Ontario
Palliative Care
Network

Ontario Palliative Care Network
Report on Action Plan Refinement Process for FY 2020-2021

January 27, 2020

Ontario Health

Ontario Palliative Care Network

Contents

Ontario Palliative Care Network

Ontario Palliative Care Network Action Plan Priorities for FY 2020/2021

Action Area A: Enhancing Patient and Caregiver Engagement in Hospice Palliative Care	
A3. HPCO will continue to develop and update materials to support patients, caregivers, substitute decision makers, and providers to engage in Person-Centred Decision-Making in alignment with Ontario's legal landscape, and the Quality Standard for Palliative Care.	A4. Each RPCN will work with local partners (i.e. hospice palliative care providers, OHTs, and others) to help patients and their caregivers understand the services that are available to meet their needs.

Action Area B: Aligning the Planning for Hospice Palliative Care across the Province					
B1. Each RPCN will develop, submit to EO, 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 populations in planning and implementation.	B2. Each RPCN will engage with First Nations, Inuit, Métis, and urban Indigenous to jointly identify gaps in hospice palliative care and develop culturally safe recommendations to inform future annual work plans.	B3. The OPCN will engage and plan with First Nations, Inuit, Métis and urban Indigenous organizations to jointly identify gaps in hospice palliative care and make recommendations to inform future annual work plans and ensure alignment with the Action Plan.	B4. Each RPCN will engage with Francophones in an equitable manner to identify gaps in hospice palliative care and develop recommendations to inform future annual work plans.	B6. 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 to inform future annual work plans.	B8. The OPCN Secretariat will develop an annual provincial work plan aligned with the Action Plan, to guide the provincially focused activities.

Action Area C: Enabling Early Identification of People Who Would Benefit from Hospice Palliative Care		
C2. To support system planning, 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.	C4. Each RPCN will promote the uptake of the tools recommended in the OPCN's Tools to Support Earlier Identification for Palliative Care to encourageroad scale implementation across care settings.	C7. DIAC and CAC will work with digital health delivery organizations to leverage digital health solutions to support earlier identification of people who would benefit from palliative care.

Action Area D: Establishing Palliative Models of Care to Increase Access and Enable Adoption of the Quality Standard	
D3. The OPCN will plan for the development of new funding mechanisms to support palliative care delivery in Ontario, and will provide future recommendations to MOH and appropriate professional bodies.	D4. Each RPCN will work with local partners (i.e. hospice palliative care providers, OHTs, and others) to plan for and implement the Delivery Framework recommendations.

Action Area E. Identifying and Connecting Hospice Palliative Care Providers
E3. The OPCN Secretariat will work with the Ontario e-Consult Program and the Ontario Telemedicine Network to increase the use of the provincial eConsult platform and virtual visits to improve access to palliative care.

Action Area F: Building Provider Competencies in Hospice Palliative Care	
F5. Each RPCN will develop and incorporate in their regional work plan, educational strategies that focus on building palliative care competencies among health care providers.	F6. The OPCN Secretariat will work with stakeholders to encourage uptake and implementation of the Ontario Palliative Care Competency Framework.

Action Area G: Measuring and Reporting on our Progress			
G1. 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. Progress at the provincial level will be reported to OPCN stakeholders.	G2. Each RPCN will incorporate the findings of these reports as they develop their annual work plans.	G3. DIAC will provide recommendations to improve the quality of data describing utilization, appropriateness and quality of palliative care services in Ontario focusing on alternative level of care tracking.	G4. Provincial distribution of the CaregiverVoice Survey will be evaluated across settings of care with the intent to obtain a representative sample of end-of-life experiences for patients and their caregivers.

Background

In November 2017, the Ontario Palliative Care Network (OPCN) released the **OPCN Action Plan 1: 2017 – 2020** (Action Plan). The Action Plan is the work plan that guides how the partners of the OPCN will work together to improve availability of, and ease of access to, equitable, high-quality, sustainable palliative care services for all Ontarians. Based on the goals of **The Declaration of Partnership and Commitment to Action: Advancing High Quality, High Value Palliative Care in Ontario** (the Declaration) and the **Office of the Auditor General of Ontario's 2014 Annual Report**, it presents a way forward for palliative care services in Ontario and promotes collaboration and standardization across the regions. Importantly, the development of the Action Plan was a collaborative process resulting from extensive engagement with over 200 stakeholders, including patient and family advisors, community organizations, volunteers, and health service providers.

