A Provincial System Design Framework

A Primer on Possible Components Of Ontario's Hospice Palliative Care System
(for consideration when developing regional systems of hospice palliative care)

September 2010

Prepared by Ontario's

Provincial End of Life Care Network

Endorsed by Quality Hospice Palliative Care Coalition of Ontario Steering Committee

Acknowledgements

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Special thanks to members of the Erie St. Clair End of Life Care Network (ESC EOLCN). The report presented here is based on the System Design Framework developed by the members of the ESC EOLCN over the course of many months (1).

This report acknowledges the collective wisdom of the many members of the regional Networks. The Networks are made up of individuals and organizations many of whom are members of The Hospice Association of Ontario and / or the Ontario Palliative Care Association as well as being involved with Cancer Care Ontario, Ontario Hospital Association and numerous other associations and organizations. Additionally, the Networks and the Palliative Pain and Symptom Management Consultation Programs have a symbiotic advisory relationship. As such, significant 'collective wisdom' is brought to bear on any development processes undertaken by the Regional Networks and the Provincial End-of-Life Care Network (PEOLCN).

Revisions and Editing

Thanks to Siu Mee Cheng (Executive Director Toronto Central Palliative Care Network) for content related to the Integration realm. Thanks to Julie Johnston (Coordinator Palliative Pain and Symptom Management Program Southwestern Ontario -Serving Erie St. Clair and Southwest Regions) for editing and formatting.

Limitations / Scope of the Report

This report is narrowly focused on **System Design**. It does not provide an extensive preamble of information relating to: definitions, models of care, importance of Hospice Palliative Care (HPC), nor does it seek to review all aspects of HPC service delivery. Key considerations are listed but not described or explained. Many issues are intentionally not addressed, in the interest of presenting a framework that is specific to system design.

The initial focus of this work is on developing a Regional System Design Framework with provincial consistency in approach and intent. The regional systems work together to form the provincial "system". Significant synergies can be realized as we work together at a provincial level.

Previous Work

Much previous work is acknowledged; work which informs this report and provides the necessary backdrop of knowledge and information that allows us to move forward. Of particular importance is the Canadian Hospice Palliative Care Association (CHPCA) Model to Guide Hospice Palliative Care (17). The values and guiding principles underpin every aspect of this framework. The assumptions and descriptions, domains of issues etc. articulated in the CHPCA Model are used as a foundation for this system design framework.

The report titled *Review of Foundational Concepts Relating to Hospice Palliative Care Service Delivery* (24) provides background information about how palliative care is delivered.

System Design Framework Development Process

The process for developing this Framework has taken place over 14 months and has involved much consultation and many iterations. Formal consensus around this framework was reached with the Provincial End-of-Life Care Network in June 2010 and with the Quality Hospice Palliative Care Coalition of Ontario in July 2010.

Background relating to the development of this Framework is summarized below:

Purpose and Scope of this Report - This System Design Framework lists and categorizes elements to consider when developing regional systems of hospice palliative care. It provides us with a "way to further organize our thinking and our work" as we develop regional systems of care.

End-of-Life Care Network Role Related to System Design- System design is one of the designated roles for Ontario's Regional End of Life Care/Hospice Palliative Care Networks (EOLCN/HPCN) (2). A strategic priority of the Provincial End of Life Care Network (PEOLCN) is to create a system design framework document (3). The mission of the PEOLCN is to champion an integrated quality of life strategy of end of life care for all individuals, through collaboration and best practice (4). A System Design Framework is a key step in advancing this mission.

Need for Systematic Approach – Many Hospice Palliative Care/End-of-Life Care Networks have produced reports relating to HPC service delivery in their respective regions within the context of system design. (5) (6) (7) (8) (9) (10) (11) (12). Every region is looking at many of the same elements. It thus became evident that the 'next step' involved creation of a 'systematic approach' to guide ongoing development of regional HPC systems across Ontario.

Working Group - A working group of the PEOLCN, in concert with The Seniors Health Research Transfer Network (SHRTN) End of Life Care Community of Practice (CoP) was formed to explore the creation of this 'systematic approach' (Refer to Acknowledgement page for listing of members).

Source Document Review – The working group reviewed many source documents with many common elements of an "integrated system" emerging from this review (refer to listing of source documents at end of report). It became clear that there is a high level of consensus around what elements contribute to an integrated system and many listings and descriptions of these elements have been compiled (13) (14) (15). One region used a composite listing of key elements to review current status of its regional system (5). The utility of this listing was limited because it was not sorted or categorized in a practical way that facilitated a functional review.

Sorting / Categorizing / Understanding Linkages - Since there was already much consensus on key elements, the task of this working group became not so much identifying new elements, but building on previous work by "sorting", "categorizing" and "linking" these elements into a functional, practical framework that would facilitate not only description of the current system but development of a new system.

Plan / Do / Study / Act Cycles -This Framework has been widely vetted and revised over the course of a 16 month period culminating in September 2010. Several iterations of a system design framework were initially reviewed by the PEOLCN working group. The thinking of this working group coalesced around work done in the Erie St. Clair region by the End-of-Life Care Network (ESC EOLCN) (1).A summary version of the ESC EOLCN work was presented and revised at a meeting of the Provincial EOLCN (Spring 2009). The ESC EOLCN work was then redefined within a provincial context and was presented at the provincial workshop *Improving the Quality of Hospice Palliative Care Across Ontario* (June 2009), as a work in progress, for further review. The document was distributed to all attendees of that event and then more widely distributed to palliative care network members and providers across the province. Feedback was incorporated into a revised document. Results from a follow-up survey (February 2010) distributed to the participants of the workshop *Improving the Quality of Hospice Palliative Care Across Ontario*, validated the realms and pillars of this framework. Further discussion about this framework took place at the PEOLCN table in April 2010 and revisions from several HPC/EOLC networks were incorporated between April and June 2010. That revised document was approved by the PEOLCN (June 2010) and by the Quality Hospice Palliative Care Coalition of Ontario (July 2010). Final revisions were incorporated following the September 2010 meeting of the Steering Committee of Quality Hospice Palliative Care coalition of Ontario.

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Executive Summary

This System Design Framework lists and categorizes the basic elements of an integrated regional hospice palliative care system for Ontario. The categorization acknowledges the multi-sector nature of Hospice Palliative Care (HPC) service delivery. The listed elements serve as a practical template against which the current state can be compared. This comparison will identify gaps and issues which will form the foundation for the planning and building of cross sector regional Hospice Palliative Care Systems/Programs.

This report is narrowly focused on System Design. It does not provide extensive preamble information relating to definitions, models of care, importance of Hospice Palliative Care, nor does it seek to review all aspects of service delivery. Key considerations are listed but not described or explained in detail. Many issues are intentionally not addressed in the interests of presenting a framework that is specific to system design.

Introduction

"Each 'regional system' of Hospice Palliative Care in Ontario is really a 'system of systems'. Health care in Ontario is delivered by sectors and by independent service providers, each with its own Board of Directors, individual mandate, operational imperatives and strategic directions. For most HPC providers, Hospice Palliative Care is but one of many services they deliver. This primer on system design framework elements seeks to articulate and categorize 'key considerations' related to developing a Regional System of Hospice Palliative Care within the context of our 'system of systems'" (1).

To move from our current system of sector-specific service provision to a true regional system of palliative care service provision requires that:

1. **A full continuum of care settings and services is in place;**
2. **In each care setting where patients die, there is a clearly defined Palliative Care Program;**
3. **Sectors and services are linked by common practice, processes, structures and education;**
4. **Adequate numbers of trained professionals are available;**
5. **System level accountability is clearly defined and communicated; *and***
6. **Funding models, guidelines and policy directions support an integrated system.**

These six "requirements/standards" are the **foundational pillars** around which the system design framework is constructed

Developing a regional system of Hospice Palliative Care, within Ontario's complex healthcare environment requires a system design framework that is multifactoral and multidimensional. Such a framework simultaneously focuses attention and activity on several realms of system development. The 6 realms cited below flow from the 6 foundational pillars cited above.

