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POSTER ABSTRACT

It Takes a Village: Coordinating and Streamlining Access to Palliative Care Resources through a Centralized Referral and Contact

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Introduction/Background: The Couchiching Ontario Health Team (COHT) is a first-round health team in rural Ontario, Canada, designed as part the Provincial Government's new model of health care delivery that puts patients, families and caregivers at the center of the health care system. The COHT members include Family Health Teams, primary care physicians, home care support services, an acute care hospital, Indigenous healing providers, community housing support services, a fulsome Patient and Family Advisory Council and many others. As part of the year-one priority population strategy, improving resource allocation and multi-provider care delivery for Palliative Patients was identified as of utmost importance.

The COHT Palliative Care Network identified multiple doors of resource access, multiple referrals and a variety of disparate services available, but not formally connected, for one of the most vulnerable populations. We heard from patients, families and caregivers that they were confused about who to contact first, specifically those without a Primary Care Provider, and would often turn to acute care services as a result.

Engagement – Shared Values and Vision: The Palliative Care Network Working Group brought together a fulsome compliment of multi-sectoral, interdisciplinary team members, on a monthly basis, to work towards a common goal; ensuring one-door access to all palliative care services within the Couchiching area.

After a gap analysis identified not only gaps in the system, but also instances where work was being duplicated (from a lack of shared care plans and standardized communication), the group started to focus on identifying the needs for the palliative population, and their caregivers to access a fulsome resource complement, geared to every stage of their care journey, by ensuring no door would be the wrong door.

This led to the creation of One-number and One-referral accessed by Primary Care, Nurse Practitioners, Nurses and even community members themselves, for the purpose of accessing and navigating necessary services. By completing one referral form and answering a few simple questions a patient or their caregiver can be directed to Nursing Services for symptom relief or end of life goals, Hospice to inquire about a bed, Social Work for grief and bereavement services, volunteer or faith groups and even connected with Primary Care.

System Wide Governance and Leadership: By assigning governance through shared accountability agreements, to a multi-organizational OHT, each group member feels responsible

for the outcomes of the population as a whole, providing a team-based approach to care delivery. While still working within the constraints of traditional funding principles, organizations are dividing up work, and creatively finding ways to ensure care is provided to patients in their preferred setting, which is often their own home. With human health resource scarcity, and burnout at the forefront of healthcare, the centralized referral's ability to triage patients with the greatest needs, and share that responsibility with other Working Group members has been incredibly impactful and has allowed for the navigation, and coordination of integrated services to be seamlessly delivered by a varied group of providers to offer wraparound care for the most vulnerable population.