Since the launch of the Action Plan in 2017, the OPCN Secretariat has been assessing provincial and regional progress against the items outlined in the Action Plan through regular reporting mechanisms. Over the past 3 years, the OPCN has made significant progress, including successful completion of a number of action items (see "Key Accomplishments in Action Areas Since 2017" on pg. 19). However, there have also been some challenges that have restricted progress in some action areas, most notably the changes resulting from the health system transformation.

At the provincial level, a new Crown agency, Ontario Health, has been established to oversee health care delivery, improve clinical guidance and provide support for providers to ensure better quality care for patients. Multiple provincial health agencies and programs have transitioned into Ontario Health to provide for a single point of accountability and oversight. At the local level, the new legislation supports the establishment of Ontario Health Teams (OHTs), groups of health care providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population. OHTs are a new way of organizing and delivering services for patients and are being established in phases across the province. Finally, the 14 LHINs have been clustered into five interim geographic regions. These are all significant changes that have resulted in both direct and indirect impacts on the capacity for the various partners of the Ontario Palliative Care Network, including the Regional Palliative Care Networks.

There are increasing demands being placed on partner organizations, along with various competing priorities, and resource constraints, including a predominant focus on the newly developing OHTs. Recognizing that there is still more work to do to complete the actions outlined in the Action Plan, instead of creating a new plan, the existing action items were reviewed and refined to reflect the changing health care landscape. This refinement will enable the OPCN to focus on key priorities during a time of change, and will help bridge the gap between the expiring Action Plan, and the future state. This document summarizes the Results of the Refinement Process, outlines the Ontario Palliative Care Network Action Plan Priorities for FY 2020/2021, and highlights Key Accomplishments in Action Areas Since 2017 to date.

Ontario Palliative Care Network

Understanding the Refinement Process

The refinement process included consultation with regional and provincial stakeholders to identify areas where efforts may need to be adjusted, and where any changes may be required, in order to determine priority actions for fiscal year 2020/2021.

All of the original action items were classified into one of five categories: unchanged, changed, completed, closed and not in FY20/21. The action items classified as 'unchanged' or as "changed" are action items that have been identified as priorities for FY20/21 and are highlighted in The Ontario Palliative Care Network Action Plan Priorities for FY 2020/2021, on page 3. The action items classified as "changed" underwent further refinement to update the language to align with health system transformation, and other relevant changes. The action items classified as "completed" are summarized in more detail in Key Accomplishments in Action Areas Since 2017(pg. 20). The action items that have been classified as "closed" or 'Not for FY 2020/2021' are outlined in the Results of the Refinement Process (starting on pg. 6), including the relevant rationale for their classification.

On January 27th, 2020, the Executive Oversight provided conditional approval for the Action Plan Priorities for FY 2020/2021, acknowledging that the actions reflected the current health system. However, recognizing that the system is continuing to change, the priorities will continue to be monitored and further changes may be required to ensure they remain aligned with the ongoing transformation.

Ontario Palliative Care Network

Results of the Refinement Process

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.

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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, Métis, and urban Indigenous languages in the regions, and include them in a standardized provincial-scale catalogue.	Not in FY 20/21	Challenges to implementing this action item since 2017 include a lack of resources to ensure educational resources are consistent and up-to date across the province; and the risk of providing inaccurate information to the public. However, regional work plans indicate that most RPCNs have already completed an inventory of resources and/or have/are developing mechanisms for patients and caregivers to have access to these.
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).	Not in FY 20/21	Due to the health system transformation, and current resource constraints, a provincial-scale catalogue is currently not feasible. Therefore, this action item has been deprioritized.
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.	Changed	HPCO will continue to build on successes to date. The language has been adjusted to reflect current terminology. Language for 20/21: *Hospice Palliative Care Ontario (HPCO) will continue to develop and update materials to support patients, caregivers, substitute decision makers, and providers to engage in Person-Centred Decision-Making in alignment with Ontario's legal landscape, and the Quality Standard for Palliative Care.*

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Changed	Considering the successes achieved to date, this action item was revised to be more actionable and to align with the current health system transformation. Language for 20/21: *Each RPCN will work with local partners (i.e. hospice palliative care providers, OHTs, and others) to help patients and their caregivers understand the services that are available to meet their needs.*

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 including the development and implementation of Ontario Health Teams.