1. Care Settings and Services: **A full continuum of care settings and services is in place**

We must understand what the component parts of a "Service Delivery System" are before we can address system development. Patients requiring hospice palliative care have fluctuating and complex needs which change over time. Rarely can these needs be completely met by any one facility, one service or one provider. Many care settings and services are required**.**

This system design framework lists key sectors and services that together make up a Regional System. These component parts of an integrated hospice palliative care system include:

- 24/7 Care Settings (and the HPC specialist consultation services serving those settings)
- Ambulatory Care / Day Programs
- Community Support Services / Programs

2. ***Programs within Care Settings and Services***: **In each care setting where patients die, there is a clearly defined Palliative Care Program.**

Each care setting and service contributes to the system as a whole. Therefore, as we are developing a "whole system" attention must be given to key elements of service delivery *within* each of the component parts. The system as a whole is only as strong as the weakest of its component parts. Basic elements indicating that a hospice palliative care program exists within a specific care setting include:

- Clearly articulated model of care
- Clear processes to access specialist level expertise
- Key organizational contact
- Admission Criteria

3. ***Integration / Linkages:*** **Sectors and services are linked by common practice, processes, structures and education**:

Transitions between sectors are important to patients and families. The patients' and families' perspective of the coordination, seamlessness and integration of our HPC care system, is directly proportional to our success (or lack thereof) at integration and linkages between / among sectors. Integration essentials include:

- Common practice and processes
- Collaborative structures
- Common understanding of service delivery models
- System level data collection and evaluation
- Connections with broad system, of health care
- Region-wide strategies and blueprints
- Provincial level leadership and consistency

4. ***Human Resources***: **Adequate numbers of trained professionals are available**

Compassionate, skilled people are at the very core of Hospice Palliative Care. Equipment is important, medication is vital, but without the people the right care does not reach the patient. Shortages of HPC personnel are reportedly endemic across Ontario.

Key considerations, related to human capital, include:

- Team composition - listing of Key HPC professionals
- Delineation of education and training at primary and specialist levels for various professional categories (undergraduate training requirements for all providers; post-graduate courses, in-service training)
- Development of population based guidelines
- Enhancement of innovative care models

5. ***System Accountability***: **System level accountability is clearly defined and communicated**

If we are to develop a functioning cross sector Regional System of Hospice Palliative Care we need to develop "regional HPC program accountability models" that support and advance the care of patients across sectors, while aligning with operational accountabilities within each sector/service.

Key considerations related to system accountability include defining:

- Key functions of system level accountability
- Key mechanisms that would facilitate system level accountability
- Fundamental principles that advance system level accountability

6. ***Policies, Guidelines and Funding***: **Funding models, guidelines and policy directions support an integrated system**

Policies, guidelines and funding directly impact not only patient care but system design and development. Awareness of these issues is necessary to alert the Local Health Integration Network (LHIN) and others to significant issues and to create "temporary work around" solutions to offset the negative impact of these issues on patient care. Issues that would benefit from provincial level strategies / guidelines / initiatives to advance system level HPC delivery include:

- Consistent and adequate funding
- Full scope opportunities
- Population based planning guidelines
- Standardized accessible data sets with performance data linked to quality indicators

Document Overview

The document which follows includes:

Introduction

The introduction establishes context through:

- a brief comment on the health care system in Ontario
- an overview explanation of the system design framework
    - description of purpose of the framework
    - listing of 6 pillars around which the framework is formed
    - overview of framework
    - summary schematic of the framework
- a review of the definition of Hospice Palliative Care.

Body of the document

The main body of this document focuses on the six realms and six pillars of the system design framework.

For each realm:

- the corresponding pillar/ standard is articulated ;
- rationale for inclusion is highlighted;
- limitations are cited;
- key search questions are posed
- the search questions are answered with a listing of key considerations; *and*
- practical comments relating to the use of the listing when conducting a regional review are included.

Next Steps

Next step are very briefly articulated. A System Level Framework enhances our ability to plan and review how each part of the system impacts the system as a whole. This Framework will serve as a "touchstone" - a reference point - from which to evaluate current status and progress towards an integrated cross sector system of Hospice Palliative Care Delivery in Ontario.

Appendices

Appendices expand on specific elements of the System Design Framework.

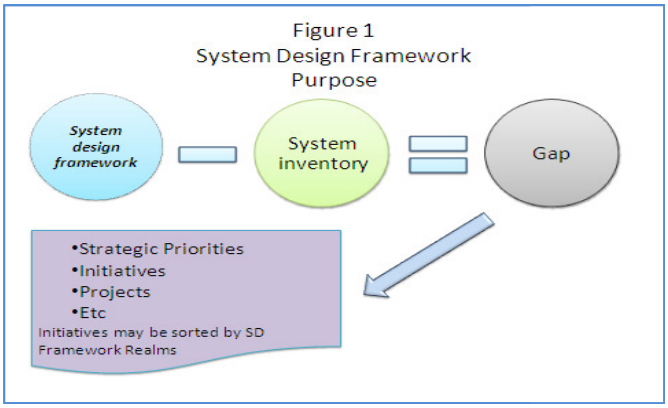
Hospice Palliative Care defined -*Hospice palliative care is a holistic, interdisciplinary approach to care that aims to relieve physical, psychosocial, and spiritual suffering associated with living with a progressive life-threatening illness. It can be provided at home, in hospitals, nursing homes or free-standing hospices. It is most effectively delivered by an interdisciplinary team of health care providers. It is more than end-of-life care. In fact, hospice palliative care can (and often should) be initiated at the same time that a patient is receiving treatment to modify his or her disease(s). As such, it can be seen as a key element of any chronic disease management strategy. It assists patients to make informed choices by discussing disease status, prognosis, etiology of symptoms, assessment of risks, and benefits of treatment choices.*

(Cavanagh P. (2009) adapted from the CHPCA Model to Guide Hospice Palliative Care (2002) and the South West End-of-Life Care Network 06-07 Annual Report.)

Introduction

"Each 'regional system' of Hospice Palliative Care (HPC) in Ontario is really a 'system of systems'. Health care in Ontario is delivered by sectors and by independent service providers, each with its own Board of Directors, individual mandate, operational imperatives and strategic directions. For most HPC providers, Hospice Palliative Care is but one of many services they deliver. The system design framework, described here, presents 'key considerations' related to developing a Regional System of Hospice Palliative Care within the context of our 'system of systems' (1).

The "regional system" of Hospice Palliative Care in Ontario is really a "system of systems"



Purpose of the System Design Framework

This System Design Framework is a tool for preliminary system level evaluation and development. The framework cites and categorizes elements of an integrated system of Hospice Palliative Care. It lists details of a desired future state. Current status can be evaluated relative to this. A gap analysis will emerge and recommendations and action plans can be organized around the framework categories/realms. The categorization (by realm) is designed to facilitate a high level "check listing" process of review which may lead to closer evaluation of specific elements. Figure 1 illustrates this function.
This Framework was used in a preliminary inventory of Provincial Hospice Palliative Care (16).

System Design Framework Pillars

To move from our current system of sector-specific service provision to a true regional system of hospice palliative care service provision requires that:

1. **A full continuum of care settings and services is in place;**
2. **In each care setting where patients die, there is a clearly defined Palliative Care Program;**
3. **Sectors and services are linked by common practice, processes, structures and education;**
4. **Adequate numbers of trained professionals are available;**
5. **System level accountability is clearly defined and communicated; *and***
6. **Funding models, guidelines and policy directions support an integrated system** (1)**.**

These six requirements/ standards are the foundational pillars around which the system design framework is constructed.

System Design Framework Overview

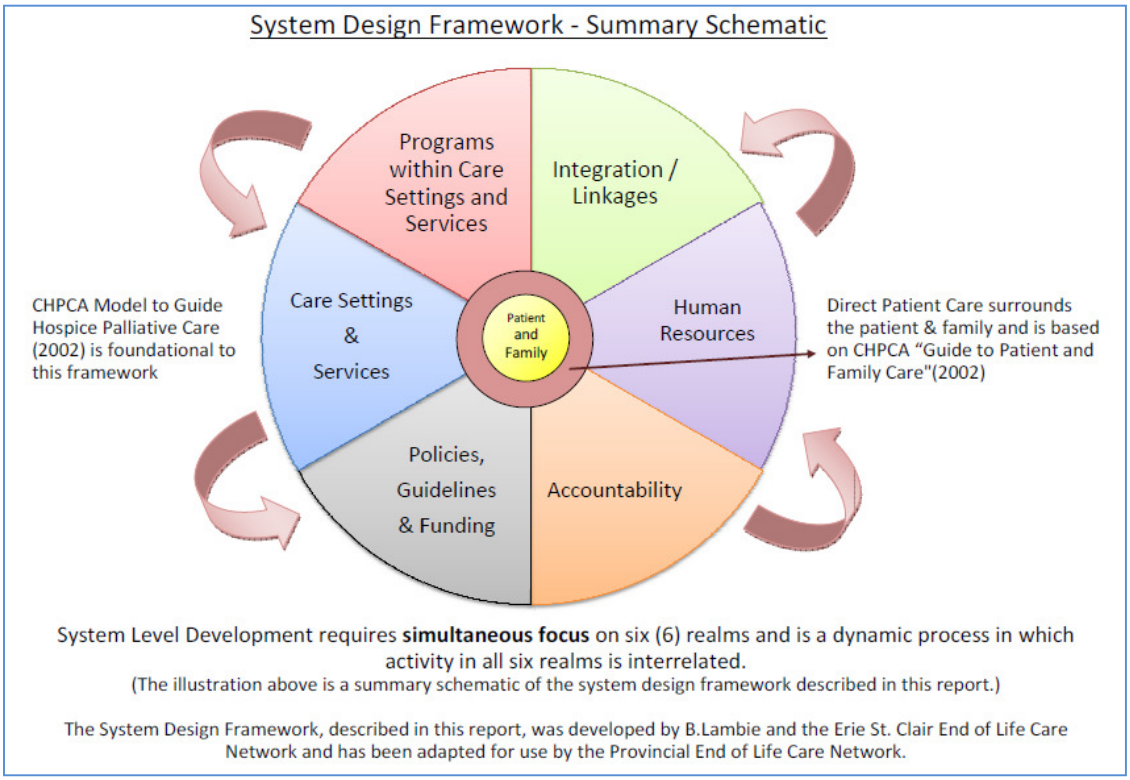
Developing a regional system of Hospice Palliative Care, within Ontario's complex healthcare environment requires a system design framework that is multifactoral and multidimensional. Such a framework simultaneously focuses attention and activity on several realms of system development.

