Ontario
Palliative Care
Network

Action Plan 1: 2017 – 2020

For Information Only

OPCN Overview

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THE ONTARIO PALLIATIVE CARE NETWORK

The Ontario Palliative Care Network (OPCN) is a province-wide partnership of healthcare providers and organizations, health system planners, patients, families and caregivers. We are working together to ensure the delivery of coordinated, high-quality hospice palliative care for everyone in Ontario, regardless of their age, illness, or where they live. The OPCN is guided by the report *Advancing High Quality, High Value Palliative Care in Ontario: The Declaration of Partnership and Commitment to Action*.

Funded by the Ministry of Health and Long-Term Care, the OPCN was launched in March 2016.

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Mandate of the Ontario Palliative Care Network

Be a principal advisor

to government for quality, coordinated, hospice palliative care in Ontario

Be accountable

for quality improvement, data and performance measurement and system level coordination of hospice palliative care in Ontario

Support regional implementation

of high-quality, high-value hospice palliative care

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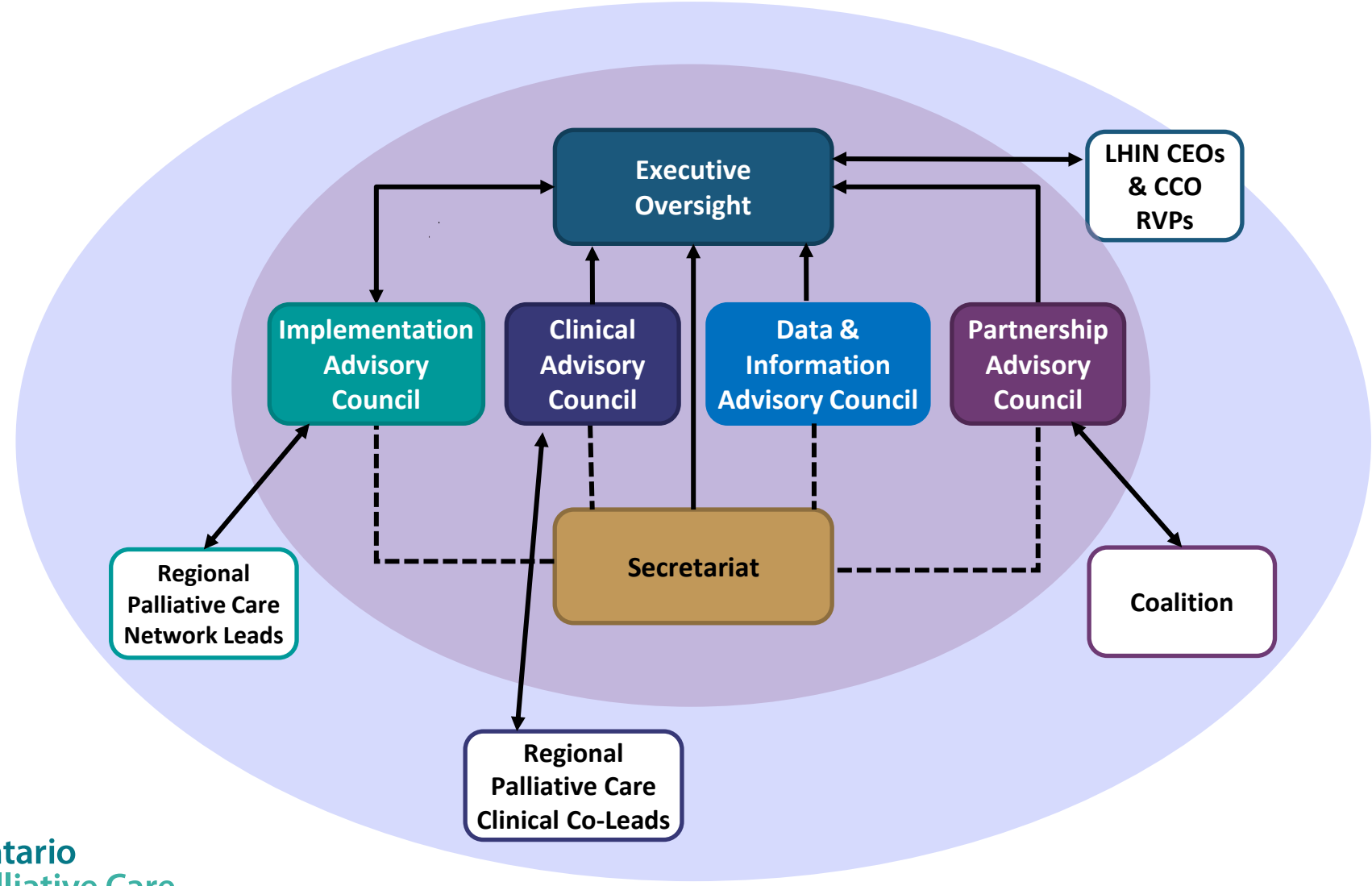
OPCN Governance Structure



