Improving the Quality of Palliative Care Services for Cancer Patients in Ontario

October 2006
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About Cancer Care Ontario

Cancer Care Ontario (CCO) is an umbrella organization that steers and coordinates Ontario’s cancer services and prevention efforts so that fewer people get cancer and patients receive the highest quality of care. CCO fulfills its mandate by:

- Directing more than $500 million public healthcare dollars annually to prevent and detect cancer and help health care providers deliver the highest quality of care, as close to home as possible.
- Operating province-wide screening and prevention programs.
- Collecting and monitoring information about the rate and impact of cancer across the province, and putting this information in the hands of policy makers, researchers and care providers.
- Supporting providers to deliver the highest quality of care by quickly turning research into standards and guidelines that they can use to improve patient care.
- Promoting accountable and efficient cancer care by measuring and reporting to the public about the performance of cancer services, and working with doctors, hospitals and other care providers to continually improve.
- Advising the Ontario government.

Cancer Care Ontario derives its authority under the Cancer Act.

Regional Cancer Programs

Ontario now has 14 Regional Cancer Programs (RCPs), aligned with Local Health Integration Network (LHIN). These programs:

- Help to make the journey through cancer care easier for patients to navigate by linking together health care providers, organizations, patients and decision-makers across the full spectrum of cancer services.
- Bring care providers and community members together within a region to create solutions to local cancer issues.
- Facilitate better connections between cancer care providers so that every patient has access to an equally high quality of cancer care, as close to home as possible.

CCO supports the work of RCPs by providing information and setting standards. RCPs are responsible for ensuring local care providers put provincial standards into practice at the point of care, while responding to local needs.
Preamble

This document articulates the core components of Cancer Care Ontario’s (CCO’s) palliative care strategy. As one of the many organizations working to improve the quality of palliative care services for patients, the strategy will guide CCO in it’s efforts to improve the quality of palliative care for cancer patients while ensuring congruence of activities with other provincial efforts including the Ontario Ministry of Health and Long-Term Care’s End-of-Life Care (EOLC) Strategy. CCO acknowledges the valuable collaboration of the EOLC Strategy team in the development of this strategy.

Background

In November 2004, Cancer Care Ontario (CCO) released the Ontario Cancer Plan – a comprehensive plan to address the gaps in cancer care delivery across the province. Improving the quality of palliative care for patients was one of the specific areas identified as requiring greater strategic direction.

In 2005, CCO assembled a panel of palliative care leaders from each regional cancer program (see Appendix A). Deliberations of this group informed the development of a draft strategy, as did collaboration with the Provincial EOLC Strategy team of the Ministry of Health and Long-Term Care. The draft strategy was presented for discussion at a March 6, 2006 symposium hosted by the Cancer Quality Council of Ontario (CQCO) in partnership with CCO.

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1 Available at www.cancercare.on.ca

2 The symposium - Towards seamless transitions in palliative care for cancer patients – involved approximately 200 participants representing individuals involved in providing palliative care, home care, community care, and hospital care. Also in attendance were a number of representatives from national and provincial health care agencies, Local Health Integration Networks in Ontario, and patient representatives.

3 In 2002, the Ontario Minister of Health and Long-Term Care established the CQCO. A quasi-independent body, and the first of its kind in Canada, the CQCO is mandated to improve the quality and performance of all cancer services so that patients receive care that is timely, accessible and appropriate. Working with its partners in the cancer system, the CQCO:
   - Monitors and reports on the quality and performance of the cancer system.
   - Provides strategies for health care providers and decision-makers to capitalize on opportunities to improve cancer services.
Participants at the Symposium were invited to comment on the draft strategy. Advice received from participants was used to finalize the action plan articulated in this document. The strategy covers a three-year planning horizon.

The Need for a CCO Palliative Care Strategy

Although cancer survival rates are improving, cancer remains the second leading cause of death in Ontario. This year, more than 25,000 people in the province will die from cancer resulting in about seventy deaths per day, or one death every twenty minutes. Cancer patients make up 80-85% of patients seen by palliative care teams.

