



Ontario Palliative Care Network Action Plan 1: 2017 – 2020

Action Areas, Actions and Timelines

Introduction

Every day, people with life-limiting illnesses are seeking a high quality of life and access to compassionate hospice palliative care from caring and knowledgeable healthcare professionals, volunteers and loved ones in hospitals, hospices, homes and long-term care facilities across Ontario. But, despite the outstanding work being done by those in the palliative care sector, not enough patients receive hospice palliative care supports and services as early as they need them, and in the most appropriate setting. As noted in the [2014 Annual Report of the Office of the Auditor General of Ontario](#) "...Ontario does not yet have a coordinated system for the delivery of hospice palliative care that enables patients to move easily among health-care providers to receive needed services on a timely basis."¹

This Action Plan (2017 to 2020) is the work plan that will guide how the partners of the [Ontario Palliative Care Network](#) (OPCN) will work together to improve availability of, and ease of access to, equitable, high-quality, sustainable palliative care services for all Ontarians. It presents a way forward for palliative care services in Ontario and promotes collaboration and standardization across the regions.

Over the next three years, these actions will advance our ability to improve access to high-quality hospice palliative care for patients and their loved ones regardless of where they live or receive their services, their age or their illness. This Action Plan recognizes the diverse needs of Ontarians and aims to continue to strengthen access to culturally and linguistically appropriate care for Francophone and First Nations, Inuit and Métis communities.

This plan identifies 38 ambitious but achievable actions in seven areas aligned with the goals of The Declaration and builds on the significant work in hospice palliative care already underway provincially, regionally and locally within the 14 Regional Palliative Care Networks. It underscores the interrelationships with other health system improvement initiatives. This plan aligns with key policy and foundational documents including:

- [Declaration of Partnership and Commitment to Action](#) (December 2011), a collaborative, stakeholder-driven, multi-year framework for improving hospice palliative care in Ontario;
- The [2014 Annual Report of the Office of the Auditor General of Ontario](#), which called attention to the need for an integrated, coordinated system to deliver hospice palliative care in Ontario;
- The Ministry of Health and Long-Term Care's [Patients First: A Roadmap to Strengthen Home and Community Care](#) (May 2015), which highlights a commitment to improved access and equity in hospice palliative care at home and in the community; and
- [Palliative and End-Of-Life Care Provincial Roundtable Report](#) (March 2016), which explores the important steps to achieve the goals set in *Patients First*.

The three goals of the OPCN and of this Action Plan are the same as the core system goals set by The Declaration. As we advance these goals Ontarians will have improved access to high quality palliative care.

Goals

Quality

To improve client/family caregiver and provider experience by delivering high quality, seamless care and support

Population Health

To improve, maintain and support the quality of life and health of people with progressive life-limiting illnesses

Sustainability

To improve system performance by delivering better care more cost-effectively and creating a continuously self-improving system

To ensure we are moving in a meaningful way toward strengthening hospice palliative care in the province, we will use system-level measures with regional targets set jointly by each Local Health Integration Network (LHIN) and Regional Cancer Program. These system-level measures are supported by additional indicators that will offer insights into our progress.

A. Enhancing Patient and Caregiver Engagement in Hospice Palliative Care

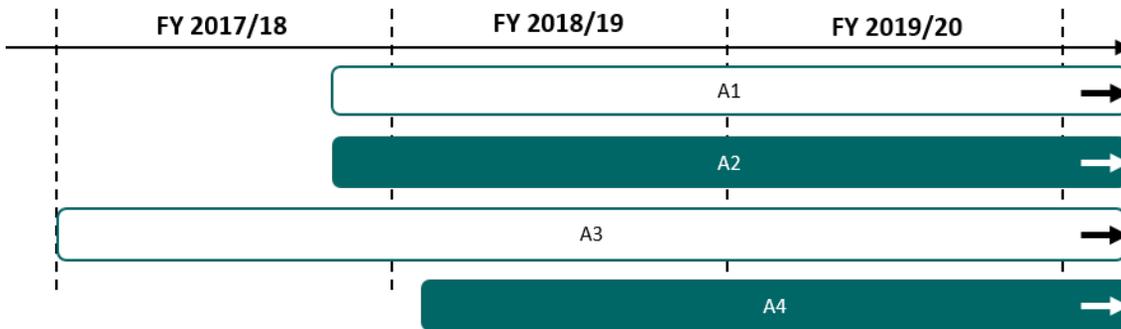
Over the course of the Action Plan, Ontarians will develop a better understanding of, and engage in discussions about, palliative and end of life care.