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OPCN's Accomplishments to date

Since its launch in March 2016, the OPCN has:

- ✓ Supported the development of standardized and consistent multidisciplinary clinical co-leadership and administrative supports across the province
- ✓ Used a data-driven and evidence-based approach to provide recommendations on allocation of new residential hospice beds
- ✓ Provided the LHINs with regional and sub-regional data describing what services are available to support regional capacity planning
- ✓ Put processes in place to ensure patients have ongoing access to high-strength long-lasting opioids as needed for palliative care purposes
- ✓ Engaged 200+ stakeholders in the development of the OPCN Action Plan

OPCN Action Plan

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The Need for an OPCN Action Plan

Background

- Through the OPCN Secretariat's consultations with LHIN CEOs and CCO RVPs an overwhelming need was identified for multi-year goals and objectives for provincial and regional work
- Partnership Advisory Council requested a multi-year goals and objectives framework to inform their constituents
- The OPCN Secretariat identified the need to have a common understanding of which partners are leading action items stemming from the Declaration

The Action Plan will enable the OPCN to:

- Demonstrate a provincial vision for palliative care services in Ontario
- Align provincial and regional networks' priorities through to 2020
- Promote collaboration and standardization across regions
- Advance the measurement of quality of care and performance management for palliative care services

OPCN's Work Moving Forward

The Action Plan guides the work of the OPCN between now and 2020; it:

- Places patients and their caregivers at the centre of planning and care
- Supports coordinated system level change through alignment of planning, implementation, monitoring, and reporting both at, and across the regional and provincial levels of focus
- Aligns with the structural changes occurring in Ontario's health system through *Patients First*
- Addresses the full spectrum of settings in which palliative care services are delivered (home, community, long term care, hospice, or hospital) as well as the broad range of geographies in which Ontarians live (north and south; urban, rural, and remote)

Action Plan Goals

OPCN's Executive Oversight Committee confirmed that the goals of the Action Plan will be the goals from the Declaration

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

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Specific action areas identified in the Action Plan

A	• Enhancing Patient and Caregiver Engagement in Hospice Palliative Care
B	• Aligning the Planning for Hospice Palliative Care Across the Province
C	• Enabling Early Identification of People Who Would Benefit from Hospice Palliative Care
D	• Establishing Palliative Models of Care to Increase Access and Enable Adoption of the Quality Standard
E	• Identifying and Connecting Hospice Palliative Care Providers
F	• Building Provider Competencies in Hospice Palliative Care
G	• Measuring and Reporting on our Progress

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Measuring Progress

Four system level measures have been identified to measure progress on "moving the mark" on hospice palliative care in the province

1

% of caregivers of decedents who received palliative care services who were invited to respond to a CaregiverVoice survey

2

% of community dwelling decedents who received physician home visit(s) and/or palliative home care in the last 90 days of life

3

% of decedents who had a) 1 or more ED visits *or* b) 2 or more ED visits in the last 30 days of life

4

% of decedents who died in hospital*

* Other locations of death will continue be reported, but are not system level measures

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Thank You

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