Currently, however, patients and families experience various degrees of physical, psychological, social and spiritual distress and suffering as a result of a cancer diagnosis. Some of this suffering could be diminished if the principles of good palliative care were practiced and a comprehensive model of care that includes both disease/cure-oriented and palliative/symptom-oriented treatments was embraced.

Although there is a tremendous amount of work under way to improve palliative care practices, indicators show that there remains significant room for improvement on a number of fronts. For example, at the provincial level:

- More than 56% of cancer patients die in acute hospitals, despite research indicating that 80-90% would prefer to die elsewhere
- 8.8% of all hospital deaths among Ontario cancer patients occur in the intensive care unit

In addition, there is significant variation in care between regions of the province. For example:

- The percentage of cancer patients receiving a palliative care physician visit in their home in the last two weeks of life varies across regions from 10%-32%
- Outpatient palliative care physician assessments in the last two weeks of life varies from 4% to 33%
- Inpatient palliative care physician assessments in the last two weeks of life varies from 14% to 26%

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4 Ontario Cancer Plan Update, Cancer Care Ontario, 2005
5 OACCAC, 2003 available at [http://www.oaccac.on.ca/media/Palliative_Issues_Paper_REV.doc](http://www.oaccac.on.ca/media/Palliative_Issues_Paper_REV.doc)

6 Barbera L, BSc, MD, MPA, FRCPC, Institute for Clinical Evaluative Sciences, 2002 data as published in the Cancer System Quality Index, 2005 at [http://www.cancercare.on.ca/qualityindex](http://www.cancercare.on.ca/qualityindex)
Some variations in care patterns may be attributed to regional differences in care protocols and available resources. Other differences are attributed to the fact that palliative patients often receive care throughout the course of their illness in a variety of settings across the care continuum including primary, acute, chronic, home and long-term care. Some of these settings include designated palliative programs, but many do not. The factors contributing to variation are further complicated by the fact that palliative care is delivered in different ways based on the training and expertise of the broad range of care providers involved.

Current variation in practices by different providers along the care continuum, coupled with fragmentation and an overall lack of coordination and integration of palliative care services across the continuum are major obstacles to achieving high quality care.\(^8\)

Given the high volume of cancer patients that require palliative care services and what is known about the gaps in service provision, it is incumbent upon CCO to develop an action plan. This paper describes CCO’s strategy to improve the quality of palliative care services in Ontario. The strategy builds on the growing body of literature highlighting the current shortfalls in the system, similar efforts being undertaken by other care providers to advance a stronger focus on quality improvement, and the recent interest and investment by the Ontario government in strengthening end-of-life care.

\(^7\) Ibid.

\(^8\) OACCAC, 2003 available at http://www.oaccac.on.ca/media/Palliative_Issues_Paper_REV.doc
The Provincial End-of-Life Care Strategy

In July, 2004 the Ministry of Health and Long-Term Care (Ministry) announced its intent to support the development of a comprehensive Provincial End-of-Life Care (EOLC) Strategy focused on:

- Shifting care of the dying from acute care settings to appropriate alternate settings of individual preference (e.g. home, long-term care home, residential hospice);
- Enhancing and developing client-centered and multidisciplinary service capacity in the community; and
- Improving access, coordination and consistency of services and supports across the province.

Each region was provided with support to establish a regional EOLC network. These networks are accountable for broad system design across the care continuum including coordination and integration of services at a systems level, identification and assessment of community needs and promotion of service innovations. Another key component being advanced through the EOLC strategy relates to development of multidisciplinary and integrated EOLC service delivery models at the local level. These models are intended to improve access to appropriate services (including pain and symptom management), offer 24-hour on-call health services in the community, provide a coordinated point of entry for clients, and apply technology in innovative ways to meet the needs of service providers and clients.

The Ministry endorsed the Canadian Hospice Palliative Care Association’s Model to Guide Palliative Care as the foundation for the planning activities at both the ‘network’ level and the service delivery level. (See Figure 1 for the guiding principles for the provision of palliative care.)