Patients and caregivers will be increasingly empowered to identify their goals, access services, and manage their care.

Continued development of quality resources, appropriate to the Ontario context will increase understanding of the palliative approach to care and palliative care services.

In the next three years:

1. The Partnership Advisory Committee (PAC) will develop, monitor, and update a process and framework to identify existing patient/caregiver educational resources in English and French and First Nations, Inuit and Métis languages in the regions, and include them in a standardized provincial-scale catalogue.
2. Each Regional Palliative Care Network (RPCN) will identify existing patient/caregiver educational resources within their region and catalogue them in a standardized provincial-scale catalogue, which will be made publicly available online in English and French. The catalogue will include the products developed by Hospice Palliative Care Ontario (HPCO) to adapt Advance Care Planning, Goals of Care, and Health Care Consent Resources to the Ontario context (identified in A3).
3. HPCO will continue to develop and update materials for patients, caregivers, substitute decision makers, and providers to engage in Advance Care Planning Conversations, Goals of Care Discussions and Health Care Consent in alignment with Ontario's legal landscape, and the Quality Standard.
4. Each RPCN, working with the hospice palliative care providers in their region, will develop mechanisms to help patients and their caregivers understand the services that are available and to develop an appropriate care pathway to meet their needs.



Legend

- A1 Provincial focus of activity
- A3 Regional focus of activity
- Italicized* Setting specific focus

B. Aligning the Planning for Hospice Palliative Care Across the Province

Engagement and planning both at the regional and provincial level will result in enhanced patient and caregiver understanding of, and improved access to, hospice palliative care that is high quality, responsive to their needs, sustainable, and equitable.

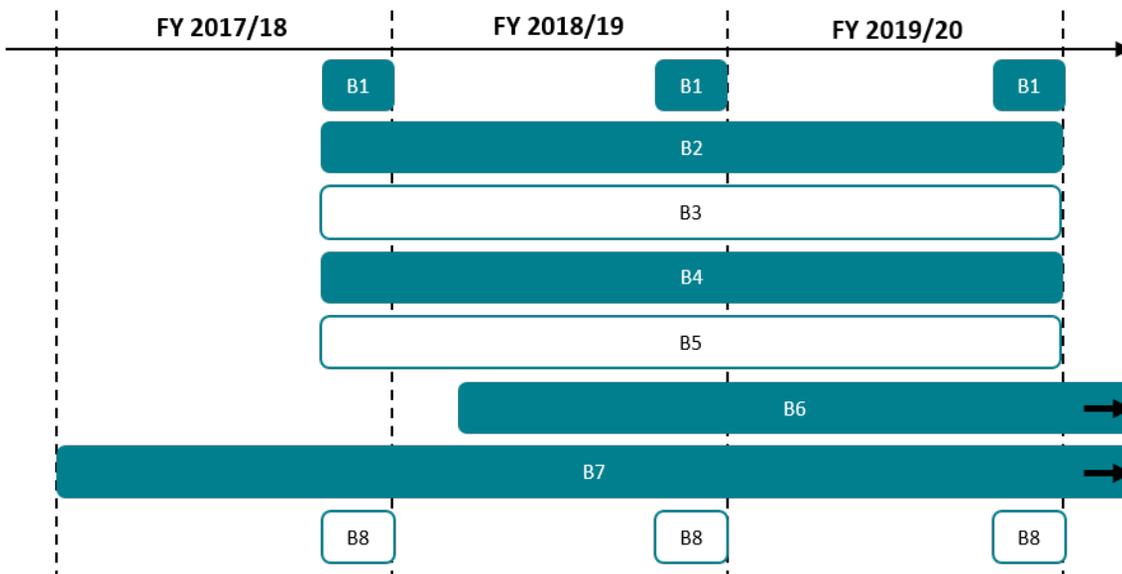
Annual planning will frame and guide regional work on hospice palliative care, ensure it aligns with provincial activities, and underscore the interrelationships with other health system improvement initiatives.

