BACKGROUNDER

Innovative Models of Integrated Hospice Palliative Care

About “The Way Forward” Initiative:
In 2012, the federal government announced one-time funding of $3 million over three years to support the development and implementation of a framework for community-integrated hospice palliative care models in Canada. “The Way Forward: An Integrated Palliative Approach to Care” (The Way Forward initiative), led by the Quality End-of-life Care Coalition of Canada and managed by the Canadian Hospice Palliative Care Association, aims to improve access to hospice palliative care in a broader range of settings. A number of discussion documents have been created to encourage stakeholder dialogue, and inform the development of the framework. This Backgrounder on the discussion document Innovative Models of Integrated Hospice Palliative Care highlights lessons learned from 11 innovative models of community-integrated hospice palliative care in Canada, England, New Zealand and Australia. These models were chosen based on reports in the literature and recommendations from key informants.

The Context for Action:
A more integrated approach to palliative care in the community shifts hospice palliative care from being a specialized service available to the few to a more general integrated service available to people with life-limiting conditions in all settings where they live and receive care. The innovative models explored in the discussion document may vary by care setting (e.g., primary care, long-term care homes) and geographical focus (e.g., urban, rural, etc.), yet all share common elements that make them successful and transferrable to the Canadian context.

Overall, the programs focus on increasing the capacity of different parts of the health-care system – mainly primary care, home care and long-term care – to provide hospice palliative care. They use interdisciplinary teams to support the delivery of integrated palliative care in different settings, and offer a seamless network of primary-community-hospital-hospice services to support individuals and families as needs change.

All or many share a number of success factors, such as:

- Vision—focus on person-centred care and building community capacity, as well as gaining senior management buy in and changing organizational culture;
- People—use an inter-professional team of physicians, nurses, allied health professionals, care aids and sometimes volunteers (with strong family physician involvement, key roles for nurses, and dedicated coordinators);
- Care delivery—offer a single access point and 24/7 service, ensure continuity and coordination of care between care settings, provide culturally-responsive care (e.g., with and for indigenous populations and cultural communities), and engage in advance care planning; and
- Supportive tools—have common frameworks, standards and assessment tools, offer flexible provider education, share electronic records, and monitor and measure performance.

The models report similar positive impacts on people who are dying and their families, health-care providers and the health-care system. For instance, hospice palliative care is easier to access, enabling more patients to die at home or in their communities and reducing stress on families. Among health-care providers, ongoing training and professional education is more accessible, and there is less distress, burnout and turnover. At a system level, there are fewer unplanned hospitalizations and lower acute care costs, a more skilled workforce, and progress in policies for advance care planning, improved transition between care settings, and after-hour services.

Areas of Opportunity:
Effectively integrating a palliative approach into the management of life-limiting conditions is a health-care priority in Canada. Governments, regions, health-care organizations and providers can learn from the experiences of innovators in both Canada and internationally to develop their own integrated approach to care.

To access the full discussion document, visit: http://www.hpcintegration.ca