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9 Initially, the term ‘region’ referred to the boundaries of the former 17 District Health Councils in Ontario. The definition of ‘region’ is now evolving to be consistent with the 14 LHIN boundaries.
Figure 1: Guiding Principles for the Provision of Palliative Care

<table>
<thead>
<tr>
<th>Patient/family focused</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe and effective</td>
<td>Accessible</td>
</tr>
<tr>
<td>Adequately resourced</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Knowledge-based</td>
<td>Advocacy-based</td>
</tr>
<tr>
<td>Research-based</td>
<td></td>
</tr>
</tbody>
</table>

Source: Canadian Hospice Palliative Care Association

In October 2005, the Ontario Government announced an investment of $115.5 million over three years in support of the EOLC Strategy. Initial funding is being targeted at expanding the capacity of the community EOLC service delivery system to meet the needs of palliative clients and thereby reducing utilization of more costly tertiary acute care services. For example, in 2005/06, $39 million was provided to improve care services at home and in the community by:

- Supporting the planning and integration of local palliative care services through establishment of Palliative/End-of-Life Care Networks;
- Funding Community Care Access Centres (CCACs) to provide more and better end-of-life care to alleviate pressures on the acute sector;
- Funding support for nursing and personal support services in residential hospices; and
- Strengthening the role of hospice volunteers.

The other key commitment of the Provincial EOLC Strategy is to continue to plan and integrate local services through the work of the Palliative/End-of-Life Care Networks and through early engagement of these networks with the Local Health Integration Networks (LHINs).
A Strategy for Improving Palliative Care for Cancer Patients

Defining Palliative Care

The following definitions of palliative care are consistent with CCO’s approach focused on capturing the breadth and complexity of palliative care and variations in need for palliative care services. These definitions also envision a role for palliative care all along a patient’s illness trajectory:

**Palliative care** is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (World Health Organization)

**Palliative care** is aimed at relief of suffering and improving the quality of life for persons who are living with or dying from advanced illness or are bereaved. (Canadian Hospice/Palliative Care Association)

**Palliative care** refers to both a program and a concept of care based on the provision of comfort. It is designed for individuals who are living with, or dying from, a progressive life threatening illness. The program enhances quality of life through pain and symptom control and provides emotional and spiritual support for both patients and families. Compassionate and specialized care is provided with specialized knowledge and skills. (Canadian Cancer Society)

The definition of “palliative care” is distinguished from that of “end-of-life care,” which specifically refers to services provided to dying patients and their families.

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11 Canadian Hospice/Palliative Care Association, available at [http://www.chpca.net/menu_items/faqs.htm#faq_def](http://www.chpca.net/menu_items/faqs.htm#faq_def)

12 [http://www.cancer.ca/ccs/internet/standard/0,3182,3225_464587570_langId-en,00.html](http://www.cancer.ca/ccs/internet/standard/0,3182,3225_464587570_langId-en,00.html)
Articulating a Vision for Palliative Care

The CCO Palliative Care Strategy is based on the following vision:

*Every person, when faced with a cancer diagnosis, has the opportunity to live life fully, to receive timely and appropriate symptom management, to be supported along with his/her family with dignity and respect throughout the course of his/her illness, and in the face of incurable disease, to have the opportunity to die in a setting of his/her choice.*

In practical terms, achieving this vision will require a well-planned and integrated system of care that best meets the needs of the individual and his/her families and caregivers, and that strengthens system and service integration (See Figure 2).

