Ontario Palliative Care Network

Frequently Asked Questions: Palliative Care Health Services Delivery Framework
Focus Area 1: Adults Receiving Care in Community Settings

1. What is the Palliative Care Health Services Delivery Framework ('Delivery Framework')?

The Delivery Framework is a model of care for adults with a life-limiting illness who are living at home or in community settings and their families/caregivers. Its goal is to enable patients to remain at home as long as possible. It provides a framework for organizing and delivering palliative care in Ontario to: improve patient care based on what patients and their families/caregivers have told us what they want; better support health care providers in caring for their patients; and supports ending hallway healthcare by reducing unnecessary hospitalizations and emergency department visits.

The Ontario Palliative Care Network (OPCN) released its first Action Plan in 2017. One of the actions in this plan is to establish palliative models of care to increase access and enable adoption of Health Quality Ontario's (HQO) Quality Standard, *Palliative Care: Care for Adults with a Progressive, Life-Limiting Illness*. The Delivery Framework was developed to complete this action.

2. What do you expect patients and health care provider to experience through this new model of care?

The primary audiences of the Delivery Framework are individuals and organizations who provide or plan care for patients with life-limiting illness and include system planners (e.g. the Ministry of Health and Long-Term Care [the ministry], LHINs, and Regional Palliative Care Networks), providers (e.g. physicians, nurses, allied health) and provider agencies (e.g. contracted nursing agencies, community service agencies, hospices, and long-term care).

The Delivery Framework is intended to provide guidance for regions in optimizing the way they deliver palliative care ensuring that the right care is provided by the right provider at the right time. This includes recommendations such as:

- Identifying patients in need of palliative care earlier – at the time of diagnosis, assessing their ongoing needs, and supporting them through end of life and bereavement care
- Focusing on the patient's and family's wishes throughout the patient's journey, ensuring care is culturally sensitive
- 24/7 access to seamless care for patients, with a designated care coordinator
- 24/7 help support for providers providing the care
- Clear roles identified for providers

3. How was the Delivery Framework developed?

In August 2017, the OPCN established a working group, a multi-disciplinary stakeholder panel from across Ontario comprised of palliative health care providers, administrators, and patient/family advisors, to develop the Delivery Framework. The document was informed by the review of the scientific and grey literature, as well as current practices in Ontario and other jurisdictions, the HQO Quality Standard, *Palliative Care: Care for Adults with a Progressive, Life-Limiting Illness*, and earlier work done by the OPCN predecessor, the Hospice Palliative Care Provincial Steering Committee.

The Delivery Framework was developed over almost 18 months of work and broad consultation across healthcare and the province. Targeted stakeholder engagement was conducted with patient and family advisors, First Nations, Inuit, Métis and urban Indigenous representatives, hospice representatives, providers for vulnerably housed populations, long-term care representatives, as well as French Language Health Planning Entities. Feedback from all engagements was reviewed and incorporated in the Delivery Framework where appropriate.

The final Delivery Framework document was unanimously endorsed by the four OPCN Partners – CCO, LHINs, Health Quality Ontario and the Quality Hospice Palliative Care Coalition of Ontario .

4. Is the Delivery Framework describing palliative care delivery for all patients and families? What's in scope?

The first focus area of the Delivery Framework is adults with a progressive, life-limiting illness. In scope are individuals living in their 'usual place of residence', i.e., patients' homes, retirement residences, assisted living facilities, supportive housing, long-term care homes, Indigenous communities (on and off reserve), streets and shelters. While residing in the community, it is recognised that these patients may receive palliative care at home, in outpatient settings, and, occasionally, in acute care. Future phases of the Delivery Framework will address the needs of adult patients receiving palliative care in acute and complex continuing care hospitals and pediatric patients.

5. Is the Delivery Framework about the last year of life?

The Delivery Framework is not just about the last year of one's life, it applies to all patients with a life-limiting illness who would benefit from palliative care.