The system design framework presented here, embraces six realms of system development. These six realms flow from the six foundational pillars cited above. These realms are:

- Care settings and Services
- Programs within care settings and services
- Integration / Linkages
- Human Resources
- System Accountability
- Policies, Guidelines and Funding

Figure 2 illustrates these six realms of System Design and System Development

Figure 2



In addition to depicting the realms of system design / development, Figure 1 attempts to illustrate the following key considerations of HPC system design and system development:

- Centrality of patient and family,
- Provision of direct clinical care surrounding the patient and family - A system design framework does not directly address clinical practice. However the fundamental purpose of the framework is to enhance the milieu in which direct patient care is provided, thereby enhancing care for the patient and family. Much excellent work is available to guide processes related to direct patient care, including the Canadian Hospice Palliative Care Association (CHPCA) Model to Guide Hospice Palliative Care. (17)
- Dynamic nature of system design and system development - the arrows indicate that this framework is not intended to serve as a tool for static description but rather is intended to provide a template for action.
- Interrelatedness of all realms – The relationship between each realm is not linear. All realms converge in the centre and simultaneous focus and activity is required in all 6 realms.
- Foundational values and guiding principles articulated in the CHPCA Model (17) underpin all aspects of this framework.

In the report which follows, each of the 6 realms is described in more detail.
For each realm:

- the corresponding pillar/ standard is articulated,
- rationale for inclusion is highlighted;
- limitations are cited;
- key search questions are posed
- the search question are answered with a listing of key considerations; *and*
- practical comments relating to the use of the listing when conducting a regional review are included.

Appendices expand on specific elements of the System Design Framework.

Hospice Palliative Care Defined

In conceptualizing the system design framework, we anchored our thinking in the CHPCA Model to Guide Hospice Palliative Care (2002); a definition of hospice palliative care with national consensus (17).

Hospice palliative care (HPC) aims to relieve suffering and improve the quality of living and dying. It 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.

HPC aims to:

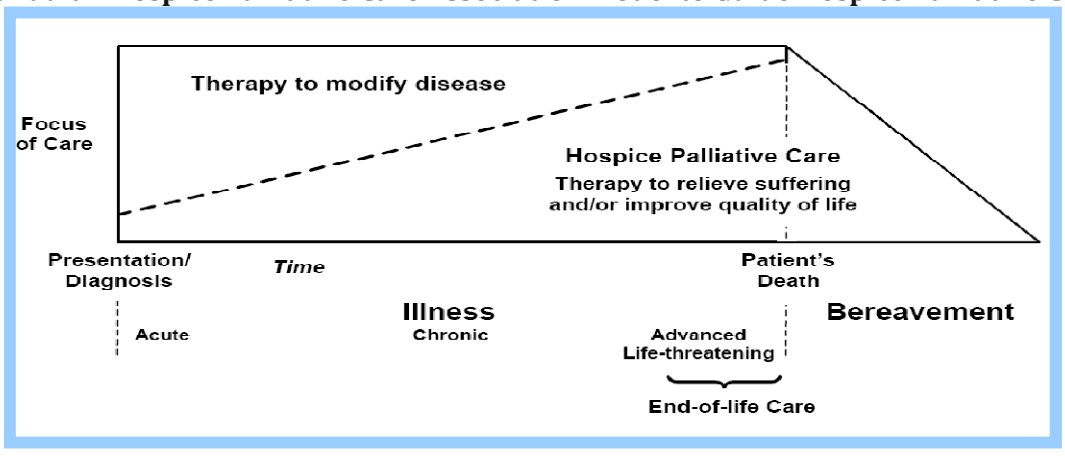
- treat all active issues
- prevent new issues from occurring
- promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization.

HPC 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. It may complement and enhance disease- modifying therapy or it may become the total focus of care. It is most effectively delivered by an interdisciplinary team of healthcare providers who are both knowledgeable and skilled in all aspects of the caring process related to their discipline of practice. These providers are typically trained by schools or organizations that are governed by educational standards. Once licensed, providers are accountable to standards of professional conduct that are set by licensing bodies and/or professional associations.

While hospice palliative care has grown out of and includes care for patients at the end of life, today it should be available to patients and families throughout the illness and bereavement experiences.

Figure 2 illustrates the typical shift in focus of care over time. The top line represents the total 'quantity' of concurrent therapies. The dashed line distinguishes therapies intended to modify disease from therapies intended to relieve suffering and/or improve quality of life (labeled hospice palliative care). The lines are straight for simplicity. In reality, the total 'quantity' of therapy and the mix of concurrent therapies will fluctuate based on the patient's and family's issues, their goals for care and treatment priorities. At times, there may not be any therapy in use at all.

Figure 2: The Canadian Hospice Palliative Care Association Model to Guide Hospice Palliative Care (2002)



Note: Foundational concepts / assumptions relating to how Hospice Palliative Care is delivered are summarized in Appendix 4 and are fundamental to this framework

System Design Realm One:
Care Settings and Services

Desired Standard /Pillar:

A full continuum of care settings and services is in place as per population based needs.

Rationale

Patients requiring hospice palliative care have fluctuating and complex needs which change over time. Rarely can these needs be completely met by any one facility, one service or one provider. **Many care settings and services are required.**

Thus when we are seeking to describe the system of HPC we must include all these care settings and services. Each of these care settings and services are component parts of the Hospice Palliative Care System. Once we understand the component parts we then can determine sector / service gaps that may exist and develop inclusive system level indicators and evaluation processes.

Patients requiring hospice palliative care have fluctuating and complex needs which change over time. Rarely can these needs be completely met by any one facility, one service or one provider. ***Many care settings and services are required.***

Criteria for inclusion

For the purposes of this listing of services and sectors the following inclusion criteria are used:

- Sectors and Services that have an explicit mandate &/or dedicated funding for HPC service delivery; and/or
- Settings of care where a significant number of patients die; and/or
- Settings and services that have specific data codes related to HPC; and/or
- Services that are supported as essential components of a HPC program even if little data is available (e.g. Grief and bereavement services)

Limitations

The component parts (listed below) related to care settings and services simply name a number of key sectors and services to be considered in our "system of HPC". Each sector / service is described in greater detail in various regional reports (12) (10) (5) (6) (7) (9) (11) (8). The need for numerous sector / services is supported by the CHPCA Model to Guide Hospice Palliative Care (17).

Search Questions:

What are the key sectors & services (component parts) which comprise a "Regional System of HPC"?

What volumes of each service would comprise a "full continuum"?

Key Considerations related to care settings and services include the following:

1. Component parts of the System

a. 24/7 Care Settings

- Hospitals
  - Acute Care
  - Complex Continuing Care
- Long Term Care Homes
- Residential Hospices
- Patients' Home:(CCAC & Direct Care Service Providers) – note "patients' home" in this context includes: community living homes and the many other settings where patients live and die

Access to specialist level HPC varies in these settings. Access models include:

- Palliative Care units,
- Palliative Care interdisciplinary consultation teams
- Palliative Care consultation physicians
- Palliative Care Consultation nurses etc.

(Refer to next section – Programs within Care Settings)

b. Ambulatory Care / Day Programs

- Outpatient Clinics
- Day Programs (including those run by volunteers)
- Physician's offices, Community Health Centres, Family Health Teams etc.

c. Community Support Services / Programs

- Palliative Pain & Symptom Management Consultation Program (capacity building resource)
- Education Programs
- Volunteer Hospice Programs

2. Use of population based guidelines to help determine "full continuum".

Population based guidelines help determine how much of each service is considered "adequate" to make up the "full continuum".

