

Toronto Central Palliative Care Network
2009-10 to 2011-12 Strategic Plan:
Setting a new course



Toronto Central Palliative Care Network
1/27/2009

VISION

- A full range of high quality hospice palliative care services will be available to the people of Toronto Central and their families across all care settings.

MISSION

- The Toronto Central Palliative Care Network will provide leadership and the structure to facilitate the development of a comprehensive, integrated and coordinated system of hospice palliative care for Toronto Central.

NETWORK GOALS

1. Promote quality in hospice palliative care services through the recommendation and advancement of accepted standards and best practices, education and innovation.
2. Advance accountability through measurement and evaluation of the regional hospice palliative care system.
3. Provide leadership and structure in the provision of hospice palliative care services through the collaboration and cooperation of hospice palliative care providers and organizations from a variety of disciplines and care settings.
4. Advise on and influence policy in hospice palliative care.
5. Raise public awareness of hospice palliative care services and the regional system.
6. Embrace and promote individualized, family-centered service delivery.

VALUES AND GUIDING PRINCIPLES

1. Diversity provides richness and must be valued.
2. Hospice palliative care services must be delivered with sensitivity and compassion to meet the unique needs of each individual client and their families.
3. Quality hospice/palliative services must be delivered by skilled knowledgeable and qualified staff and volunteers.
4. Community partnership and collaboration must exist to support and enhance service delivery.
5. Available resources will be used wisely and creatively.
6. TCPCN leadership will foster the development of hospice palliative care.

(NETWORK – INTERNAL NETWORK ISSUES)

1. **Limited TCPCN Organizational Structure & Momentum**

- a. What is TCPCN's role & mandate in the area of influencing public policy and policy-making?
- b. What are the appropriate structural supports to enhance input from front-line HPC players?
- c. How do we regain the Network's momentum and identify accountabilities for its successes?
- d. How do we build our 'street cred'?
- e. Need for additional and sustainable revenue and resource sources and expansion.
 - i. Can TCPCN create sustainable and dedicated funding to support the administration and operations of the Network?
 - ii. Are there other sustainable funding sources that can support TCPCN initiatives?

(NETWORK – EXTERNAL NETWORK REGIONAL ISSUES)

2. **Knowledge Management and Knowledge Transfer Strategy Void**

- a. A need for e-Health strategies to support data needs and to create a common data base (ex: Strata – GTA Rehab / CCAC)
- b. A need for data on the system's performance:
 - i. What are the services? Where are the services? Who are providing the services?
 - ii. What are the key performance measures and indicators?
- c. A need for more activity in knowledge creation (Research and development).
- d. Require a more coherent Knowledge Transfer / Education Strategy to meet the needs of our region.
 - i. Need a knowledge transfer plan for health care providers.
 - ii. HPC is a component in some, but not all health professions' curricula.
 - iii. Need more specialized HPC training for health professionals.

3. **Poor Service Delivery Coordination and Planning**

- a. Access to Services
 - i. Limited focus on the front-end of HPC continuum.
 1. Advanced care planning.
 2. "Earlier identification and earlier intervention"
 - ii. People dying on waiting lists.
 - Duplication in accessing services for patients (Ex: multiples requests to multiple organizations in order to access bed – no common point of referral).
- b. Coordinate regional service provider program changes and enhancements.
 - "Silo" mentality does exist.
- c. Healthcare provider engagement in hospice palliative care services:
 - Family physician engagement.
 - Specialists' engagement.
- d. Common language adoption across spectrum of the HPC players.
 - Uptake of PPS and ESAS (acute and community sectors).

4. **Lack of capacity in the HPC sector**

- a. Certain parts of Toronto are not receiving appropriate service levels.
- b. There are not enough residential and transitional beds in Toronto Central.
- c. Funding disparities across the HPC sector
 - i. Not enough resources flowing to community HPC services.
 - ii. Funding disparities in HPC envelopes for inpatient beds (EX: i) residential hospices are funded \$580,000 to operate, but require at least \$1M to operate fully. ii) funding matrix exists for inpatient beds -- LTC beds and acute beds, and etc.).
- d. Health human resourcing:
 - i. Access to formal care teams, volunteers, family physicians.
 - ii. Disparities in salary scales across various sectors in HPC.

