Partnering for Change in Palliative Care in Ontario; Update from the Clinical Advisory Council of the Ontario Palliative Care Network

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Relationships with commercial interests:

“NOT APPLICABLE”
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Relationships with commercial interests:

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Learning Objectives

1. Describe how multidisciplinary clinical partnerships will be used to support change in hospice palliative care

2. Explore clinical progress in hospice palliative care in Ontario and how these successes will be leveraged to drive change

3. Identify opportunities to align current and future work so we can partner together to change the culture of hospice palliative care in Ontario
Workshop Outline

1. Overview of the Ontario Palliative Care Network
2. Overview of the OPCN’s Clinical Advisory Council
3. Strategic Documents that Drive Our Work
4. Current Work & Priority Areas
5. Partnering Together to Drive Change
Overview of the Ontario Palliative Care Network
What is the OPCN?

An organized partnership of community stakeholders, health service providers and health systems planners responsible for the development of a coordinated, standardized approach to the delivery of hospice palliative care services in Ontario.

Collectively, these partners have the skills, knowledge, resources and reach to provide the leadership, practical knowledge, oversight and governance to deliver on the mandate of the network.
The Mandate Of The Ontario Palliative Care Network

Be a principal advisor
to government for quality, coordinated, hospice palliative care in Ontario

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

Support regional implementation
of high-quality, high-value hospice palliative care
Governance Structure

Ministry of Health and Long Term Care

Executive Oversight

Implementation Advisory Council
Clinical Advisory Council
Data & Information Advisory Council
Partnership Advisory Council
Secretariat
Engagement and Implementation

- Regional Palliative Care Network Leads
- Implementation Advisory Council
- Clinical Advisory Council
- Data & Information Advisory Council
- Partnership Advisory Council
- Secretariat
- LHIN CEOs & CCO RVPs
- Coalition
The Governance Structures of the 14 Regional Palliative Care Networks will work with stakeholders and providers to ensure delivery of consistent person-centred care at the local level through:

- A standardized **joint accountability** model

- A **regional work plan**, developed and supported by **shared regional leadership teams**:
  - Regional Multidisciplinary Clinical Co-leads
  - Network Director
Overview of the Clinical Advisory Council
Purpose and Accountability of the Clinical Advisory Council

• Accountable to the OPCN Executive Oversight

• Keeps patient and family needs as the centre of its purpose

• Provides recommendations to the Executive Oversight for clinical improvements in hospice palliative care in Ontario

• Provides advice on clinical implications of policy
The Role of the Clinical Advisory Council

• Promote an excellent person and family centred palliative approach to care

• Work in partnership with the other components of the OPCN to ensure alignment with provincial direction

• Collaborate with the Regional Multidisciplinary Clinical Co-Leads Table to gather advice, insights and recommendations from clinical partners to inform activities of the OPCN

• Establish provincial direction for hospice palliative care education and mentorship to guide local and regional improvements and to support an integrated approach to hospice palliative care
The Role of the Clinical Advisory Council

• Identify clinical best practice, evidence, and guidelines to support the advancement of high quality and patient-centred multidisciplinary hospice palliative care in Ontario

• Identify clinical priorities, and develop quality standards to drive practice change

• Build sustainable multidisciplinary capacity in regional clinical services and leadership

• Provide advice to Executive Oversight on clinical implications of policy

• Provide advice to Executive Oversight on access to care, quality improvement strategies and service structure
Membership of the Clinical Advisory Council

• Multidisciplinary membership, reflecting competencies that include clinical and program leadership, system expertise, academic leadership, clinical health informatics, quality and performance improvement, change management, caregiver expertise, health equity and cultural competence, and pediatric palliative care