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 and Reporting on our Progress.

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Unchanged	

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Changed	The term "urban Indigenous" has been added to this action item to reflect current terminology. The language has also been revised to reflect that this work will be at the local level. Language for 20/21: *Each RPCN will engage with First Nations, Inuit, Métis, and Urban Indigenous to jointly identify gaps in hospice palliative care and develop culturally safe recommendations to 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.	Changed	This action item has been changed to reflect the current system changes. Language for 20/21: *The OPCN will engage and plan with First Nations, Inuit, Métis and urban Indigenous organizations, regional groups and communities to jointly identify gaps in hospice palliative care and develop culturally safe recommendations 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.	Changed	The language has been revised to reflect that this work will be at the local level. Language for 20/21: *Each RPCN will engage with Francophones in an equitable manner to identify gaps in hospice palliative care and develop recommendations 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.	Not in FY20/21	Currently there are limited provincial-level Francophone stakeholder organizations to engage in this work. Without provincial mechanisms to support Francophone engagement, we will leverage efforts at the regional level (see A4)
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.	Changed	The language has been revised to reflect that this work will be at the local level. It is important to note the Paediatric Provincial Palliative Care Steering Committee (PPPC-SC) continues to advance important work at both the provincial and regional levels to establish a system for the delivery of hospice paediatric palliative care. RPCNs are encouraged to work closely with the PPPC-SC to ensure ongoing collaboration and alignment.

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
		Language for 20/21: *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 to inform future annual work plans.*
7. Each RPCN 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.	Not in FY20/21	Due to the health system transformation, and current resource constraints, this action item has been deprioritized.
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.	Changed	The language has been revised to reflect that the work plan will be developed by the OPCN Secretariat. Language for 20/21: *The OPCN Secretariat will develop an annual provincial work plan aligned with the Action Plan, to guide the provincially focused activities.*

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

The intent of early identification is to define the patient 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 individual patients 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.

Ontario Palliative Care Network

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Completed	This action item has been completed. Find the OPCN *Tools To Support Earlier Identification for Palliative Care* at this link.
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.	Unchanged	
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.	Not in FY20/21	Due to the health system transformation, and current resource constraints, this action item has been deprioritized.
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.	Changed	Due to resource constraints, a phased approach will not be feasible. Instead, provincial mechanisms and existing initiatives will be leveraged to promote implementation. Language for 20/21: *Each RPCN will promote the uptake of the tools recommended in the OPCN's Tools to Support Earlier Identification for Palliative Care to encourage broad scale implementation across care settings.*
5. The Advisory Councils will advise on refining the tool(s) and provide implementation advice based upon the lessons learned in Action C4.	Closed	The recommended tools were selected because they were evidence-based. The Advisory Councils will not be conducting further evaluation on these tools and as such, refinement of the tools will not occur.
6. All RPCNs will plan for and implement the tool(s) refined in Action C5.	Closed	Given that refinement will not occur, this action item is no longer relevant.
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.	Changed	This wording has been revised to reflect the health system transformation and to align with the language in the Digital Health Playbook. The Digital Health Playbook has been created by Ministry of Health (MOH) to support the entire health care system including prospective OHTs in the development of their digital health strategy.

Ontario Palliative Care Network

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
		Language for 20/21: *The DIAC and the CAC will work with digital health delivery organizations to leverage digital health solutions to support earlier identification of people who would benefit from palliative care.*

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 urban Indigenous and Francophones. This work will build upon existing local models and initiatives underway across the province.

The models of care will enable the implementation of the Palliative Care Quality Standard – a concise set of evidence-based, measurable statements with associated 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.