**Figure 2: Ontario’s Palliative Care System – Today and Tomorrow**

<table>
<thead>
<tr>
<th>Current Palliative Care System</th>
<th>Future Palliative Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SYSTEM INTEGRATION</strong></td>
<td></td>
</tr>
<tr>
<td>Fragmentation</td>
<td>Planned, integrated system</td>
</tr>
<tr>
<td>Inequity across regions, service sectors and within sectors</td>
<td>Equity across regions, service sectors and within sectors</td>
</tr>
<tr>
<td>Poor accountability structure</td>
<td>Transparent accountability structure</td>
</tr>
<tr>
<td><strong>SERVICE INTEGRATION</strong></td>
<td></td>
</tr>
<tr>
<td>Sector-based funding streams</td>
<td>Services offered throughout the entire health continuum</td>
</tr>
<tr>
<td>Difficult to navigate services</td>
<td>Coordinated access &amp; care</td>
</tr>
<tr>
<td>Difficult to access specialists</td>
<td>Timely access to specialized, inter-disciplinary consultation</td>
</tr>
<tr>
<td>No standards</td>
<td>Family practitioners integrated with other primary and community care providers</td>
</tr>
<tr>
<td></td>
<td>Consistent care according to quality standards</td>
</tr>
<tr>
<td><strong>PALLIATIVE CLIENT AND CAREGIVER EXPERIENCE</strong></td>
<td></td>
</tr>
<tr>
<td>Lack of staff skilled in palliative care</td>
<td>The ‘right mix’ of workers</td>
</tr>
<tr>
<td>Little integration</td>
<td>The right balance of formal and informal care</td>
</tr>
<tr>
<td>Caregiver burnout</td>
<td>Appropriate support for informal caregivers</td>
</tr>
<tr>
<td>Hospitals primary place of death</td>
<td>Shift dying to the most appropriate setting in terms of patient choice and need</td>
</tr>
<tr>
<td>Poor pain and symptom management</td>
<td>Good bereavement and psychosocial support, pain and symptom management</td>
</tr>
<tr>
<td></td>
<td>Greater focus on the provision of culturally sensitive services</td>
</tr>
</tbody>
</table>

Source: Adapted, with permission from the Ontario End-of-Life Care Strategy
Building on CCO’s Strategy Map for Cancer Services

The vision for palliative cancer care developed by CCO articulates the ultimate goal of advancing the quality improvement efforts articulated in the Strategy Map for Cancer Services developed by Cancer Care Ontario, in conjunction with the CQCO. The Strategy Map was developed to guide CCO in its efforts to improve quality across the cancer care continuum (Figure 3) based on four areas of strategic focus. Each area of strategic focus builds on the others to ultimately reduce the burden of cancer and improve outcomes.

Figure 3: CCO Strategy Map

CCO’s palliative care strategy focuses on addressing all aspects of the strategy map:

- Improving measurement through the development of quality indicators
- Increasing the use of evidence by developing, implementing and disseminating evidence-based guidelines and standards, and
- Fostering the development and uptake of tools to increase efficiency and access to care.
Collaborating with the EOLC Strategy

CCO will continue to work closely with the Ministry and the regional EOLC networks to ensure that activities are aligned and complementary. Although each strategy has a unique area of focus, it is important to note that there is overlap (Figure 4).

Figure 4: Scope of Ministry and CCO Initiatives

As the figure shows, there are similarities and differences between the Provincial EOLC Strategy and the CCO Palliative Care Strategy. The similarities (i.e., areas of overlap) between the two strategies occur for those individuals who have cancer and are in the terminal phase of their illness. The distinction between the two strategies is that each addresses the needs of different patient groups: the Provincial EOLC Strategy includes non-cancer patients, and the CCO Palliative Care Strategy includes cancer patient in the curative phase of their illness.

While the populations are distinct, there is considerable overlap in the needs of all of the patients and in the caregivers involved in meeting those needs. While the focus of each strategy is different, strong collaboration and alignment of the work between the two initiatives will be essential.
Embracing a ‘Simultaneous Care’ Model

Within the cancer population, the vast majority of people currently seen by palliative care teams are in the terminal phase of their illness with an estimated prognosis of only weeks to months. The belief that palliative care begins when the disease becomes ‘terminal’ has often delayed the appropriate entry to formal palliative care. Providing care only for the imminently dying has been described as a potential indicator of poor quality of care.\(^\text{13}\) In fact, many palliative care providers believe that referrals are often made “too late” to be able to optimize the care received by patients and their families. Preliminary studies looking at the advantages of a “simultaneous care” (SC) model (compared to “usual care” (UC) model) have demonstrated improved quality of life for the SC group with diminished quality of life in the UC group.\(^\text{14, 15}\)

CCO supports the need to change the current focus from providing palliative care only to ‘terminally’ ill cancer patients to one that emphasizes the importance of providing a more ‘simultaneous’ approach to care regardless of an individual’s prognosis.