The Executive Oversight will ensure there is alignment both across the regions and between the regional and provincial work.

Together, these activities will drive the implementation of the Action Plan and enhance the quality of palliative care services in Ontario. Progress on the annual work plans and the Action Plan will be measured through the actions described in Action Area G: Measuring our Progress.

In the next three years:

1. Each RPCN will develop, submit to Executive Oversight, and regularly report on an annual work plan. The work plan will be aligned with the Action Plan to guide the regional implementation activities, ensure alignment with other regional and provincial work, and ensure engagement of the appropriate populations in planning and implementation.
2. Each RPCN will engage with First Nations, Inuit, and Métis Peoples on and off reserve to jointly identify gaps in hospice palliative care and develop recommendations (both at the regional and provincial levels) that will inform future annual work plans.
3. The OPCN, through a dedicated First Nations, Inuit, and Métis engagement plan, will engage and plan with First Nations, Inuit, and Métis organizations, regional groups and communities to jointly identify gaps in hospice palliative care and report on recommendations to all OPCN Advisory Councils to inform future annual work plans and to ensure alignment with the Action Plan.
4. Each RPCN will engage with Francophones in an equitable manner to identify gaps in hospice palliative care and develop recommendations (both at the regional and provincial levels) that will inform future annual work plans.
5. The OPCN will engage and plan with Francophone stakeholder organizations, to jointly identify gaps in hospice palliative care and report on recommendations to all OPCN Advisory Councils to inform future annual work plans and to ensure alignment with the Action Plan.
6. Each RPCN will identify vulnerable populations within its catchment area (e.g. paediatric and homeless populations) and engage them and their families/caregivers to identify gaps in hospice palliative care and develop recommendations (both at the regional and provincial levels) that will inform future annual work plans.
7. The RPCNs will assess the service delivery gaps between existing services and those articulated in the models of care (Action Area D), and will – through their annual work plans – identify current and recommended capacity and the associated resource requirements to close the gaps over time.
8. The Executive Oversight will develop an annual provincial work plan that is aligned with the Action Plan to guide the provincially focused implementation activities.



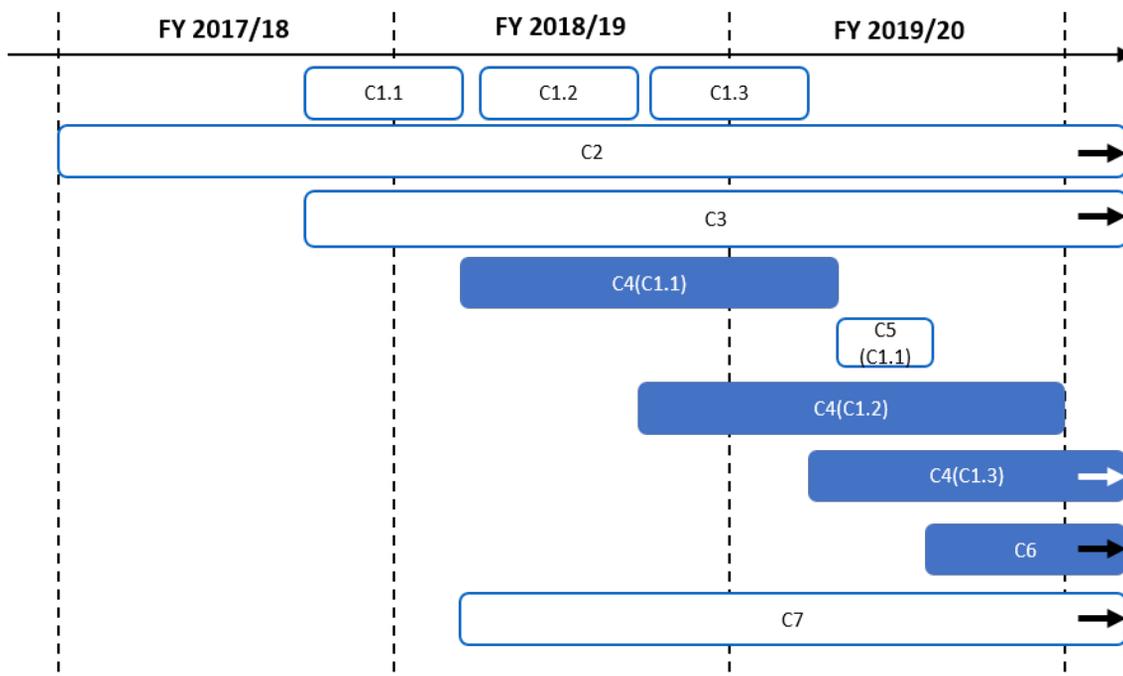
C. Enabling Early Identification of People Who Would Benefit from Hospice Palliative Care

