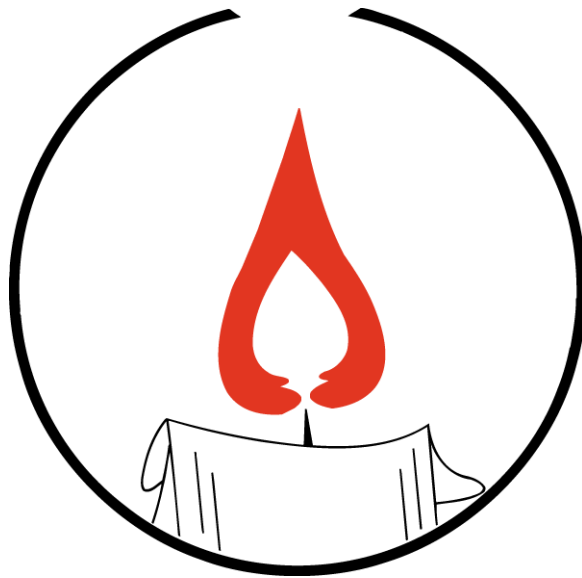


**ONTARIO PALLIATIVE CARE
ASSOCIATION**



ANNUAL REPORT

January 1, 2007 to December 31, 2007

2007 Executive and Board of Directors

Executive

PRESIDENT	Chris Sherwood, Palliative Pain & Symptom Management, HNHB CCAC
PAST PRESIDENT	Patricia Van Den Elzen, Executive Director, PalCare Network for York Region
VICE PRESIDENT	Lesia Wynnychuk, Consultant, Palliative Medicine, Sunnybrook Hospital
TREASURER	Gail Ure, Consultant, EMC (Ure) Inc.
SECRETARY	Barb Linkewich, VP Health Services, Meno Ya Win Health Centre
MEMBERSHIP	Karen Fisher, Clinical Educator, Knowledge & Practice, Saint Elizabeth Health Care

Regional Representatives

Erie St. Clair (LHIN 1)

Sharon Allen, Nurse Practitioner Palliative Care, Hotel Dieu Grace Hospital

South West (LHIN 2)

Marie Palmer, Pain & Symptom Consultant/Educator Grey Bruce, St. Joseph's Health Care, London

Waterloo Wellington (LHIN 3)

Karen Fisher, Clinical Educator, Knowledge & Practice, Saint Elizabeth Health Care

Hamilton Niagara Haldimand Brant (LHIN 4)

Lesley Hirst, RN, MSCS (C), MN (C), HNHB CCAC

Central West (LHIN 5)

Amanda MacLennan, CNS Palliative Care, William Osler Health Centre

Mississauga Halton (LHIN 6)

Diane Reid

Toronto Region (LHIN 7)

Vicki LeJambe

Central (LHIN 8)

Carol Ford, Regional Clinical Programs Coordinator, PalCare Network for York Region

Central East (LHIN 9)

Theresa Morris, PC Nurse Consultant/Manager, Peterborough Regional Health Centre

South East (LHIN 10)

Sharon Preston, Palliative Pain & Symptom Management Consultant, South East CCAC

Champlain (LHIN 11)

Debbie Gravelle, Manager, Regional Palliative Care Community Services

North Simcoe Muskoka (LHIN 12)

Kelly Emerson, Physician, North Simcoe Palliative Care Network

North East (LHIN 13)

Elaine Klym, Pain & Symptom Management Consultant, VON Algoma

North West (LHIN 14)

Marg Poling, Palliative Care Advisor, Victorian Order of Nurses

Liaison - OMA Palliative Care Section...[Position Open] – **OHA...**Deborah Lavender



President's Report

We live in a world of change, an axiom which is evident everywhere, but especially when observing what is occurring within Ontario's health care system. As I write this, my first President's Report, I'm aware of how much hospice palliative care in Ontario over the last year has been part of that change. Advances have included the following:

