

Ontario Palliative Care Network

Overview

At maturity, all Ontario Health Teams (OHTs) are expected to deliver services across the full continuum of care. Palliative care is provided in all sectors that are “in scope” for OHTs, and integrating palliative care into service-delivery planning from inception can enable OHTs to have early success in achieving a full and coordinated continuum of care.

The Ontario Palliative Care Network (OPCN) is a health-system partner with palliative-care expertise, resources and data to help OHTs provide better, more integrated care across the province. The OPCN is a partnership funded by the Ministry of Health, with a mandate to improve access to equitable and sustainable quality hospice palliative-care services in Ontario. At the local level, the OPCN has Regional Palliative Care Networks (RPCNs) across the province that are led by a Network Director, and two Clinical Co-Leads. The RPCNs provide the structure and leadership to facilitate the development of a comprehensive, integrated and coordinated system of hospice palliative care.

The existing local leadership, expertise and relationships within RPCNs can provide a critical mechanism to support OHTs in planning and implementation. To connect with your local RPCN, email info@ontariopalliativecarenetwork.ca to request their contact information.

This brief shares some of the OPCN’s key resources developed in collaboration with provincial and regional partners, to enable better care for individuals and their families wherever they receive care. These tools are implementation-ready and coupled with the support of their RPCN, will provide OHTs with valuable guidance for integrating palliative care into their service-delivery planning.

Palliative care health services delivery framework

One of the key resources developed by OPCN that will be of use to OHTs is the [Palliative care health services delivery framework](#) (delivery framework). This framework can be used to optimize the way OHTs deliver care. The delivery framework describes a model of care that will enable adults with a life-limiting illness who are living at home or in community settings, and their family/caregivers, to remain at home as long as possible. The 13

Health-system partner(s)

RISE brief 27: Ontario Palliative Care Network and how it can support OHTs as a health-system partner (Last updated 23 March 2021)

Box 1: Coverage of year 1 priority populations and OHT building blocks

This RISE brief addresses two of four priority populations that are the focus of approved OHTs:

- 1) older adults and/or people with chronic conditions
- 2) people with mental health and addictions issues;
- 3) **people who could benefit from a palliative approach to care;** and
- 4) people at risk of or affected by COVID-19.

This RISE brief primarily addresses **building block #4** and secondarily addresses **building blocks #2, #3, and #8:**

- 1) defined patient population
- 2) **in-scope services**
- 3) **patient partnership and community engagement**
- 4) **patient care and experience**
- 5) digital health
- 6) leadership, accountability and governance
- 7) funding and incentive structure
- 8) **performance measurement, quality improvement, and continuous learning**

recommendations aim to improve equitable access for individuals and their family/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. The model of care is a guide for continued evolution of palliative care across Ontario. It builds on existing capacity and supports local flexibility. Ultimately, it leads towards sustainable, equitable and coordinated palliative care for Ontarians experiencing a life-limiting illness and their family/caregivers.

The delivery framework aligns with the vision for OHTs and the overall goal of delivering high-quality integrated care including:

- providing a full and coordinated continuum of care for an attributed population within a geographic region;
- 24/7 access to coordination of care and system navigation as well as seamless transition through services;
- measurement, reporting and improving performance across the quadruple aim;
- improving access to secure digital tools including online health records; and
- using available data and pooling local intelligence to understand population needs.

Importantly, implementation of the recommendations in the delivery framework is expected to improve patient experience, while supporting sustainability, and create more effective use of palliative-care resources, ultimately leading to reduced hospitalizations and avoidable emergency-department visits.

OHTs can use the delivery framework to guide the future organization and delivery of palliative care, from earlier identification of individuals who would benefit from palliative care through to the end of life, and bereavement. OHTs should use the delivery framework as a roadmap, leveraging the recommendations to:

- clarify roles for OHT members in providing palliative care;
- identify how providers and services can be organized and coordinated based on the needs of the individual and their family/caregivers; and
- identify opportunities to create and/or strengthen supports for the OHT to provide high-quality, person-centred palliative care in their communities.

