driving a car, tax breaks on the purchase of healthy foods, gym memberships and/or sporting equipment.[xvi]
- This age group is heavy readers of magazines; consider a brochure that is created in an easy-to-read, engaging format.
- Add sign language interpretation whenever possible and ensure messages on television are captioned for the deaf, deafened and hard of hearing.

The sandwich generation:

- Taking responsibility for aging parents and still involved with growing up children.
- Suffering from stress and caregiver fatigue.
- Very much a group that could benefit from support in a variety of way.

Seniors, 65+ year-old Canadians

Demographics:

- Over 3.9 million Canadians fit within this age group in 2001; of them, over 430,000 Canadians were 85 or older.[xvii]
- Women skew: 56 per cent of the overall Canadian senior population is women; 60 per cent of the seniors aged 75 to 84 are women; 70 per cent of the seniors aged 85 or older are women.[xviii]
- Seniors aged 85 and over represent the fastest growing segment of the senior population. In fact, about one in 10 Canadian seniors are now 85 or over, the number of people in the oldest age groups is also expected to increase rapidly in the approaching decades. Women represent a substantial majority of the oldest segment of the population. [xix]
- By 2011 the Canadian population aged 80 and over is expected to surpass 1.3 million, up from 932,000 in 2001.[xx]
- Over 580,000 seniors have completed a college diploma and/or a university degree.[xxi]
- Generally better educated than earlier generations—17 per cent have a university degree.[xxii]
- The language composition of this age group is: 2.5 million speak English, 520,000 speak French, 487,000 speak both English and French and 161,000 speak neither official language.[xxiii]
- The Atlantic Provinces and Quebec have populations older than the Canadian average. Ontario and the western provinces, as well as the territories, have younger populations. The one exception was British Columbia, where the population was relatively older due to the migration of older people.[xxiv]

Lifestyle:

- 75 per cent live in an urban/metropolitan centre.[xxv]
- Over three million seniors are married, and not separated.[xxvi]
- Over 1.3 million seniors are widowed.[xxvii]
- Marked difference in marital status as over 75 per cent of senior men are married while 41 per cent of women are married.[xxviii]
- Between 1996 and 2001, the number of working seniors rose from 255,000 to 305,000. These numbers would be higher if mandatory retirement policies did not apply to about half of Canadian workers—up to 20 per cent of whom would like to work beyond the age of 65.[xxix]
- Chances for healthy aging are significantly enhanced with a strong sense of coherence—finding life meaningful, manageable and comprehensible.[xxx]
- For seniors living in private households and residential facilities, social contacts and networks have been identified as highly important influences on their quality of life.[xxxi]

Health information:

- 25 per cent have a long-term disability.
- 80 per cent are living at home suffer from a chronic health condition.
- Hospitalization of seniors: seniors are generally far more likely than those in younger age groups to be hospitalized. Seniors also tend to stay in hospital for considerably longer periods, on average for 10-14 days.
- Dementia issue.
- Leading causes of death amongst seniors were cancers and heart diseases, followed by stroke and respiratory diseases.[xxxii]
- Large majority of seniors in all age groups consider themselves to be in good health. Only 23 per cent described it as fair or poor.[xxxiii]
- In 1999, 83 per cent of all seniors living at home reported they had been diagnosed with at least one chronic health condition. Arthritis and rheumatism were the most common, other highly occurring conditions include high blood pressure, allergies, cataracts, back problems, heart problems and diabetes.[xxxiv]
- Even at age 85+ over 80% of men and 77 per cent of women who were household-dwelling seniors could perform “activities of daily living”—bathing, dressing, eating, taking medicine and moving about inside the house—without another person’s help. However, only 54 per cent of men and 35 per cent of women in this same group were able to complete the “instrumental activities of daily living”—getting to appointments and running various errands.[xxxv]

- At ages 65-74 the average hospital stay was about nine days; at ages 85+ it increased to about two weeks.[xxxvi]
- In 2003, over 566,000 non-institutionalized seniors reported receiving home care from care providers and/or caregivers. 57 per cent received that care exclusively from formal sources, 28 per cent from family, friends and neighbours, while the remaining 15 per cent received both types of assistance.[xxxvii]
- Over 88 per cent of seniors had visited a family physician in 2003. They were also more likely to seek out the services of pharmacists, eye specialists, speech-language pathologists, audiologists and occupational therapists.[xxxviii]