- Additional funding has been provided to residential hospices to cover capital costs;
- End-of-Life/Hospice Palliative Care Networks have continued to develop across the province within Local Health Integration Network (LHIN) areas;
- End-of-Life/Hospice Palliative Care Networks continue to grow at a provincial level via the Provincial End-of-Life Care Network;
- Cancer Care Ontario's Provincial Palliative Care Integration Project has been widely adopted, for which the evidence will, presumably, demonstrate a number of needs that exist;
- For the first time in several years Ontario hosted the National Hospice Palliative Care Conference, which nine hundred plus people attended;
- Ontario has begun the process of developing and implementing its Aging at Home Strategy, which, in certain areas within Ontario has a hospice palliative care emphasis; and
- Community based Interdisciplinary Palliative Care Consult teams are developing in many portions of the province.

The above list is not exhaustive, but does reflect the commitment of many individuals and organizations that have been working in and advocating for hospice palliative care in Ontario.

The Ontario Palliative Care Association (OPCA) can not take credit for the successes noted in the above list, but we have been involved as partners directly or indirectly in many of them. We have also taken the lead on a number of other projects... all with the ultimate goal of fulfilling our vision, which is: *Quality end-of-life care for all Ontarians.*

In the fall of last year, OPCA conducted a survey of our membership and other interested parties to examine individuals' perceptions of the priority issues existing at the time. The top five issues that were identified formed the basis for a Position Paper that OPCA published titled, *Ontario is a good place to live ...but, is it a good place to die?* This document served to inform dialogue prior to Ontario's provincial election in 2007.

OPCA has endeavored to stay apprised of the hospice palliative care issues occurring at the provincial, national and international levels and to keep our membership similarly informed. Through the services of Barry Ashpole, on a weekly basis by e-mail our membership has been receiving *Media Watch*, a collated set of news stories on hospice palliative care. Feedback to this service has been very positive. However, it is with regret that I must inform our membership that we are no longer able to provide this service because financial resources within our organization are currently insufficient to do so, at least for now.

We continue to appreciate our partnerships with the Humber College Institute of Technology and Advanced Learning and the Conference Planning Committee to provide an annual conference that demonstrates excellence in hospice palliative care. This conference is so well established and has a reputation that is second to none for providing opportunities for learning and networking. On behalf of OPCA, I would like to extend my sincere gratitude to all those who have played a role in supporting this year's 18th Annual Provincial Conference in Palliative and End-of-Life Care.

Finally, after almost 6 years of work, the DNR Task Force that OPCA spearheaded was able to say that its work was mostly done. The *Do Not Resuscitate Confirmation (DNRC) Form* was implemented February 1, 2008. If not for OPCA, it is quite possible, if not probable, that paramedics and firefighters would still be required to perform CPR against the wishes of patients. The DNR Task Force will soon be looking to undertake an evaluation of the *DNRC Form* and the associated Standard (Emergency Health Services lingo for Policy and Procedure) to elicit the experiences – positive and negative – of health-care providers utilizing this process.

The Certification of Expected Death Task Force, another group spearheaded and Chaired by OPCA, is comprised of multiple provincial stakeholder organizations. This group has been working for two years in an effort to respond to the many needs that exist in the process of pronouncement and certification of death and transfer of bodies afterward. The Task Force is very close to finalizing a document for submission to the Ministry of Government Services that will enable them to pursue making the necessary legislative and/or regulatory changes required to enact the Task Force's recommendations. If we are successful, Ontario will be one of the first, if not the first, jurisdiction internationally to adopt this approach.

OPCA has also played a key role on a committee that was struck to create guidelines for Symptom Response Kits across the province. Unfortunately, funding for this project ran out prior to completion of the work, but it is hoped that this project can be resurrected in the near future where we can look at evidence to support the kits as well as developing policies which can be adopted throughout the province.