The intent of early identification is to define the population who would benefit from hospice palliative care early in the illness trajectory and improve access across healthcare settings. This work will build upon the initiatives underway in the RPCNs and existing tools used for identification. There are two broad purposes for this work:

- By applying evidence-based tools to support the identification of individuals who would benefit from hospice palliative care, patients and their caregivers will have earlier access to the palliative care services they need.
- By understanding the number of Ontarians across care settings for whom palliative care services and resources would be advantageous, we can improve system level planning and better support the appropriate allocation of hospice palliative care resources.

In the next three years:

1. The Advisory Councils will identify evidence-based tool(s) and make implementation recommendations to support early identification of the defined population at the point of care in: 1) *the home care setting*, 2) *hospitals*, and 3) *primary care*.
2. To support system planning, the Data and Information Advisory Council (DIAC) will use administrative data sets to produce refined provincial and regional estimates of the number of people that would benefit from hospice palliative care; this will be updated annually.
3. DIAC will explore opportunities to use predictive analytics using data from multiple care settings to prospectively identify at a system level individuals who would benefit from hospice palliative care.
4. For each setting, up to four RPCNs will plan for and implement the tool(s) identified in Action C1.1 – C1.3 as tests of change, and report on their impact to the Advisory Councils.
5. The Advisory Councils will advise on refining the tool(s) and provide implementation advice based upon the lessons learned in Action C4.
6. All RPCNs will plan for and implement the tool(s) refined in Action C5.
7. DIAC and the Clinical Advisory Council (CAC) will work with OntarioMD, eHealth Ontario, and other digital health influencers to work towards incorporating the tools identified in Actions C1 in digital health solutions across Ontario's health system.



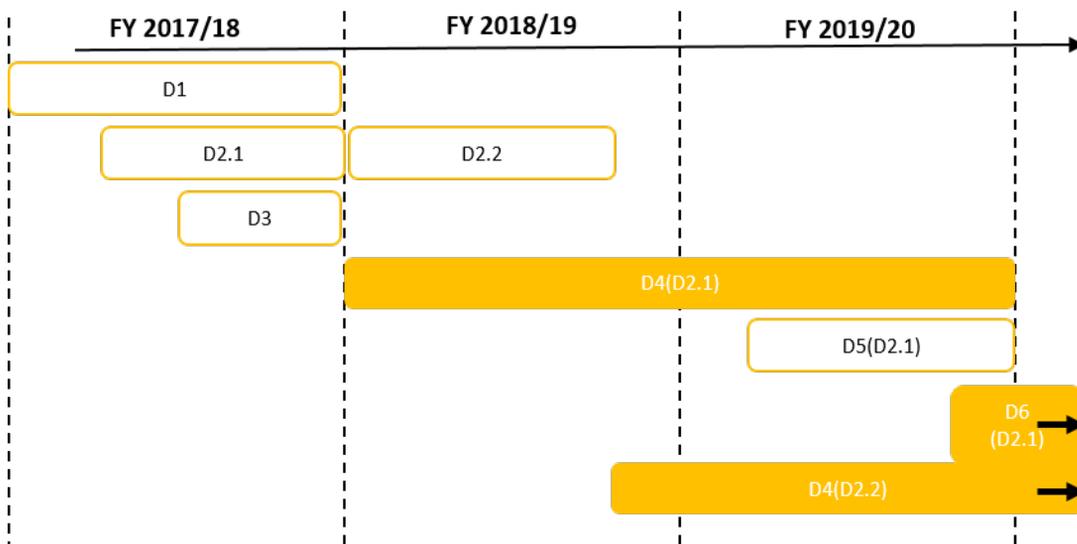
D. Establishing Palliative Models of Care to Increase Access and Enable Adoption of the Quality Standard

