RISE
Rapid-Improvement Support and Exchange

Year 1 priority population

RISE brief 18 (draft): Resources to support population-health management for people who could benefit from a palliative approach to care (Last updated 12 February 2020)

Overview

Many OHTs selected people at the end of life and/or needing palliative care as one of their year 1 priority populations and have established working groups focused on 'moving the needle' on quadruple-aim metrics for this population. Central to such work is developing a population-health management plan, which includes four steps:

1) segmenting the priority population into groups with shared needs;
2) co-designing care pathways and in-reach and out-reach services for each group;
3) implementing pathways and services in a way that reaches and is appropriate to each group; and
4) monitoring implementation and evaluating impact.

To support this work, RISE has:

1) updated RISE brief 6 on population-health management;[1] and
2) developed a list of questions related to developing a population-health management plan (which is available as an appendix to RISE brief 6).

Palliative care is a continuum of services and supports that focuses on comfort and quality of life.[2] The goal is for individuals to continue to live well, through meticulous attention to: controlling pain and other symptoms; supporting emotional, spiritual, and cultural needs; and maximizing functional status.[3] This includes frequent symptom assessment, engaging in discussions about the goals of care, and tailoring treatment accordingly. A palliative approach to care can be introduced as early as diagnosis of a life-limiting illness, and may be integrated throughout the illness trajectory. Patients and families who would benefit from a palliative approach to care may be identified in any care setting, including in home and community care, primary care or acute care.

When undertaking population segmentation, OHTs will likely want to be sensitive to the diversity of patients and families who can benefit from a palliative approach to care. When co-designing care pathways and in-reach and out-reach services, OHTs will likely want to consider the full continuum of palliative care. And when implementing pathways and services, OHTs will likely want to proactively identify and address palliative-care needs.

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

This RISE brief addresses the fourth of four year 1 priority populations that were frequently selected by cohort 1 OHTs:

1) people with chronic conditions, which were sometimes more specifically defined by OHTs as including congestive heart failure, chronic obstructive pulmonary disease, dementia, diabetes, and those with complex-care needs
2) people with mental health and addictions issues
3) older adults with greater needs, which was variably defined by OHTs as including 'at risk,' co-morbidities/chronic conditions, complexity, frailty, and high service users
4) **people at the end of life and/or needing palliative care**.

This RISE brief primarily addresses **building block #4** and secondarily addresses **building blocks #3, #5 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**

OHTs will ideally develop their population-health management plans in collaboration with:
1) other OHTs focused on the same year 1 priority population;
2) experts who are aware of the many resources available in Ontario to support their efforts; and
3) experts who have experience with one or more of the four steps in population-health management.

As part of the first of these three types of collaborations, OHTs may wish to discuss together:
1) whether to seek agreement about whether the scope includes palliative care for all who could benefit from it (i.e., after a diagnosis of a life-limiting illness) or palliative care only for those at the top of the risk pyramid (e.g., those at the end of life and using acute-care services), and whether it excludes or includes medical assistance in dying, which is not considered by some to be part of a palliative approach to care (this RISE brief addresses the first framing in both of these choice sets); and
2) whether and how to differentiate their work from those focused on related year 1 priority populations, such as:
   a. people with chronic conditions, some of whom could benefit from a palliative approach to care, and
   b. older adults with greater needs, some of whom could also benefit from this approach.
For all three of these types of collaborations, OHTs may benefit from a planned OHT Forum and the 'learning and improvement' collaboratives that are being considered for each year 1 priority population.

This RISE brief provides a first draft of a summary of the resources available to support the development of a population-health management plan for people who could benefit from palliative care. Priority was given to those resources that are provincial in scope and free to access. Once proposed additions and corrections from the OHT Forum and participating experts has been acted on, an updated version will be made publicly available through the RISE website and newsletter.

We have organized these resources into five groups:
1) resources related to each of the four steps in population-health management;
2) resources related to each of the eight OHT building blocks;
3) provincial organizations;
4) government-supported initiatives; and
5) key legislation.

Resources related to each of four steps in population-health management

While not always directly targeting or using language directly related to the four steps in population-health management (or the first four steps in a 'rapid learning and improvement' cycle to which they correspond), a number of resources can be drawn upon to inform these steps (Table 1).

