Staffing a Specialist Palliative Care Service, a Team-Based Approach: Expert Consensus White Paper

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Abstract

Palliative care is an evolving field with extensive studies demonstrating its benefits to patients, families, and the health care system. Many health systems have developed or are developing palliative care programs. The Canadian Society of Palliative Care Physicians (CSPCP) is often asked to recommend how many palliative care specialists are needed to implement and support an integrated palliative care program. This information would allow health service decision makers and educational institutions to plan resources accordingly to manage the needs of their communities. The CSPCP is well positioned to answer this question, as many of its members are Directors of palliative care programs and have been responsible for creating and overseeing the pioneering work of building these programs over the past few decades. In 2017, the CSPCP commissioned a working group to develop a staffing model for specialist palliative care teams based on the interdependence of three key professional roles, an extensive literature search, key stakeholder interviews, and expert opinions. This article is the Canadian Society of Palliative Care's recommended starting point that will be further evaluated as it is utilized across Canada. For more information and to see sample calculations go to the Canadian Society of Palliative Care Physicians Staffing Model for Palliative Care Programs (<https://www.cspcp.ca>).

Keywords: multidisciplinary team staffing; needs-based model; specialist palliative care team staffing; staffing model

Introduction

CALCULATING STAFFING NEEDS for specialist palliative care services is complex, and there is little published evidence to suggest best practice. Most of the existing data indicate how many physicians are needed per population but does not take into consideration the interdependence of other team members. Staffing needs are often dependent on factors such as patient demographics, access to primary care, competency levels, models of care, and geography, to name a few.

Recognizing these challenges, the Canadian Society of Palliative Care Physicians (CSPCP) has developed a model

based on a review of international literature, expert opinion from Canadian palliative care medical directors, and feedback from key stakeholder groups.

Definition and model of palliative care

The World Health Organization defines palliative care as “an approach to care that uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated.”¹

Palliative care is a philosophy of care best delivered by an interprofessional team. Therefore, it is essential that any model incorporates other health care professionals. In this

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model, nurses, physicians, and social workers have been included as foundational roles for a specialist palliative care team. Future models will ideally include other important palliative care team members including volunteers, pharmacists, spiritual care providers, program managers, administrative assistants, and others. These team members should be added when possible, during the development of the specialist team.

In a palliative approach to care, as described in *The Way Forward*,² the role of primary care is central.³ For the sake of this model we use the term primary care to include providers who have a role in primary palliative care including but not limited to family physicians, medical specialists (oncologists, internists, geriatricians, etc.), nurse practitioners, nurses from a variety of settings (home care, ambulatory care, residential care, etc.), social workers, pharmacists, volunteers, spiritual care workers, physiotherapists, occupational therapists, and speech-language pathologists.

To facilitate care for all patients throughout the many transitions, it is recommended that core competencies and understanding of a palliative approach to care be developed in all practice settings for all disciplines. Specialist palliative care teams provide education and mentoring with the ultimate goal being that both formal and informal care providers deliver integrated palliative care.² A collaborative approach is needed between primary care³ and all sectors and disciplines.

With the aging baby boomers and the advances in medicine, we are seeing an exponential increase in people living longer with multiple comorbidities leading to an increase in demand for Palliative Care Specialist support.⁴

Discussion

The model embraces a team approach to care and recognizes that the numbers of palliative care physicians, nurses, and social workers are all interdependent.

The model supports the philosophy that specialist palliative care teams need to be involved in both clinical and nonclinical domains:

1. Clinical Care responsibilities:
 - a. Direct Patient Care—including consultation, shared care, or most responsible physician (MRP) care based on patient need.
2. Nonclinical responsibilities:
 - a. Education—including direct teaching of learners, continuing education of other providers and the public, and mentorship of colleagues.
 - b. Administration—including developing metrics to measure outcomes, quality improvement measures and processes, and development of tools, standards, policies, and programs.
 - c. Research—scholarly work to contribute to the larger body of knowledge in palliative care.

This model focuses on care for adults. A similar process could be used to develop a staffing model for pediatric palliative care, although in smaller regions the specialist palliative care team will likely be involved with both adults and children.