Other “competing” health information:
- Injuries are an important issue for seniors and many worry about falling and hurting themselves.
- Seniors are interested in ‘healthy aging and healthy human development’.
- Not all seniors who lose their health do so for good, over 20 per cent of those who did not have good health recovered over successive two year periods between 1994/95 and 2002/03.[xxxix]

Other relevant communications considerations:
- The vast majority of seniors can speak at least one official language.[xl]
- Over 2.1 million seniors did not complete a degree, certificate or diploma of any level, including high school.[xli]
- But: levels of formal education are increasing. Baby boom generation will also contribute to increasing the level of formal education. Also, seniors are active in continuing education (nearly 100,000 seniors are enrolled in a form of educational program).
- While internet penetration in households headed by seniors is lower compared to households headed by non-seniors, internet usage within the group is increasing.
- Add sign language interpretation whenever possible and ensure messages on television are captioned for the deaf, deafened and hard of hearing.

Women, 35-49 year-old Canadians

Demographics:
- Over 3.7 million women fit within this age group.[xlii]
- Over 1.6 million women within this age group have completed a college diploma and/or a university degree.[xliii]
- The language composition of this age group is: 2.4 million speak English, 470,000 speak French, 625,000 speak both English and French and 84,000 speak neither official language.[xliv]

Lifestyle:
- 70 per cent of working females held full-time jobs.[xlv]
- Women accounted for two-thirds, or 884,400, of the overall 1.3 million gain in the labour force between 1991-2001.[xlvi]
- Over 2.2 million women in this age group are married, and not separated.[xlvii]

Health information:
- Cardiovascular disease tends to appear about 10 years later in women than in men.
- 87 per cent of women have contacted a physician in the past 12 months (versus 74 per cent for men).
- Life expectancy of females in this age bracket is approximately 75 years.[xlviii]
- About 20 per cent of women reported taking care of a senior, compared with 15 per cent of men. Only a fraction of the population - less than 4 per cent of women and 2 per cent of men - reported devoting more than 10 hours to caring for a senior.[xlix]
- Migraine headaches are three times more common in women with this age group being particularly affected. Migraine sufferers also have a greater tendency to report other chronic conditions such as allergies, arthritis and rheumatism, back problems, sinusitis and ulcers.[l]

- Nutrition tends to be more important to women. Women are more likely than men to consider overall health, weight and specific diseases when choosing food. 80 per cent of women were concerned about maintaining or improving health through food choice.[li]
- 72 per cent of women reported making complex health decisions in the past versus 56 per cent for men.[lii]

Other "competing" health information:

- Women experience more illness, more years of disability and more stress than men, but they also live longer. Even when diagnosed with a fatal disease, women survive longer than men.[liii]

Other relevant communications considerations:

- This age group is heavy readers of magazines; consider a brochure that is created in an easy-to-read, engaging format.
- All forms of direct mail—brochure, envelope, and flyers—are generally popular with this age group.
- Add sign language interpretation whenever possible and ensure messages on television are captioned for the deaf, deafened and hard of hearing.

Target Audiences—Health Care Providers

This group includes family physicians, specialists, nurses, social workers, volunteers and other health care providers.

- It is also important to reach interpreters, interveners and translators who facilitate communication between health care providers and patients.

SINGLE-MINDED PROPOSITION

These value propositions are concise expressions of the vision, perception and actions we desire from the audience and stakeholders. They help focus all communications toward consistent, relevant messaging that reflects the realities of receivers and givers of care.

Desired Vision

For people facing prolonged or life-threatening illnesses, their caregivers and care providers, Hospice Palliative Care provides an integrated array of services for care, comfort and support to improve the quality of life, dying and death.

Desired Perception

Hospice Palliative Care is total/holistic care to maximize quality of life, dying and death.

Desired Action

Discuss with close ones, plan and make informed decisions for inevitable dying and death in advance of need.

Single-Minded Messages for Canadian audiences

Stage One— "Hospice Palliative Care is important and relevant to everyone, and touches us all at some time in some way."

