Enhancing family physician capacity to deliver quality palliative home care

An end-of-life, shared-care model

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ABSTRACT

PROBLEM BEING ADDRESSED Family physicians face innumerable challenges to delivering quality palliative home care to meet the complex needs of end-of-life patients and their families.

OBJECTIVE OF PROGRAM To implement a model of shared care to enhance family physicians' ability to deliver quality palliative home care, particularly in a community-based setting.

PROGRAM DESCRIPTION Family physicians in 3 group practices (N=21) in Ontario's Niagara West region collaborated with an interprofessional palliative care team (including a palliative care advanced practice nurse, a palliative medicine physician, a bereavement counselor, a psychosocial-spiritual advisor, and a case manager) in a shared-care partnership to provide comprehensive palliative home care. Key features of the program included systematic and timely identification of end-of-life patients, needs assessments, symptom and psychosocial support interventions, regular communication between team members, and coordinated care guided by outcome-based assessment in the home. In addition, educational initiatives were provided to enhance family physicians' knowledge and skills.

CONCLUSION Because of the program, participants reported improved communication, effective interprofessional collaboration, and the capacity to deliver palliative home care, 24 hours a day, 7 days a week, to end-of-life patients in the community.

RÉSUMÉ

PROBLÈME À L'ÉTUDE Le médecin de famille rencontre d'innombrables défis lorsqu'il veut prodiguer des soins palliatifs de qualité à domicile pour répondre aux besoins complexes des patients en fin de vie et à ceux de leur famille.

OBJECTIF DU PROGRAMME Instaurer un modèle de soins partagés pour permettre au médecin de famille de prodiguer de meilleurs soins palliatifs à domicile, particulièrement en milieu communautaire.

DESCRIPTION DU PROGRAMME Des médecins de famille pratiquant en groupe dans 3 établissements (n=21) de la région Niagara-Ouest de l'Ontario ont collaboré avec une équipe interdisciplinaire de soins palliatifs (incluant une infirmière praticienne spécialisée en soins palliatifs, un médecin de soins palliatifs, un conseiller en deuil, un conseiller du domaine psycho-socio-spirituel et un gestionnaire de cas) à la prestation de soins palliatifs complets à domicile. Les principales caractéristiques de ce programme comprenaient l'identification en temps approprié des patients en fin de vie, l'évaluation des besoins, les interventions visant les symptômes et le support psychosocial, la régularité de la communication entre les membres de l'équipe et la coordination des soins évaluée d'après les issues à domicile. On a aussi tenu des séances de formation pour parfaire les connaissances et habiletés des médecins de famille.

CONCLUSION Les participants ont déclaré que le programme avait entraîné une meilleure communication, une collaboration interdisciplinaire plus efficace et la capacité de dispenser en tout temps des soins palliatifs à domicile aux patients en fin de vie.

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Program Description

Enhancing family physician capacity to deliver quality palliative home care

While family physicians wish to remain active in the care of their dying patients,[1] it can be a challenge to address the complex issues at the end of life (EOL).[2-4] Additionally, family physicians often receive insufficient training in palliative care[5-7] and experience difficulty in accessing specialist resources for support. Effective, sustainable models of palliative care that support optimal care and death at home can be achieved, however, when family physicians work in collaboration with interprofessional, specialist palliative care teams.[8-13] In the United Kingdom, such models of care demonstrate improvement in all parameters of community-based care.[12,14]

Across the country, a number of service gaps continue to exist similar to those identified in previous publications (**Table 1**).[15] There is an urgent need to develop a true shared-care model of interprofessional palliative home care to enable family physicians to provide effective care in the context of an aging population, a rising prevalence of cancer,[16] chronic illness, and shortages of hospital-based resources. The focus of this paper is to describe the shared-care model that was created in the Niagara West region of Ontario (620 km^2, 3 towns, and a total population of 80 000) and discuss the interventions and outcomes that pertain to family physicians and primary caregivers. Most patient outcomes are reported in a separate paper.

Program objectives and goals

The overall goal of the program was to enhance family physician capacity to deliver palliative home care through collaboration with interprofessional palliative care specialists in a shared-care model. Specifically, this goal entailed improving access to palliative care through the use of screening criteria and case finding in family practice offices; improving primary care physicians' knowledge, skills, and confidence in providing palliative care through practice-based education and shared clinical care with palliative care experts; and improving the quality of palliative home care through specialist team enhancements.