\(^{13}\) Higginson, I.J. (1999) In: Tebbit P. Palliative Care 2000 Commissioning through Partnership: National Council for Hospice and Specialist Palliative Care Services, Northhamptonshire, UK


\(^{15}\) Ferrell, BR. Late referrals to palliative care. Journal of Clinical Oncology 2005 April 20;23 (12) 2588
A SC approach focuses on helping patients move through the trajectory of a progressive, life-threatening disease by enabling their changing goals of care to be met at all stages based on an inter-disciplinary approach to care that attends to psychosocial issues, advance care planning, and symptom management – the essence of palliative care. Consequently, a key objective in enhancing the quality of palliative care is to ensure earlier identification of patients with advancing illness to allow them to receive appropriate palliative care earlier in the illness trajectory (See Figure 5). Achieving this, would provide opportunities for case managers and other health professionals to educate the client and caregiver on resources available to support them through their illness, allow for potential enhancements to quality of life and care planning and avoid crisis management and hospitalization. Key outcomes of earlier identification would also contribute to earlier prevention and detection of symptoms, improved quality of life, and ultimately enhanced ability of patients and families to receive and provide the necessary supports to remain in the home environment longer.

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Steps to Achieving the Vision

The following represents a short-term (i.e., three-year) work plan to support achievement of the Vision. The work plan is organized around the elements of the CCO strategy map for the cancer care system (Figure 3) the ultimate goal of which is to improve the quality of the cancer care system and reduce the burden of cancer for individuals and society by advancing efforts in the following areas:

*Improving efficiency and integration*

*Increasing the use of evidence*

*Improving access*

*Improving measurement*

The specific objectives and actions outlined in this plan capitalize on opportunities that have arisen both within and outside CCO and in most cases, provide opportunities to achieve immediate gains. The objectives/actions are part of a multi-year work plan and will be shared widely with key partners. Specific roles/actions have been articulated for CCO as well as some of the other key players. The identification of specific roles for some of the key players (e.g., care providers, Regional Cancer Programs, LHINs) are not intended to represent a comprehensive list of actions, rather are noted for discussion purposes, and to illustrate critical dependencies.
**Improve efficiency and integration**

Some regions of the province have made significant progress in addressing issues related to coordination and integration of palliative care services for cancer patients. As an example, The Hospice of Windsor and Essex County is Canada’s largest and oldest community based Hospice. Among its many accomplishments, it has facilitated with its many partners the development of a regional palliative medicine program. Partners include each of the regions three hospitals, CCAC, fundraisers, 800 volunteers, the Regional Cancer Centre and more. This regional program has achieved the implementation of a region-wide ambulatory pump program “one region/one pump”, a home symptom response kit, a region-wide echart housed by the regional cancer centre, a home pronouncement plan in partnership with physicians, CCAC and funeral homes, and a bereavement program in partnership with the Canadian Mental Health Association.

High quality palliative care that supports care and death at home requires the consistent application of palliative care knowledge, skills, common tools and protocols effectively orchestrated and employed by a system of community partners. Application of standardized tools and protocols can help to enhance coordination and integration of care across the continuum of care.

**Objective:** Standardize patient assessment and patient-related communication according to best practice.

**Actions:** Implement standardized patient assessment tools and standards for documentation and communication.

**2006/07 Work Plan**

**CCO will:**

- Broker knowledge regarding the simultaneous care (SC) model and standardized patient assessment tools (Edmonton Symptom Assessment Scale (ESAS) and Palliative Performance Scale (PPS))

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18 These partners include primary care physicians, palliative care specialists, hospitals, cancer centers, nurse specialists, interdisciplinary teams, CCACs, hospice and other care facilities working collaboratively to address complex patient/family needs through integration of services and care approaches.
- Explore other potential measures for psychosocial assessment beyond ESAS and PPS
- Develop standards for documentation and communication
- Ensure designation of a CCO Regional Vice-President for cancer services or delegate participates in each regional EOLC network
- Appoint and sponsor a palliative care physician from each region to work collaboratively with the EOLC network and to sit as a member of the executive team of each regional cancer program

**Care providers will:**
- Participate in the development of standards for documentation and communication
- Implement standardized patient assessment tools (e.g., ESAS, PPS)

**LHINS and Regional Cancer Programs will:**
- Endorse use of standardized assessment tools
- Seek ways to facilitate their adoption

**Increase the use of evidence**

Evidence-based practice is at the heart of being able to improve the quality and integration of palliative care services for cancer patients in Ontario. CCO has developed a neuropathic pain management guideline and a series of collaborative care plans (CCPs). These are intended to strengthen the evidence base to deliver ‘best practice’ care and advance equity and consistency in care approaches and practices across the province. Passive dissemination of these guidelines/care plans alone, however, will not result in practice change. Future efforts are needed to encourage ‘uptake’ of these guidelines across the regions to improve quality of care and reduce variability of practice.