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
1. As an OPCN partner, Health Quality Ontario will develop and publish the Palliative Care Quality Standard, and support provincial adoption.	Completed	This action item has been completed. Find the *Quality Standard for Palliative Care* at this link.
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.	Completed	This action item has been completed. Find the *Palliative Care Health Services Delivery Framework – Focus Area 1: Adults Receiving Care in Community Settings* at this link.
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.	Changed	This action item has been revised to be more inclusive to capture the ongoing work to promote uptake of the physician funding recommendations developed in September 2018. It will also reflect new work to develop funding model(s) in the home and community care sector. Language for 20/21: *The OPCN will plan for the development of new funding mechanisms to support palliative care delivery in Ontario, and will provide future recommendations to MOH and appropriate professional bodies.*

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Changed	The language has been revised to align with health system transformation. Language for 20/21: *Each RPCN will work with local partners (i.e. hospice palliative care providers, Ontario Health Teams, and others) to plan for and implement the Delivery Framework recommendations.*
5. CAC will refine the models of care based upon an evaluation and the lessons learned in Action D4.	Closed	A phased implementation and evaluation of the model will no longer occur. Given this change in D4, this action item is no longer relevant.
6. All RPCNs will plan for and implement the models of care refined in Action D5.	Closed	This action item is now captured in D4, so D6 has been closed to avoid duplication.

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.

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Not in FY20/21	The OPCN Secretariat has determined that all regions are using thehealthline.ca and have a page named "End-of-Life" which has a list of some of the available local resources and services. Given the decreased capacity at the OPCN Secretariat and the changes in the healthcare system, a provincially accessible directory has been deprioritized.
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.	Not in FY20/21	Given that a provincial directory has been deprioritized (E1), this action item has also been deprioritized. The intent of this action item is for RPCNs to ensure that the information is available on the selected technology platform.

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Changed	This action item has been revised to be more inclusive to capture the ongoing work to increase access to eConsult and virtual visits. Language for 20/21: *The OPCN secretariat will work with the Ontario e-Consult Program and the Ontario Telemedicine Network to increase the use of the provincial eConsult platform and virtual visits to improve access to palliative care.*

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 patients who are dying. Education will include not only professional competencies but also cultural and communication competencies.

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
1. In alignment with the models of care and the Palliative Care Quality Standard, the Education Steering Committee will determine the required competencies to enable high quality hospice palliative care. The Education Steering Committee will include direction from the First Nations, Inuit Métis, and urban Indigenous 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, Métis, and urban Indigenous.	Completed	This action item has been completed. Find the *Ontario Palliative Care Competency Framework* at this link.
2. Each RPCN will inventory existing continuing educational programs offered within their region.	Closed	A provincial inventory has been provided to the regions. As such, regional inventories are no longer required.
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	Completed	A provincial inventory has been completed. An assessment of the educational programs will not be feasible, given resource constraints.

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Closed	The development of recommendations will not be feasible due to resource constraints, as noted in F3.
5. Each RPCN 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).	Changed	The language has been revised to be more actionable. Language for 20/21: *Each RPCNs will develop and incorporate in their regional work plan, educational strategies that focus on building palliative care competencies among health care providers*
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.	Changed	Due to resource constraints, this action item was not feasible. The language has been reframed to be more actionable. Language for 20/21: *The OPCN Secretariat will work with stakeholders to encourage uptake and implementation of the Ontario Palliative Care Competency Framework.*

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.

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Changed	The language for this action item has been revised to reflect the current health system transformation. Language for 20/21: *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. Progress at the provincial level will be reported to OPCN stakeholders.*
2. Each RPCN will incorporate the findings of these reports as they develop their annual work plans (Action B1).	Unchanged	

Action Item as per Action Plan 1 – 2017-2020	Classification	Rationale and Revised Language for Changed Items (indicated in italics)
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.	Changed	The language of this action item has been revised to reflect resource constraints and the required scale and scope of work required to deliver on the PCU beds aspect of this action item, it has been reframed on ALC to be more actionable. Language for 20/21: *DIAC will provide recommendations to improve the quality of data describing utilization, appropriateness and quality of palliative care services in Ontario focusing on alternative level of care tracking.*
4. The CaregiverVoice survey (CVS) 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.	Changed	The language of this action item has been revised to reflect foundational work that will enable successful implementation of the CaregiverVoice survey. Language for 20/21: *Provincial distribution of the CaregiverVoice Survey will be evaluated across settings of care with the intent to obtain a representative sample of end-of-life experiences for patients and their caregivers.*

Ontario Palliative Care Network

Key Accomplishments in Action Areas Since 2017

Provided below are some highlights of the achievements made over the past three years through our collective efforts at the regional and provincial level. This work would not have been possible without the combined efforts of the OPCN partners.

