

Algorithm for Creating a Multidisciplinary Team in the Palliative Care System

Algorytm tworzenia zespołu multidyscyplinarnego w systemie opieki paliatywnej

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SUMMARY

Aim: The study aimed to develop an algorithm for organizing the work of a multidisciplinary palliative care team in a territorial community.

Materials and Methods: The following methods were employed: analysis of the regulatory framework, statistical data, international and domestic experience, scientific literature, opinion survey, strategic sessions, participant observation. The field research was conducted by the Center for Social Research of Sumy State University together with the NGO "Family Circle of Trostianechchyna (Trostianets district)" in the Trostianets territorial community of Sumy region (Ukraine) during September–October 2021. Eighty respondents took part in the survey. Up to 30 people joined the strategic sessions at different stages.

Results: The survey discovered that at the research time in the pilot territorial community, the needs of palliative patients were more restrained than those who rendered assistance. However, in both cases, there is a high demand for social services against the background of medical services. Proceeding from the identified needs and by the results of strategic sessions, we proposed an algorithm for organizing the work of a multidisciplinary palliative care team at the territorial community level. The algorithm distinguishes between the program and operational levels. We put forward the structure of the interdisciplinary palliative care team.

Conclusions: As a conclusion, we can specify the following points. The study confirmed the hypotheses that the basics of the identified needs and the use of strategic sessions with multidisciplinary participation of community members facilitate the development of an efficient algorithm. The designed operational level of the interdisciplinary team recorded the practices available in the pilot community. Simultaneously, the collaborative design determined the development of the multidisciplinary team itself. The involvement of management representatives, junior medical staff, and social workers became an essential factor in their inspiration, contributing to the development of human resources for a new level of quality in palliative care.

Key words: need, palliative care, multidisciplinary team, healthcare professionals, social workers

Słowa kluczowe: potrzeba, opieka paliatywna, zespół multidyscyplinarny, pracownicy służby zdrowia, pracownicy socjalni

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INTRODUCTION

As of the beginning of 2019, 324,113 people in Ukraine needed palliative care, of whom adults amounted to 258,207 and children to 65,906. In 2020, the National Health Service of Ukraine, for the first time, concluded agreements on the groups of services "Inpatient palliative care for children and adults" with 431 medical institutions and "Mobile palliative care for children and adults" with 203 medical institutions. In total, 66,187 patients in hospitals and 26,913 patients in mobile services entered into a contract for palliative care [1].

Currently, Ukraine has adopted regulatory legal documents that provide a multidisciplinary approach to rendering palliative

care by doctors, nurses, social workers, psychologists, lawyers, clergy, and others when required [2]. In other words, services are supposed to be provided both by health care structures and social protection authorities involving other professionals. However, regulations offer minimum standards, whereas each community can expand the range of services and choose its model of palliative care.

International experience attests that high-quality palliative care can come into effect subject to a strong interaction between health professionals and social workers, volunteer services, service providers (including spiritual support or legal advice), the community, and families in need of assistance.

RESULTS

Surveys conducted by Monterosso L, Kristjanson L, Phillips M. (2009) proved the urgent need for multidisciplinary family support [3]. Whereas the study by Boddart, M., Stoppelenburg, A., Hasselaar, J. et al. (2021) dedicated to improving the activities of Specialist palliative care teams (SPCTs) identified significant differences in the integration and versatility of patient care [4].

A literature review showed that papers on palliative care problems focus on the multidiscipline team composition analysis in palliative care for patients with Parkinson's disease [5]; on effective interaction of representatives of medical, social, psychological, and other spheres to meet the needs of patients with life-limiting illnesses and the coherence among multidisciplinary team members, patients, and families [6]; on highlighting the necessity to support an interdisciplinary team [7], on statistical data and other quantitative indicators to determine the actual needs of palliative patients [8].

The research supports the benefits of multidisciplinary palliative care teams. The optimal team formation should occur based on the palliative care needs analysis. Providing palliative care in the whole complex, including psychological and social services, which is necessary for patients with a palliative diagnosis and their families, requires appropriate organization and resources, including local resources of territorial communities.

AIM

The study aims to propose an algorithm for organizing the work of a multidisciplinary palliative care team at the level of a territorial community, which would allow for people's current needs and available resources.

The tasks are as follows:

1. Analysis of the available international and Ukrainian experience in palliative care needs assessment;
2. Conducting a pilot study to investigate the needs in a pilot community - Trostianets territorial community of Sumy region (Ukraine);
3. Designing an algorithm for organizing the work of a multidisciplinary palliative care team at the territorial community level.