STRATEGIC DIRECTIONS AND CORRESPONDING ACTIONS

1) Create appropriate Network infrastructure and processes to support and advance the work of the Network

- a. Create governance and operational structures for the Network that will facilitate its activities:
 - i. Committees and working group structures.
 - ii. Accountabilities and roles of TCPCN partners: OCSMC, PPSMC, Other.
- b. Advance a branding and marketing strategy:
 - Website revitalization; marketing package; visibility within regional health care system.
- c. Increase and diversify the Network's revenue base to support the work of the network to ensure its on-going momentum:
 - i. Explore all possible alternatives for sustainable funding sources:
 - Membership expansion, legal entity status, products & services, Ontario Trillium Foundation, Ministry of Health and Long-Term Care, Toronto Central Local Health Integration, Other LHINs.
- d. Create strategic and administrative processes in order to leverage external environmental opportunities (LHIN, MOHLTC, other):
 - Business planning cycle; policies and procedures; and measurement and evaluation.

2) Develop and Implement a knowledge management and knowledge transfer strategy

- a. Develop and implement a performance management and evaluation framework to assess and improve performance of the HPC system and the Network – determine the value-add:
 - i. Performance indicators and measures and a balanced scorecard.
- b. Develop a framework and implementation plan for a common data access for all hospice palliative care services within Toronto Central.
- c. Systematic framework of gathering valid and reliable planning data to support decision-making and policy-making:
 - i. Asset mapping: who are the service providers, what are the services being provided, and where are the services being provided.
- d. Create structures and processes that enable sustainable commitment to innovation:
 - Create and implement an innovation plan that reflects the Integration Plan (Strategic Direction #3) and is aligned with the annual business planning cycle.
 - Create an implementation plan of successful and sustainable innovations.
- e. Advise on current and emerging HPC issues to inform research efforts within the region.
- f. Engage in knowledge transfer:
 - i. Develop and implement a Knowledge Transfer plan that will enable the Network to:
 - Disseminate information on education opportunities available;
 - Outline evaluation of education efforts (effectiveness and efficiency and relevance);
 - Determine mechanisms for identifying educational needs within the region;
 - Promote awareness of the regional HPC service delivery system.
 - This plan will support capacity building within the community sector (**Strategic Direction #4**) and reflects the Network's partnership and collaboration with:
 - Hospice Association of Ontario (Hospice Association of Ontario's Interdisciplinary Palliative Education); and
 - Palliative Pain & Symptom Management Collaborative (PPSMC).
- ii. Develop a framework that enables knowledge translation of HPC research.

3) Enhance collaboration and coordination

- a. Develop a regional hospice palliative care integration plan (target completion date before end of 2009/10) with the goal to ensure comprehensive HPC to patient and families:
 - i. Define the scope of the integration plan: what is the network's role in regional integration of hospice palliative care services.
 - ii. Acquire planning information: epidemiology, demand, utilization and access, projections, etc. (aligned with **Strategic Direction #2c**).
 - iii. Ensure the plan addresses engagement of relevant hospice palliative care sector stakeholders, including:
 - Primary care sector, with an emphasis on primary care physicians.
 - Clinical specialists in all relevant fields (i.e., cancer, cardiovascular, mental health, etc.).
 - Other relevant stakeholders.
 - iv. Ensure integration plan reflects the intent and focus of the following definition (aligned with LHIN Act, 2006 definition):
 - **co-ordinating services and interactions between different persons and entities;**
 - **partnering with another person or entity in providing services or in operating**
- b. Develop an implementation plan for the Integration Plan and initiate implementation.
 - Implementation plan to include an action plan to address common language and terms uptake across the regional hospice palliative care system (i.e., ESAS and PPS).
 - Align with CCAC, Ontario Cancer Symptom Management Collaborative and PPSMC.
- c. Develop a framework and an implementation plan for sustainable single-point-of-access that is reflected in the regional integration plan (**Strategic Direction #3**).
 - Electronic common referral.
 - Review on the role of a bed registry.
- d. Develop a promotional framework to address advanced care planning:
 - Advances public and patient education and promotion.
 - Reflects education to care providers, formal and informal.
 - Seeks to ensure provider engagement / involvement.
- e. Act as the regional lead in hospice palliative care and provide advice and recommendations to decision-makers and policy-makers on hospice palliative care.
- f. Engage in dialogue and coordination of the Network's integration plan with key Network partners.
 - i. Ensure that the Integration Plan is responsive to the Toronto Central LHIN's regional Integrated Health Service Plan and its priorities, including the regional Aging at Home Strategy;
 - ii. Ensure that the integration plan supports The Ministry of Health and Long-Term Care's Transformation Agenda and priorities (e.g., ER / ALC; Wait Times) at the regional level; and
 - iii. Ensure that the integration plan supports and/or aligns with other end-of-life Networks and LHINs (i.e., Central, Central West and Central East).
 - iv. Ensure that the integration plan supports and/or aligns with other hospice palliative care stakeholders and partners (e.g., OCSMC, Palliative Pain & Symptom Management Collaborative (PPSMC), CCO, other).