It has been encouraging to see that in the ever-changing health-care landscape, so much progress has been occurring. However, perhaps what remains uncertain is how these core structural changes will affect hospice palliative care and OPCA in the future. What is certain is that the health care system a year from now will not operate the same as it did a year ago. And, over time, given that decisions for how healthcare funds will be spent will be determined by 14 distinct LHINs, the roles of provincial organizations such as OPCA will also change.

What do we need to do to further strengthen hospice palliative care in Ontario and to ensure that its voice is heard in this new health-care system that has been decentralized? The first step OPCA took last year was to restructure our Board to reflect the 14 LHIN areas - a transition that has gone relatively smoothly. OPCA now meets on a quarterly basis with the Hospice Association of Ontario and the Provincial End-of-Life Care Network to strategize jointly. The relationships between these three groups are now stronger than ever, which has enabled partnerships to occur on such projects as the Fireside Chats that were utilized in the implementation of the *DNRC Form*. We have worked to strengthen our Board by inviting Deborah Lavender, the Executive Director of the Hospice Association of Ontario, who now sits as a Member at Large.

We will also be saying goodbye to a few of our Board members, who will be stepping down this year – Vicki Lejambe, Sharon Preston, Diane Reid and Gail Ure. I would like to extend my personal thanks to you for your commitment and support of OPCA over the years. It has been a pleasure working with each one of you.

OPCA is indeed comprised of extremely dedicated and committed individuals. In no particular order, these include: Ellen Power, who is the hub of the organization and without whom the organization's business would come to a grinding halt; Barry Ashpole, whose expertise in communications has been invaluable; the Board, who have consistently volunteered their time to a number of key projects; and, most importantly, every one of our members, without whom there would be a much quieter voice for the silent constituency that is the community of people living with progressive life-limiting illness in Ontario.

But, this is a very important juncture in the life of OPCA! Even with all of our dedicated members and partners, OPCA remains challenged in a number of ways:

1. We always seem to operate on a very thin line financially, which limits the extent to which we can accomplish work that needs to occur;
2. We have one paid "staff" – Ellen Power, exemplary as she is – but otherwise, we are an organization of volunteers, which

inherently means that we have less time to commit than is needed;

3. We are one of now four provincial groups that has as its sole mandate hospice palliative care, which creates some challenges for OPCA and hospice palliative care in general to form one voice that can advocate within Ontario.
4. Strengthening our membership. If you are reading this and you are not member, consider becoming one or if you are a member but you know someone who isn't, encourage them to join so we can continue to grow as an organization.

These issues are of paramount importance! We must find ways to further build on the partnerships that we have and to come together strategically to be a more cohesive hospice palliative care community that has the ability to influence policy – something that will require a different approach than it has in the past.

Perhaps one of the hospice palliative care community's most challenging issues on the horizon is to come to a better understanding (and possibly reach a position(s)) on the issues of physician-assisted suicide and euthanasia and how these may or may not relate to hospice palliative care. The Canadian Hospice Palliative Care Association (CHPCA) in November 2006 released the *CHPCA Issues Paper on Euthanasia, Physician-Assisted Suicide and Quality End-of-Life Care* and is continuing to look for feedback on the document's content. OPCA would like to facilitate a survey process through which the hospice palliative care community's views on this issue can be more clearly determined and which can be used to

inform CHPCA in its efforts to develop a final document.

It is often said that there are two certainties in life – death and taxes – but, perhaps there is one more – change. This is our challenge and this is our opportunity. It may be that we will only know retrospectively whether it was one or the other, but I look forward to finding out with all of you what it will be. Thank you for entrusting me with the position of President. I often find myself wondering whether or not I do justice to it, but it is nevertheless a truly humbling experience and an honor to serve. In this regard, please note that the door for communication is always open... together we can be the vocal constituency that is otherwise silent.

