

## **Review of Foundational Concepts Relating to Hospice Palliative Care Service Delivery Erie St. Clair End of Life Care Network - 2009**

### **A. Introduction**

Prior to exploring the topic of System Design and Development of a System for Palliative Care Delivery it is important to review and define key foundational concepts relating to care provision for patients requiring Hospice Palliative Care. These concepts are interrelated and build one upon the other. These concepts are summarized from the Canadian Hospice Palliative Care Association (CHPCA) Model of Care (1) as well as international (2) concepts of how palliative care is delivered. Definitions of Palliative Care and Hospice Palliative Care (HPC) are not included in this review but are assumed to be understood as those used in the CHPCA model. (1)

### **B. Listing of Concepts**

**Foundational Concepts include:**

- 1. Many care settings and services are required.**
- 2. Both Specialists and Primary Level Providers are needed (Specialist care is typically subdivided into two levels – Secondary and Tertiary).**
  - a. The majority of HPC needs are met by Primary Care providers.**
  - b. Consultation Models are required to link primary and specialist level care providers throughout the patients HPC journey .These consultation models may include: Consultation only; Consultation and shared care (with or without repeat consultation); Consultation and care provision (by specialist as Most Responsible Provider).**
- 3. Every care setting/service, caring for dying patients requires access to Specialist Level Hospice Palliative Care expertise (in addition to Primary Level Providers).**
  - a. Access to expertise may be “in-house” or external.**
- 4. Teamwork is essential - *Collaborative Care / Interdisciplinary Care* involves more than one profession. (Teamwork is important within the primary care team and within the specialist level team).**
  - a. Palliative Care Consultation Teams (PCCT) are a preferred approach to delivering HPC.**

### C. Descriptions of Key Concepts

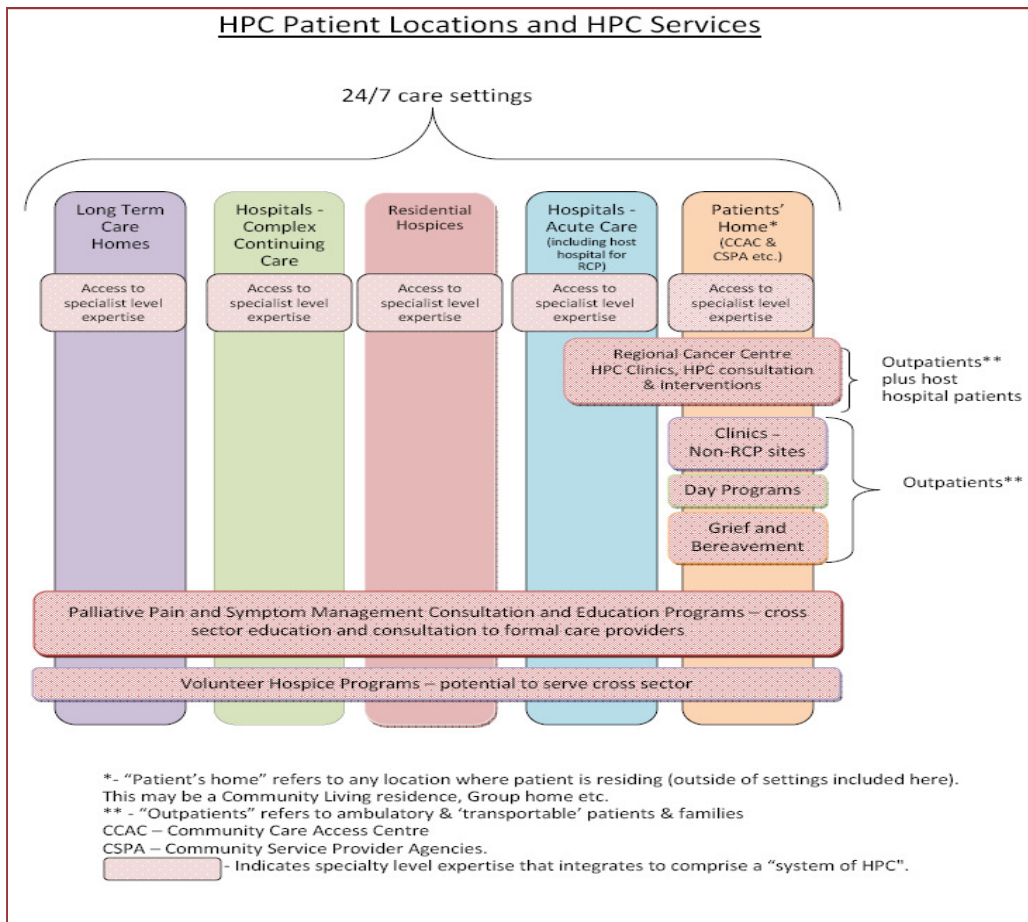
The summary descriptions below seek to provide some clarity related to key concepts of Hospice Palliative Care provision. The explanations use schematic depictions to help to explain these concepts.

