A Team-Based Approach to Delivering Person-Centered Care at the End of Life

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The use of team-based models of care is widely regarded as a mechanism for enhancing the delivery of high-quality care, especially at the end of life. Active collaboration to promote effective coordination and delivery of person-centered care is an integral part of the team-based model that is the focus of this article.

Introduction

For patients with life-limiting illnesses, hospice provides end-of-life medical care, symptom management, and psychosocial and spiritual support specifically tailored to the patients' needs and wishes. Members of the hospice team, which consists of medical staff including physicians, registered nurses (RNs), certified nursing assistants (CNAs), and non-medical staff including social workers, chaplains, music therapists, and volunteers, work together to meet each patient and family's individual needs. The variety of disciplines that make up the hospice team ensures that the full range of needs of the patient and family are met. This interdisciplinary team-based approach is a distinctive feature of the hospice model of care delivery and has been a part of the model since the inception of hospice as a grassroots movement in the 1960s. This interdisciplinary approach to hospice care is mandated by the Medicare Conditions of Participation (CoPs), which states that "hospice must designate an interdisciplinary group or groups to work together to meet the physical, emotional, and spiritual needs of patients facing terminal illness and provide bereavement services [1]."

The role of the hospice team is first to care for the patient and their family. An important component of the hospice philosophy is the recognition of the patient and their family as the recipients of care, rather than the patient alone. This means that the hospice team needs to understand the relationships between the patient, their family, their community, and their medical team. While a physician is required to direct the care of the patient (per CoPs), hospice designates an RN to coordinate the work of the interdisciplinary team [1]. All interdisciplinary team members participate in the process of conducting a comprehensive assessment of the patient and family at the time of hospice admission and throughout the course of care. The team then provides care to the patient and family based on those initial and ongoing assessments. Any team member who recognizes an unmet patient and/or family need contacts the appropriate team member for assistance. The hospice team meets regularly to collaboratively review and plan for all patients and families under their care.

A second, and equally important, role of the hospice team is to care for each other. A well-functioning team recognizes that each member brings a unique skill set and that no single team member can meet all of the patient and family's needs. This allows each team member to practice their discipline to the fullest potential and improves the quality of care provided, while reducing the burden carried by any one member. Each individual team member must understand the roles of the other members and recognize when involving another discipline would be beneficial. This mutual respect and trust provides the team with an open space to discuss challenges faced, to grieve when patients die, and to celebrate the joys of life. A well-functioning team recognizes and supports the humanity of each of its members.

Along with the training necessary for their licensure, each member of the hospice team is expected to be well-versed in hospice philosophy. Four Seasons Compassion for Life uses a competency based model to enhance the care team's skill in interprofessional collaborative practice (IPCP). This model was developed as part of a Heath Resources and Services Administration (HRSA) Nurse Education, Practice, Quality and Retention (NEPQR) grant Four Seasons received in 2013 for "Advancing Interprofessional Collaborative Practice in Hospice and Palliative Care." The model guides the development of IPCP competency in 4 domains: roles and responsibilities of each team member; communication; collaboration; and values and ethics (see Figure 1). The core competencies contained in the Four Seasons IPCP model were adapted from competencies originally developed by the Interprofessional Education Collaborative Expert Panel [2]. The Four Seasons model expands the articulated competencies to define the behaviors that demonstrate competency at various levels from novice to expert [3]. This continual