Population based guidelines have been used by Fraser Health region in British Columbia (18). These guidelines are based on work done in Australia. (15). Several regions in Ontario are reviewing the use of such guidelines (5) (10) (7) (12).

This is an area for future development in Ontario (refer to realm number 6 – Policies, Guidelines and Funding).

3. Partners

In addition to the core components listed above, many partners are required to provide quality Hospice Palliative Care (e.g. ALS society, Heart and Stroke Foundation etc.).

Comments relating to use of this listing when reviewing regional HPC systems

Since population based guidelines are not yet widely available, it is suggested that for each care setting current volumes of service are listed. This will provide baseline information.

Under "partners"- a statement around how partners are engaged and who the partners represent is suggested.

System Design Realm Two:

Programs within Care Settings and Services

Desired Standard / Pillar:

In each care setting where patients die there is a clearly defined Palliative Care Program

All Hospice Palliative Care Services (e.g. Day Programs, Clinics, Consultation Services, Volunteer Services and Education Services) articulate a clear mandate and service specific criteria.

Rationale

Every care setting/service caring for dying patients requires access to specialist level Hospice Palliative Care expertise. The Canadian Hospice Palliative Care Association indicates that this speciality service is best provided in an interdisciplinary team program (17).

The listing below provides a checklist of basic elements indicating that a HPC program exists *within* a specific care setting.

If we are seeking to develop a whole system attention must be given to key elements of service delivery *within* each of the component parts. The system as a whole is only as strong as the weakest of its component parts. (Component parts are listed in realm 1)

If we are seeking to develop a "whole system" attention must be given to key elements of service delivery within each of the component parts

The concept of integration (see realm 3) presupposes the presence of several functioning independent programs linking across sectors. We cannot link to something that does not exist. Thus we must have some basic understanding of (and some way to define) what constitutes a HPC program within each sector/setting. Additionally we must have a sense of the mandate of all HPC services as they provide support to patients, families and care providers in a variety of care settings. A clear understanding of this mandate will prevent duplication and will maximize access to these services.

As we continue to refine programming within each of the component parts and strengthen linkages between and among providers it is our vision that a "gestalt" will emerge in which "the whole" becomes greater than the sum of its component parts.

Limitations

This highlighting of these "program elements" and "clear mandates" does not seek to replace or summarize the many excellent: accreditation processes (19), gold standard documents (20), best practice reviews etc. that exist to provide comprehensive guidance to provision of high quality of care and internal functioning of an organization/service. It is assumed that general principles of safe and effective care are in place in each care setting/service.

Search Questions:

What are the basic elements that support a HPC program within a specific care setting?

- A listing of these key elements will help specific sectors/organizations answer the question "*Do we have a Hospice Palliative Care program in our setting?"*

What are the basic elements of a 'clear mandate' for HPC community services and education services?

Key Considerations related to programs within care settings and services

1. Basic elements indicating that a HPC program exists within a specific care setting include:

- A model of care is articulated
- Processes, to access specialist level expertise, are clearly defined (including 24/7 access)
- Relationship between primary and specialist care is articulated
- Clear admission criteria is cited
- Education about HPC is offered to specialist providers and to primary level providers (to enable primary providers to address basic HPC needs and to know when the patient requires a referral to specialist level care providers)
- Key organizational contact is identified
- Access to Interdisciplinary expertise is available
- Linkages with partners is evident
- Reporting, evaluation, CQI and data accountability occurs
- Relevant accreditation standards/ best practice guidelines are in evidence
- Evidence of an awareness of the CHPCA Model to Guide Hospice Palliative Care (17) and its *"Guide to Organizational Development & Function": Mission & Vision, Square of Organization and Care, Principles and Norms of Practice*

2. Basic elements of a 'clear mandate' for HPC community services and education services involve answers to specific questions including:

- "What populations do we serve / not serve?"
- "What is our scope?"
- "How do we report our work (data, accountability, evaluation)?"
- "How do we integrate with our partners?"

Comments relating to use of this listing when reviewing regional HPC systems:

For each care setting a template which allows for narrative response is useful. **(See Appendix 3).**

This template requires that each care setting describes how the specific elements are considered and articulated. It does not prescribe what those elements look like, only that they be in place and described.

These are high level minimum expectations.

System Design Realm Three

Integration / Linkages

Desired Standard / Pillar:

Sectors and services are linked by common practice, processes, structures and education.

Rationale

Transitions between sectors are important to patients and families. The patients' and families' perspective of the coordination, seamlessness and integration, of our HPC care system, is directly proportional to our success (or lack thereof) at integration and linkages between / among sectors. Integration is a key focus in health care in Ontario.

Discussion related to Integration (refer also to Appendix 5)

A number of integration definitions exist, including: "services, providers and organizations from across the continuum working together so that services are complementary, coordinated in a seamless unified system, with continuity for the client" (21).

Integration should be regarded as a means to assist in achieving desired system performance or patient outcomes and extremely important in assisting hospice palliative care systems to be effective. Based on an extensive literature review by Suter et al (21), there are ten key principles to successfully integrated health systems that may need to be considered when it comes to integrated hospice palliative care systems:

1. There should be comprehensive (hospice palliative care) services across the care continuum. – This will need to address the issue of care and services across a patient's disease trajectory from the most predictable of journeys to the most complex. (Refer to realm 1 for listing of care settings and services)
2. Patient focus in the integration of health care systems – Integrated systems design should be patient-centered – integration elements must be designed with the need to address patient issues first (and not only provider issues).
3. Geographic coverage / rostering of patients is an important consideration. - Focus on geographic regions is important when it comes to services integration. Impact of physical geography can have significant impact on the degree and effort required to ensure integration (i.e., rural vs. urban, rural/urban mix).
4. Standardized care delivery through interprofessional teams is key.- Although patient experiences will be different depending on the type of illness, social and other determinants impacting the patient and the surrounding health care system, the existence of interprofessional care that is standardized will be important in supporting integration.(Refer to realm 4 and Appendix 1 for expanded comments on interprofessional team.)
5. Performance management of integrated systems is integral. - The degree of integration and its impact on clients must be monitored and a focus on continuous improvement is critical for sustainability and quality.
6. Financial management of integrated systems is an important consideration. - In order to integrate health systems, financial investments are required.
7. Information technology and information management systems (IT/IM) are important enablers towards successful integration.- As with all cross sector services, IT/IM will be required to support such issues as access to patient records, management of wait times and access (i.e., intake and referral). IT/IM considerations include central access to the same systems by all relevant health care workers (primary care, acute care and hospice palliative care) in all care settings (home/community, residential hospice, long term care and hospital).
8. Organizational culture and leadership towards integration are essential. - A cultural commitment and focused leadership in integration will be fundamental in initiating as well as sustaining integrated systems. Within hospice palliative care, many service providers comprise the whole system. Sharing the same cultural and leadership values and beliefs will assist in cementing a sense of partnership, collaboration and coordination towards integration.
9. Governance structure considerations around integrated systems are necessary. - In Ontario, hospice palliative care systems governance is decentralized at the provincial level and varies across regions. (Refer to accountability – realm 5).
10. Physician engagement is a vital issue. - Literature reveals that physician engagement will be necessary in driving integrated systems. In hospice palliative care, physician engagement is important for a number of reasons including (list not exhaustive):
    - Capacity within the hospice palliative care system in the face of an aging population; and
    - Continuity of care and the issue of the most responsible person on care issues.

(It is important to note the issues of orphan patients and access to physician care for vulnerable and marginalized populations [i.e., homeless])

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Search Questions:

How do we in the HPC system address integration?
What are the fundamental integration essentials?

Key Considerations related to Integration include the following:

1. **Common practice and processes:**

- Clear criteria differentiating roles of various sectors and services within a given geographic area
- Clear access points/ processes for admission and discharge to / from sectors / services
- Clear transition processes (hand-offs) between sectors / services
- Use of Common tools

2. **Functional and Clinical Infrastructures include:**

- Venues for integrated care planning (cross sector patient specific rounds, team meetings)
- Venues for collaborative process development (EOLCN tables etc.)
- Shared communication/IT with accessible patient records between sectors/services (e-health: communication and knowledge management)

3. **Common understanding of service delivery models including:**

- Common understanding of how specialist level expertise / consultation teams function including:
  - type of "Shared Care Model" used in each sector
  - how specialists/teams link with Primary Care
  - how specialists in each care setting link with each other

4. **System Level Data collection and evaluation**

- Development of system level indicators, evaluation framework and CQI activities using balanced scorecard approach with quadrants that address:
  - patient / family perspective
  - utilization
  - financial
  - innovation

5. **Connections with broad system of health care including:**

- shared approaches to Health Care Consent and Advance Care Planning
- connections with Provincial, National & International bodies
- connections with broader Health Care system regionally and provincially

6. **Region-wide strategies and blueprints for:**

- education
- communication

7. **Provincial level leadership and consistency:**

- Continued advancement of use of common tools
- Development of provincial balanced scorecard etc.
- Ongoing provincial level venue to continue collaborative cross sector system development.