Further details are presented in the report *Hospice Palliative Care in Erie St. Clair; Report on Current Services and Recommendations for Future Systems*. (3) These concepts are utilized in the Erie St. Clair System Design Framework. (4)

#### 1. Many care settings and services are required

Comprehensive Hospice Palliative Care is not the purview of only one setting or service but **is required in all settings where patients die**. Figure One below depicts a number of typical care settings and services that provide care to patients requiring Hospice Palliative Care in Ontario. This figure also illustrate the next concept which is the all these care settings require access to specialist level HPC.

**Figure One**



## **2. Specialists and Primary Care Level Providers are Needed**

Patients' care needs vary throughout their palliative care journey. Therefore, comprehensive Hospice Palliative Care requires access to different levels of expertise at different points/times in this journey. **Both specialist level care and primary care is required.** The level of HPC expertise required is dependent upon level of patient's need.

The Canadian Hospice Palliative Care Association (1) describes roles for three levels of care providers

*Primary providers* – available in all settings

- *Manage disease, its manifestations and the predicaments it creates*
- *Identify issues*
- *Provide the core competencies of hospice palliative care*
- Have enough basic level HPC awareness that they can identify patients requiring HPC and refer them appropriately

*Secondary Experts* – available in all settings – preferably on site

- *Are experts in hospice palliative care*
- *Support primary providers in every setting where patient/families receive care*
- Identify patients requiring tertiary level HPC and refer them appropriately

*Tertiary Experts* – available to patients in all settings (may not be on site, but must be available)

- *Consult to secondary experts and primary providers on difficult-to-manage cases*
- *Educate/train secondary and tertiary experts*
- *Conduct research*
- *Develop advocacy strategies.*