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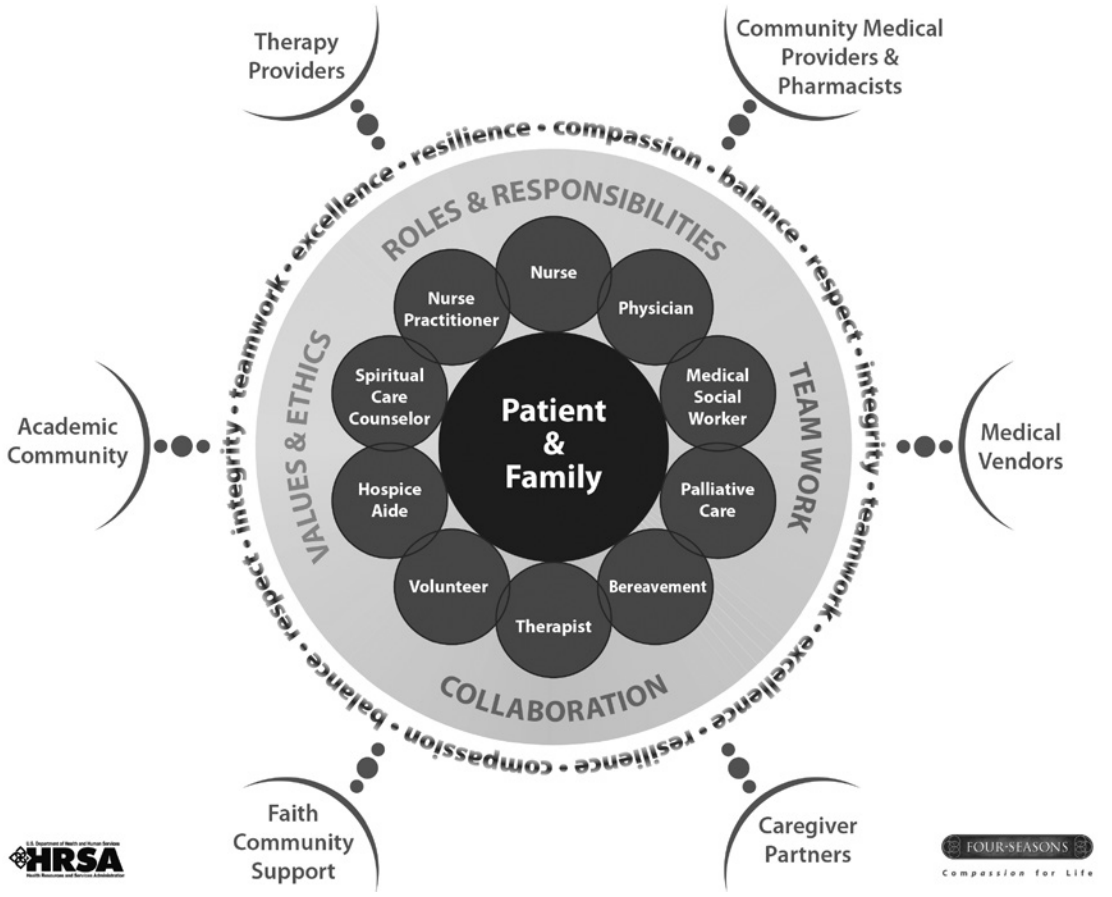
FIGURE 1.
Interprofessional Collaborative Practice Model
The Four Seasons Interprofessional Collaborative Practice (IPCP) model in end-of-life care guides the development of IPCP competency in 4 domains: roles and responsibilities of each team member; communication, collaboration, and values and ethics.



Source. HRSA and Four Seasons.

assessment of team performance and learning as clinicians engage in the care process promotes advanced skills development [4]. Those who are assigned to lead and supervise the team also receive training on how to lead an interprofessional team, effectively facilitate team meetings, set goals, establish accountability, successfully execute tasks, coach employees, and what constitutes a healthy team. Every staff member in a leadership role participates, and having staff of all disciplines, including those not involved in direct patient care, enhances teamwork and collaboration. This develops individuals' capacities for and skills in transformational and situational leadership and prepares leaders to effectively lead and develop diverse, continuously improving teams. These trainings allow staff to build relationships across departments and encourage the entire organization to work together to meet the needs of patients and families.

The interdisciplinary hospice team is largely financed through the Medicare hospice benefit. Medicare and other insurers typically provide a per diem or per member per day rate that is expected to cover the provision of all core clinical staff services, drugs and biologicals, medical supplies, and durable medical equipment related to the terminal prognosis. This financing also supports the use of the team-based care model that is the accepted standard for hospice care delivery. It allows for the inclusion of multiple disciplines in the team and supports increasing the intensity of services in the last days of a patient's life. However, decreasing lengths of stay and the increasing complexity of care needs for patients and families at the end of life have resulted in financial challenges. A report from The National Hospice and Palliative Care Organization (NHPCO) demonstrated that about 40% of hospice Medicare beneficiaries received care for 14 days or less in 2016 [5]. This time frame is thought to be too short a period for patients and families to fully benefit from hospice care. The decreasing length of hospice stays is due to a number of factors. To be eligible for the Medicare hospice benefit patients must forego other treatments for their terminal illness and related conditions

and instead accept comfort care. With an increase in the availability of different therapies for certain diseases, more patients are seeking alternative treatments before hospice. More patients are choosing to stay in a skilled nursing facility and decline hospice services. This is because Medicare pays for room and board for a certain number of skilled days, and room and board is not covered under the hospice benefit. Furthermore, hospice is largely misunderstood, leading to patient and family resistance. Hospice is often seen as a death sentence or brink-of-death care, and there is a misinterpretation that hospice is only available at inpatient units and not in the community. When the needs of a more complex patient outweigh the usual hospice provisions and the team's capacity to provide needed clinical services, the limitations of insurance require the team to be creative in meeting those needs. Most hospices receive significant support from private donors, and many have met this challenge by seeking alternative funding sources, including grants. In addition, many hospices have a number of volunteers who can assist in meeting patient and family needs.

Summary

An interdisciplinary team-based model of care is a hallmark of the philosophy of hospice care. Hospices are encouraged to develop strong teams, allowing each team member to practice to their fullest potential. Developing strong relationships within the team and advancing expertise in IPCP through care coordination and collaboration, teamwork, core competency training, and team self-care allows the members of the team to care for each other and provide the best possible care to patients and families. NCMJ

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