- Ahmed Jakda, MD
- Melody Boyd, RN
- Robin Cano, RN
- Darren Cargill, MD
- James Downar, MD
- Russell Goldman, MD
- Elan Graves, RN
- Deb Harrold, MD
- Tracey Human, RN/PPSMC
- Jill Marcella, SW
- Robert Parke, SW/Ethicist
- Adam Rapoport, MD
- Robert Sauls, MD
- Joshua Shadd, MD
- Cindy Shobbrook, NP
- Kirsten Wentlandt, MD
Strategic Documents
Driving our Work
The Declaration of Partnership and Commitment to Action

Shared Priorities:
1. Broaden access & increase timeliness of access.
2. Strengthen caregiver supports.
3. Strengthen service capacity & human capital in all care settings.
5. Strengthen accountability & introduce mechanisms for shared accountability.
Auditor General Report 2014: Palliative Care Focus

- A strategic policy framework is required for palliative care delivery system
- Better information for decision-making and planning is required
- Services should be reviewed for cost-effectiveness
- Access should be equitable
- Patient care can be improved
- Education standards needed for providers and awareness needed for the public
The Patients First roadmap (Feb 2015) outlines a plan for:

- Greater consistency in care
- Better understanding of services available
- More support for caregivers
- Better access to the right care

The Patients First proposal (December 2015) suggests expanding the role of the LHINs to achieve these goals.
Progress to Date
Progress To Date: Clinical Leadership

**Hiring multidisciplinary co-leads in each region**

- Each region has multidisciplinary leadership in place
- Disease-agnostic scope

**Leadership Development**

- In March 2017, the clinical co-leads came together to participate in a 2-day regional leadership development program
### Progress To Date: Tools and Supports

<table>
<thead>
<tr>
<th><strong>Pain Symptom Management Guide</strong></th>
<th>• Working with CCO’s Patient Reported Outcomes Program and Program in Evidence Based Care to develop a disease agnostic symptom management guideline for pain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Palliative Care Guidelines</strong></td>
<td>• Working with CCO’s Program in Evidence Based Care to review existing palliative care guidelines that are available in the public domain</td>
</tr>
</tbody>
</table>
| **Common Language Guide**        | • Includes key definitions and emerging language norms to help create a shared understanding of hospice palliative care  
• Clarifies important concepts to improve awareness, and reduce confusion                                                                 |

Progress to Date:
A Focus on Access
Facilitating Access To Opioids for Palliative Purposes

Background

In July of 2016, the Ministry of Health and Long-Term Care announced that the Ontario Drug Benefit (ODB) Formulary/Comparative Drug Index would be updated in January 2017.

These changes included delisting the following higher strengths of long-acting opioids:

- Morphine 200 mg tablets;
- Hydromorphone 24 mg and 30 mg capsules; and
- Fentanyl 75 mcg/hr and 100 mcg/hr patches.

**Rationale:** to raise awareness and encourage appropriate prescribing in accordance with clinical practice guidelines.

**To note:** Lower-strength, long-acting opioids continue to be funded under the ODB program.
Facilitating Access To Opioids for Palliative Purposes

Background

<table>
<thead>
<tr>
<th>Previous Listing for Palliative Care Facilitated Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diazepam</td>
</tr>
<tr>
<td>Dimenhydrinate</td>
</tr>
<tr>
<td>Furosemide</td>
</tr>
<tr>
<td>Glycopyrrolate</td>
</tr>
<tr>
<td>Glycopronium Bromide</td>
</tr>
<tr>
<td>Hyoscine Butylbromide</td>
</tr>
<tr>
<td>Lorazepam</td>
</tr>
<tr>
<td>Methadone</td>
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</tbody>
</table>

(1mg/ml, 10mg/ml, 1mg, 5mg, 10mg, 25 mg)
Facilitating Access To Opioids for Palliative Purposes

Process

- Ongoing meetings with Ministry
- Formed clinical advisory subgroup
- Negotiated access of high strength opioids for PCFA prescribers
- Recommendations to delist other PCFA listed drugs
- Revised PCFA applicant process
Facilitating Access To Opioids for Palliative Purposes
Revised PCFA and Changes to the General Formulary