Comments relating to use of this listing when reviewing regional HPC systems

This listing is not exhaustive but is aimed at triggering cross sector patient focused activity.

All regions are seeking enhanced integration and have made some progress on each of these considerations.

System Design Realm Four

Human Resources

Desired Standard/Pillar:

Adequate numbers of trained professionals are available as per population based needs assessment.

Rationale

Compassionate, skilled people are at the very core of Hospice Palliative Care. Equipment is important, medication is vital, but without the people the right care does not reach the patient. Shortages of HPC personnel are reportedly endemic across Ontario. (16) Addressing human resource issues is fundamental to developing a functioning system of HPC.

Limitations

Many limitations exist as we explore the Human Resources realm of system design / system development. We will "touch the surface" by listings issues that need to be considered.

Search Questions:

What are the key categories of professionals that make up a HPC team?
What training is required at what level?
What are "adequate numbers"? (i.e. population based ratios per professional category)
What innovative care models can we recommend to maximize Human Resource expertise?

Key Considerations related to human resources include the following:

1. **Team composition -** HPC is by definition an interdisciplinary / collaborative care and shared care process. Therefore a broad spectrum of care providers is required.
2. **Delineation of education and training at primary and specialist levels** - CHPCA describes 3 levels of expertise (see Appendix 4). More work is required to delineate and standardize HPC training requirements for all providers in terms of undergraduate, post-graduate, continuing education etc..
3. **Development of population based guidelines to help determine needs and a resultant HPC Human Resource Plan for the region/province. -** Population based guidelines help determine how many of each profession is considered "adequate". Population based guidelines have been used by Fraser Health region in British Columbia. (18) . These guidelines are based on work done in Australia. (15). This is an area for future development in Ontario (refer to realm number 6 –Policies, Guidelines and Funding).
4. **Enhancement of innovative care models. –** Innovative care models are being developed to maximize the use of specialist level experts.

Comments relating to use of this listing when reviewing regional HPC systems

Since population based guidelines are not yet widely available, it is suggested that for each professional category current numbers of 'specialist level' professionals are listed.

Since clear criteria are not yet available for defining 'specialist level' in each professional category, it is suggested that 'specialist level', as understood by each region, be described. This will provide a baseline of information.

System Design Realm Five

Accountability

Desired Standard/Pillar:

System level accountability is clearly defined and communicated.

Rationale

In as much as a regional system of care is really a "system of systems", system level accountability is shared accountability. System level accountability is "vested accountability"; vested by those with funding and accountability authority (e.g. the Local Health Integration Network [LHIN]), operational responsibility (e.g. hospitals, CCAC etc.) and oversight and coordinating roles (e.g. Cancer Care Ontario etc.).

If we are to develop a functioning cross sector Regional System of Hospice Palliative Care we need to develop "regional HPC program accountability models" that support and advance the care of patients across sectors, while aligning with operational accountabilities within each sector/service.

The LHINs are key in defining the parameters of this regional accountability. Provincial consistency is important, in terms of high level expectations of structures, processes and outcomes related to regional system level accountability models.

If we are to develop a functioning cross sector Regional System of Hospice Palliative Care we need to develop "regional HPC program accountability models" that support and advance the care of patients across sectors, while aligning with operational accountabilities within each sector / service.

Limitations

The discussion, which follows is preliminary work related to system level accountability. In Ontario, where each organization has its own board and each board has its individual fiduciary responsibility for the specific organization (versus for the system as a whole), this cross sector accountability is a complex issue and is only touched upon in this document.

Search Questions:

What are key functions of system level accountability?

What are key mechanisms which facilitate system level accountability?

What fundamental principles should be followed to advance system level accountability?

Key Considerations related to accountability include the following:

1. Key Functions of system level accountability include:

- evaluation of HPC outcomes at a system level
- broad system design
- system level integration of services
- promotion of service innovations
- developing system level communication - knowledge management transfer
- monitoring and assessment of needs

2. Key Mechanisms which facilitate regional system level accountability are listed below:

- A 'regional accountability structure' is established. The role and accountability mechanism for this accountability structure:
  - is endorsed by the LHIN & aligns with MOHLTC policies / directions
  - aligns with system-wide cancer plan and system plans from other relevant disease specific initiatives
  - aligns with sector-specific accountability agreements / reporting requirements
  - includes clear accountability agreements in terms of operational roles, advisory roles and evaluation roles as vested by the LHIN and other relevant operational sectors / services
- System level indicators and CQI activities are developed, monitored and reported
- This 'regional accountability structure' has accountability to the LHIN
- Provincial consistency in terms of accountability expectations is developed

3. Fundamental Principles to advance system level accountability are based on principles of effective accountability (as outlined in the December 2002 Report of the Auditor General of Canada (22)) and include:

- clear roles and responsibilities
- clear performance expectations
- balanced expectations and capacities
- credible reporting
- responsible communication
- reasonable review and adjustment.

Comments relating to use of this listing when reviewing regional HPC systems

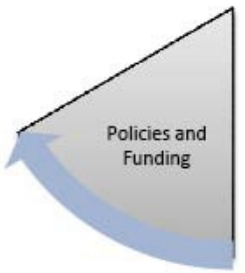
This listing is intended to bring attention to the need for clear accountabilities in a cross sector system.

In Ontario's 'system of systems' cross sector accountability is often difficult to operationalize.

It is suggested that each region articulate its accountability understandings as related to a cross sector HPC program. This system design framework listing will serve as a prompt for specific description.

System Design Realm Six

Policies, Guidelines and Funding



Desired Standard/Pillar:

Funding models, guidelines and policy directions support an integrated system.

Rationale

Remediation of policy and funding issues may be beyond the scope of an individual region. However such issues are included in a regional framework because they directly impact not only patient care but system design and development. Work on these issues is incorporated into regional work plans as local providers work collaboratively with provincial partners to begin to address these issues. Awareness of these issues is necessary to alert the LHIN to such shortfalls and to create "temporary work around" solutions to offset the negative impact of these issues on patient care. The suggestions are starting points for collective work at the provincial level.

Policy and funding issues are included in a regional framework because they directly impact not only patient care but system design and development.

Discussion related to Policies, Guidelines and Funding

The primary policy issue in Ontario is the absence of an integrated system-wide policy related to Hospice Palliative Care.

The Ontario government showed leadership in 2004 by funding a provincial end-of-life care strategy. This strategy was an important first step, but it fell short of creating an effective system of hospice palliative care services in Ontario.
The strategy was less effective than envisioned due to the lack of an integrated system-wide policy. There is significant disparity among Local Health Integration Networks in adopting hospice palliative care as a component of their regional priorities. This regional inconsistency creates a provincial landscape in which hospice palliative care is patchy. Furthermore, long-term sustainability was not addressed by the strategy.

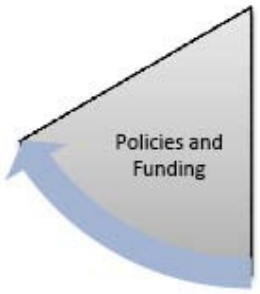
A provincial policy related to Hospice Palliative Care would enhance integrated Hospice Palliative Care in Ontario.

Additionally Hospice Palliative Care planning and service delivery will be facilitated by increased standardization and provincial level guidelines.

Strategic funding approaches will fill specific gaps in care delivery.

Limitations

The discussion below highlights a number of key issues without providing details on why these are seen to be important. Many of these issues are addressed in more detail in other reports (23) (14) (16).



Search Questions:

What policy enhancements would most facilitate an integrated system of HPC in Ontario?

What provincial level strategies/guidelines/initiatives are needed to advance system level HPC delivery?

What are examples of strategic funding investments that would improve the care of people requiring Hospice Palliative Care?

Examples of key considerations related to policies, funding and guidelines include the following:

1. Policy and funding issues:

- A comprehensive Hospice Palliative Care Policy for Ontario is needed.
- Consistent and adequate funding for:
  - professionals (e.g. Alternate payment plan for physicians)
  - programming (including residential hospices) and supplies (medication etc.)
  - regional accountability structures and provincial level support structure
- Full scope opportunities for Nurse Practitioners and others

2. Provincial level guidelines for:

- Population based ratios for:
  - specialist consultation teams/services,
  - dedicated beds including residential hospices
  - profession specific ratios (Refer to Australia work (18))
- Reporting – standardized accessible data sets with performance data linked to quality indicators
- CQI and research activities
- Education – basic and advanced.