- 90 per cent of us will die of a protracted life-threatening illness. (Anderson)
- Less than 10 per cent of us will die of sudden events (e.g., Myocardial infarction or accidents). (Anderson)
- Every year three million Canadians are caring for a loved one with a life-threatening illness. (Living Lessons)
- Less than 20 per cent receive Hospice Palliative Care. (Living Lessons)
- Taking care of loved ones can be a full time job—average time spent caring for dying loved one at home is 54 hours per week. (Ipsos-Reid 2004)
- Every year one million Canadians are affected by the loss of a loved one. (Living Lessons)
- Palliative and end-of-life care includes families as it includes emotional support for bereavement and grief—50-70 per cent of calls from caregivers requesting information were actually calls for emotional support. (Dunbrack 2003)

Stage Two— "Hospice Palliative Care provides options that guide Canadians through dying and death."

- Managing expectations: estimated that the caregiver in the home palliative care setting provides 80-90 per cent of all care. This environment often leaves the caregiver's self-esteem and confidence battered. Emotionally and physically, they spread themselves too thin. (Ashpole 2004)
- Concerns that caregivers have include dealing with symptoms of pain, coping with cognitive impairment, bathing the patient and tending to bodily functions. (Ashpole 2004)
- At the point when a cure is no longer possible, comfort for the patient and support for the family becomes the focus of care. (Ashpole 2004)
- Range of options in support services—hospices, hospitals, homes (private homes, nursing homes and long-term care facilities).
- Range of care—physical, emotional, spiritual, financial.
- Minimize feelings of loneliness and abandonment.
- Frequent information requests relate to how one obtains bereavement support. Repeat calls to telephone services were fairly common if the information service was able to provide listening time. (Dunbrack 2003)
- 30 per cent of Canadians have prepared a living will. (Ipsos-Reid 2004)
- Palliative care does not hasten nor prolong life.
- Range of audiences.

Stage Three— "Hospice Palliative Care is holistic, integrated care."

- The greatest gifts that formal caregivers can give to their patients and their family members are quality palliative care for everyone involved, through physical, emotional, spiritual and financial support; and, communications skills for the patient, the family and other caregivers to improve their time spent together. (Ashpole 2004)
- Judging from the comments reported to information services, it is likely that many caregivers are unaware of information sources or do not use them until a crisis occurs, such as uncontrolled pain or even death. (Dunbrack 2003)
- Only seven per cent of respondents identify "compassionate care" on an unprompted basis. (Ipsos-Reid 2004)
- Caregivers have many requests for information from practical care giving information to understanding "how things will unfold" to the needs of children and youth. (Dunbrack 2003)
- The rights of patients, what they're entitled to.
- Help when it matters most.
- Nuance messages to specific groups including Aboriginals, rural families, culture-specific-groups, people with disabilities, homeless people, prisoners and people with mental illness.

Single-Minded Message for the Health Care Providers

"Transitioning patients to Hospice Palliative Care requires compassionate communications."

- Many are faced with increased anxiety and stress as they attempt themselves to build the bridge from one world to another. (Ashpole 2004)
- Patients being oriented toward Hospice Palliative Care have new needs: in addition to prompt medical attention, they require information and emotional support.
- Health care providers need to develop the skills, tools and strategies to improve communications and the dissemination of information.
- There is a universal recognition of the need to facilitate communications in a sensitive and timely manner, and in general improve access to appropriate information for families and those caring for a terminally ill patient. (Ashpole 2004)
- The focus switches to providing comfort to the patient and, in general, support to the family when a cure is no longer possible. The dynamics of the situation alter drastically and there is a greater need to improve communications and share information. (Ashpole 2004)
- There needs to have a collaborative effort between organizations and those focused on palliative and end-of-life care at the time when a cure is no longer possible. (Ashpole 2004)
- Caregivers who were interviewed reported an almost "brutal shift" in the care team's attitude and in the focus of care when active treatment ceased. (Ashpole 2004)
- Caregivers have many questions about the signs of approaching death, indications that death may be imminent, what happens when the patient dies, the formalities of dying and coping with personal emotional support. (Ashpole 2004)

