Ontario Medical Association

OMA Palliative care advocacy plan

Introduction

This plan was created through application of the new OMA Advocacy Toolkit to the issue of reducing hospital backlog by prioritizing palliative care. The plan is intended to serve both as an advocacy roadmap and, in part, as an example of the Toolkit's implementation to assist members in filling out the kit for their own advocacy efforts.

<table>
<tr><td colspan="3">What needs to change? Reducing delays in patient care</td></tr>
<tr><td colspan="3">What is your goal(s)? Prioritize palliative medicine.
Addressing issues with referrals, reducing wait times, increasing access to quality care through allied health supports</td></tr>
<tr><th>Who do we need to influence?</th><th>What is important to them?</th><th>How can we influence them?</th></tr>
<tr><td>Physician leaders</td><td>• Reducing delays in patient care
• Reducing physician burnout and moral distress
• Improving patent experience</td><td>Sharing information through social media, blogs, or infographics</td></tr>
<tr><td>Ontario Health Teams</td><td>• Improving patient experience
• Improving population health outcomes</td><td>Building partnerships by knowledge sharing or hosting joint meetings</td></tr>
<tr><td>Patient advocate groups</td><td>• Higher quality care for those waiting for, or in palliative care
• Improving patient experience</td><td>Supporting advocacy champions by building community networks or mentorship programs</td></tr>
<tr><td>Government</td><td>• Reducing healthcare cost
• Improving patient experience
• Reducing wait times</td><td>Use data-driven advocacy to demonstrate cost savings and system improvements.</td></tr>
<tr><td colspan="3">What do we need to do this?
• Register for OMA advocacy network for further advocacy training
• Connect with groups via email
• Connect with people with writing/graphic design skills
• Register for the OMA Healthcare Advocates Program</td></tr>
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Identify your contacts

It is important to identify your contacts for your outreach and any other referrals that may come from your advocacy work to successfully engage them and develop relationships. Keep track of your meetings with them and any key points to advancing your cause.

Targeted Audience	Contact Name	Title
OMA Physician leaders	Nicole Biordi	Sr. Director, Physician Leader Engagement, Ontario Medical Association
• Palliative medicine	Joyce Cheung Sukhjeet Dhillon	Section Chair Section Vice-chair
• Emergency medicine	Angela Marocco Tonja Stothart	Section Chair Section Vice-chair
• Section of General and Family Practice	David Barber Beth Perrier	Section Chair Section Vice-chair
• Geriatric medicine	Rajin Mehta Ali Ahmad	Section Chair Section Vice-chair
• Long term care/care of the elderly	Mohamed Abu-Abed Abhishek Narayan	Section Chair Section Vice-chair
• Radiation oncology	Thomas McGowan Peter Chung	Section Chair Section Vice-chair
• Haematology & medical oncology	Joanna Gotfrit Patricia Disperati	Section Chair Section Vice-chair
• General internal medicine	Bilal Munir Rishi Parihar	Section Chair Section Vice-chair
• Hospital medicine	Stephen Chin William Coke	Section Chair Section Vice-chair
• Psychiatry	Diana Kljenak Katherine McKay	Section Chair Section Vice-chair
• Critical care medicine	David Katz Ian Randall	Section Chair Section Vice-chair
• Pediatrics	Jane Healey Shawn Kao	Section Chair Section Vice-chair
• Rural Medicine Forum	Christine Seidler	Fora Chair
Patient advocate groups	Tara Walton Rick Firth	Manager, Ontario Palliative Care Network CEO, Hospice Palliative Care Ontario Unhoused advocacy groups
Indigenous Physicians Association of Canada	Melanie Osmack	Executive Director
Ontario Health Teams	ontariohealthteams@ontario.ca	https://www.ontario.ca/page/ontario-health-teams
Ministry of Health	Peter Kaftarian	Associate Deputy Minister, Clinical Care and Delivery

What needs to change?

To reduce delays in patient care by prioritizing palliative medicine

What are we asking for?

1. **Equitable and timely access to palliative care**
    1.1. Create a heat map that shows Ontario's gaps in palliative care versus the areas of the province with the greatest number of ALC days and longest hospital wait times and use it as a guide to determine how many palliative care and hospice beds Ontario needs, and where they should be placed.
    1.2. Address inequities and imbalances in the existing physician funding models, such as AFP and Community Palliative On-Call applications, to help reduce system fragmentation.
    1.3. Consistent access to specialized palliative care and resources in the community to provide guidance around end-of-life care and symptom management.
    1.4. Identify areas of the province with limited or no 24/7 support for patient, families, and caregivers, and invest in provision of on-call supports for those areas
    1.5. Expand access to telemedicine-based palliative care consultation for patients in rural, remote, and underserviced areas.
    1.6. Work to ensure telephone/virtual access to on-call palliative specialists for areas of the province where direct palliative care consultation is not yet available, to help provide the opportunity for all patients to die at home, should they choose.
2. **Reduce reliance on acute care settings at end of life**
    2.1. Calculate the cost of palliative care ALC days, and reinvest that money into palliative home and community supports.
    2.2. For the areas of the province with the greatest need, fund, create, and operate new chronic palliative care beds within existing infrastructure such as long-term care homes.
    2.3. Amend criteria for hospice and palliative care involvement to focus on provider recommendation and patient benefit, rather than expected prognosis.
    2.4. Address barriers to home care support—especially in rural and remote settings.
    2.5. Increase number of skilled palliative care providers, including physicians, nurses, and other allied professionals.
3. **Integrated person-centered system**
    3.1. Reduce preventable admissions by identifying successful home frailty programs, investing further in them, and expanding them into other areas of the province.
    3.2. Ensure all patients have discharge options to allow for them to die in their preferred setting, whether in the hospital or community.