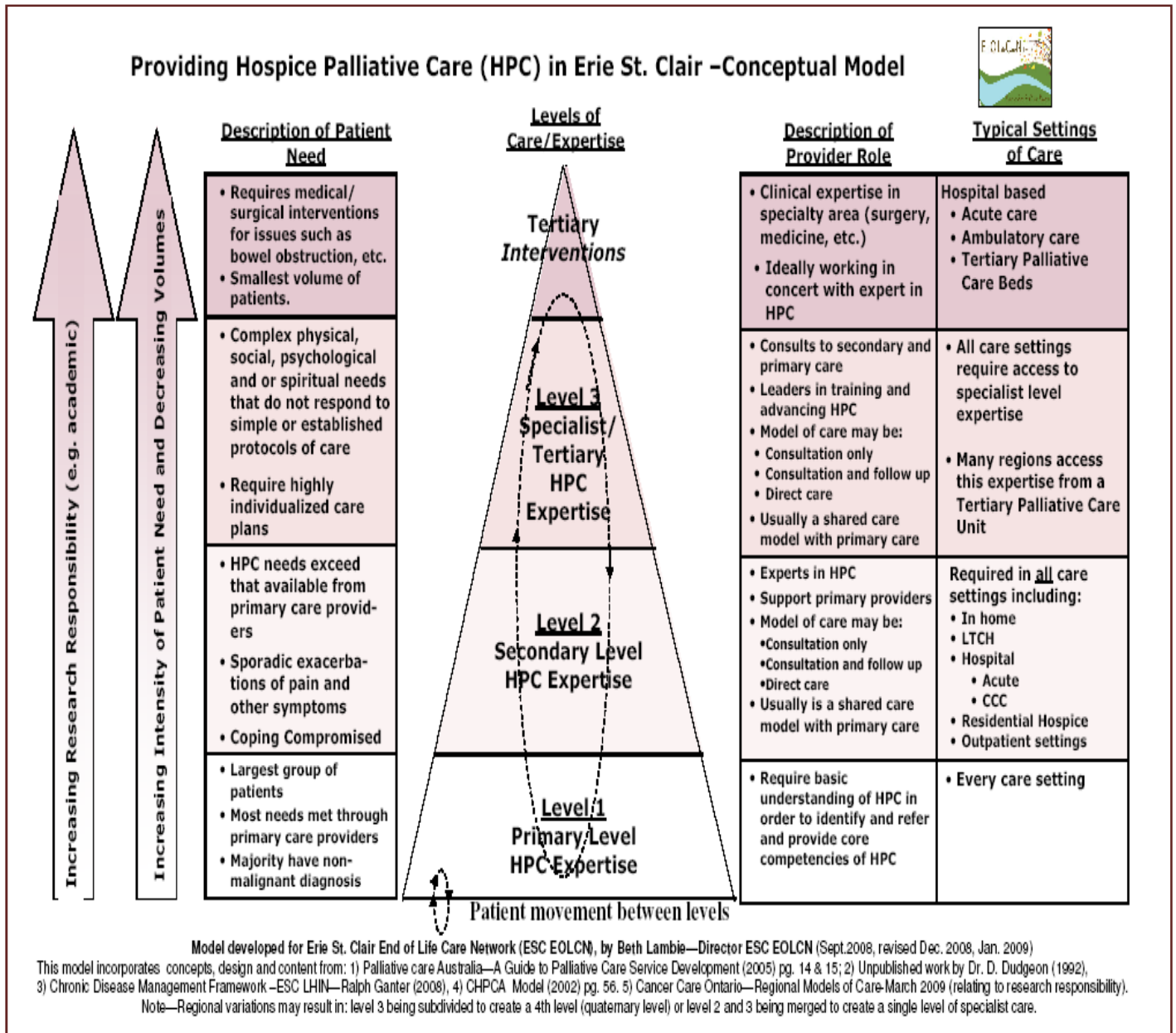
(Note: CHPCA. descriptions are shown in italics above—other details are added to link these descriptions to care settings and referral levels). (1) (3)

### **2a -The majority of HPC needs are met by Primary Care providers.**

Most HPC needs can be met by Primary Care providers, if specialist level care is available when/if needed.

The conceptual model below (Figure Two) illustrates the levels of care expertise required and links this to provider role, settings of care, intensity of patient care needs and volumes of patients. This conceptual model also illustrates that the majority of HPC needs can be met by Primary Care providers, (assuming specialist level care is available when/if needed).

Figure Two



**2b - Consultation Models are required to link primary and specialist level care providers throughout the patients HPC journey.**

These consultation models may include:

- Consultation only;
- Consultation and shared care (with or without repeat consultation);
- Consultation and care provision (by specialist as Most Responsible Provider).

In this context, the term *shared care* describes the relationship between Primary Care Providers and Specialist Level providers. Frequently the term *shared care* refers to care shared between providers of *the same profession*. For example shared care between two physicians: one who is in family practice and has no additional training in HPC and another physician who is a specialist in HPC.