MESSAGING

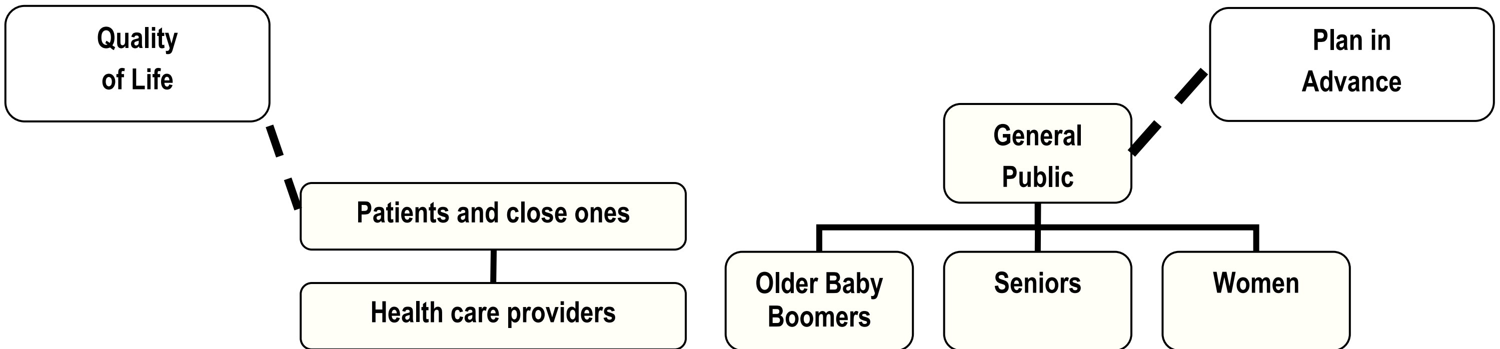
Umbrella Theme

The overall theme of the messaging is "quality of life". It is important that care and genuine concern for the patient and close ones is provided to the end.

Other themes that were considered included:

a) Making dying more livable

b) Caring for the living in dying



Key Messages for the General Public

	Public Awareness (Stage One)	Mobilization (Stage Two)	Consolidation (Stage Three)
Target Audience	50-64 year-old Canadians in their pre-retirement and early retirement years	Seniors, 65+ year-old Canadians	Women, 35-49 year-old Canadians
Message	*Because everyone is touched by life-ending illness, Hospice Palliative Care touches everyone.*	*Make the most of living, right to the end.*	*There are many people who can help and many ways to provide comfort and support.*
Alternative Message	*Most Canadians will die of a long term, life-threatening illness. All Canadians have a stake in Hospice Palliative Care.*	*There are ways to live with a life-ending illness.*	*Hospice Palliative Care creates a plan of comfort, caring and manages pain.*
Rationale	90 per cent of Canadians will die of a long term life-threatening illness, and all of us are affected by it. Each year, three million people are caring for a close one who is dying, and providing everyday comfort and support can be a full-time job. Hospice Palliative Care provides end-of-life support that makes dying more	The need for maintaining the best possible quality of life does not end when you or someone close is diagnosed with a terminal or life-threatening disease. There remains the need to ensure the best possible quality of dying. There are many choices to be made when dealing with	Even if you're currently untouched by illness, you can learn how to plan for the best possible quality of life by recognizing the physical, emotional, spiritual and social challenges associated with palliative care. Hospice Palliative Care provides moments of joy and peace by managing the pain

	livable, both for the patient and those who are close.	terminal and life-threatening illnesses. These include preferred settings, such as hospital, hospice or home. They may also include choices regarding the types of treatment or who provides care. And they encompass social arrangements, such as family, ceremonial, and estate plans. It's important to discuss Hospice Palliative Care options, and associated issues. And share your ideas of how to live life to the fullest, right to the end.	of Canadians who face a life-threatening illness and their close ones. Talking about death—both our own and our close ones'—may be difficult, but facing it without adequate planning will make the inevitable worse. Learn about the guidance and compassionate care that Hospice Palliative Care options provide you. Discuss end-of-life choices with those closest to you.
Guided Response	Seek information on support and Hospice Palliative Care	Consider the options and discuss your preferences for Hospice Palliative Care	Talk about Hospice Palliative Care

For each stage, the organization may find that it targets more finely a specific target audience. Based on the profile of each target audience, the most relevant consumer insight for Baby Boomers includes a stronger death-defiance attitude and a focus on health, diet and exercise to postpone discussions of death. They are a prime target for the basic awareness building message of Stage I as they become aware that Hospice Palliative Care concerns them as well, either directly or indirectly.