By developing and implementing models of care for hospice palliative care, we will improve equitable access for patients and caregivers, and ensure that they are able to receive the holistic, proactive, timely, and continuous care and support they need through the entire spectrum of care. At a system level, we will enhance the optimal use of healthcare personnel and resources across the settings of care. The models of care will be developed using a health equity approach to incorporate the needs of First Nations, Inuit, Métis and Francophones. This work will build upon the existing models and initiatives underway within the LHINs.

The models of care will enable the implementation of the Palliative Care Quality Standard – a concise set of evidence-based, measurable quality indicators that outline what high quality care should look like for patients and caregivers – and help teams and providers prioritize improvement efforts and measure success.

In the next three years:

1. As an OPCN partner, Health Quality Ontario will develop and publish the Palliative Care Quality Standard, and support provincial adoption.
2. CAC and the Health Services Delivery Framework Working Group will develop models of care for 1) *patients residing at home* and 2) *patients in the long-term care setting* with input from the regional and provincial stakeholders.
3. CAC will identify physician compensation mechanisms required to support the implementation of the models of care (and specifically the physician elements of team-based service delivery supporting these models), and will provide recommendations to MOHLTC and appropriate professional bodies.
4. For each setting in D2, up to four RPCNs will plan for and implement the models of care as tests of change, and report on their impact to the CAC.
5. CAC will refine the models of care based upon an evaluation and the lessons learned in Action D4.
6. All RPCNs will plan for and implement the models of care refined in Action D5.

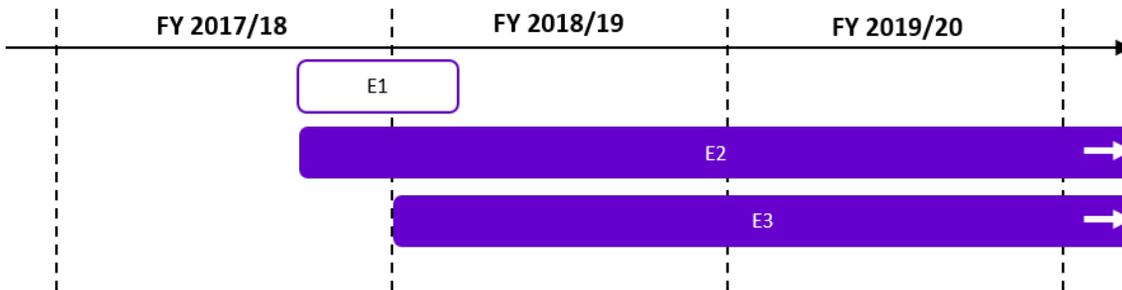


E. Identifying and Connecting Hospice Palliative Care Providers

Giving providers the information they need to access palliative care services, and resources for their patients, in a timely and efficient manner will allow them to work together to better achieve each patient's goals, to enhance continuity of care, and to increase access across settings throughout the patient's pathway. The directory will include information on available services that provide culturally and linguistically sensitive care.

In the next three years:

1. The Implementation Advisory Council (IAC) will select (from amongst those provincial solutions currently in use) a technology platform on which the accessible directory developed in Action E2 will be housed.
2. RPCNs will work with their stakeholders to complete a mapping process of providers and services, and develop and maintain an accessible directory (see Action E1) of available hospice palliative care providers and supports.
3. OntarioMD will work with hospice palliative care providers and the Regional Palliative Care Networks to increase the use of the provincial eConsult platform to provide physicians and nurse practitioners with electronic access to specialist hospice palliative care advice.