The research hypothesis assumes that developing an effective algorithm is possible based on identified needs through strategic sessions with multidisciplinary participation of society representatives.

MATERIALS AND METHODS

We used methods such as analysis of the legal and regulatory framework, statistical data, international and domestic experience, scientific literature, opinion survey, strategic session, and participant observation during the research. The activity was implemented by the Center for Social Research of Sumy State University, in cooperation with the NGO "Family Circle of Trostianechchyna (Trostianets district)" during September-October 2021 as part of the project "Development and implementation of tools for training volunteers toward providing medical (including palliative) care in Trostianets community". The study was conducted in the Trostianets territorial community of the Sumy region (Ukraine).

The face-to-face method stipulated an opinion survey of palliative care recipients and their family members (including caregivers), a total of 80 respondents, 62.5% of whom were women and 37.5% men. The distribution of surveyed palliative patients by social categories included: the elderly (50.6%), the low-income (36.7%), people with incurable diseases, diseases requiring long-term treatment (32.9%), people with partial or complete loss of physical activity, memory (31.6%), people with disabilities (20.3%), with mental and behavioral disorders, in particular, due to the use of psychoactive substances (7.6%) and the homeless (5.1%).

Studying the needs of society is a crucial component of ensuring people's quality of life. A qualitative and timely needs assessment is an integral part of proper governance based on data analysis, an essential tool for the local governments' work efficiency. It allows them to consider the problems, limitations, and consequences of decisions and programs for different population groups.

The world uses a wide range of methods to identify the need for palliative care, both at the community level and at the level of the individual family or client/patient. There are several sets of indicators and quality-of-life assessment scales.

Comparison of rendering palliative care in different countries occurs according to the death quality index. Thus, the Economist Intelligence Unit ranked countries depending on attendance conditions for those nearing the end of their lives and dying. The methodology assumes expert assessment and statistical analysis of 24 qualitative and quantitative indicators, grouped into four main sections: primary social and medical services for people at the end of life; availability and accessibility of services; service cost; service quality [9]. The WHO Guidelines for Program Managers "Planning and Implementing Palliative Care Services" [10] defines four groups of indicators due to consideration when implementing palliative care services: education indicators; service delivery indicators; drug indicators; result indicators.

It is stipulated that every palliative care service should initially include accounting and evaluation mechanisms to ensure that effective programs are supported, and resources are not wasted on ineffective programs.

Based on the approaches proposed in the Global Atlas of Palliative Care [11] and Assessment of the Need for Palliative Care for Children (International Children's Palliative Care Network, UNICEF), 2013], in the autumn of 2017, Ukrainian Center for Public Data modeled the need for palliative care in children and adults based on mortality data and prevalence of certain diseases in Ukraine [1]. By this model, according to 2018 data, the need for palliative care in the Trostianets territorial community is at the level of 240 people (including 22 children).

Our study assumed:

- Detection of physical, emotional, social, and spiritual condition in patients and their family members (including caregivers);

- Identification of medical, social, psychological, and spiritual services required by the patient and his family members (including caregivers);
- An assessment of the interaction between the main actors of palliative care.

The study also considered that a common practice in identifying palliative care needs is interviewing palliative patients and caregivers.

56.7% of patients receive care at home and 43.3% in health care facilities. Rural residents are more likely to receive medical care (65% of rural residents and 35% of urban ones).

Assessing their own physical and psychological condition, clients noted that they suffer from depression (44.4%), incapability of self-caring (40.3%), suffer from weight loss (33.3%), sleep disturbances (33.3% each), chronic fatigue and tiredness, anxiety/stress (25% each). In turn, 29.2% of respondents among family members of palliative patients note the impossibility of caring for the patient, 24.6% confess to deteriorating their health and anxiety/stress, 23.1% - to the feeling of depression, 20% - to chronic diseases, 18.5% - helplessness and 16.9% - physical fatigue.

Among the declared needs for palliative care, patients note: home care, daycare (32.5%), social support (18.33%), and access to medicines (10.83%) (Figure 1).

In turn, those caring for palliative patients point out the need for: assistance in attendance (35%), health professionals' counseling (33.3%), psychological assistance (31.7%) (Figure 2).

Thus, the results of the palliative patients' survey and caregivers allow us to identify diverse needs (physical, social, legal, emotional, psychological, spiritual) and form the optimal multidisciplinary team.