Various shared care scenarios occur depending on the relationship with and relative expertise of the providers. The level of specialist involvement is frequently negotiated on a case by case basis, or may, in some situations, be delineated by policy (e.g. –admissions to some Residential hospices assume that the most responsible provider be the specialist).

Frequently specialist level involvement is episodic in nature.

Figure Three below shows the Palliative Care journeys of four different people, depicting different requirements for primary care and specialist level care over time.

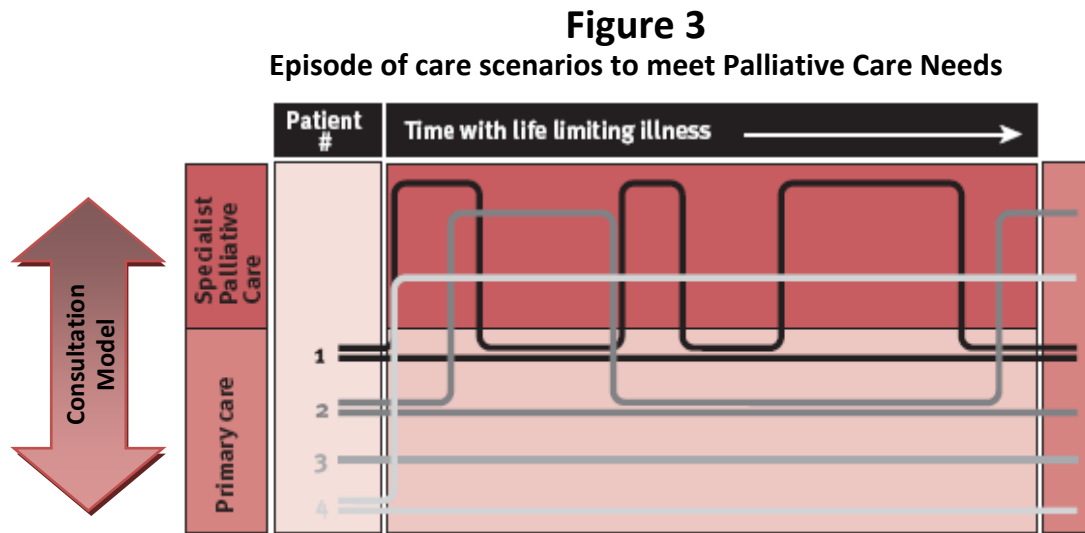
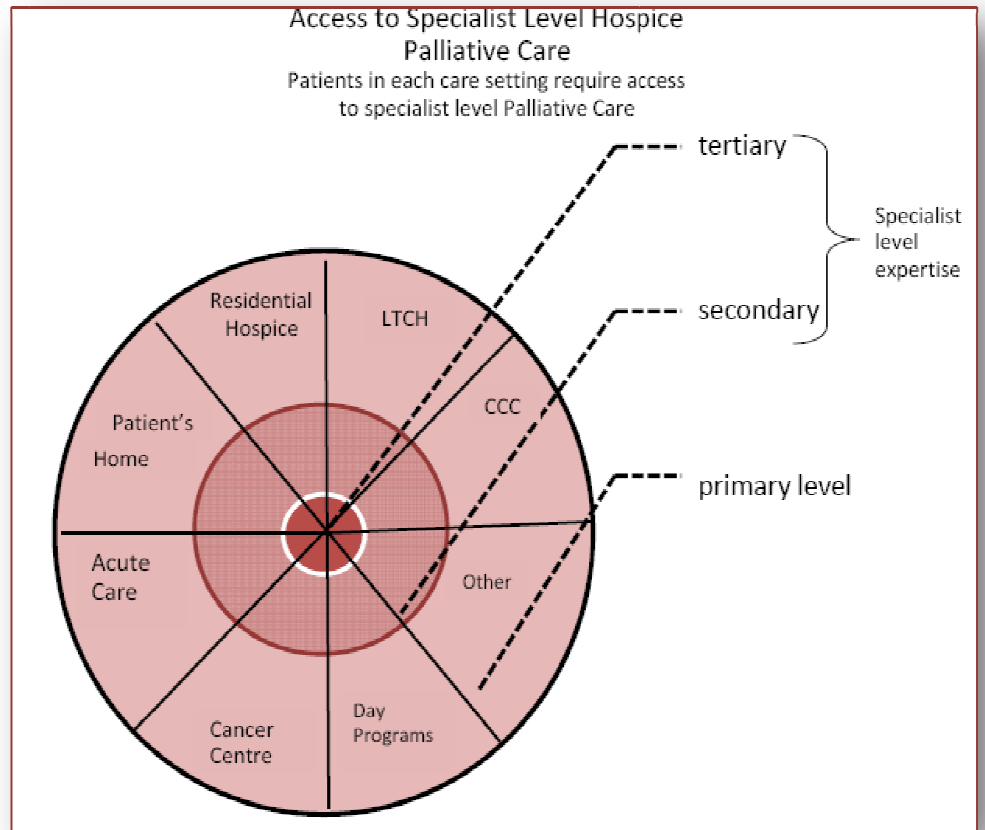