Resources for prioritized priority populations

In addition to the delivery framework, the OPCN has produced a number of other resources that can support teams with integrating palliative care into their service-delivery planning for two frequently selected priority populations for approved OHTs (Table 1).

Table 1: Assets and resources related to prioritized populations

Populations prioritized by approved OHTs	Assets and resources
Older adults with greater needs and/or those with chronic conditions	<ul style="list-style-type: none"> • Palliative care quality standard describes what high-quality palliative care should look like, and provides quality indicators to inform quality measurement <ul style="list-style-type: none"> ○ Palliative care implementation support group is a community of practice to support organizations who have adopted the palliative-care quality indicator as part of their quality-improvement plan • Palliative care health services delivery framework describes the key processes, team structures and roles that are important for the delivery of high-quality palliative care • Tools to support earlier identification for palliative care provides guidance on preferred identification tools and assessment tools to support providers and system-level leadership in earlier identification of individuals who would benefit from palliative care
People at the end of life and/or needing palliative care	<ul style="list-style-type: none"> • Palliative care competency framework describes the knowledge, personal attributes and skills providers need to deliver high-quality palliative care

	<ul style="list-style-type: none"> • Palliative care toolkit includes links to best-practice tools to support primary-care providers with palliative-care delivery • The OPCN regularly collects and reports on a number of system-level indicators for palliative care, which can be tailored to the local level to inform OHT planning and implementation, and can be requested by emailing info@ontariopalliativecarenetwork.ca
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Assets and resources to support population-health management

The OPCN’s assets and resources can also help teams adopt a population-health management approach for their prioritized and attributed populations (Table 2).

Table 2: Assets and resources to support OHTs with population-health management

Steps in a population-health management approach	Resources
Step 1: Segmenting for needs, risks and barriers	<ul style="list-style-type: none"> • Data and findings from available reports can be used to understand the current state of palliative care in Ontario, including: <ul style="list-style-type: none"> ○ Ontario Health’s report Palliative care at the end of life ○ OPCN’s performance summary report and regional profiles tool (available by request through info@ontariopalliativecarenetwork.ca)
Step 2: Co-designing care models and service mix	<ul style="list-style-type: none"> • Ontario Health’s Quality standard for palliative care describes what high-quality palliative care should look like, and provides quality indicators to inform quality measurement • The OPCN’s Palliative care health services delivery framework describes a set of 13 recommendations to guide the organization and delivery of palliative-care services • The OPCN’s Competency Framework outlines the knowledge, attributes and skills providers need to deliver high-quality palliative care in Ontario
Step 3: Implementing and increasing reach	<ul style="list-style-type: none"> • The Regional Palliative Care Networks can support planning for the integration of palliative-care services, addressing challenges, and linking teams with local initiatives • The Quality standard for palliative care includes a guide to getting started
Step 4: Monitoring and evaluating	<ul style="list-style-type: none"> • The Quality standard for palliative care includes a measurement guide to support monitoring and evaluation • The OPCN’s Performance summary report and Regional profiles tool (available on request through info@ontariopalliativecarenetwork.ca) can help to monitor and evaluate performance through provincially tracked system-level measures, including: <ul style="list-style-type: none"> ○ ED visits in the last 30 days of life; ○ percent of decedents with weekday ED visits; ○ percentage of community-dwelling decedents who received physician home visit(s) and/or palliative home care in the last 90 days of life; ○ percentage of decedents who died in hospital and other settings; and ○ deaths of long term care residents in hospital.

Walton T, Waddell K. RISE Brief 27: Ontario Palliative Care Network and how it can support OHTs as a health-system partner. Hamilton: McMaster Health Forum, 2021.

RISE prepares both its own resources (like this RISE brief) that can support rapid learning and improvement, as well as provides a structured ‘way in’ to resources prepared by other partners and by the ministry. RISE is supported by a grant from the Ontario Ministry of Health to the McMaster Health Forum. The opinions, results, and conclusions are those of RISE and are independent of the ministry. No endorsement by the ministry is intended or should be inferred.

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