A. Enhancing Patient and Caregiver Engagement in Hospice Palliative Care

- **Identification of existing Patient and Caregiver Resources**
  The Regional Palliative Care Networks (RPCNs) continue to progress on identifying existing patient and caregiver educational resources within their regions and ensuring that those resources are made available to as many patients and caregivers as possible and as appropriate. They also continue to work with local hospice palliative care providers to help patients and caregivers understand services that are available at the local level.

- **Release of Advance Care Planning (ACP), Goals of Care (GoC) and Health Care Consent (HCC) Toolkit**
  HPCO assembled and launched a standardized Ontario HCC, ACP GoC Toolkit to support implementation of the **Palliative Care Quality Standard**, the **Delivery Framework** and **HQO's Quality Improvement Plan Indicators**, and promotes public awareness of ACP through distribution of workbooks, and other resources. Hospice Palliative Care Ontario (HPCO) continues to advance education and mentoring with respect to Person-Centred Decision-Making (ACP, GoC and HCC). HPCO also responds to requests for review of materials related to HCC, ACP and GoC to ensure organizations and healthcare providers are complying with Ontario's legal framework.

- **Release of HPCO's Caregiver Modules**
  HPCO launched Caregiver Modules, available at http://www.caregiversupport.hpco.ca/. The goal of these modules is to provide informal caregivers with support, resources, and information they need to be the best caregiver they can be.

- **Release of OPCN's Goals of Care Resources (April 2019)**
  The OPCN Secretariat developed four Goals of Care tools available within the OPCN's **Palliative Care Toolkit**. These resources support healthcare providers to engage in discussions with their patients to ensure treatment decisions align with the patient's wishes, values and beliefs for their care.

- **Partnering with the Ontario Caregiver Organization (Spring 2018)**

OPCN's Partnership Advisory Council includes representation from Ontario Caregiver Organization (OCO) to enhance knowledge sharing, and ensuring ongoing alignment of work is focused on supporting caregivers. In 2018, the OCO was established to enhance the caregiver experience in Ontario by helping caregivers feel supported and valued.

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

- **Regional Hospice Palliative Care Work Plans aligned to Provincial Direction**
  Every year, the 14 RPCNs submit work plans aligned with the Action Plan, which serve to guide their regional implementation activities, ensure alignment with other regional and provincial work, and ensure inclusion of priority populations in planning and implementation.

- **First Nations, Inuit, Métis, and urban Indigenous Engagement**
  The OPCN Secretariat, through its First Nations, Inuit, Métis, and urban Indigenous Lead, engaged with First Nations, Inuit, Métis, and urban Indigenous organizations, regional groups and communities to identify gaps and inform recommendations, at provincial and regional levels, based on those consultations. The Lead raised awareness about the OPCN and its work amongst these communities as well as facilitated receiving input into various OPCN resources including the Delivery Framework and the Palliative Care Competency Framework. The Lead also enabled OPCN to engage and develop relationships with the provincial First Nations, Inuit, Métis, and urban Indigenous organizations and offered support and advice to the 14 RPCNs to develop similar relationships at the local level.

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

- **Release of Tools to Support Earlier Identification for Palliative Care report (April 2019)**
  Developed by an expert panel, the Tools to Support Earlier Identification for Palliative Care report provides guidance on preferred identification tools and assessment tools to support providers and system level leadership in earlier identification of patients who would benefit from palliative care.
  - The uptake of OPCN recommended Tools for Earlier Identification is being promoted at the provincial level through **HQO'S Quality Improvement Plans** (QIP). For FY 2019/20, an optional palliative care indicator focused on Earlier Identification was introduced, and 623 organizations (across all regions) selected it for their QIP. OPCN and HQO, now Ontario Health, Quality Unit, jointly support a Community of Practice that offers monthly webinars to support organizations who have selected this indicator.
  - OPCN Secretariat Regional Liaisons have been supporting regions to plan, implement and spread earlier identification initiatives at the local and regional levels.