**Objective:** Evidence-based clinical practice guidelines and organizational standards for palliative care delivery are utilized to ensure palliative care services are of consistently high quality.

**Actions:** Develop and implement evidence-based standards and guidelines

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19 Collaborative Care Plans (CCPs) define activities, interventions and outcomes that should occur within a specific stage or time frame. Three generic CCPs were developed to identify appropriate care of patients in the Stable, Transitional and End of Life stages of palliation. CCPs were developed for Pain, Dyspnea and Fatigue to guide the management of these symptoms often experienced by palliative patients.
2006/07 Work Plan

CCO will:

- Continue development of clinical practice guidelines for pain and symptom management through the Program in Evidence-based Care (PEBC). This includes finalizing and disseminating the pain management guideline #13-8.
- Support ongoing development of multi-disciplinary care plans ("collaborative care plans")
- Broker knowledge with respect to the clinical practice guidelines, multi-disciplinary care plans and the Canadian Council of Health Services Accreditation (CCHSA) standards for palliative care
- Seek opportunities to measure concordance of practice with evidence-based standards and guidelines
- Begin to examine current practices in advanced care planning

Care providers will

- Apply evidence-based guidelines in patient care
- Participate in the development of new practice guidelines and organizational standards
- Work to implement the CCSHSA standards

LHINs and Regional Cancer Programs will:

- Endorse use of evidence-based standards and guidelines
- Seek opportunities to facilitate their implementation

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20 Advanced care plans help to ensure that an individual’s care is customized to reflect their personal preferences and health needs, as well as meet their social, cultural and religious requirements. Advanced care plans can consist of any number of written documents including: advance care directives; do-not-resuscitate orders; living wills; power of attorney, and financial plans.
Increase Access

Significant variation and inequity exists in the availability of palliative care services for cancer patients across the province. The lack of appropriate data, however, makes it difficult to know the extent to which capacity, utilization, and workload issues are contributing to access barriers both within and across regions.

One of the initiatives undertaken as part of the current Provincial EOLC Strategy has been the provision of stipends to physician leaders within regions as the basis for addressing some of the concerns related to access to palliative care pain and symptom management in the home and community care environment. Efforts are needed to build on this work and further address issues prohibiting access to appropriate palliative care services.

**Objective:** Patients and families/caregivers are identified and referred to appropriate services as soon as the need arises.

**Actions:** Work to bridge the gap between service availability and demand. Introduce tools to accurately identify patient needs in a timely fashion.

2006/07 **Work Plan**

**CCO will:**
- Review service and infrastructure availability (such as number and designation of beds for palliative patients) with a view to working toward development of service standards.
- Begin to assess current utilization and workload measures in the palliative care system as the basis for developing planning guidelines and standards to support future planning.
- Broker knowledge about opportunities for advanced practice roles as a tool to enhance access.
- Continue to advise government on development of an alternate payment plan for palliative care physicians to promote ongoing availability of skilled physicians.
Together we can:
- Use available data to identify service gaps and inequities.
- Seek opportunities to implement automated patient assessment tools that drive relevant referrals in a timely fashion.
- Improve continuity of physician care

**Improve Measurement**

The current palliative care system for cancer patients has a number of strengths based on the provision of a broad range and diversity of programs and services across the province delivered by dedicated inter-disciplinary teams. A key shortcoming in the current system, however, continues to be the lack of appropriate data to assess the full range of services available and/or to determine the adequacy of these services in meeting required needs, responding to workload requirements, etc.