6. Is the Delivery Framework building on existing resources and experiences or proposing to start from scratch?

The Delivery Framework's 13 recommendations build on existing high quality palliative care services and allow for local adoption and adaptation to suit local contexts and geographies. It recognizes that pockets of excellence in palliative care services exist across the province, but there are persistent gaps resulting in inequities for patients and families/caregivers. The Delivery Framework is building on what is already working well locally. The implementation of the Delivery Framework will mean building and strengthening the current programs and resources and developing new ones where they do not exist.

7. The Delivery Framework describes an 'interdisciplinary palliative care team.' What is meant by this term?

The 'interdisciplinary palliative care team' is the group of care providers each with different skills and qualifications (such as a personal support worker, registered nurse, nurse practitioner and a physician) who work together to care for a patient and their family/caregivers based on the person's care plan. With the Delivery Framework, this team will consist of one person designated the "most responsible medical provider" (physician or nurse practitioner), a designated care coordinator and will have an established connection with a palliative care specialist(s) whose role on the team will be to consult with team members and to provide direct patient care as needed. The team will often be expanded to include other providers, for example, nurses, disease-specific specialists, social workers, psychologists, spiritual care providers, pharmacists, personal support workers, dietitians, Indigenous providers, and volunteers.

8. Is the Care Coordinator described in the Delivery Framework different from the LHIN Home and Community Care Coordinator?

The Delivery Framework expects that the bulk of the care coordinators described in the Delivery Framework will be a part of LHIN Home and Community Care Services. However, care coordination may also be provided by others such as, Family Health Team care coordinators, Health Links, long-term care staff, Indigenous/Aboriginal Navigators, or case managers who support the homeless and vulnerably housed. In some cases, collaboration between these roles may be needed to achieve effective coordination of services.

9. How is the Delivery Framework different from the Health Links approach to care?

The Delivery Framework describes care for all patients who have palliative care needs extending from diagnosis to bereavement. The Health Links approach is focused patients living with multiple chronic conditions and complex needs. A significant percentage of patients identified through the Health Links approach to care will have palliative care needs but, not all patients with palliative care needs will be identified by the Health Links approach. The

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Delivery Framework recommends that patients identified through a Health Links approach, and who would benefit from palliative care, should have access to palliative care services that meet their needs.

10. What are other OPCN tools that are enablers to the implementation of the Delivery Framework?

The Delivery Framework is one of the deliverables outlined within the OPCN Action Plan. Other deliverables from the Action Plan that are integral to this work and are available on the OPCN website and include:

- **Action Plan, Area C: Enabling Early Identification of People Who Would Benefit from Hospice Palliative Care** – An expert panel developed the *Tools to Support Earlier Identification for Palliative Care* report that 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 Preferred Earlier Identification Tools are:
    - SPICT (Supportive & Palliative Care Indicator Tool);
    - Early ID Guide (Adaption of UK GSF - PIG for Ontario use);
    - NECPAL CCOMS-ICO tool (NECesidades PALiativas Centro de la Organizacion Mudial de la Salud);
    - RADPAC (RADboud Indicators for Palliative Care Needs);
    - RESPECT (Risk Evaluation for Support: Prediction for Elder-life in the Community Tool); and
    - HOMR (Hospital-patient One-year Mortality Risk).

- **Action Plan, Area D: Establishing Models of Care to Increase Access and Enable Adoption of the Quality Standard** – OPCN established a Working Group to examine funding and incentive structures for palliative care specialist physicians. Recommendations have been submitted to the ministry and Ontario Medical Association. A strong emphasis was placed on improving the current Alternate Funding Plan (AFP) for palliative care specialists, along with improving and expanding on call support to enable 24/7 access.

- **Action Plan, Area F: Building Provider Competencies in Hospice Palliative Care** – Developed by the OPCN's Provincial Education Steering Committee, the Ontario Palliative Care Competency Framework is a document that outlines the range of knowledge, personal attributes, and skills that prepare health and social care professionals 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 (LTC), hospice and home).

11. What are the next steps once the Delivery Framework is released?

Post publication of the Delivery Framework to the OPCN website, the OPCN in collaboration with the Regional Palliative Care Networks will then undertake a current state and readiness assessment to determine the required supports to implement it.