“Unfortunately, in end-of-life care we do not have a vocal constituency. The dead are no longer here to speak, the dying often cannot speak and the bereaved are often too overcome by their loss to speak”

Harvey Chochinov, testimony before the Senate Subcommittee to update Of Life and Death, February 28, 2000



Chris Sherwood
President, Ontario Palliative Care Association

MEMBERSHIP REPORT

We are happy to report that 2007 was a very successful year in terms of membership—the number of members was the highest in the last five years, and we initiated some innovations in our methods of communicating with our members.

Our membership grew to 391, an increase of 25% over 2006 and our highest since 2002! We believe a number of factors contributed to this growth:

- ❖ The quality of our Annual Provincial Conference and its status as the premier educational event in hospice palliative care in Ontario.
- ❖ The growing sophistication of our Interest Group Network and the commitment of the participants.
- ❖ Our continuing recognition of excellence in hospice palliative care through the *Dorothy Ley Award of Excellence* and the *Outstanding Philanthropist* awards.
- ❖ The benefits available to our members in reduced registration fees at our Annual Provincial Conference and reduced subscription rates for the *Journal of Palliative Medicine*.

We have long recognized that communication with our members needed improvement if our goals were to truly reflect those issues important to our members. In July 2007, we completed a comprehensive independent survey to identify the most important issues as identified by our members. Your responses to the survey led to the publication of our Position Statement “*Ontario is a good place to live...but, is it a good place to die?*” The document was completed in time to distribute to all Ontario politicians and candidates prior to the provincial election.

We are grateful to Barry Ashpole for his contributions to our Association, especially for his “*Media Watch*” which keeps us fully informed of hospice palliative care issues in the media and which he graciously allows us to share with our members.

Late in 2007, we launched a three-pronged membership drive to:

- ❖ Encourage lapsed members to return to the fold.
- ❖ Inspire current members to introduce their colleagues to the benefits of membership in OPCA.
- ❖ Educate non-members on what we do and why they should join OPCA.

We are now starting to see some feedback from this campaign and look forward to reporting some very pleasing results next year. Our goal is to have every individual involved in providing end-of-life care in Ontario as a member—imagine how strong our voice would be with those numbers and how much progress we could make towards turning our vision, “*Quality end-of-life care for all Ontarians*”, into a reality!

My thanks to fellow Membership Committee members, Marg Poling and Barry Ashpole for all their hard work, dedication, and commitment to OPCA, and to Ellen Power for her support to us all.

Karen Fisher

Chair, OPCA Membership Committee

History of the Ontario Palliative Care Association

On November 12, 1980, the Palliative Care Work Group, Toronto chairman Dr. Larry Librach, chaired the first informal meeting of representatives from all parts of Ontario. The enthusiasm generated by this meeting led to the formation of the Ontario Palliative Care Association and our first official meeting was held May 11, 1981 at Toronto Grace Hospital with 27 in attendance. The first executive elected were Dr. Larry Librach, Sister Judith Souliere, Dr. John Scott, and Dr. Ann Thomas. The initial tasks taken on by the executive were:

- affiliation with the Ontario Hospital Association (accomplished November 1981)
- funding of palliative care (on-going)
- educational events (on-going)
- assisting in the development of Guidelines and Standard for Palliative Care in Ontario (on-going)
- development of a manual of palliative care programs and members (on-going)
- development of a newsletter (established in 1982 and on-going)

During 1984/85, the Regional Groups were developed to expand our provincial representation. We currently have 7 Regions across Ontario and two representatives from each Region (three representatives from the North Region) sit on our Board of Directors.

In 1989, we received our Letters Patent and were incorporated as a registered charitable organization.

Our membership has grown from 57 at our first Annual General Meeting in 1982, to over 300 currently and includes the full spectrum of individuals involved with and committed to palliative care in Ontario.

Definition of Hospice Palliative Care

Hospice palliative care aims to relieve suffering and improve the quality of living and dying.

Hospice palliative care strives to help patients and families:

- address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears
- prepare for and manage self-determined life closure and the dying process
- cope with loss and grief during the illness and bereavement.

