Ontario Health

Backgrounder: Implementing the Community Model of Care

The immediate focus for implementing the Model of Care is to address unmet palliative care needs in the community, with the goal of improving access to care within identified geographic areas across the province. These geographic areas will be determined by the individual Ontario Health regions; they could be an Ontario Health Team (OHT) or a smaller catchment area. Each geographic area will be served by a Clinical Coach, with palliative care expertise, who will be hired through a local palliative care outreach team. This Clinical Coach will guide implementation of the community model of care recommendations in the Health Services Delivery Framework (the Delivery Framework) in a group of connected community organizations, which could include Long Term Care homes and other organizations such as Family Health Teams, Community Health Centres, Home and Community Care Support Services, etc. Implementation in each individual community organization will involve assessment of the current state of palliative care services, tailored education, resources, and coaching, as well as quality improvement activities to support change management. Implementation in each Ontario Health region will be accomplished in a phased manner, with one cohort of organizations starting each year and continuing for several years.

Our ultimate goal is to use implementation of the Delivery Framework to establish permanent changes in the way that palliative care is organized and delivered in the community. Through implementation and additional funding requests, the Ontario Palliative Care Network (OPCN) will continue to build a provincial palliative care program. Implementation in a cohorted manner will help to strengthen relationships between the selected community organizations and health service providers within a specified geographic area. This will enable ongoing support and resources for these organizations in the form of opportunities for refresher education as well as improved access to palliative care experts (such as palliative care specialists, and nursing outreach teams) for coaching and consultation if required. Implementation in a cohorted manner will help to establish consistent messaging throughout the community, such as the importance of advance care planning and engaging in goals of care discussions (regardless of whether these conversations occur with the care team at the Family Health Team, or the Home and Community Care Support Services care coordinator or the physician/staff in long-term care).