Table 1: Resources by step in population-health management

Step	Resources

Segmenting the population into groups (or population segments) with shared needs [or more generally identifying a problem (or goal) through an internal and external review]	• OHTs were each provided with a data package from the Ministry of Health that includes utilization and referral data on their attributed population, some of which may be relevant to understanding the needs of people who could benefit from a palliative approach to care
	 • Data and findings from available reports can be used to understand the current state of palliative care in Ontario, including:
	    o Ontario Health's Quality Business Unit's (formerly Health Quality Ontario) report *Palliative care at the end of life*
	    o Ontario Palliative Care Network's *Performance Summary Report and Regional Profile Tool* (available by request through info@ontariopalliativecarenetwork.ca)

Co-designing care pathways and in-reach and out-reach services appropriate to each group	• Care standards and best practice guidelines can be used to design care pathways, including:
	    o Ontario Health's Quality Business Unit's *Quality standard for palliative care*
	    o Registered Nurses Association of Ontario's best practice guidelines:

[or more generally designing a solution based on data and evidence generated locally and elsewhere]	▪ _End of life care during the last days and hours_ ▪ A palliative-care approach for the last 12 months of life (to be released in early 2020) ▪ _Pain and symptom management_ (with an update scheduled for 2021) ▪ _Delirium, dementia and depression in older adults_ ▪ _Assessment and management of pressure injuries for the interprofessional team_ ▪ _Person- and family-centred care_ ○ Cancer Care Ontario's _guideline_ for those with cancer in need of palliative care - Ontario Palliative Care Network's _Palliative care health services delivery framework_ describes a set of 13 recommendations to guide the organization and delivery of palliative-care services - Ontario Palliative Care Network's _Palliative care competency framework_ outlines the knowledge, attributes and skills providers need to deliver high-quality palliative care in Ontario - Canadian Hospice Palliative Care Association's _A model to guide hospice palliative care_ supports the development of a standardized approach to delivering care, education and advocacy
Implementing pathways and services in a way that reaches and is appropriate to each group [or more generally implementing the plan, possibly in pilot and control settings]	- The Regional Palliative Care Networks can support planning for the integration of palliative-care services, addressing challenges, and linking teams with local initiatives - Ontario Health's Quality Business Unit (formerly Health Quality Ontario) quality standard for palliative care includes a _guide to getting started_ - Hospice Palliative Care Ontario's toolkit helps to ensure healthcare consent and advance care-planning documents, resources and policies are compliant with Ontario's legal landscape - Ontario Telemedicine Network offers remote access to palliative care through their Virtual Palliative Care project - Implementation challenges can be discussed with others in the province through: ○ Health Quality Ontario's (now Ontario Health Quality, Business Analysis Unit) Community of Practice to support implementation of the Palliative Care Quality Improvement Indicator, or ○ Hospice Palliative Care Ontario's communities of practice
Monitoring implementation and evaluating impact [or more generally evaluating to identify what does and does not work]	- Ontario Health's Quality Business Unit (formerly Health Quality Ontario) quality standard for palliative care includes a _measurement guide_ to support monitoring and evaluation - Ontario Palliative Care Network's _Performance summary report and regional profile tool_ can help to track system level measures (available on request through info@ontariopalliativecarenetwork.ca)

Resources related to the OHT building blocks

A number of resources can also be drawn upon that relate to those OHT building blocks that are most connected to population-health management for people who could benefit from a palliative approach to care (Table 2).

Table 2: Resources by OHT building block

Building block	Resources
Building block #1: Defined patient population (who is covered, and what does 'covered' mean?): Identified population and geography at maturity and target population for year 1. Process in place for building sustained care relationships with patients. High-volume service delivery target for year 1. _Year 1 expectations_: Patient access and service delivery target met. Number of patients with sustained care relationship reported. Plan in place for expanding target population. _At maturity_: Teams will be responsible for the health outcomes of the population within a geographic area that is defined based on local factors and how patients typically access care.	• None identified
Building block #2: In-scope services (what is covered?): Existing capacity to deliver coordinated services across at least three sectors of care (especially hospital, home care, community care, and primary care). Plan in place to phase in the full continuum of care and include or expand primary-care services. _Year 1 expectations_: Additional partners identified for inclusion. Plan in place for expanding range and volume of services provided. Primary-care coverage for a significant portion of the population. _At maturity_: Teams will provide a full and coordinated continuum of care for all but the most highly-specialized conditions to achieve better patient and population health outcomes.	• None identified