4) Support capacity building within the regional hospice palliative care system

- a. Develop and implement a Knowledge Transfer Plan with an emphasis on the community sector needs (Same as **Strategic Direction #2f**):
 - i. Address the needs of community and long-term care nurses, family physicians, personal support workers, and etc.;
 - ii. The plan is to reflect the Network's partnership and collaboration with:
 - Hospice Association of Ontario (Hospice Association of Ontario's Interdisciplinary Palliative Education); and
 - PPSMC.
 - iii. The plan ensures coordination and integration of all educational services within the region.
- b. Identify service level needs and advise policy-makers and decision-makers (aligned with **Strategic Direction #2c**):

- Hospice palliative care bed needs.
- Community resources.
- Long-term care facilities.
- Acute care sector services.
- Primary care services.

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MISSION
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NETWORK GOALS

- Goal 1:** Promotes quality in HPC services through the advancement of accepted standards and best practices, education, and innovation.
- Goal 2:** Advances accountability in HPC through measurement and evaluation.
- Goal 3:** Provides leadership and structure in hospice palliative care through the collaboration and cooperation of hospice palliative care providers and organizations.
- Goal 4:** Advises on and influences policy on hospice palliative care.
- Goal 5:** Raises public awareness of hospice palliative care services and the regional system.
- Goal 6:** Embraces and promotes individualized, family-centered service delivery.

STRATEGIC ISSUES

Knowledge Management and Knowledge Transfer Void

- Lack data.
- No commitment to research and innovation.
- Uncoordinated training and education.

Poor Service Delivery Coordination and Planning

- Access to services
- Wait lists & wait times exist.
- Duplication in accessing services
- Program planning in silo.
- Lack of common language usage.

Limited TCPCN Organizational Structure & Momentum

- Lack of regional leadership in policy-making.
- Minimal front-line HPC player involvement.
- Lost Network momentum.
- Unknown Network accountabilities.
- Unknown credibility and reputation.

Lack of capacity in the HPC sector

- Under-served communities.
- Bed availability.
- Funding disparities across the HPC sector.

STRATEGIC DIRECTION & ACTIONS

Knowledge Management and Knowledge Transfer

- Measurement & Evaluation.
- Research and Innovation.
- Education & Training.

Enhance coordination and collaboration within the system

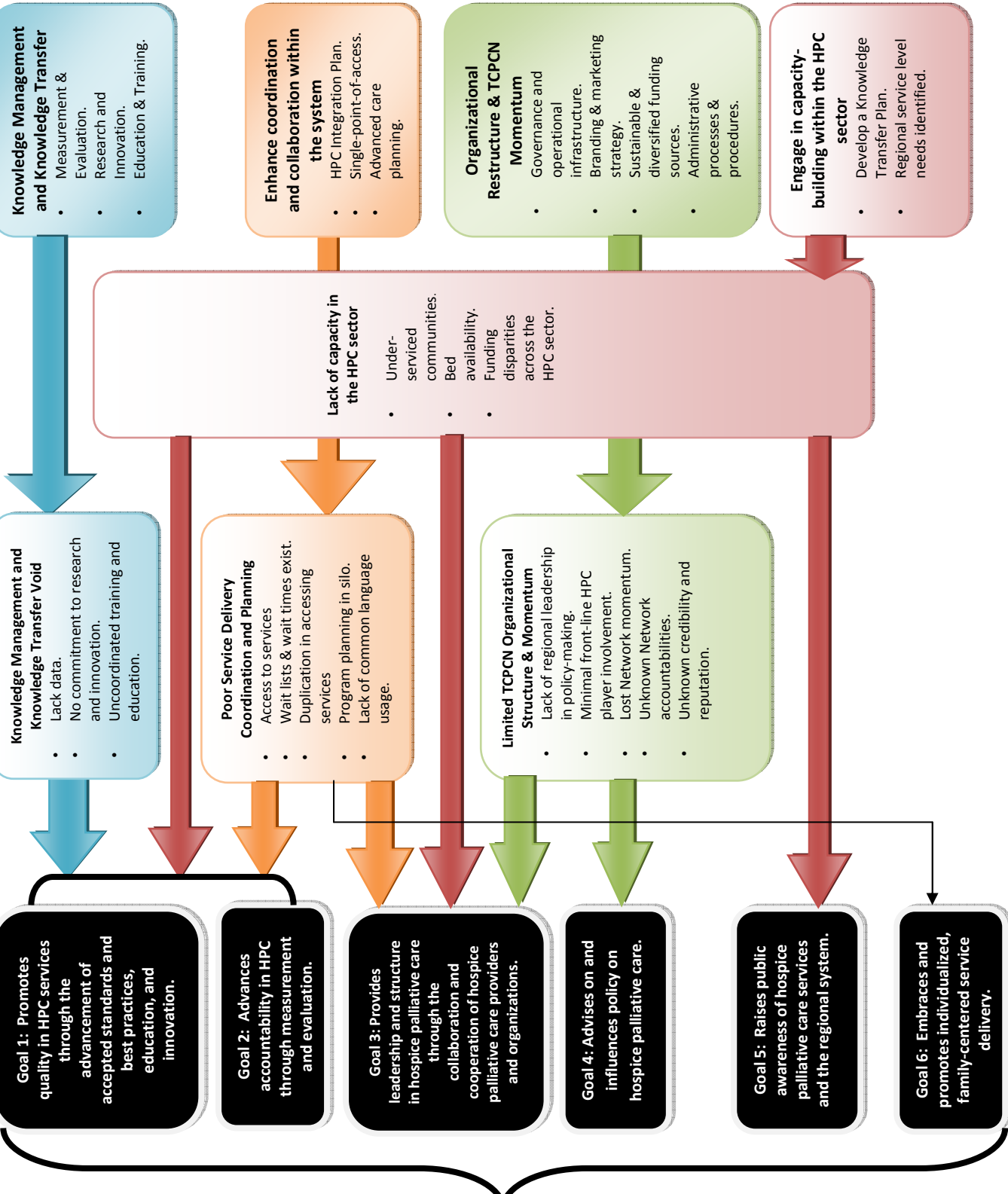
- HPC Integration Plan.
- Single-point-of-access.
- Advanced care planning.