There is a need to expand the collection of data beyond the current administrative data sets. For example, qualitative measures are needed to assess the demand for palliative care services, workload measures to support services, and the quality of services at both the individual or systems’ level.

**Objective:** Accurate data is available to plan services and guide quality improvement

**Actions:** Develop, disseminate and use indicators to measure and improve access and quality.

**2006/07 Work Plan**

**CCO will:**
- Publish existing indicators in the Cancer System Quality Index
- Coordinate identification of additional or alternative indicators, and information needs for planning, and develop a data collection plan.

**Care Providers, Regional Cancer Programs and LHINs will:**
- Analyze available data and begin to use it to guide planning and quality improvement efforts.
- Participate in the identification of future indicators and data requirements for planning.
Implementing the Strategy: Levers and Barriers to Consider

Much of the implementation of this strategy will occur at the LHIN level. Participants at the March 6th Symposium identified a series of key levers and barriers that need to be considered with respect to implementation of CCO’s palliative care strategy. Following is a summary of some of the key issues that will need to be considered in developing provincial and regional specific implementation plans with respect to the goals, objectives and actions articulated above.

Levers

- Build on the success of Regional EOL Networks (and the potential of LHINs) to facilitate communication and provide opportunities for collaborative partnerships and alliances needed to achieve goals/objectives across the care continuum
- Strengthen involvement of the broader community and Family Health Teams in the work of Regional EOL Networks and Regional Cancer Centres
- Recognize and leverage existing strengths/talents of particular LHINs (e.g., Southwest LHIN has strong education program – Comprehensive Advanced Palliative Care Education; Southeastern Ontario developed and implemented an integrated assessment, delivery and communication system for palliative care medicine)
- Strengthen opportunities for palliative care training across the care continuum (e.g., train the trainer modules for interdisciplinary teams, specialized training for family practitioners – GPs and nurse practitioners).

Barriers

- Financial issues related to constraints imposed by physician billing (e.g., billing only allows for last year of life) with a focus on developing a payment system for palliative care specialists and specialist training
- Human resource issues including recruitment and training of adequate numbers of care providers including Family Physicians training in palliative care, Nurse Practitioners, and Personal Support Workers
- Lack of infrastructure and IT support to implement common data measurements and assessment tools
- Addressing the current inequity in ‘preparedness’ and ‘progress’ at the individual LHIN level.
Next Steps and Concluding Remarks

In light of service gaps for palliative service in the cancer care community, CCO has developed this strategy as a plan of action to improve quality, consistency and availability of palliative care services across LHINs. The complex nature of palliative services dictates that this work must be undertaken using a variety of tactics and, most importantly, using a collaborative approach. Accordingly, the strategy outlined in this document serves as a quality improvement initiative to improve integration of palliative care services through embracing a simultaneous model of care and initiating a series of specific actions to begin to move the system toward achieving the vision for palliative services.
Appendix 1: CCO’s Palliative Care Program Committee

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Dr. Howard Burke
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Lakeridge Health

Dr. Ed Fitzgibbon
Ottawa Regional Cancer Centre
The Ottawa Hospital

Dr. Ingrid Harle
London Health Science Centre

Doris Howell, RN, PhD
Princess Margaret Hospital/University Health Network

Dr. Charmaine Jones
Windsor Regional Cancer Centre
Hospice of Windsor and Essex County

Susan King
CCO/Provincial Palliative Care Integration Project

Dr. Andrew Knight
Sudbury Regional Hospital

Dr. Larry Librach
Temmy Latner Centre for Palliative Care

Jean Mackay
Program in Evidenced Based Care, McMaster University

Dr. Bryan MacLeod
Regional Cancer Centre
Thunder Bay Regional Health Sciences Centre
Dr. Nancy Merrow  
Southlake Regional Health Centre

Dr. Sharon Russell  
Hamilton Regional Cancer Centre  
Juravinski Cancer Centre

Dr. Robert Sauls  
The Carlo Fidani Peel Regional Cancer Centre

Dr. Donna Ward  
Grand River Regional Cancer Centre

Dr. Lesia Wynnychuk  
Sunnybrook Health Sciences Centre

Dr. Camilla Zimmerman  
Princess Margaret Hospital/University Health Network