3. Local understanding of policy issues and the impact on regional care provision is needed.

Comments relating to use of this listing when reviewing regional HPC systems

Issues relating to policy, funding and guidelines impact every regional program.

Since this section is primary related to work yet to be done, it is suggested that when reviewing its regional HPC system, each region include the following:

- A description of *what* policy issues most impact local care provision,
- A description on *how* these policy issues impact local care,
- A description on how these issues are being coped with at the regional level (i.e. describe any 'work around' solutions).
- A description on what local members are doing to help rectify these issues.

Summary and Next Steps

THE SYSTEM DESIGN FRAMEWORK discussed here provides us with a way to organize our thinking and our work. It directs our activity to six realms of system development and provides key consideration in each realm. System level development requires simultaneous focus on these interrelated realms. A system level framework will enhance our ability to plan and review how each part of the system impacts the system as a whole.

This framework provides a way to view our multisector system of palliative care in Ontario. This system of palliative care is really a "system of systems"

To move from our current system of sector-specific service provision to a true regional system of palliative care service provision requires that:

1. **A full continuum of care settings and services is in place;**
2. **In each care setting where patients die, there is a clearly defined Palliative Care Program;**
3. **Sectors and services are linked by common practice, processes, structures and education;**
4. **Adequate numbers of trained professionals are available;**
5. **System level accountability is clearly defined and communicated; *and***
6. **Funding models, guidelines and policy directions support an integrated system.**

These six "requirements/standards" are the **foundational pillars** around which this system design framework is constructed

This framework has been used to complete a preliminary inventory of Hospice Palliative Care Service in Ontario. (16)
It is has been used to help frame systematic reviews of Hospice Palliative Care Systems/Programs at a regional level.

It can be used as a tool to assist with:

- System reviews/evaluation/inventories
- Gap analysis
- Framing of:
    - Strategic priorities
    - Goals / objectives
    - Work plans
- Status / update reports (Refer to Appendix 3 for an example of a very rudimentary attempt at presenting a multifactoral review of system level activities – based on this framework).

(Refer to Appendix 1 for a Summary Table of: Framework Realms, Standard Statements/Pillars and Key Considerations)
(Refer to Appendix Two for an Expanded Schematic of the System Design Framework including Realms, Standard Statements/Pillars and Highlights of Key Considerations)

NEXT STEPS include using this framework as a stimulus for further discussion related to development of regional systems of hospice palliative care delivery in Ontario and leveraging these regional systems to advance a province-wide system. It is anticipated that this framework will be used to help develop a provincial level policy for Hospice Palliative Care in Ontario and may be used as a template to help direct the creation of Hospice Palliative Care plans in each LHIN region.

This framework is a work in progress and will evolve as we continue to create regional systems of Hospice Palliative Care in Ontario within a province-wide context.

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Appendix 1

Summary Table of Details to consider under each of the 6 Realms

Care Settings and Services

Desired Standard: A full continuum of care settings / services is in place as per population based needs

A full continuum of Care Settings and Services for Hospice Palliative Care includes the following:

1. **Component parts of the System**

a. **24/7 Care Settings**

- Hospitals
  - Acute Care (including Tertiary Care and host hospitals for Regional Cancer Programs)
  - Complex Continuing Care
- Long Term Care Homes
- Residential Hospices
- Patients' Home (CCAC & Direct Care Service Providers) - note "patients' home" in this context includes: community living homes and the many other settings where patients live

b. **Ambulatory Care / Day Programs**

- Regional Cancer Centres including Palliative Care Clinics in the Centre or host hospital
- Clinics in other locations
- Day Programs (including those run by volunteers)
- Physician's offices, Community Health Centres, Family Health Teams etc.

c. **Community Support Services / Programs**

- Palliative Pain & Symptom Management Consultation Program
- Education Programs
- Volunteer Hospice Programs
- Grief and Bereavement Services

d. **Expert Palliative Care Consultation Teams / Services serving patients in the 24/7 care settings, Ambulatory care / Day programs etc.**

- Teams serving only one care setting
- Teams serving across several sectors

2. **Use of population based guidelines to help determine "full continuum"**

3. **Partners – list partners and how they are engaged with core HPC services.**

Programs within Care Settings and Services

Desired Standard: In each care setting where patients die, there is a clearly defined Palliative Care Program developed. (i.e., 24/7 care settings) All HPC Services (e.g., Day Programs, Clinics, Consultation Services, Volunteer Services and Education Services) articulate a clear mandate and service specific criteria.

1. **Basic elements indicating that a HPC program exists within a specific care setting include:**

- A model of care is articulated
- Processes, to access specialist level expertise, are clearly defined (including 24/7 access)
- Clear admission criteria
- Education about HPC is offered to primary level providers (to enable them to address basic HPC needs and to know when the patient requires a referral to specialist level care providers)
- Key organizational contact is identified
- Access to Interdisciplinary expertise is available
- Linkages with partners is evident
- Reporting, evaluation, CQI and data accountability occurs
- Relevant accreditation standards/ best practice guidelines are in evidence
- Evidence of an awareness of the CHPCA Model to Guide Hospice Palliative Care (17) and its *"Guide to Organizational Development & Function": Mission & Vision, Square of Organization and Care, Principles and Norms of Practice*

2. Basic elements of a 'clear mandate' for HPC community services and education services involve answers to specific questions including:

- "What populations do we serve / not serve?"
- "What is our scope?"
- "How do we report our work (data, accountability, evaluation)?"
- "How do we integrate with our partners?"

Integration / Linkages

Desired Standard: Sectors and services are linked by common practice, processes, and structures and possess a common understanding of service delivery models.

Regional Integration Essentials

1. Common practice and processes:

- Clear criteria differentiating roles of various sectors and services within a given geographic area
- Clear access points/ processes for admission and discharge to / from sectors / services
- Clear transition processes (hand-offs) between sectors / services
- Use of Common tools

2. Collaborative structures include:

- Venues for integrated care planning (cross sector patient specific rounds, team meetings)
- Venues for collaborative process development (EOLCN tables etc.)
- Shared communication/IT with accessible patient records between sectors/services
- Defined access to specialist expertise / expert consultation teams-with cross sector "connections" and identified human "connectors" from each care location/service
- Cross sector registry of HPC patients

3. Common understanding of service delivery models including:

- Common understanding of how specialist level expertise / consultation teams function including:
  - type of "Shared Care Model" used in each sector
  - how specialists/teams link with Primary Care
  - how specialists in each care setting link with each other

4. System Level Data collection and evaluation

- Development of system level indicators, evaluation framework and CQI activities using balanced scorecard approach with quadrants that address:
  > patient/family perspectives > financial
  > utilization > innovation

5. Connections with broad system of health care including:

- Shared approaches to Health Care Consent and Advance Care Planning
- Connections with Provincial, National & International bodies
- Connections with broader Health Care system regionally and provincially

6. Region-wide strategies and blueprints for:

- Education
- Communication (1)

7. Provincial level leadership and consistency:

- Continued advancement of use of common tools (e.g. Ontario Cancer Symptom Management Collaborative)
- Development of provincial balanced scorecard etc.
- Ongoing provincial level venue to continue collaborative cross sector system development.

Human Resources

Desired Standard: Adequate numbers of trained professionals are available as per population based needs assessment.

1. **Team composition - Listing of key HPC professionals**
   HPC is by definition an interdisciplinary / collaborative care and shared care process Therefore a broad spectrum of care providers is required.
   Specialist /Tertiary Level Providers include:

- HPC Physicians
- Nurse Practitioners trained in HPC, Expert HPC Nurses,
- HPC Specialists in all other relevant professions including:
  - Social Work
  - Psychologists
  - Volunteers, etc
  - Spiritual Care
  - Grief and Bereavement
  - Personal Support Workers (PSWs)
  - Allied Health (e.g. Pharmacists, Rehabilitation Therapies, Respiratory Therapy, Dietician, etc.)

  Primary Care Providers
- Physicians including:
  - Family Physicians
  - Family Health Teams
  - Community Health Centres
  - Specialists in other non-palliative fields (Surgeons etc)
  - Other physicians not trained in HPC
- Nurses
- Primary Care providers in all other relevant professions including:
  - Social Work
  - Psychologists
  - Volunteers and others
  - Spiritual Care
  - Grief and Bereavement
  - Personal Support Workers (PSWs)
  - Allied Health (e.g. Pharmacists, Rehabilitation Therapies Respiratory Therapy, Dietician, etc.)