Hospice palliative care aims to:

- treat all active issues
- prevent new issues from occurring
- promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization.

Hospice palliative care is appropriate for any patient and/or family living with, or at risk of developing, a life-threatening illness due to any diagnosis, with any prognosis, regardless of age, and at any time they have unmet expectations and/or needs, and are prepared to accept care.

Source: A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice, Canadian Hospice Palliative Care Association, March 2002, page 17

Guiding Principles

Patient/Family Focused – As patients are typically part of a family, when care is provided the patient and family are treated as a unit. All aspects of care are provided in a manner that is sensitive to the patient's and family's personal, cultural, and religious values, beliefs and practices, their developmental state and preparedness to deal with the dying process.

High Quality – All hospice palliative care activities are guided by:

- the ethical principles of autonomy, beneficence, nonmaleficence, justice, truth-telling and confidentiality
- standards of practice that are based on nationally-accepted principles and norms of practice, and standards of professional conduct for each discipline
- policies and procedures that are based on the best available evidence or opinion-based preferred practice guidelines
- data collection documentation guidelines that are based on validated measurement tools.

Safe and Effective – All hospice palliative care activities are conducted in a manner that:

- is collaborative
- ensures confidentiality and privacy
- is without coercion, discrimination, harassment or prejudice
- ensures safety and security for all participants
- ensures continuity and accountability
- aims to minimize unnecessary duplication and repetition
- complies with laws, regulations and policies in effect within the jurisdiction, host and hospice palliative care organizations.

Accessible – All patients and families have equal access to hospice palliative care services:

- wherever they live
- at home, or within a reasonable distance from their home
- in a timely manner.

Adequately Resourced – The financial, human, information, physical and community resources are sufficient to sustain the organization's activities, and its strategic and business plans. Sufficient resources are allocated to each of the organization's activities.

Collaborative – Each community's needs for hospice palliative care are assessed and addressed through the collaborative efforts of available organizations and services in partnership.

Knowledge-Based – Ongoing education of all patients, families, caregivers, staff and stakeholders is integral to the provision and advancement of quality hospice palliative care.

Advocacy-Based – Regular interaction with legislators, regulators, policy makers, healthcare funders, other hospice palliative care providers, professional societies and association, and the public is essential to increase awareness about, and develop hospice palliative care activities and the resources that support them. All advocacy is based on the Canadian Hospice Palliative Care Association's model to guide hospice palliative care.

Research-Based – The development, dissemination, and integration of new knowledge are critical to the advancement of quality hospice palliative care. Where possible, all activities are based on the best available evidence. All research protocols comply with legislation and regulations governing research and the involvement of human subjects in effect within the jurisdiction.

Source: A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice, Canadian Hospice Palliative Care Association, March 2002, page 19, 20

Role of the Ontario Palliative Care Association

Advocacy - We present a strong, proactive voice on issues specific to the provision and delivery of quality end-of-life care – professional education, standards of practice, government policy development and funding, and public awareness.

Education - We promote professional education of hospice palliative care providers through our support of an annual provincial hospice palliative care conference and offering educational bursaries.

Recognition – We recognize excellence in hospice palliative care with the annual Dorothy Ley Award of Excellence in Hospice Palliative Care, and support of hospice palliative care with the Outstanding Philanthropist Award.

Communication - Our newsletter is published three times per year and is distributed to our full membership plus organizations and individuals with an interest in hospice palliative care issues.

Partnerships – We maintain a close partnership with the Canadian Hospice Palliative Care Association and develop partnerships with other organizations to address specific issues as they arise.

Mandate

Our mandate is to further the provision of high quality, timely, and effective hospice palliative care to all Ontario residents through our activities in advocacy, education, awareness, communication, and partnerships.