<table>
<thead>
<tr>
<th>Currently on PCFA</th>
<th>Transitioned to General Formulary (As of Feb 28\textsuperscript{th}, 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl Transdermal System</td>
<td>Diazepam</td>
</tr>
<tr>
<td>Glycopyrrolate</td>
<td>Dimenhydrinate</td>
</tr>
<tr>
<td>Glycoprronium Bromide</td>
<td>Furosemide</td>
</tr>
<tr>
<td>Hydromorphone (24mg/30mg)</td>
<td>Lorazepam</td>
</tr>
<tr>
<td>Hyoscine Butyrbromide</td>
<td>Metoclopramide</td>
</tr>
<tr>
<td>Methadone (1mg/ml, 10mg/ml, 1mg, 5mg, 10mg, 25 mg)</td>
<td>Phenytoin</td>
</tr>
<tr>
<td>Midazolam</td>
<td>To Be Determined:</td>
</tr>
<tr>
<td>Morphine Sulfate</td>
<td>Glycopyrrolate</td>
</tr>
<tr>
<td>Oxycodone HCL</td>
<td>Hyoscine Butyrbromide</td>
</tr>
<tr>
<td>Pamidronate Disodium</td>
<td>Midazolam</td>
</tr>
<tr>
<td>Phenobarbital</td>
<td>Scopolamine Hydrobromide</td>
</tr>
</tbody>
</table>
Facilitating Access To Opioids for Palliative Purposes: Prescribing Process

Physician with PCFA designation

- Permitted to prescribe drugs on PCFA list (including high-strength opioids)
- Supports non-PCFA prescribers with initial consultation and follow up if needed

- Prescription for high-strength opioid indicating “PCFA” on prescription

Physician without PCFA designation

- Qualified to obtain PCFA designation?

  Yes

  - Meets PCFA program criteria
  - Submits PCFA declaration/application form to OMA

  - While awaiting PCFA registration

  - If requesting high-strength long-acting opioid
    - Consult with PCFA registered physician
    - Obtain CPSO number of the PCFA consultant

  - Telephone Request Service (TRS) #: 1-866-811-9893 or 416-327-8109

  - Permitted to prescribe drugs on PCFA list (including high-strength opioids)
  - Supports non-PCFA prescribers with initial consultation and follow up if needed

  - Prescription for high-strength opioid indicating “TRS” on prescription

  - Approved by TRS

- Call or fax EAP’s TRS to obtain authorization for reimbursement of the high-strength opioid
- May also request reimbursement for other drug products on the PCFA list
- If approved, funding is granted for up to 12 months
- Renewals require a new PCFA consult for non-PCFA prescribers.
Reframing the Focus on Medical Assistance in Dying

Background: Exploring a Role for the OPCN

Feedback during regional consultations highlighted several concerns from RVPs and LHIN Leaders about access and provision of medical assistance in dying.

Given the amount of attention focused on medical assistance in dying, it was important to explore a potential role for the OPCN, and leverage the opportunity to reframe attention on the need for access to palliative care.

Further feedback was obtained to better inform the OPCN, including discussions with:

• Clinical Advisory Council
• Regional Multidisciplinary Leads
• Provincial Leadership
• Regional Directors
Reframing the Focus on Medical Assistance in Dying

Context: Current State as of March 31, 2017

- There have been 365 medically assisted deaths in Ontario, as reported by the Office of the Chief Coroner for Ontario.
  - Averages approximately 9 assisted deaths per week in Ontario since June 6, 2016.

Clinician Referral Service*:

- 332 referral matches have been made, 12 pending matches
- Overall, 43 requests have been withdrawn as the service was no longer required
- 24% of registered clinicians have placed themselves on hold (currently not taking cases)
- 16% of registered clinicians have expressed restrictions on their willingness to participate in referrals for medical assistance in dying
  (i.e. the distance they are willing to travel and/or the types of patients they will take).