Building block #3: Patient partnership and community engagement (how are patients engaged?) - Demonstrated history of meaningful patient, family and caregiver engagement, and support from First Nations communities where applicable. Plan in place to include patients, families and caregivers in governance structure(s) and put in place patient leadership. Commitment to develop an integrated patient-engagement framework and patient-relations process. Adherence to the *French Language Services Act,* as applicable. *Year 1 expectations*: Patient declaration of values is in place. Patients, families and caregivers are included in governance structure(s) and patient leadership established. Patient-engagement framework, patient-relations process, and community-engagement plan are in place. *At maturity*: Teams will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage and partner with - and be driven by the needs of - patients, families, caregivers and the communities they service.	• Ontario Palliative Care Network created a guide to support providers with engaging patients and their families and caregivers in discussions about advance care planning, goals of care and consent, and an FAQ • Ontario Palliative Care Network has created a one-page guide for healthcare providers on person-centred decision-making • Quality Hospice Palliative Care Coalition of Ontario has developed the *Patient and Caregiver Declaration of Rights at End-of-Life* (available by request through info@hpco.ca) • Hospice Palliative Care Ontario developed a strategy on how to create compassionate communities • Speak up Ontario created tools to support individuals, families and caregivers in advance care planning and designating a substitute decision-maker • Cancer Care Ontario developed a palliative care toolkit for Indigenous communities which can be used to help support those with cancer who have palliative-care need

Building block #4: Patient care and experience (how are patient experiences and outcomes measured and supported?): Plans in place to improve access, transitions and coordination, key measures of integration, patient self-management and health literacy, and digital access to health information. Existing capacity to coordinate care. Commitment to measure and improve patient experience and to offer 24/7 coordination and navigation services and virtual care.
 Year 1 expectations: Care has been redesigned. Access, transitions and coordination, and integration have improved. Zero cold handoffs. 24/7 coordination and navigation services, self-management plans, health literacy supports, and public information about the team's services are in place. Expanded virtual-care offerings and availability of digital access to health information.
 At maturity: Teams will offer patients, families and caregivers the highest quality care and best experience possible. 24/7 coordination and system-navigation services will be available to patients who need them. Patients will be able to access care and their own health information when and where they need it, including digitally, and transitions will be seamless.
	• Ontario Palliative Care Network Tools to support early identification provide 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
	 • Ontario Palliative Care Network's *Competency framework* provides a guide to palliative-care competencies required for every type of care provider/professional, from specialists to volunteers
	 • Ontario Palliative Care Network developed a glossary of terms and concepts related to hospice
	 • Canadian Hospice Palliative Care Association developed *A model to guide hospice palliative care* to share a consistent, standardized approach to the delivery of care, education and advocacy
	 • Palliative Care Innovation offers a guide called *Re-thinking palliative care in the community*
	 • Ontario Palliative Care Network created a series of resources to support providers to engage in person-centred decision-making including:
	     ○ *Making decisions about your care: Patient resource*
	     ○ *Person-centred decision making: Resource for healthcare providers*
	     ○ *Advance care planning, goals of care and treatment decisions and informed consent (frequently asked questions)*
	     ○ *Approaches to goals of care*