Goals

To support our members by:

- Providing education development opportunities to facilitate communication
- Being a central resource for information
- Being a link between local, regional, provincial and national palliative care

To encourage the development and expansion of palliative care in Ontario by:

- Advocating the importance of palliative care through influencing government policy and funding
- Promoting standards in palliative care
- Participating in the evolution and implementation of standards
- Enhancing the work of OPCA
- Maintaining financial stability

The Provincial Charter for End-Of-Life Care

How we treat those who are dying in our community reflects who we are as a society. All Ontarians have the right to die with dignity, to have access to physical, psychological, bereavement and spiritual care, and to be granted the respect consistent with other phases of life.

As professional, volunteer and family representatives of Ontario's hospice palliative care community, we are committed to providing the best possible quality end-of-life care to Ontario residents and their families. Our goal is to optimize their quality of life and to minimize the physical and emotional suffering associated with this phase of life.

We endorse an integrated approach focused on the individual and their family and caregivers, accessible through hospice palliative care services in the local community and tailored to individual needs.

Our efforts to increase awareness and availability of quality and integrated end-of-life care run parallel to our collaboration with government, social agencies and other decision makers to develop innovative clinical, community and public policy strategies.

On behalf of the residents of Ontario whom we serve, we speak with a unified and cohesive voice, share information and resources and work through a coordinated network of partners from the voluntary, public and professional sectors.

OPCA Position Paper: Regional Home Palliative Care for Ontario

The Ontario Palliative Care Association (OPCA) strongly supports government initiatives to develop regional home palliative care programs throughout Ontario. We would like to bring forward a number of principles that we feel should govern the development of these programs:

1. The planning and implementation of these programs should follow the Model to Guide Hospice Palliative Care Based on Principles and Norms of Practice as identified by the Canadian Hospice Palliative Care Association. Since these standards are being used by the Canadian Council of Health Services Accreditation to accredit institutions and agencies including home care programs and by the Hospice Association of Ontario to set standards, the norms of practice will introduce a consistency in programming and make evaluation of programs consistent.
2. Wherever possible, interdisciplinary teams of health care professionals and volunteers should form the core of services. The nature of home palliative care requires a variety of skills and maximum support to patients and their families to stay at home as long as possible. The Community Care Access Centres should be provided with funding to support advance practice nurses, social workers with specialized palliative care skills and primary palliative care nurses. The funding for palliative medicine physicians to work with these teams should be through alternate payments programs and special consideration be given to models for rural and northern practices. Volunteer hospices should receive sufficient funding to support the training of volunteers to work as part of the regional teams.
3. Regional services should not consist of a loose coalition of institutions and agencies. These institutions and agencies should be bound by legal agreements to participate actively in the regional programs and be bound by service deliverables. In the best of all models, regional teams of secondary experts should stand on their own with clear lines of responsibility back to a management group that includes members of the public. In the best of all models, personnel on the teams would be hired by or seconded to the teams and be responsible to the teams for their clinical services.
4. There should be a single focus of access for services in each region although referrals may come from many sources.
5. A common chart in the home is required in order to standardize record keeping.
6. Common data must be collected in each region so that outcomes can be monitored effectively.
7. Specialized hospice palliative care teams must be present in each institution/hospital.
8. Specialized hospice palliative care teams must be available to support patients/residents in long term care facilities and community supportive housing.

Annual Ontario Provincial Conference

The Ontario Palliative Care Association has a partnership agreement with the Humber Institute of Technology & Advanced Learning to produce the Annual Ontario Provincial Conference on Palliative & End-of-Life Care. This agreement details the responsibility of each of the partners and the financial specifics.

The Conference goals and objectives are:

- To provide the highest quality in education for practitioners involved in palliative and end-of-life care
- To provide a forum for the exchange of scientific information
- To provide opportunities for interdisciplinary education and networking
- To provide recognition of OPCA and Humber as leaders in the field of Palliative and End-of-Life Care Education
- To provide increased awareness of palliative and end-of-life care services among other care providers, government and the general public
- OPCA and Humber to engage other related Associations and individual experts to participate in a planning committee

Educational Bursaries

Educational Bursaries are awarded, usually to the Annual Ontario Provincial Conference, as determined by the Board of Directors and as our financial position allows. Applications are accepted from individuals working in a palliative care program or enrolled as a student in a palliative care field. Membership in OPCA is not a requirement. The applications are reviewed by the Awards Committee and winners selected according to a predetermined criteria.