The study emphasizes that the patient's physical suffering from pain goes along with psychological, mental anguish. Therefore, in addition to physiological and treatment needs, the patient's need for psychological and spiritual support, social support, legal counseling services is quite acute. Thus, there is a need for more extensive involvement of social work and psychology specialists, therapists, clergy, volunteers. It requires cooperation in the community between

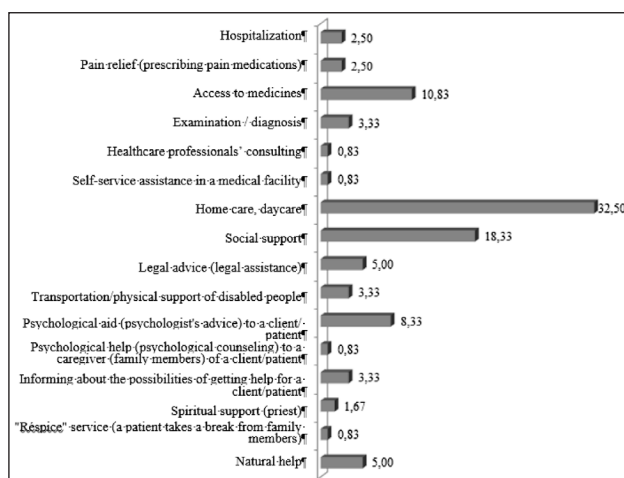


Figure 1. Types of services a palliative patient needs



Figure 2. Types of services palliative caregivers require

health care, social protection, volunteer, public, and service organizations.

Moreover, if we group the required services, we see that palliative patients give 64.15% of the need for various types of social assistance, 19.99% - medical, 8.33% - psychological, 5% - Legal, 1,67% - spiritual assistance. Caring for palliative documents, palliative patients give 88.3% of the need for various types of social service, 51.6% - medical, 31.7% - psychological. Palliative care patients' needs are more restrained, while caregivers' are much more significant. However, in both cases, the demand for social services is a priority. Accordingly, it should find its expression in the structure of the Interdisciplinary team and the content of its work.

The Trostianets territorial community has contracted palliative care for patients in hospitals and mobile palliative care. However, under the specifications, funding is provided for medical services. At the same time, interaction with social services, the involvement of at least one social work specialist, including at the expense of local budgets, and funds from other programs of the central budget are the requirements for the organization of palliative care services. Also, beyond the contracts with the National Health Service, there is social work with caring relatives in response to existing needs. Herewith, the territorial community had an initiative and an agreed position of the local self-government and the public sector on the development of the palliative care system at the current level, based on the concept of the quality of a palliative patient.

The existing contradiction between the allocation of state funds for the medical component of care and the high demand for social assistance from people determines the need for program solutions at the territorial community level. Accordingly, it seems reasonable in the algorithm of work organization of a multidisciplinary palliative care team at the territorial community level to distinguish two tiers: program and operational.

To create a multidisciplinary team, the Trostianets territorial community involved:

- The city hospital (coordinates medical care and psychological support);
- The Center for Social Services (supplies with social workers and coordinates advisory and spiritual support);
- The non-governmental organization "Family Circle of Trostianechchyna (Trostianets district)" (searches for volunteers, attracts additional extrabudgetary funds);

- Local religious organizations (coordinate spiritual assistance to palliative patients).

In the project “Development and implementation of tools for training volunteers toward providing medical (in particular, palliative) assistance in Trostianets community,” on the example of the pilot Trostianets community, we elaborated the two named levels of the algorithm through strategic sessions with the participation of local officials, doctors, social workers, junior medical staff, social workers. The structure of the algorithm program level for organizing the work of a multidisciplinary palliative care team highlights the components for identifying needs and assessing palliative patients’ quality of life, interdisciplinary training of specialists, budget planning. During generalizing the developments, there appeared the idea of rotation in the program management of the representatives of primary health care and social protection system. The work coordination in the community provided for creating a Coordinating Council with the subsequent approval of an action plan. The Coordinating Council is being created at the initiative of the public organization “Family Circle of Trostianechchyna (Trostianets district).” The multidisciplinary team developed regulations for palliative care in the Trostianets territorial community. Both representatives of the authorities and civil society took part in it. The proposed “homework” was to develop a program for 2022, including the subsequent assessment of palliative care needs, budgetary and extrabudgetary funds attraction, advanced training of specialists involved in the practical service delivery.

The operational level of the algorithm was developed as a map of receiving targeted palliative care services for a specific person at the end of life (Figure 3).

One of the further tasks for the community is to conclude agreements between the subjects of palliative services to enhance interaction between them. The contracts spell out the interaction algorithm, define the areas of responsibility and standards of rendering services, accountability, coordination, and communication of work with members of the multidisciplinary team, and monitor the agreement implementation. Thus, the agreements will formalize the relationships between the palliative care subjects, obliging them to comply with uniform standards.