Seniors are more concerned with the quality of life, are more mature, and can appreciate messages that speak to their maturity and wisdom while addressing their main objective of maximizing their quality of life. Stage II messages can thus be skewed towards them.

Stage III messaging intends to build on the awareness of Hospice Palliative Care generated from Stage I messaging as well as the options and planning that forms a part of Hospice Palliative Care from Stage II messaging. It broadens the scope of the types and providers of Hospice Palliative Care services. Stage III also addresses bereavement and emotional support which are important issues namely to women: in many ways women are the gatekeepers of their family's health (they take care of their health, the health of their spouse, the health of their children). Additionally, women are often in a position where they are caring for close ones with terminal diseases.

Key Messages for the Health Care Providers

Message	*Care for the dying is care for the living.*
Alternative Messaging	*They look to you for quality care, right to the end.*
Rationale	As health care providers, we have a special role to play in the management of Hospice Palliative Care as the special relationship we share with our patients can help them make the transition with the continuing care of someone they trust and respect. Patients and family and friends who look after them need our professional guidance and compassionate care to help them through a time of high anxiety and difficult decisions. Health care providers can support the vital roles of the close ones who act as caregivers. We can also share from our own lives the fact that we, too, must deal with death in our personal, as well as our professional, lives. We can further help patients and those close to them by learning about, and guiding them towards, the variety of services offered in their province or territory, their municipality and their community.
Guided Response	Find out how you can play a guiding role in easing the transition to Hospice Palliative Care.

AN ISSUE RELATED TO NAMING

Underlying effective communications, branding and ultimately comprehension are the twin ideas of clarity and simplicity. Messages must be simple and straightforward. Messages must be clear and to the point. An axiom of communications is that one message delivered consistently is preferable to many finely tuned messages delivered to distinct audiences.

A concern of the communications team is that the term Hospice Palliative Care which is agreed upon and completely acceptable to stakeholders may be too confusing for the general public to comprehend.

We recommend that the term Hospice Palliative Care be tested by an outside research firm to assess the degree to which it is passes the test of clarity and simplicity with the general public and is ultimately capable of being understood. If research show that the term is not understood by the general public some branding may be required.

COMMUNICATIONS ROADMAP

Target Audience: Older Baby Boomers

Objectives	Themes / Messages	Communications Vehicles	Timing and Budget	Evaluation
o Increase relevance of Hospice Palliative Care o Increase awareness of Hospice Palliative Care	Theme: o Quality of life to the end Messages: o Because everyone is touched by life-ending illness, Hospice Palliative Care touches everyone o Most Canadians will die of life-threatening illness. All Canadians have a stake in Hospice Palliative Care (as a care receiver or as a caregiver) o Hospice Palliative Care provides end-of-life care options that make dying more livable, both for the patient and those who are close	o Magazines: heavy magazine readers o TV: heavy-medium users of television; medium-light users in French Canada o Newspapers: daily newspaper readership is higher o Community newspapers o Direct mail: letters and flyers/polybags o Internet: medium-light users in English Canada and heavier in French Canada o Public Relations: Op-Ed articles (articles opposite the editorial page, columnists articles) Other vehicles for consideration: o Consider partnerships with lawyers, financial planners and advisors. Other vehicles considered but not recommended: o Can be reached with several media; radio also provides reach. Media mix will depend on actual budget and timing considerations.	To Be Determined	Quantitative survey to measure: Attitudinal change o Increase in importance / relevance of Hospice Palliative Care Change in awareness o Increase in knowledge of Hospice Palliative Care for care receivers o Increase of knowledge of Hospice Palliative Care for caregivers

Target Audience: Seniors

Objectives	Themes / Messages	Communications Vehicles	Timing and Budget	Evaluation
o Raise awareness about Hospice Palliative Care's range of support o Initiate action in planning in advance of need o Identify relevant sources for information, guidance or care providers both at a national and at a community level	Theme: o Quality of life to the end Messages: o Plan ahead to make the most of living, right to the end. Don't leave discussions and decisions about Hospice Palliative Care options, and associated planning, until it's too late o You can choose how to live, even when dying (types of treatment, hospital, hospice or home care setting, social arrangements, and health care providers)	o TV: Seniors are heavy TV viewers o Daily Newspapers: daily newspaper readership is higher o Community newspapers o Direct mail: especially for French Canada o Public Relations: Op-Ed articles (articles opposite the editorial page, columnists articles) Additional tactics for consideration: o Leaflets: distributed with prescriptions in pharmacies o Posters in shopping malls o Brochures and posters in hospitals Other vehicles considered but not recommended: o Radio is not recommended (seniors are light radio listeners) o Internet: usage is increasing but it is still limited	To Be Determined	Quantitative survey to measure: Attitudinal change o Increase in importance / relevance of Hospice Palliative Care Change in awareness o Increase in knowledge of Hospice Palliative Care