Figure from Palliative Care Australia pg.17 -adapted (2)

**3. Every care setting/service, caring for dying patients requires access to Specialist Level Hospice Palliative Care expertise.**

Patients requiring palliative care are cared for in virtually all care settings. Therefore palliative care should be provided in all care settings (1). Each sector requires internal expertise at both a primary and secondary level. Processes should be clearly articulated for access to tertiary level palliative care expertise if that expertise is not available “on site”. Figure Four below illustrates various care settings and the need for specialist level expertise in each of these settings.

**Figure Four**

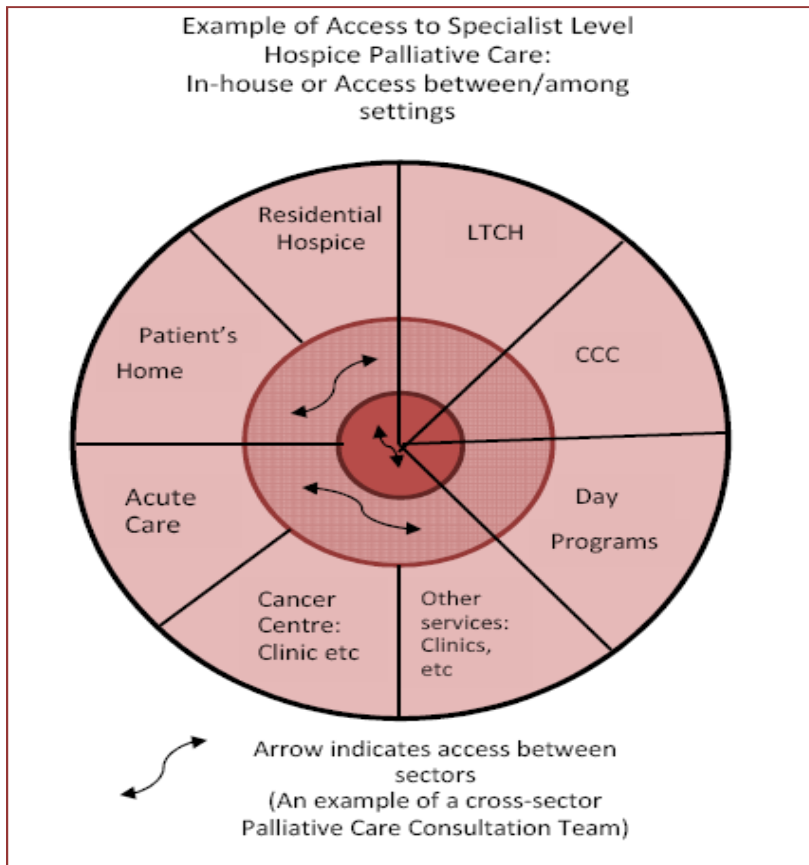


The Canadian Hospice Palliative Care Association (CHPCA) states:

*“As in any other healthcare situation when primary providers encounter care issues and situations beyond their level of confidence and expertise or when their practice outcomes are not consistent with accepted norms of practice..., they must be able to seek help and support from ... experts.” For this to be possible, interdisciplinary teams of secondary hospice palliative care experts must be readily accessible in every setting where patients and families receive care. (1)*

3a - Access to expertise may be “in-house” or external.