*Clinician registrations are voluntary; success of the service relies on willingness to provide the requested services.
Reframing the Focus on Medical Assistance in Dying

What is Working Well

• The palliative care community is offering to support education and help with difficult conversations, such as suffering.

• Palliative care providers have taken a stance that they need to be engaged with these patients, and have conversations with them.

• CCAC navigator role has emerged.

• Previous work on medical assistance in dying, institutional/hospital working groups that have convened including CCAC and expanding to include hospices, LTCH, etc.

• Leveraging provincial webinars.

• Trying to operationalize locally.

• Key is how all these groups will connect.
Reframing the Focus on Medical Assistance in Dying
Recommendations for Messaging from the OPCN

Recognizing that there is an intersection between medical assistance in dying and Palliative Care, the OPCN has developed and is finalizing some key messaging:

• To describe the role of the OPCN as it relates to medical assistance in dying

• To provide guidance to Regional Palliative Care Networks on their potential role as it relates to medical assistance in dying
Current Work & Priority Areas
Development of a Palliative Care Quality Standard

**Background**

- Working collaboratively with Health Quality Ontario
- Based on the best available evidence
- Guided by an interdisciplinary committee of clinicians, administrators, patients, and caregivers from across the province

**Scope:**

- adults* who have life threatening illnesses from which they are not expected to recover
- accessing services in all settings (primary care, hospice, home care, long-term care, and acute care)

*Development of a palliative care quality standard for infant, children, and youth populations will be considered for future development once high-quality guidelines are available*
Development of a Palliative Care Quality Standard

What is a Quality Standard?

- Concise sets of 5-15 measurable, evidence-based statements guiding care in a topic area
- Developed in topic areas identified as having high potential for better quality care in Ontario
- Each quality statement accompanied by quality indicator(s)
- Every quality standard is accompanied by a plain language summary for patients and caregivers
- An implementation plan is developed that includes various support mechanisms (ex. QIPs, ARTIC, etc...)

*Development of a palliative care quality standard for infant, children, and youth populations will be considered for future development once high-quality guidelines are available*
Development of a Palliative Care Quality Standard

Process

Scoping and Initiation (4 months)
- Determine scope
- Post open call for QS
- Working Group members
- Identify key stakeholders

Development with Working Group (7-8 months)
- 3-4 working group meetings
- Develop quality statements and indicators
- Strategize implementation

Production and Launch (7-8 months)
- Post draft for public feedback
- Finalization and launch
- Begin implementation
Assessing Funding Structures to Support Palliative Care

• Exploring the current funding model to understand barriers and identify opportunities to evolve it to encourage a person centered approach

• Meetings have occurred within CCO, with Regional Contacts, palliative physicians, as well as the Ministry to understand opportunities for moving this issue forward

Next Steps:
• Strike funding working group
• Current state assessment to explore Alternate Funding Plan (AFP), Community Palliative Care On Call (CPOC) and other payment models
• Conduct focus groups/interviews
• Draft report with recommendations
Developing Recommendations for Provincial Palliative Care Education

**Purpose:** A position on educational requirements for health care providers providing palliative care

**Goal:** Strengthen service capacity & human capital in all care settings

**Next Steps:**
- Identify education priorities, define competencies and map educational assets
- Draft report with recommendations
Palliative Care Tools and Best Practices

• Exploring tools and best practices for identifying palliative care needs, and enabling palliative care coordination, navigation & communication

Next Steps
• Ongoing review of best practices and innovative models of care across care settings, including providing advice and direction
• Identifying gaps in clinical guidelines, and prioritizing future development (i.e. provincial standards around Expected Death in the Home protocol and Symptom Response Kits)
Partnering Together
To Drive Change
With our shared passion, we can achieve high quality, high value, hospice palliative care for all.

Thank You