Target Audience: Women

Objectives	Themes / Messages	Communications Vehicles	Timing and Budget	Evaluation
o Increase awareness of Hospice Palliative Care's range of support o Increase planning in advance of need	Theme: o Quality of life to the end Messages: o There is more to dying than death. And there is more to Hospice Palliative Care than medical treatment o There are many ways to deal with death and dying. And many people who can help o Even if you're currently untouched by illness, you can learn how to plan for the best possible quality of life by understanding the physical, emotional, spiritual and social challenges associated with palliative care o Talking about death—both our own and our close ones'—may be difficult, but facing it without adequate planning will make the inevitable worse o Learn about all the options and challenges that await you. Discuss end-of-life choices with those closest to you	o Magazines: heavy magazine readers o Radio: heavy radio listeners o Direct mail: more often will open/read coupon booklets, flyers, and polybags. Other vehicles for consideration: o Brochure for distribution through Family Physicians (consider partnership with the CMA, the College of Family Physicians of Canada, and the CNA) Other vehicles considered but not recommended: o TV: women are light TV viewers, and French Canada viewership is higher but still medium light to light o Internet: Some reach can be achieved but still usage is medium to medium-light o Newspapers: not very popular o Community newspapers: some reach but low compared to other audiences	To Be Determined	Quantitative survey to measure: Attitudinal change o Increase in importance / relevance of Hospice Palliative Care Change in awareness o Increase of knowledge of Hospice Palliative Care for care providers

Target Audience: Health Care Providers

Objectives	Themes / Messages	Communications Vehicles	Timing and Budget	Evaluation
o Increase awareness of own role in Hospice Palliative Care o Increase awareness of role of other team members in Hospice Palliative Care o Increase awareness of non-medical support required by the care receiver	Theme: o Quality of life to the end Messages: o Care for the dying is care for the living o Even when the condition is incurable, care matters; quality care is to the end o As health care providers, we have a special role to play in the management of Hospice Palliative Care o Health care providers can provide support to, and validation of, the vital roles of the close ones who act as caregivers. We can also share the empathy that comes from the fact that we, too, must deal with death in our personal, as well as our professional, lives o We can further help patients and those close to them by learning about, and guiding them towards, the variety of services offered in their province or territory, their municipality and their community	o Advertising in specialized publications and specialized web sites o Brochures in direct mail through associations o E-newsletters through associations o Specialized TV programming Please note that this group is time pressed, overloaded with information and have irregular work time schedules.	To Be Determined	Quantitative survey to measure: Attitudinal change o Increase in support for non-medical care Change in awareness o Increase of knowledge of Hospice Palliative Care for care providers

Evaluation

The framework is recommended to be evaluated for its impact/results, for its reach and for its style:

- Reach: the number of organizations that have been exposed to the existence of the Communications Framework and that have received copies or have downloaded copies
- Results: the extent to which the information contained in the framework has achieved the original intent of integrating the messaging and focusing the communications efforts
- Style: the extent to which the Communications Framework was adapted to the needs of its users through its language, elements and structure.

The following grid provides suggested evaluation issues that merit investigation, possible methods and sources to obtain the information (quantitative/qualitative research). The findings from the evaluation will become more relevant as a benchmark for comparison. Future communications can then be assessed against this benchmark.