Assumptions Underlying the Model

1. The staffing numbers are based on need. They are grounded on a palliative approach to care, with early identification of patients who would benefit from this approach using tools such as the surprise question—“Would you be surprised if the patient died within the next 12 months?” This is a result of studies indicating that there are maximum benefits to patients, caregivers, and the health system in accessing a palliative approach to care early.^{5–7}
2. Key to the model is to start where a program currently functions and grow the program based on referrals while incorporating an integrated team approach into the staffing ratio. Therefore, the model provides a mechanism to plan human resources based on increasing referrals as a program is initiated and grows.
3. The model of care presented in this article is intended for a needs/population-based approach, not for a time-based approach, and growth is based on referrals. Using annual deaths, this model provides programs with an estimate of the potential staffing needs for a fully developed program. Calculations are based on annual deaths for the region and not just population, as they might not be synonymous.⁸
4. Primary care practitioners (as defined in Ref.³) with core competencies in palliative care, and with access to specialist palliative care teams, should manage most patients and families. Although core competencies in primary palliative care (or palliative approach to care) have been developed for most health care professionals, they have not been fully integrated into professional schools. This leaves practitioners feeling ill prepared to deal with patients with palliative care needs.⁹
5. Specialist palliative care practitioners have advanced competencies in consultant-level palliative care to support patients and families with the most complex needs. They also play an important role in capacity building and education to support and mentor primary care practitioners in providing palliative care to their patients.
6. The specialist palliative care team should have clear referral and discharge criteria. Communication and information must be easily shared in a responsible and timely manner.
7. The specialist palliative care team needs to consist of at least the following team members, with the following recommended credentials:
 - Palliative care physician, defined as a consultant with a minimum of a CCFP (PC)/CAC or Royal College Subspecialty designation FRCPC (PM).
 - Palliative care resource nurse (RN) with advanced training and CNA Palliative Care Certification—CHPCN(C)[®] (see further description of palliative care RN in Ref.¹⁰)
 - Social workers with a Masters in Social Work, and when advanced palliative care credentials are developed, meet this standard.
 - Note: This model does not address the role of Advance Practice Nurses in palliative care, as they may only be available in certain large centers. Where they are available, it is recommended that they have at minimum a CNA Palliative Care Certification—

CHPCN(C) and experience in the field of palliative care.

- Note: This model does not specifically address the role of nurse practitioners in palliative care, but their roles can be developed and identified in some programs across the country. It is recommended that they have at minimum a CNA Palliative Care Certification—CHPCN(C) and experience in the field of palliative care until credentials for palliative care Nurse Practitioners are established.
8. The specialist palliative care team and the primary palliative care team are collaborative in nature and are not intended to exist or operate in silos. The teams could be conceived as being one with multiple layers.
 9. It has been suggested in the literature that palliative care specialists and consultants should spend 50% of their time in clinical practice and 50% on educating colleagues and organizational leadership, that is, nonclinical responsibilities.^{11,12} Because of human resources and costs, this model has reduced nonclinical responsibilities for physicians to a more modest 30% (consistent with many academic positions in Canada, see Ref.¹³) and palliative care RNs and palliative care social workers to 10%, as a minimum.

Overview of the Model

In this model, patients and families are seen and assessed by primary care practitioners in their home, family physician's office, specialist's office, long-term care facility, hospital, hospice, or other location based on need.¹⁴

The primary care team (as defined in Ref.³) would identify patients who would benefit from a palliative approach early on to facilitate appropriate discussions and care. Recognizing the need for a palliative approach is based on need or potential need, and not on time or prognosis.¹⁵ The primary care team continues to assess, educate, manage, and support these patients and families, and ideally creates a roster/monitoring system. Then as changes occur or issues arise, the degree of care can be adjusted to meet the patient's goals and needs.

We ask much of our families when providing care at home for their loved ones at the end of life. One critical element that must be available to support caregivers is access to skilled home care nursing 24/7. This may be only by phone in some areas. For many families, with good preplanning, it is enough to know that they can call and speak to someone for support. Secure virtual technologies such as Skype for Business, telemedicine, and telephone, or utilizing other providers such as paramedics trained in palliative care, can fill some of the voids where 24/7 home visits are not feasible.^{16–18}

At any point in the care journey, if the primary care provider/team needs support in managing issues/needs of a patient or family, they may request a palliative care consult with the specialist palliative care team to support them. Specialist palliative care teams are a valuable resource and collaborative partner to primary care teams. Their knowledge, expertise, and skills in dealing with issues related to the multiple domains of care makes the members of the specialist palliative care team useful facilitators of care.

Palliative care RNs can advise, coach, and model comprehensive palliative care assessments, ensuring that advance care planning, goals of care, and end-of-life care planning takes place in a timely way. They can also help coordinate appropriate and timely care in the various places where patients and families want their care to occur (home, care residences, hospice). Involving the specialist palliative care team, as needed, enables the primary care team to remain the primary point of contact for the patient.

Support from the specialist palliative care team in its various forms has the potential to enhance the capacity of the primary care team and optimize care for the individual in the right place by the right person at the right time. In straightforward situations, the palliative care RN may simply give advice to the primary care physician or primary care nurse after reviewing the situation with the specialist palliative care physician and team. Examples of this would be a one-time visit to help with advance care planning or management of a symptom such as opioid neurotoxicity. If the case is more complex, the specialist palliative care team may continue to follow the patient for a period of time providing advice to the primary care team.