Building block #5: Digital health (how are data and digital solutions harnessed?): Demonstrated ability to digitally record and share information with one another and to adopt/provide digital options for decision support, operational insights, population health management, and tracking/reporting key indicators. Single point of contact for digital health activities. Digital health gaps identified and plans in place to address gaps and share information across partners. *Year 1 expectations*: Harmonized information-management plan in place. Increased adoption of digital-health tools. Plans in place to streamline and integrate point-of-service systems and use data to support patient care and population-health management. *At maturity*: Teams will use digital-health solutions to support effective healthcare delivery, ongoing quality and performance improvement, and better patient experience.	• The Ontario Telemedicine Network supports remote access to palliative care through their Virtual Palliative Care project, and through their eConsult and Virtual Visit platforms • Ontario Health's Quality Business Unit (formerly Health Quality Ontario) developed a coordinated care plan template intended to streamline coordinated, collaborative approaches to meeting the patient's goals and support holistic care across programs, organizations, and sectors (this is a living document that requires regular review and updates driven by changes to the patient's status)
Building block #6: Leadership, accountability and governance (how are governance and delivery arrangements aligned, and how are providers engaged?): Team members are identified and some can demonstrate history of working together to provide integrated care. Plan in place for physician and clinical engagement and inclusion in leadership and/or governance structure(s). Commitment to the Ontario Health Team vision and goals, developing a strategic plan for the team, reflecting a central brand, and where applicable, putting in place formal agreements between team members. *Year 1 expectations*: Agreements with ministry and between team members (where applicable) in place. Existing accountabilities	• None identified

continue to be met. Strategic plan for the team and central brand in place. Physician and clinical-engagement plan implemented. *At maturity*: Teams will determine their own governance structure(s). Each team will operate through a single clinical and fiscal accountability framework, which will include appropriate financial management and controls.	
Building block #7: Funding and incentive structure (how are financial arrangements aligned?): Demonstrated track record of responsible financial management and understanding of population costs and cost drivers. Commitment to working towards integrated funding envelope, identifying a single fundholder, and reinvesting savings to improve patient care. *Year 1 expectations:* Individual funding envelopes remain in place. Single fund holder identified. Improved understanding of cost data. *At maturity:* Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations.	• None identified

Building block #8: Performance measurement, quality improvement, and continuous learning (how is rapid learning and improvement supported?): Demonstrated understanding of baseline performance on key integration measures and history of quality and performance improvement. Identified opportunities for reducing inappropriate variation and implementing clinical standards and best evidence. Commitment to collect data, pursue joint quality-improvement activities, engage in continuous learning, and champion integrated care. *Year 1 expectations*: Integrated quality-improvement plan in place for the following fiscal year. Progress made to reduce variation and implement clinical standards and best evidence. Complete and accurate reporting on required indicators. Participation in central learning collaborative *At maturity*: Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators aligned with the quadruple aim will measure performance and evaluate the extent to which Ontario Health Teams are providing integrated care, and performance will be reported.	• Ontario Health's Quality Business Unit (formerly Health Quality Ontario) included earlier identification for palliative care as a quality priority for the 2020/21 Quality Improvement Plan
	• Ontario Health's Quality Business Unit (formerly Health Quality Ontario) hosts a community of practice for palliative-care implementation that specifically targets palliative-pain and symptom-management consultants
	• Hospice Palliative Care Ontario hosts a number of communities of practice focused on different aspects of delivering palliative care for those with life-limiting illnesses
	• Data on current palliative-care services in Ontario and system performance are featured in the following:
	  ○ Ontario Health's Quality Business Unit (formerly Health Quality Ontario) 2019 update of *Palliative care at the end of life* report
	  ○ Ontario Palliative Care Network's Performance Summary Report and Regional Profile Tool (available by request through info@ontariopalliativecarenetwork.ca)

Provincial organizations as resources

A number of provincial organizations support the development, implementation, delivery, and evaluation of best practices for life-limiting illnesses in Ontario (Table 3). These organizations offer information, evidence and pre-packaged resources relevant to OHTs' efforts to improve outcomes for people with life-limiting illnesses and their families and caregivers.

Table 3: Organizations as resources

Organization	Description

Ontario Palliative Care Network (OPCN)	• Partnership of community stakeholders, health-service providers and health-system planners given a mandate by the Ministry of Health to:
	  ○ act as a principal advisor to the Ontario government for quality, coordinated hospice palliative care in the province
	  ○ 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

Regional Palliative Care Networks	• Local network that plans, coordinates and improves the delivery of palliative care within each of the 14 regions (formerly matched to Local Health Integration Networks), and it includes clinical and administrative leadership with expertise in palliative care and who can help support service-delivery planning and integration