Evaluation Issues	Indicators and Data Collection Methods	Information Source	Bases for Comparison
Dissemination of the Communications Framework			
How many organizations received/retrieved the framework?	o Internal documents to track number of organizations that requested copies of the framework. o Attach a survey to the Communications Framework itself to voluntarily report information o Survey organizations one month after the completion of the dissemination activities of the framework to assess its reach	o Health Canada and partners (e.g., CHPCA, QEOLCC) o Health Canada o Health Canada or third party	Compare with results from other Communications Frameworks* at Health Canada or other Government of Canada department / Agency with similar audiences (grassroots organizations)
Implementation of the Framework (Results in terms of Integration and Consistency)			
To what extent were the messages disseminated by organizations integrated and consistent with the recommendations of the framework?	Survey organizations up to a year after the receipt of the framework to gather the messaging they are using and compare with the Communications Framework original messaging	Health Canada or third party research organization	Compare with results from other Communications Frameworks* at Health Canada or other Government of Canada Department / Agency with similar audience (grassroots organizations)
To what extent were the targets identified by the framework utilized by organizations?	Survey organizations up to a year after the receipt of the framework to identify the targets they have selected and compare with the Communications Framework suggested targeting	Health Canada or third party research organization	Compare with results from other Communications Frameworks* at Health Canada or other Government of Canada Department / Agency with similar audience (grassroots organizations)
To what extent were the	Survey organizations up to a	Health Canada or third party	Compare with results from

media vehicles recommended in the framework used by organizations?	year after the receipt of the framework to identify the communications vehicles they are using and compare with the Communications Framework suggested communications vehicles	research organization	other Communications Frameworks* at Health Canada or other Government of Canada Department / Agency with similar audience (grassroots organizations)
Were there unintended impacts and effects?	Survey organizations up to a year after the receipt of the framework to identify any unintended effects in audience acceptance of messages, internal communications or media coverage	Health Canada or third party research organization	
Improvement of the Framework (Structure and Style of the Framework)			
To what extent was the framework easy to use?	Survey organizations up to a year after the receipt of the framework to gather feedback on its language and structure	Health Canada or third party research organization	Compare with results from other Communications Frameworks* at Health Canada or other Government of Canada Department / Agency with similar audience (grassroots organizations)

* Results from research related to the effectiveness of this Communications Framework could be compared to results from other Communications Frameworks projects if they are similar in audience and tasks. Several cases could be needed if other Communications Frameworks are different (e.g., difference in the number of organizations, messaging complexity).

MEDIA RECOMMENDATIONS

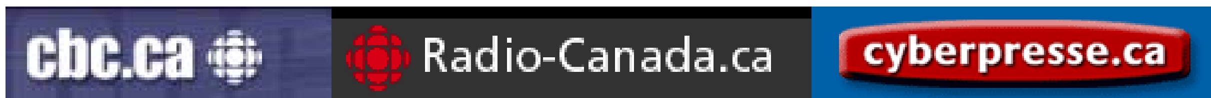
Working with a small scale media budget, the media recommendations were developed to provide a variety of options which would maximize impact of Hospice Palliative Care messaging and resonate with the intended target audience.

Option One: Advertising

The following option recommends advertising that is intended to reach baby boomers with spillover to health care professionals.

Web banner ads on CBC/RDI/Canada.com and Cyberpresse.ca.

- Total budget of $75,000
- Average impressions for 8 week flight is 765,000
- Cost-per-thousand impressions is $98.04



Advertising in Reader's Digest and Coup de Pouce, these publications have an editorial focus from health to food.

- Total budget of $53,202
- Circulation is 1,155,498
- Cost-per-thousand impressions is $46.04

Develop a Hospice and Palliative Care web site.

- The new site would be referenced from the www.chpca.net web site and the Canadian Virtual Hospice site

Option Two: Advertising and Media Relations

The following option recommends a combination of advertising and media relations that is intended to reach baby boomers with some spill over to health care providers.

Media Relations

- News release – newswire and key media list
- Proactive media relations – national and regional resources in key markets (Halifax, Montreal, Toronto, Edmonton and Vancouver)
- Fact sheets – distributed to provinces and territories
- Maintain contact with key journalists
- Total budget of $37,500

Advertising

CARP – Canadian Association for Retired Persons – an organization targeting older boomers with a magazine 50 Plus and web site, editorial focus ranges from health to finance.

- Total budget of $50,000
- Circulation is 201,000,
- Cost-per-thousand impressions is $60.53

Good Times – a magazine targeting boomers with editorial focus that ranges from health to gardening, publication and web site available.

- Total budget of $50,000
- Circulation is 155,356
- Cost-per-thousand impressions is $52.74

Option Three: Media Relations

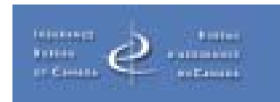
The following option recommends media relations that would be launched on a national scale with a concentration in major markets.