FIG. 1. Interaction of specialist palliative care teams with primary care teams based on levels of complexity. (Adapted from LEAP Core, Pallium Canada.)

FIG. 2. Relative involvement of primary team versus specialist team based on patient needs and complexity. (Source: Palliative Care Australia. Palliative Care Service Development Guidelines, 2018. https://palliativecare.org.au/wpcontent/uploads/dlm_uploads/2018/02/PalliativeCare-Service-Delivery-2018_web-1.pdf)

This may require a one-time palliative care physician or palliative care social worker visit or a period of shared care.^{16,19,20} Involvement of the specialist palliative care team will wax and wane depending on the complexity of the needs of the patient and family (Figs. 1 and 2).

The Numbers: Palliative Care Specialist Team Staffing

The staffing numbers for palliative care nurses, physicians and social workers are based on expert opinion unless indicated by reference.

Staffing in the community

The staffing for a new program will be based on need and will grow as referrals increase. Regions with very small populations will often start with one or more palliative care RN(s) with access to a palliative care physician for support.

- Assume that one palliative care RN can carry a caseload of 25 patients at any one time.
- Generally, one palliative care physician would be needed for four palliative care RNs (each carrying an active caseload of 25 patients), which would indicate a program caseload of ~100 patients at a time.
- For every six palliative care RNs (150 patients), the program would require one palliative care social worker.
- For each full time equivalent (FTE) palliative care physician, 30% of dedicated time goes to nonclinical responsibilities.¹³
- Therefore, for 10 required clinical FTEs, you would need an additional 3.0 nonclinical FTEs to meet the 10 FTE clinical time.
- 10% of palliative care nursing and social worker time is dedicated to nonclinical responsibilities such as education/administration/research and must be considered in any calculations (CSPCP recommendation).

The service will grow based on the referral rates leading to the end point.

Staffing in the hospital

The calculations in the hospital are based on the number of inpatient beds and referrals. If there is more than one hospital, apply the same calculation to each.

Hospital palliative care specialist consult teams

For hospitals without a dedicated palliative care unit (PCU), staffing is based on the numbers of referrals. Referrals can result in one-time visits, intermittent follow-up or shared care with a member of the specialist palliative care team.

- For smaller hospitals, consider starting with a minimum of 1 FTE palliative care RN who has access to a palliative care physician who can do referrals as needed.
- For every 25 referrals per month, it is recommended that there be 1 FTE palliative care RN, 1 FTE palliative care physician and 0.5 FTE palliative care social worker to do inpatient referrals, provide education to staff, and provide leadership.

PCUs (10 beds, nontertiary)

Recommended minimum staffing:

- The recommended minimum nursing staffing is two RNs and one LPN/RPN (licensed/registered practical nurse) from 7 am to 7 pm and two RNs from 7 pm to 7 am.⁹
- All staff would require training in palliative care. RNs should ideally have CHPCN® certification (16 and CSPCP recommendation).
- The recommended minimum dedicated clinical physician staffing is 0.5 FTE palliative care physicians plus nonclinical time built in.
- Primary care physician(s)/hospitalists/nonpalliative specialists (MRPs) should remain involved with the patients on the PCU to promote shared care, shared learning, and optimal patient care.

Tertiary care PCUs

Tertiary care PCUs with high acuity and short stays will require 1 FTE palliative care physician per five to six beds with registered nurse staffing determined by standard acute care operations for medical units.²²

Clinics

Palliative care teams providing service in clinics (e.g., oncology, cardiology, neurology, dedicated palliative care clinics) will require additional staffing based on the number of clinics and time requirements.

For each clinic day:

- 0.2 FTE palliative care physician, 0.2 FTE palliative RN, and 0.2 FTE palliative care social worker plus appropriate nonclinical time built-in.

Conclusion

We have entered into a unique time in the history of health care with the baby boomers now entering their 60s and beyond, leading to an exponential increase in demand for services including palliative care. People are living longer with multiple comorbidities leading to more complex dying. There is a great need for primary and specialist palliative care, and up until now there has not been any way to calculate staffing needs for specialist palliative care teams. The CSPCP has used their access to palliative care program leaders and key stakeholders to develop a model that can be applied in to develop and grow a specialist palliative care program.

For more information and to see sample calculations go to the Canadian Society of Palliative Care Physicians Staffing Model for Palliative Care Programs, see <https://www.cspcp.ca>

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Author Disclosure Statement

No competing financial interests exist.

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