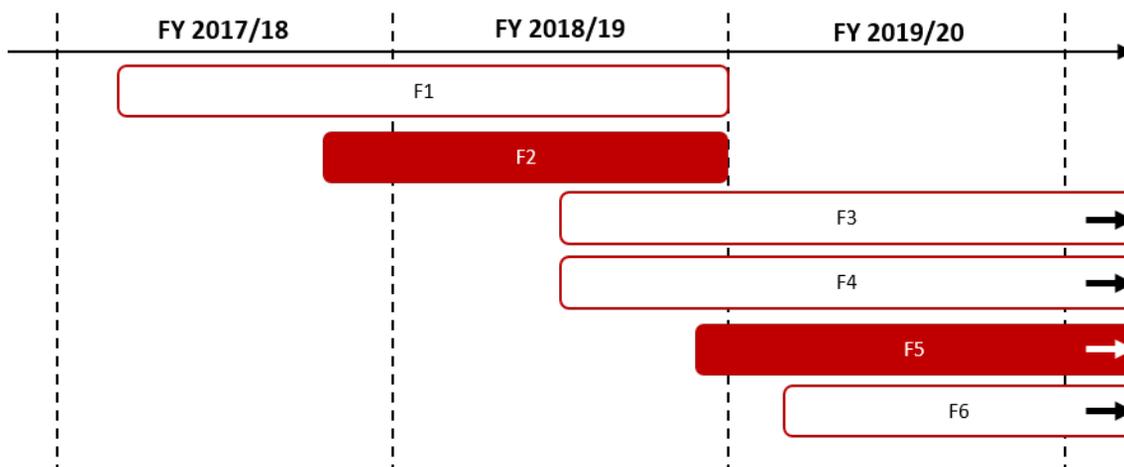
F. Building Provider Competencies in Hospice Palliative Care

Building provider competencies in hospice palliative care will improve access and strengthen providers' ability to identify individuals who would benefit from palliative care services, and to work with patients and caregivers to identify and meet their needs.

There will be a focus on the education of primary care providers. This will ensure that they are sufficiently knowledgeable about the palliative approach to care and are comfortable having end-of-life conversations with their patients, including discussing a terminal diagnosis and care options with people who are dying. Education will include not only professional competencies but also cultural and communication competencies.

In the next three years:

1. In alignment with the models of care and the Palliative Care Quality Standard, the Education Steering Committee will determine the required competencies¹ to enable high quality hospice palliative care. The Education Steering Committee will include direction from the First Nations, Inuit and Métis Palliative and End-of-Life Care Education Working Group on developing Palliative and End-of Life Care competencies to address the needs of First Nations, Inuit, and Métis Peoples.
2. Each RPCN will inventory existing continuing educational programs offered within their region.
3. Based on the input from the RPCNs (Action F2) and other stakeholders, the Education Steering Committee will develop a provincial inventory of existing educational programs (certification programs, undergraduate, postgraduate) and assess the degree to which they address the competencies (established in Action F1).
4. The Education Steering Committee will recommend *continuing education programs* that meet the criteria (established in Action F1) required to develop the appropriate hospice palliative care competencies.
5. The RPCNs will develop, implement, and incorporate in their regional work plan, a regional continuing education plan for *primary care providers*, aligned with the recommendations of OPCN's Education Steering Committee (Action F4).
6. Building on F5, the OPCN Secretariat will work with academic institutions, and licensing and regulatory bodies, to begin to embed the hospice palliative care competencies into *undergraduate* curricula for providers. In support of these discussions, the OPCN will provide regular updates to the MOHLTC and MTCU.



¹Competencies are for all providers across hospice palliative. They are a combination of observable and measurable knowledge, skills, and abilities that contribute to enhanced employee performance and ultimately result in organizational success. They include not only professional competencies, but also cultural and communication competencies. To understand competencies, it is important to define the various components of competencies.