Figure 5



Most large organizations, caring for many dying patients, will have access to **in-house** expertise. Regional Cancer Centres and host hospitals typically provide tertiary level HPC expertise. Smaller organizations may access external expertise and may join with other organizations to combine access to expertise. As noted below collaborative care consultation teams are a preferred approach to providing specialist level care. Figure Five provides an **example** of how access to expertise may be “in-house” (as illustrated for LTCH, CCC, Day Programs) or shared between/among sectors. (In this illustrated example, one set of secondary level expertise is shared among Acute Care, Cancer Centre and Other Services such as

clinics, and a second set of secondary level experts is shared between patients in their own homes and patients in the residential hospice. In this example tertiary level expertise is shared among 5 sectors).

Typically in areas of smaller population and smaller organizations there may be more shared expertise between/among sectors vs. in house expertise.

#### 4. Collaborative Care / Interdisciplinary Care involves more than one profession

In this context *collaborative care* refers to the overlap of roles *between / among different professionals*. Figures Six and Seven below speak to the concept of collaborative care team between two or more professionals. The Physician/Nurse clinical team is frequently referred to as a collaborative care “dyad”.

**Figure Six**

##### 4a - Palliative Care Consultation Teams (PCCT) are a preferred approach to delivering HPC. –

Expert teams/ Consultation teams are a core element of a regional palliative care program and are cited as an essential component of care in every benchmarked regional program (e.g. Fraser Health, Edmonton’s Capital Health, Australia’s model etc.). These teams may operate across sectors or in one sector only. Expert teams are the preferred method of providing “tertiary level / specialist level expertise”.

Frequently a team is what defines a “program” – i.e. patients referred to the team are considered to be “in the program”. There is a significant body of literature to support the development of Expert Palliative Care teams. (3)



CHPCA’s Pan-Canadian Gold Standard for Palliative Home Care lists consultation teams as important for quality palliative care. (5)

Typically a HPC team is comprised of several professions (as illustrated in Figure Six).

Minimally a team would have a MD and RN dyad with access to other professions (as illustrated in Figure Seven).

**Figure Seven**



## **D. Summary**

This summary of *foundational concepts relating to Hospice Palliative Care service delivery* provides background information about the provision of HPC and expands on the work presented in the ESC EOLCN December 2008 (3) report. These foundational concepts/ assumptions are summarized from the Canadian Hospice Palliative Care Association Model (1) and form the backdrop to the ESC System Design Framework. (4)

## Works Cited

1. **Canadian Hospice Palliative Care Association.** *A Model to Guide Hospice Palliative Care: based on National Principles and Norms of Practice.* Ottawa : Canadian Hospice Palliative Care Association, 2002. ISBN: 1-896495-17-6.
2. **Palliative Care Australia.** *A Guide to Palliative Care Service Development - A Population Based Approach.* [Online] 2005. [Cited: January 15, 2009.] [www.pallcare.org.au](http://www.pallcare.org.au).
3. **ESC EOLCN (Lambie, B.).** *Hospice Palliative Care in Erie St. Clair, Report on Current Services and Recommendations for Future Systems.* 2008.
4. —. *System Design Framework - Developing a Regional System of Hospice Palliative Care Delivery in Erie St. Clair.* Erie St. Clair Region : Erie St. Clair End of Life Care Network, 2009.
5. **Canadian Hospice Palliative Care Association.** *The Pan-Canadian Gold Standard for Palliative Home Care.* Ottawa : CHPCA, 2007.