Organizational Restructure & TCPCN Momentum

- Governance and operational infrastructure.
- Branding & marketing strategy.
- Sustainable & diversified funding sources.
- Administrative processes & procedures.

Engage in capacity-building within the HPC sector

- Develop a Knowledge Transfer Plan.
- Regional service level needs identified.



STRATEGIC PLAN – 3-YEAR MAPPING WITH KEY DELIVERABLES & MILESTONES

YEAR 1 2009-10

S1. INFRASTRUCTURE & PROCESSES

- 1) Create appropriate governance and operational structures for the Network.
- 2) Branding and marketing strategy.
- 3) Increase and diversify revenue base.
- 4) Create administrative processes.

S2. KM / KT

- 1) Develop a performance management framework.
- 2) Implement an evaluation framework.
- 3) Gather planning data - Asset Map & Projections.
- 4) Create an Innovation Plan
- 5) Develop framework for common data access.

S3. COLLABORATION & COORDINATION

- 1) Develop regional hospice palliative integration plan.
- 2) Develop Single-Point-of-Access Framework.

- S4. CAPACITY BUILDING**
- 1) Identify service level needs.

YEAR 2 2010-2011

S1. INFRASTRUCTURE & PROCESSES

- 1) Branding and marketing strategy.
- 2) Increase and diversify revenue base.
- 3) Create administrative processes.

S2. KM / KT

- 1) Implement performance management and evaluation framework.
- 2) Knowledge transfer of planning data.
- 3) Develop framework for common data access.
- 4) Initiate Implementation of the Innovation Plan
- 5) Develop a Knowledge Transfer Plan.

S3. COLLABORATION & COORDINATION

- 1) Initiate implementation of regional hospice palliative integration plan.
- 2) Develop an Implementation Plan for Single-Point-of-Access.

S4. CAPACITY BUILDING

- 1) Knowledge Transfer Plan (*same as S2.5*).
- 2) Develop policy position re: service level needs.

YEAR 3 2011-2012

S1. INFRASTRUCTURE & PROCESSES

- 1) Branding and marketing strategy.
- 2) Increase and diversify revenue base.
- 3) Create administrative processes.

S2. KM / KT

- 1) Implement performance management and evaluation framework.
- 2) Knowledge transfer of planning data.
- 3) Implementation plan for common data access.
- 4) Implement the Innovation Plan.
- 5) Implementation plan for Knowledge Transfer Plan.

S3. COLLABORATION & COORDINATION

- 1) Implementation of regional hospice palliative integration plan.
- 2) Initiate Implementation Plan for Single-Point-of-Access.
- 3) Develop a framework to promote advanced care planning.

S4. CAPACITY BUILDING

- 1) Knowledge Transfer Plan (*same as S2.5*).
- 2) Engagement strategy re: service level needs policy position.

ORGANIZATIONAL STRUCTURE

(REVISED: APRIL 22, 2009)