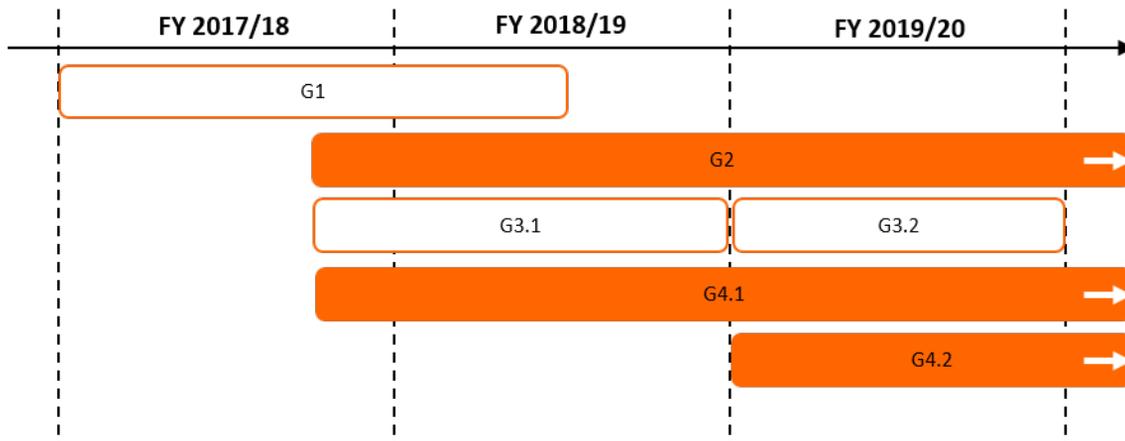
G. Measuring and Reporting on our Progress

Ensuring consistent use of indicators and benchmarks will assist the provincial and regional networks in understanding their progress towards increased consistency and enhanced quality of palliative care services across the province, and will inform the annual work plans as they are developed.

Reports will also be made available publicly to support transparency and accountability to patients, caregivers, and the greater public.

In the next three years:

1. DIAC will develop provincial and regional measures and reports that will support planning and quality improvement and measure the impact of implementing the Action Plan. Health Quality Ontario will publicly report on our progress.
2. RPCNs will incorporate the findings of these reports as they develop their annual work plans (Action B1).
3. DIAC will provide recommendations to improve the quality of data describing utilization, appropriateness and quality of palliative care services in Ontario focusing on 1) *alternative level of care tracking* and 2) *palliative care unit beds tracking*.
4. The CaregiverVoice survey² will be 1) implemented across all LHINs for all patients *who received palliative home care services and hospice services, and 2) begin to be used for all patients who received hospice palliative care in long-term care*.



²CaregiverVoice survey supports the capture of the patient and caregiver experience at the end of life. It supports the evaluation of the experiences of care by the deceased and the bereaved caregiver(s), who are persons who provided end-of-life care to a friend or family member in their final 3 months of life, and is intended to help improve the care for people who are dying, and for their family and friends.

Appendix

Glossary

ACP	Advance Care Planning
Caregiver	A caregiver is an unpaid person who provides care and support in a nonprofessional capacity, such as a family member, a friend, or anyone else identified by the person with a progressive, life-limiting illness.
CAC	Clinical Advisory Council
DIAC	Data and Information Advisory Council
The Declaration	ADVANCING HIGH QUALITY, HIGH VALUE PALLIATIVE CARE IN ONTARIO A Declaration of Partnership and Commitment to Action December 2011
Home	Home is defined as the usual place of residence.
Hospice Palliative Care	<u>Hospice palliative care is a philosophy of care that aims to relieve suffering and improve the quality of living and dying.</u>
HPCO	Hospice Palliative Care Ontario
IAC	Implementation Advisory Council
LHIN	Local Health Integration Network
MOHLTC	Ministry of Health and Long-Term Care
MTCU	Ministry of Training, Colleges and Universities
Model of Care	A Model of Care describes the way health services are designed and delivered for a person as they progress through the stages of a condition, injury, or event.
PAC	Partnership Advisory Council
RCPN	Regional Palliative Care Network