Palliative Care Consultants Network (PCCN)	• Network of palliative-pain and symptom-management consultants that builds the capacity of healthcare providers to deliver palliative care
Hospice Palliative Care Ontario	• Provincial association of hospices, palliative-care providers, professionals and volunteers that focuses on providing leadership, education and guidance for hospice palliative care in Ontario
Quality Hospice Palliative Care Coalition of Ontario	• Partnership of organizations, universities and research institutions working at the provincial level in the hospice palliative-care field
Ontario Long Term Care Association	• Association that promotes safe, quality long-term care to Ontario's seniors and aims to build excellence in long-term care through leadership, analysis, advocacy and member services
Ontario Centres for Learning, Research & Innovation in Long-Term Care	• Network that carries out research, knowledge mobilization and education in the long-term care sector, including those related to palliative care, to ensure leading practices are adopted in Ontario
Alzheimer's Society of Ontario	• Society that provides education and resources related to palliative care for providers and caregivers of individuals living with dementia at the late and end stages of the disease
Ontario Caregiver Coalition	• Coalition that advocates and provides support for caregivers providing care for individuals along the illness continuum, which in many cases includes palliative care

Government-supported initiatives as resources

Many government-supported initiatives are underway that aim to increase access to, and quality of, palliative care in Ontario (Table 4). OHTs can draw on these existing initiatives to complement and strengthen their services for those who could benefit from a palliative approach to care.

Table 4: Other initiatives as resources

Initiative	Description
Palliative Care Facilitated Access Program	• Program to support providers in the prescription of high-strength opioids to individuals who require them for symptom management • Coordinated by the Ontario Drug Benefit Program
Speak Up Ontario	• Tools and information regarding consent and advance-care planning for non-healthcare professionals, individuals with life-limiting illnesses, their families and caregivers • Coordinated by Hospice Palliative Care Ontario and the National Advance Care Planning Task Group

Health Links	• Coordinated care planning for patients who often see multiple healthcare providers, access a range of services, and may find it difficult to navigate the health system
	  o Development of a patient-centred care plan based on the individual's needs and goals
	  o Coordination of the care plan across multiple health providers, services and sectors
	• Geographically based, inter-sectoral collaboration
	• In full implementation in 82 networks of providers

Key legislation

While many pieces of legislation touch on the lives of those who could benefit from a palliative approach to care, two pieces of legislation are particularly key to the development of population-health management plans (Table 5). Additional information about relevant legislation, such as legislation that governs the places in which care is provided and the providers who deliver it, can be found in chapter 7 of *Ontario's health system: Key insights for engaged citizens, professionals and policymakers*, which is available for free online.

Table 5: Key legislation

Legislation	Description
Substitute Decisions Act	• Governs what happens when someone does not have the capacity to make certain decisions about their own property or personal care

Health Care Consent Act	• Sets out rules for obtaining informed consent and determining capacity to consent with respect to treatment decisions, admissions to a care facility, and personal-assistance services

If OHTs choose to include services related to medical assistance in dying as part of their population-health management plans for this priority population, then the OHT would be responsible for ensuring that medical assistance in dying is provided in accordance with the federal *Criminal Code*, which sets out the rules for medical assistance in dying in Canada, including eligibility criteria and safeguards that must be followed. If OHTs are interested in learning more about the process of delivering medical assistance in dying services, the OHTs may access the Centre for Effective Practice's medical assistance in dying tool.

Additional tips about how to draw on evidence sources to improve patient care and experience can be found in RISE brief 9 on evidence sources.

As noted in the introduction, an updated version of this RISE brief will be made publicly available through the RISE website and newsletter once proposed additions and corrections from the OHT Forum and participating experts have been acted on. If you would like to propose additions or corrections, please email your input to rise@mcmaster.ca.

References

1 Waddell K, Reid R, Lavis JN. RISE brief 6: Population-health management. Hamilton, Canada: McMaster Health Forum; 2020.
2 Health Quality Ontario. Patient reference guide: Palliative care. Quality Standards. Toronto: Health Quality Ontario; 2018.
3 Ontario Hospital Association. Palliative care when and where it is needed. Toronto: Ontario Hospital Association; 2018. https://www.oha.com/news/palliative-care-when-and-where-it-is-needed1 (accessed 9 February 2020).

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