2. **Delineation of education and training at primary and specialist levels for various professional categories (undergraduate training requirements for all providers; post-graduate courses, in-service training).**

3. **Development of population based guidelines to help determine needs and a resultant HPC Human Resource Plan for the region/ province.**

4. **Enhancement of innovative care models including:**

- Shared care between primary care and specialist levels (with capacity building intent)
- Enhanced team roles – collaborative care
- Development of trans-discipline consultation models

Accountability

Desired Standard: System level accountability is clearly defined and communicated.

1. **Key Functions of system level accountability include:**

- evaluation of HPC outcomes at a system level
- broad system design
- system level integration of services
- promotion of service innovations
- developing a system level communication strategy
- monitoring and assessment of community needs

2. **Key Mechanisms which facilitate regional system level accountability are listed below:**

- A 'regional accountability structure' is established. The role and accountability mechanism for this accountability structure:
  - is endorsed by the LHIN & aligns with MOHLTC policies / directions
  - aligns with system-wide cancer plan and system plans from other relevant disease specific initiatives
  - aligns with sector-specific accountability agreements / reporting requirements
  - includes clear accountability agreements in terms of operational roles, advisory roles and evaluation roles as vested by the LHIN and other relevant operational sectors / services
- System level indicators and CQI activities are developed, monitored and reported

- Regular reporting to the LHIN from this 'regional accountability structure' occurs
- Provincial consistency in terms of accountability expectations is developed (1 pp. 13, 14)

3. Fundamental Principles to advance system level accountability are based on principles of effective accountability (as outlined in the December 2002 Report of the Auditor General of Canada (22)) and include:

- clear roles and responsibilities
- clear performance expectations
- balanced expectations and capacities
- credible reporting
- responsible communication
- reasonable review and adjustment.

Policies, Guidelines and Funding

Desired Standard: funding models, guidelines and policy directions support an integrated system.

1. Policy and funding issues:

- A comprehensive Hospice Palliative Care Policy for Ontario is needed.
- Consistent and adequate funding for:
  - physicians
  - programming (including residential hospices) and supplies (medication etc.)
  - regional accountability structures and Provincial level support structure
- Full scope opportunities for Nurse Practitioners and others

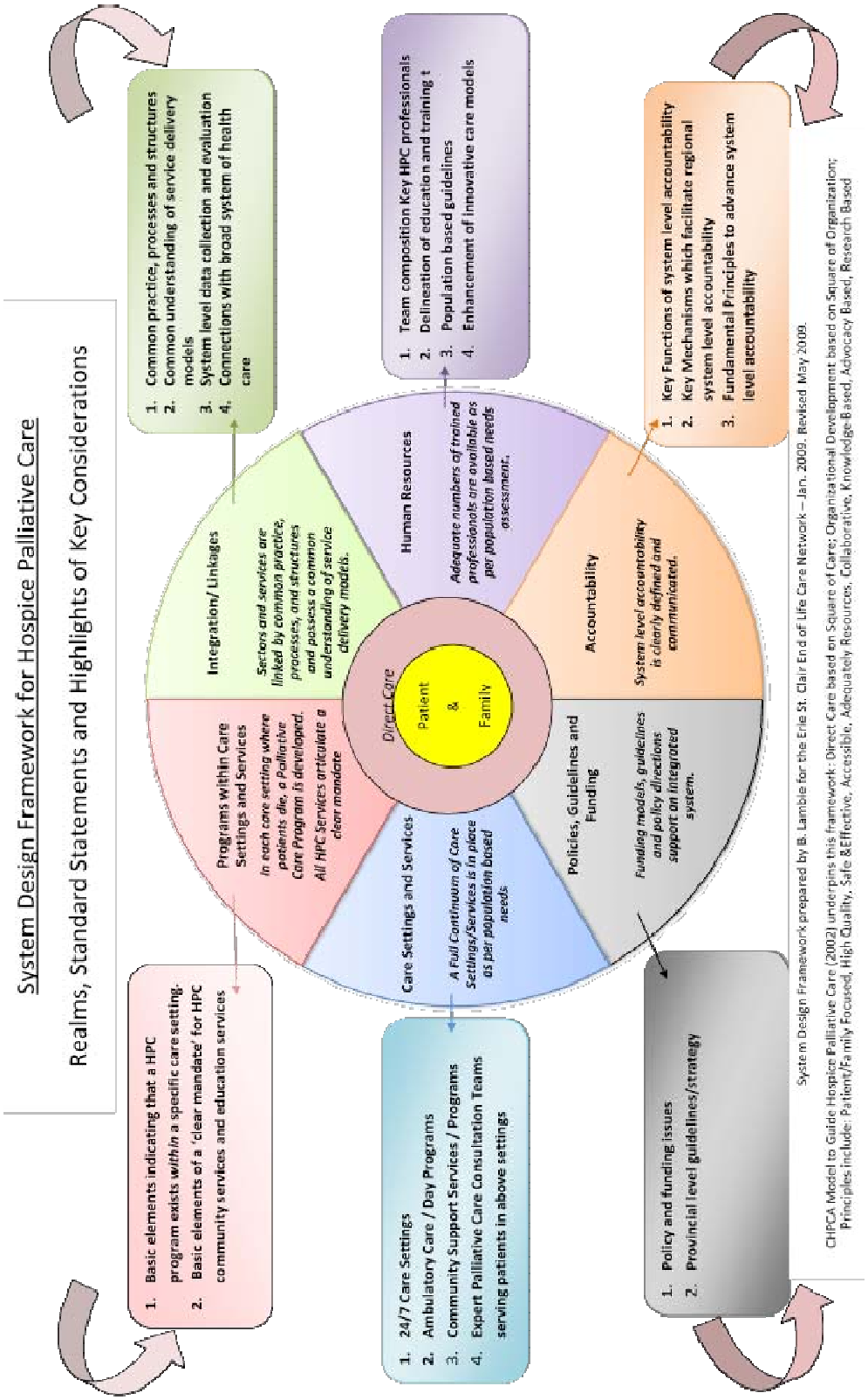
2. Provincial level guidelines/strategy for:

- System design
- Population based ratios for:
  - specialist consultation teams/services,
  - dedicated beds including residential hospices
  - profession specific ratios (Refer to Australia work (18))
- Reporting – standardized accessible data sets with performance data linked to quality indicators
- CQI and research activities
- Education – basic and advanced. (1 p. 16)