Palliative Care Outstanding Philanthropist Award

This award is designed to recognize and show our appreciation for those individuals, families, corporations, foundations, and community and service organizations who best exemplify vision, financial support and dedication towards fostering the true spirit of palliative care in Ontario.

While the financial support offered by these philanthropists is important to our cause, it is the encouragement and validation of our efforts that means so much to us as individuals. They are truly the “unsung heroes” of palliative care in Ontario.

Honour Roll Recipients of the Palliative Care Outstanding Philanthropist Award

Knoll Pharma Inc. (1997)
Glaxo Wellcome (1998)
Saint Elizabeth Health Care Foundation (1999)
Parkwood Hospital (2000)
Peterborough Festival of Trees (2000)
Barrie Rose (2001)
Purdue Pharma Inc. (2003)
Care for Kids (Toronto) (2004)
Albert Latner (2004)
Stuart and Irene Lunn (2004)
Harold Wolfe & Phyllis Flatt (2006)
Margaret Anderson (2006)

Note: No award presented for 2002 and 2005.

Dorothy Ley Award of Excellence in Hospice Palliative Care

The late Dorothy Ley was one of Canada's first champions for quality care at the end of life. She brought a unique individuality to the field of hospice and palliative care, and maintained a highly visible and vocal presence during her distinguished career until her death in 1994. Dr. Ley was a pioneer and she broke new ground in fields of medicine and in health care in general.

The Dorothy Ley Award of Excellence, established in 1996, is a perennial reminder of her truly great legacy. Presented by OPCA, the Dorothy Ley Award of Excellence is awarded annually in recognition of an individual or team effort to advance and improve the quality of palliative and end-of-life care.

Nominations are made and endorsed by three individuals, one of who must be a current member of OPCA. The nominee is not required to be a member of OPCA. The Board appoints a Selection Committee to review the nominations and select the recipient based on predetermined criteria.

Honour Roll Recipients of the Dorothy Ley Award of Excellence In Hospice Palliative Care

Mary Vachon, RN, PhD (1996)
Reena McDermott, RN (1997)
Shari Douglas, RN (1998)
Frank Ferris, MD (1999)
Linda Bowring, MD (2000)
Ivan Stewart, MD (2001)
John Flannery, RN (2002)
Deborah Dudgeon, MD (2003)
Jean Echlin, RN, MScN (2004)
Maryse Bouvette, RN, BScN, MEd, CON(C),
CHPCN(C) (2005)
Charmaine Jones, MD (2006)



Carole Gill accepts the award for Dr. Jones with a photo of Dr. Jones enjoying her vacation in the background.

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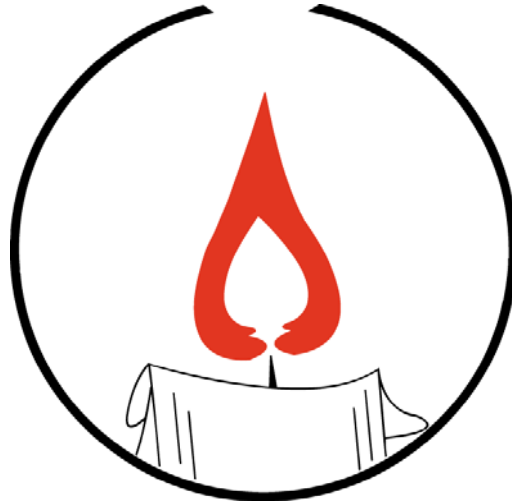
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Karen Fisher

Chair, OPCA Membership Committee

ONTARIO PALLIATIVE CARE ASSOCIATION



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