Following the proposed levels of the algorithm in the structure of the interdisciplinary team, it seems reasonable to distinguish the program level (with an annual management rotation from the direction of the primary medical care and social protection system) and operational level among doctors, social workers, junior medical staff, social workers in number corresponding to the current availability of needs. Under the present conditions at the operational team level, we plan to attract other specialists and representatives of the clergy.

DISCUSSION

The study results confirmed the necessity to assess palliative care needs. We performed such research in a pilot community - Trostianets territorial community of Sumy region (Ukraine), acquired data on residents’ needs. Besides, there is a wide

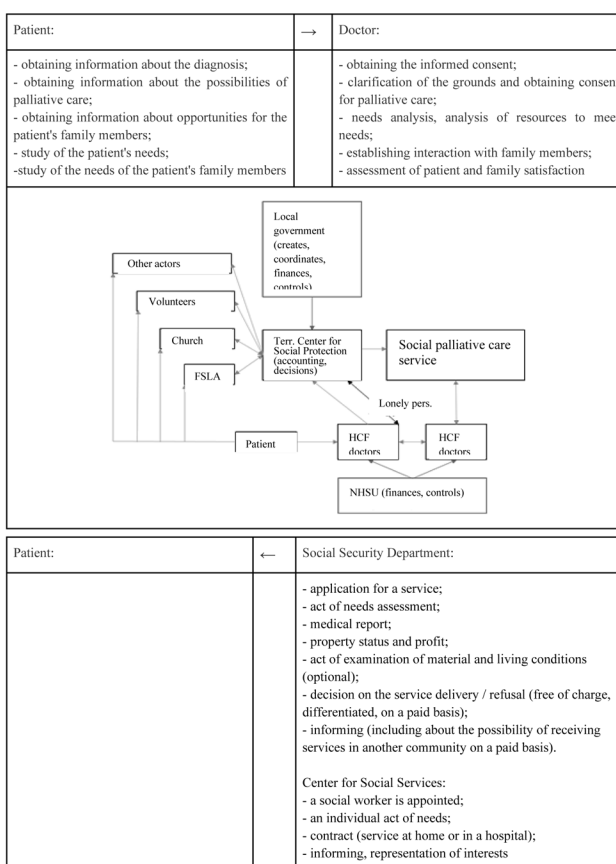


Figure 3. Algorithm for organizing a multidisciplinary team

range of approaches to studying and analyzing requirements and life quality assessment. Further improvement of the currently employed methodology seems appropriate. We must state that now Ukraine has poorly developed data collection and analysis practices. However, such research results should gradually accumulate and become the basis for decision-making.

The survey as a method of analysis has its limitations, which are determined by the subjectivity of the respondents, whose answers may be due to their physical and psychological condition. In this regard, we should subsequently use analytical techniques, which allow us to collect objective data on the needs of palliative patients and caregivers.

The social survey results obtained in the pilot community gave impetus to strategic sessions with local self-government representatives, specialists, junior medical staff, and social workers. The strategic session resulted in the development of the multidisciplinary team structure, the program and operational levels of the algorithm for organizing its work to provide palliative care services. The work became possible due to the leadership and collaboration of local self-government and the public sector. However, further regular work in the community requires explicit coordination at both the program and operational levels. The idea of leadership rotation at the algorithm program level seems debatable. This idea is currently presented as a hypothesis and still needs to be tested in practice.

CONCLUSIONS

The survey revealed that social needs exceed medical ones, and the relatives' needs exceed those of palliative patients. This situation is relevant at the research time in the pilot community. However, other options seem possible. Following them, the idea of rotation at the head of the program level of the algorithm, whether it is a representative of the primary link of the medical system or the social protection system, is sound.

It is this set of actions on the algorithm program level for organizing the work of a multidisciplinary palliative care team that seems to be complete: scrutiny of existing needs, budgeting, training, and advanced training, coordination of the operational level of the algorithm according to the needs of palliative care specific clients, their relatives, the readiness of the latter to participate.

At the implementation stage, annual cycles seem appropriate for the program level of the algorithm, then – three-year ones.

During the strategic sessions, we confirmed the hypotheses that the basics of the identified needs and the use of strategic sessions with the multidisciplinary participation of community members will facilitate the development of an efficient algorithm. The designed operational level of the interdisciplinary team (palliative care map), to some extent, captures the practices available in the pilot community. Simultaneously, collaborative design and optimization of processes contribute to multidisciplinary team formation. Involving junior medical personnel, social workers, and management representatives became a significant factor in their inspiration, contributing to the development of human resources for a new level of quality in palliative care.

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Conflicts of interest:

The Authors declare no conflict of interest

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