	Who are you asking?			
	The OMA (corporate)	**The OMA (members)**	**The government**	**The public**
What do you need from them?	Greater emphasis on palliative medicine in next large-scale advocacy campaign	Participate in OMA advocacy efforts	All Ontarians have access to quality palliative care when and where they need it	Highlight that half of Ontario may not have an option on where they choose to die. Sharing personal stories on what delays in care look like for palliative patients and families, as well as about how their lives have been affected by delays in patient care due to delayed/limited access to palliative care.

Stakeholder analysis				
Stakeholder	**Stance**	**Impact**	**Interest**	**Support for OMA position**
Ontario Palliative Care Network	The OPCN is part of OH. The OPCN acts as a principal advisor to government for quality, coordinated palliative care in Ontario. The OPCN also includes regional networks, to support local palliative care delivery. The OPCN creates delivery frameworks for the best model of care in the community, hospital and for pediatric patients. OMA/OPCN staff had a monthly touch point for several years to align our advocacy positions and discuss regional/member specific issues. These meetings are currently on hold due negotiations.	High	High	High
Hospice Palliative Care Ontario	Hospice Palliative Care Ontario is a provincial association for hospices and palliative care providers, professionals, and volunteers throughout Ontario.	High	High	High

Canadian Society of Palliative Care Physicians	The national society for palliative care physicians. Their mission is to promote palliative medicine in Canada through advanced education, strengthening the workforce, and advocacy.	High	High	High
Ontario Hospital Association	Palliative Care is an approach to care that focuses on comfort and quality of life. The goal is much more than comfort in dying; palliative care is about living well, through meticulous attention to control of pain and other symptoms, supporting emotional, spiritual, and cultural needs, and maximizing functional status.	High	Medium	Medium
Impacted OMA sections • Palliative medicine • Emergency medicine • Section of General and Family Practice • Geriatric medicine • Long term care/care of the elderly • Radiation oncology • Haematology & medical oncology • General internal medicine • Hospital medicine • Psychiatry • Critical care medicine • Pediatrics • Rural Medicine Forum	Supports the OMA on the following core functions: • Compensation • Subject matter expertise • Engagement, leadership Advocacy	High	High`	High

Key messages

Why is this an issue?

Our health care system underfunds palliative/hospice beds. As such, many who would benefit from palliative care supports are instead awaiting disposition in the acute care system.

What/How do we go about fixing it?

- Review funding model to ensure equitable access to funding for palliative care in the community, especially in small, rural, and northern communities
- Improve palliative care supports for health care providers, families and communities, especially for after-hours (CPOC, AFP, FFS, virtual)
- Use PRIME to map out what palliative services are provided in small, rural, northern communities
- Increase access to palliative care for underserved populations

What would be the benefit to your audience?

Reducing delays in care/reducing the hospital backlog by providing care in more appropriate, patient-centered settings.

A shift towards increasing palliative/hospice capacity would improve measures in a number of ways:

1. Investment in better palliative care flow will open up beds, which reduces the length of time that patients sit in ER waiting to be admitted, which reduces ER wait times overall
2. Improved patient and family satisfaction by receiving high quality palliative approach to care in teams who are trained to provide it.
3. Reduction in provider burnout caused by caring for end-of-life patients outside of supported environment.

Tactics

Integrate into OMA Advocacy Campaigns

- Use advocacy asks to strengthen advocacy campaigns that focus on reducing delays in patient care

Strengthen Collaboration with Advocacy Partners

- When appropriate, partner with organizations such as the Ontario Palliative Care Network (OPCN), Ontario College of Family Physicians (OCFP), and Canadian Society of Palliative Care Physicians (CSPCP) to align efforts.
- Work with hospital administrators and long-term care leaders to push for increased funding and staffing for palliative care units and community hospice and palliative care beds.

Engage the Public and Patient Advocacy Groups

- Collaborate with patient advocacy organizations like the Canadian Hospice Palliative Care Association (CHPCA) and grassroots caregiver networks