3. Local understanding of policy issues and the impact on regional care provision is needed

Appendix 2

Expanded Schematic: System Design Framework

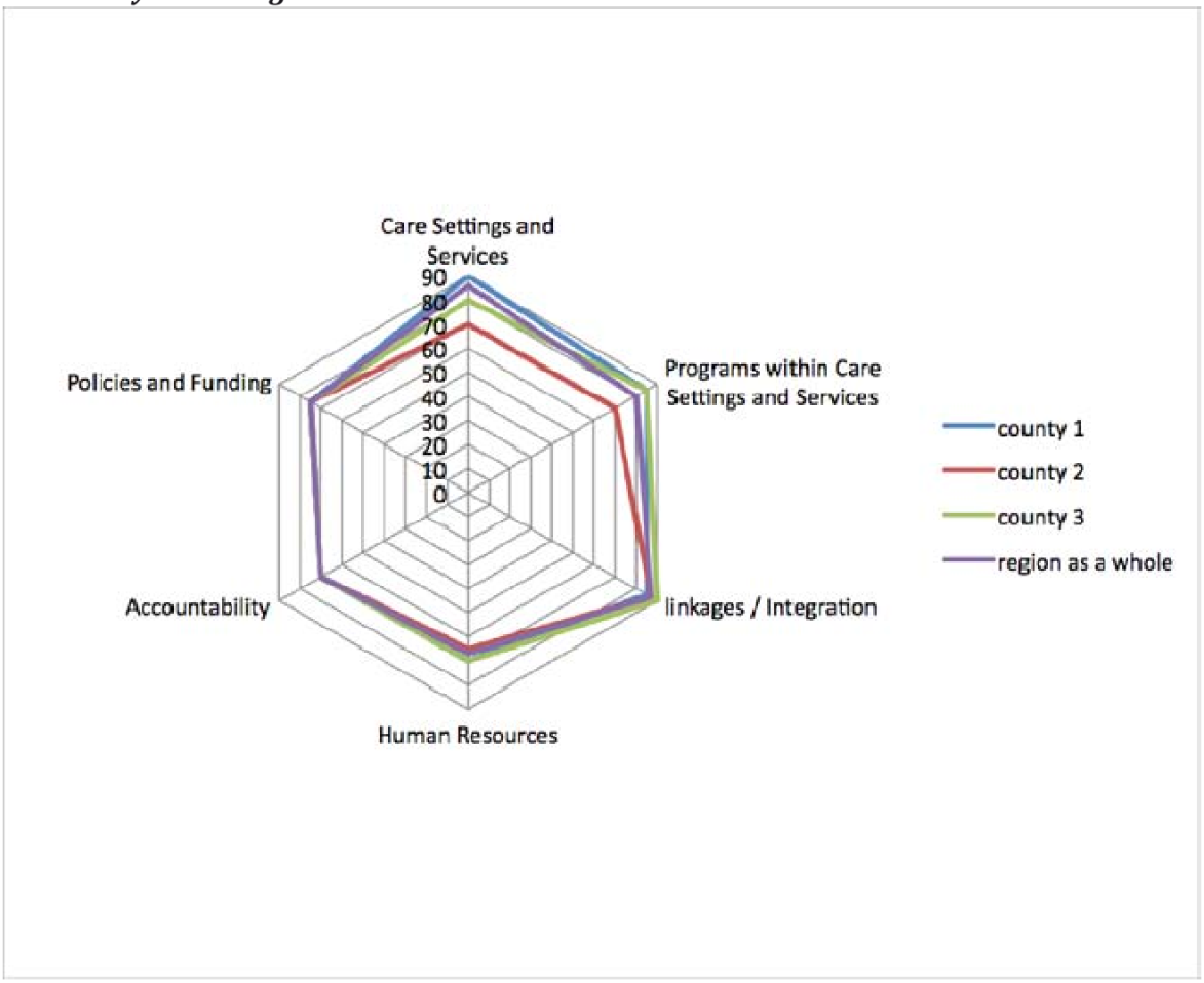


Appendix 3 – Examples of Tools for use of System Design Framework

Example one -Sample template to use for System Design Realm number two: **Programs within Care Settings** Include a brief description of each element within your specific care setting					
Care Sectors/Care Settings - 24/7 care settings					
Sectors **Sample Elements**	**In Home-** **CCAC & Community Service Provider Agencies (CPSA)**	**Residential Hospice**	**Acute Care**	**Complex Continuing Care**	**Long Term Care Homes**
Model of Care					
Clear admission criteria					
Processes, to access specialist level expertise					
Relationship between primary and specialist care is articulated					
Relevant accreditation standards/ best practice guidelines					
Education					
Key organizational contact identified					
Access to Interdisciplinary expertise is available					
Etc.					

Example two -Rudimentary overview of a Multifactoral Review of Current Status of a Regional System of Hospice Palliative Care

Based on System Design Framework Realms



Appendix 4 - Foundational Concepts Related to how HPC is provided

Foundational Concepts related to HPC Service Provision

Four foundational concepts, relating to HPC Service Provision, form the backdrop for the System Design Framework. These are:

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

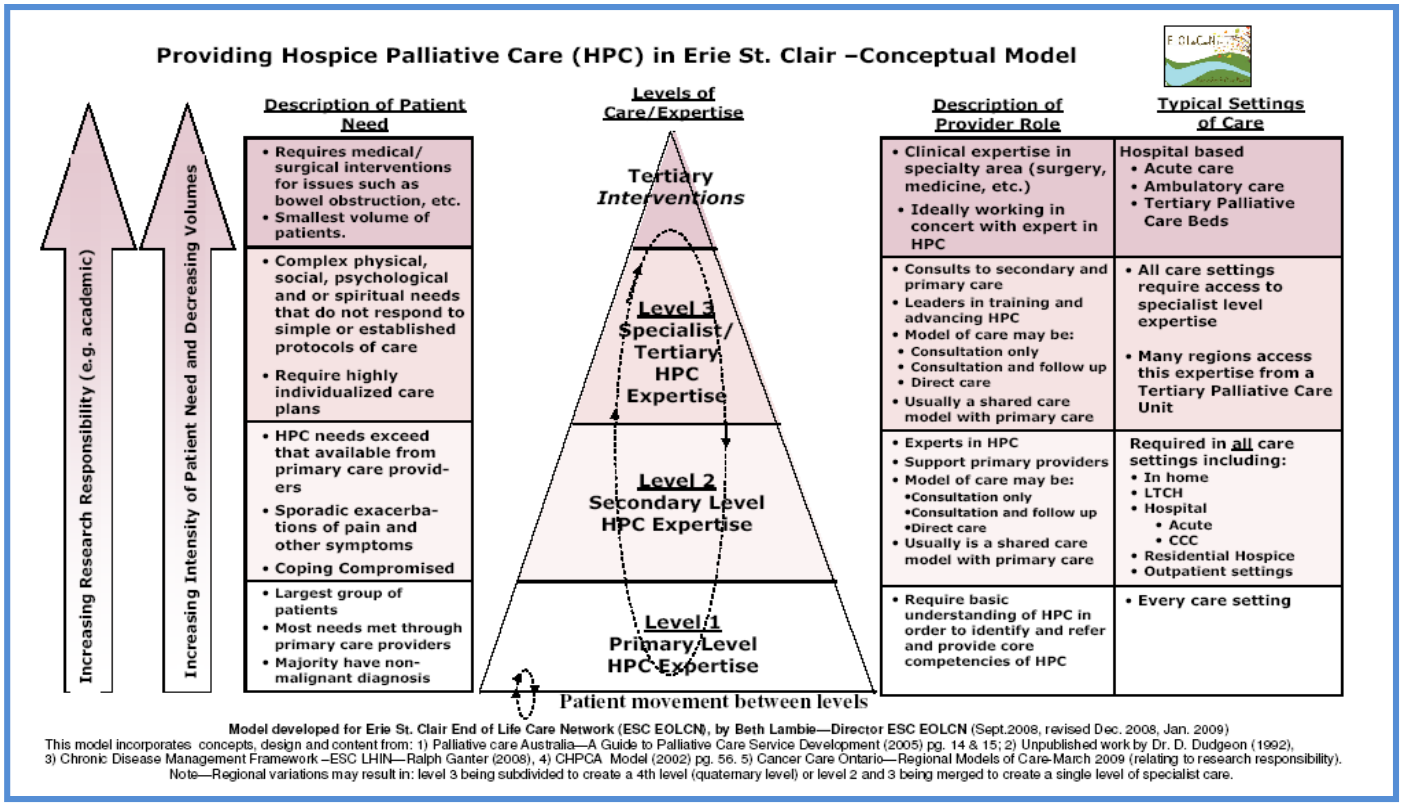
2. **Both Specialists and Primary Level Providers are needed (Specialist care is typically subdivided into two levels – Secondary and Tertiary).**
   a. **The majority of HPC needs are met by Primary Care providers.**
   b. **Consultation Models may be required to link primary and specialist level care providers throughout the patients HPC journey .These consultation models include: consultation only, consultation and shared care, consultation and care provision 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.**

Expanded explanations of the 4 foundational concepts available (24)at:
http://www.esceolcn.ca/AboutUs/documents/FoundationalConcepts.pdf

Diagram below summarizes a number of these concepts – refer to ESC December Report (5) for more detailed explanation of this diagram. Available at: http://www.esceolcn.ca/AboutUs/documents/CurrentServicesRecommend.pdf



Appendix 5

Primer on Integration

Integration is a complex issue and there are a number different ways of looking at integration:

- Focus
- Type
- Breadth
- Degree

Integration can have different foci:

- Entire communities or rosters of populations; vulnerable sub-groups; or patients with complex illnesses

Type of integration:

- Functional Integration (i.e., back office and support functions).
- Organizational Integration (between different health care organizations).
- Professional Integration (provider relationships within and between organizations).
- Service or Clinical Integration (coordination of services and the integration of care in a single process across time, place and discipline).
- Normative integration (shared values, mission, values, etc.,).
- Systemic Integration (alignment of policies and incentives).

Breadth:

- Horizontal Integration (similar organizations at the same level join together – two palliative care units).
- Vertical integration (combination of different organizations at different levels – palliative care units, community palliative care programs, long term care homes, residential hospice).

Degree:

- Linkage (least change approach): providers working together on an ad hoc basis within major systems constraints
- Coordination: structured, inter-organizational response involving defined mechanisms to facilities communication, information-sharing and collaboration while retaining separate eligibility criteria, service responsibilities and funding
- Full integration (most transformative): a "new" entity that consolidates responsibilities, resources and financing in a single organization or system in order to deliver and pay for the entire continuum of care.

(The above was based on Kodner, 2010 and Suter et al, 2010. This summary was prepared by Siu Mee Cheong – Toronto Central Palliative Care Network – May 2010).

Source Documents (The sources listed below are examples of some of the documents that were reviewed by the authors of this System Design Framework. These sources are not cited directly within the Framework document– refer to "Works Cited" for listing of works that are directly cited

(Note- Some references below may be incomplete and are included here simply as a way to acknowledge the influence of various sources on the content of this System Design Framework)

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