Who is the Freeman Outreach Program for?

The Freeman Outreach Program is for patients who are:

- Diagnosed with advanced cancer, cannot leave their homes, and find it difficult to attend clinic appointments
- Looking to improve their quality of life through a palliative care approach to care that focuses on pain and symptom management, without ongoing cancer treatment.
- Living within the following geographic boundaries: South of Steeles Ave., West of Victoria Park, North of Lawrence Ave., and East of Bathurst St.

How Long Do Services Last?

Patients will receive services for as long as they remain at home and prefer a palliative approach to care.

What if the Patient is Hospitalized?

If the patient is admitted to hospital, Freeman Outreach will resume once the patient returns home.

NORTH YORK GENERAL

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The Freeman Centre for the Advancement of Palliative Care Outreach Program

North York General Hospital

Room 3S-376

4001 Leslie Street
Toronto, ON M2K 1E1

T 416.756.6444 ext 4138

PEOPLE-CENTRED CARE

The Freeman Centre for the Advancement of Palliative Care Outreach Program

Information for patients and families

What is the Freeman Outreach Program?

The Freeman Outreach Program offers palliative care to adults living with advanced cancer who wish to remain at home for as long as possible, or to die at home.

What Services Are Provided?

The Freeman Outreach Program provides a range of services to patients, their families and loved ones including:

- Creation of a palliative and end-of-life care plan based on the patient's preferences
- Management of physical, emotional and psychological symptoms
- Coordination with the patient's healthcare team
- Connection to community resources
- Access to care 24 hours a day, 7 days a week
- Grief and bereavement support

How Does the Freeman Outreach Program Work?

- A Physician or Nurse Practitioner refers the patient to the Freeman Outreach Program.
- Our team arranges a consultation at the patient's home and can also provide consultations via phone or video if appropriate.
- Following our consultation, we work with the patient and their home and community care team to create a personalized care plan. This may include:
- Adjusting and/or prescribing medications.
- Identifying additional necessary resources, such as nursing support, a home safety assessment, and personal care assistance.
- We work closely with the home and community care team to coordinate referrals with other community support services.
- We provide regular follow up with the patient, based on their specific needs, and continue to partner with the healthcare team to support the patient at home.

Who is part of the Freeman Outreach Program Care Team?

The Freeman Outreach Program team specializes in managing symptoms associated with serious illness and end-of-life. We work with the patient's family and caregivers to deliver high quality care that aligns with the patient's wishes.

The team includes:

- Palliative Care Physicians and Advanced Practice Nurses.
- A Family Doctor if applicable.
- Professionals from community support agencies including Personal Support Workers, Nurses, Physiotherapists, Occupational Therapists and Case Coordinators among others, depending on the patient's unique needs.

"As family members, my brother and I have been **generously supported** by the Physician and Advanced Practice Nurse. **We are given the time to ask questions and discuss our feelings, and counseled with sensitivity.** Services have also been provided in our father's home which has been immeasurably valuable."

– A Patient's Family