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

- **Release of Palliative Care Quality Standard (April 2018)**
  Health Quality Ontario (HQO), a key partner in the OPCN, developed the Quality Standard for Palliative Care which outlines 13 quality statements that describe the care that patients and families needing palliative care should expect to receive.

- **Release of Palliative Care Health Services Delivery Framework – Focus Area 1: Adults Receiving Care in Community Settings (Delivery Framework) (April 2019)**
  The Delivery Framework outlines 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 model of care is designed to enable care to be delivered according to the Palliative Care Quality Standard, ensuring that patients and their family/caregivers have timely, equitable access to high quality care and support. The Delivery Framework final recommendations were the result of 18 months of system-wide engagement, reflecting the best evidence, and collective expertise of our many provincial, regional and local community partners.
  - At the provincial level, the OPCN Secretariat continues to seek opportunities to promote the recommendations, and implementation of the model through partners' levers and initiatives. An example of this is the partnership with Dr. Hsien Seow at McMaster University to leverage his Canadian Institutes for Health Research Grant funded Community Access to Palliative Care via Inter-professional primary care Teams Improvement (CAPACITI) Project. CAPACITI is a one-year quality improvement program that offers training for formal and informal teams of primary care providers to build their capacity to deliver community based palliative care. The training includes 10 educational modules, and the OPCN Secretariat has worked collaboratively with the CAPACITI project team to embed references to the Delivery Framework, and other OPCN resources, to actively promote their use and adoption of among the participating CAPACITI teams.
  - In addition, the Delivery Framework and related resources were presented at many provincial and national conferences/events in order to raise awareness about these resources.
  - OPCN Regional Liaisons have been supporting regions with the implementation of the Delivery Framework recommendations by responding to regional Delivery Framework engagement requests.

E. Identifying and Connecting Hospice Palliative Care Providers

- The OPCN Secretariat conducted a preliminary review of existing provincial accessible directory platforms and directories available in Ontario to determine current state. It was determined that all regions are using thehealthline.ca and have a page named "End-of-Life" which has a list of some of the available local resources and services. The regions continue to play a leadership role in ensuring that local information about available hospice palliative care providers and supports is complete and up to date.

Ontario Palliative Care Network

F. Building Provider Competencies in Hospice Palliative Care

- **Release of the Ontario Palliative Care Competency Framework (April 2019)**
  The Competency Framework outlines the range of knowledge, personal attributes, and skills health and social care professionals require to apply the principles of palliative care in practice. The competencies apply to all settings of care (e.g. hospital, collaborative care clinic, ambulatory clinic, long-term care facility, hospice and home). The document was developed over 18 months with broad consultation from various health professional associations and colleges representing the 16 disciplines included in the Framework. To facilitate implementation of the Competency Framework, the OPCN Secretariat has been engaging professional associations to identify opportunities to promote the document, and encourage uptake of the competencies. As a result, the OPCN Secretariat has hosted webinars and provided poster presentations to various stakeholders enabling us to reach front line providers across Ontario.

- **Provincial Inventory of Educational Programs (January 2019)**
  The OPCN's Education Steering Committee completed a provincial inventory of existing educational programs, and shared this with the RPCN leadership. The regions were encouraged to share this resource with their local providers.

G. Measuring and Reporting on our Progress

- **Release of New Reporting Products**
  The OPCN has launched three reporting products: the System Level Measure Report, the Performance Summary Report, and the Regional Profiles Tool in alignment with the four provincial indicators and sub-indicators established by DIAC. The OPCN will continue to develop and disseminate these reporting products based on the agreed upon schedules and available analytics resources to support their production.

Ontario Palliative Care Network

Glossary

Abbreviation	Definition
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	Hospice palliative care is a philosophy of care that aims to relieve suffering and improve the quality of living and dying.
HPCO	Hospice Palliative Care Ontario
IAC	Implementation Advisory Council
OHT	Ontario Health Team
MOH	Ministry of Health
MLTC	Ministry of 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