- News release - promote Hospice Palliative Care Week with a release through newswire and key media list
- Proactive media relations – focused on major markets (St. John's, Charlottetown, Saint John, Halifax, Montreal, Toronto, Regina, Winnipeg, Edmonton, Vancouver, Whitehorse and Iqaluit)
- Fact sheets – distributed to provinces and territories
- Articles – series written for community and ethnic newspapers
- Pamphlet – distributed through partner organizations and available as PDF on partner sites
- Mass mailing – cheque stuffer – opportunities to be explored such as driver's license renewals
- Maintain contact with key journalists who can move the Hospice Palliative Care agenda forward
- Fall media relations activity based on strong news hook
- Total budget of $160,000

Additional Idea: Partnership Development for Canadians

The objective is to source out partners that have vested interest in providing information to Aging Boomers, such as:

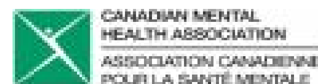
- Grey Power
- Insurance Bureau of Canada
- Shopper's Drug Mart
- Independent Drug Stores
- Home Hardware
- A major grocery chain
- Costco's membership magazine



Additional Idea: Partnership Development for Health Care Providers

The objective is to source out health care professional associations as partners. They communicate information on important subjects to their membership on a regular basis. Potential partners include:

- Canadian Medical Association
- Canadian Mental Health Association
- Canadian Nurses Association
- Canadian Pharmacists Association



APPENDIX A

Hospice Palliative Care – Associated Words

These words represent general perceptions associated with Hospice Palliative Care. They have been drawn from research conducted and various communications tools on the subject, and help to express the range of topics in the spheres of Hospice Palliative Care. The words reflect the challenges, emotions, and influences of those involved in these areas.

Acceptance	Continuum	Empathy	Guilt	Peace	Spirituality
Access	Crisis	Exhaustion	Healing	Prayer	Stress
Affirmation	Death	Family	Honour	Protection	Support
Anxiety	Denial	Fatigue	Hope	Quality care	The journey
Bereavement	Depression	Fear	Loneliness	Reflection	Trauma
Care	Despair	Financial	Loss	Relief	Treatment
Comfort	Dignity	Friends	Love	Responsibility	Unknown
Community	Distress	Grace	Meaning	Ritual	Vulnerability
Compassion	Draining	Grief	Pain management	Solitude	

APPENDIX B

Characteristics of Hospice Palliative Care

From reviewing background documents and receiving initial feedback from stakeholders, the following four characteristics were found to embody the promise of Hospice Palliative Care. These four characteristics reflect the aspects of Hospice Palliative Care that are most important to audiences and stakeholders. They recognize the sensitivity of the issues in question and address the realities of life for those involved in receiving and providing Hospice Palliative Care.

1. **Holistic**
   - Hospice Palliative Care is a comprehensive model of care that includes physical, psycho-social, spiritual and culturally appropriate care.
   - Teams are interdisciplinary.
   - Simultaneous services are provided.
   - Hospice Palliative Care overlaps with active, preventive, acute and curative care.
   - Hospice Palliative Care may continue after death in helping the bereaved.

2. **Respect**
   - Hospice Palliative Care recognizes the vulnerability of patients and the ones close to them.
   - Pain management and treatment of symptoms are ways to maximize the comfort and care for the patients and their close ones.

3. **Reflection**
   - Hospice Palliative Care recognizes that people go through a period of reflection.
   - Time is an issue that patients and their families face during the treatment, when dealing with the imminent outcome or during the healing process of bereavement.
   - Spirituality and cultural specificities surface strongly during this process.

4. **Support**
   - Hospice Palliative Care recognizes the drain that patients and their families face.
   - Hospice Palliative Care aims various support levels that can reduce the strain with social, physical and emotional assistance.
   - Hospice Palliative Care recognizes that emotions are important. They are a necessary part of the process that connects the families and the patients, the caregivers as well as the health care providers.

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[xvi] Heart and Stroke Foundation of Canada. *Report Cards on Health – 2006*, retrieved on February 17, 2006, from http://ww2.heartandstroke.ca/Page.asp?PageID=110&Article ID=4639&Src=news&From=SubCategory.

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