Program description

The program involved 3 months of resource development, 15 months of service delivery, and 3 months of data analysis. The pre-existing West Lincoln Memorial Hospital Palliative Care Team, a part-time community team, expanded into the Enhanced Palliative Care Team (EPCT). **Figure 1** illustrates the 4 key components of the care model, which are as follows:

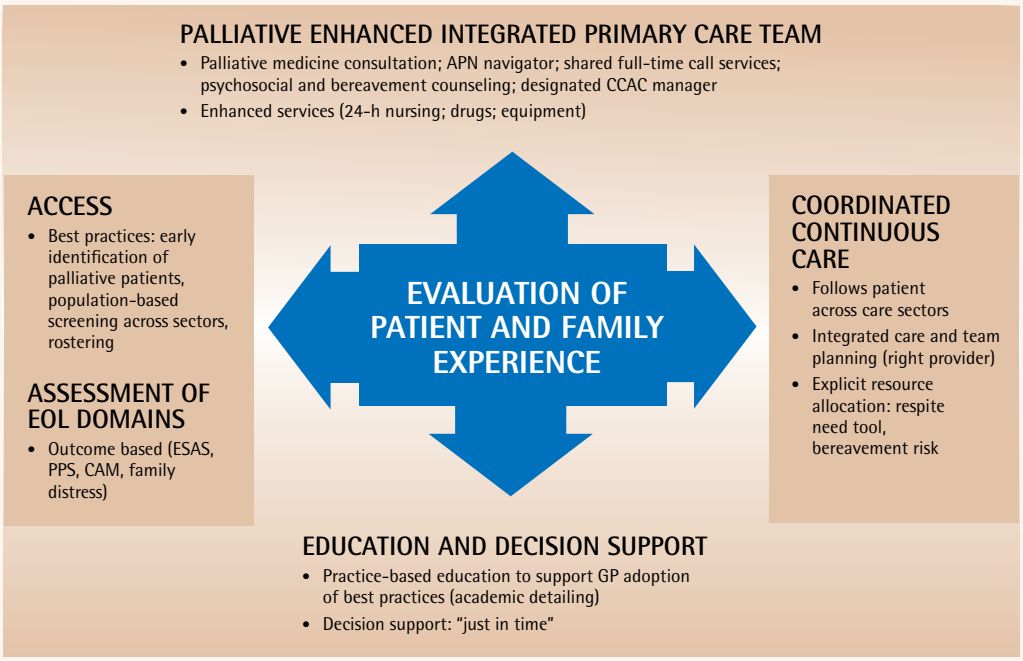
Enhanced and integrated teams. The EPCT included a full-time palliative care advanced practice nurse (APN), a part-time palliative medicine physician (PMP), a psychosocial-spiritual advisor, a bereavement counselor, and a full-time Community Care Access Centre (CCAC) case manager. Self-selected "Physician Practice Leaders" from each of the 3 family practice groups involved in the project were mentored by the EPCT in palliative care knowledge and skills and given support to attend training courses. The practice leaders, the APN, and the PMP all joined an on-call roster available to the community nurses and doctors 24 hours a day, 7 days a week, for advice during off hours. The APN was a "navigator"

Table 1. Service gaps in current practice

TYPE OF GAP	DESCRIPTION
Access	• Lack of early identification of patients owing to differing definitions of *palliative population* • Persistent lack of designated and dedicated coordinators or navigators to oversee organization, support case finding (patient rostering), and coordinate best practices across relevant care sectors • Lack of sufficient expert medical palliative care resources to assist family physicians with the provision of care (timely and consistent access, eg, after hours)
Assessment	• Lack of appropriate tools that allow family physicians to provide best practices care in home and community settings • Inconsistent or nonexistent application of outcome-based, EOL care domain assessment tools
Care	• Lack of skilled psychosocial, spiritual, and bereavement supports for EOL patients and families living in these communities • Lack of timely respite care, necessitating unwanted and undesirable hospital admissions and emergency room visits • Lack of timely communication and flow of information in a manner that allows family physicians to remain the key providers of continuous care • Lack of mechanisms that allow family physicians, in the context of their own office "teams," to interact and collaborate directly with community palliative care team providers
Education and decision support	• Inability to model comprehensive palliative care, including best practice skills, knowledge, behaviour, and resources, for medical students and family medicine residents, owing to lack of structured contacts and resources • Lack of opportunities for practice-based continuing education utilizing academic detailing to develop best practices and collaborative skills • Lack of opportunities and resources (eg, salary replacement dollars) for mentorship, role modeling, and development of family physician practice "leads" who can be trained in turn

EOL—end of life.

Figure 1. Key components of the shared-care model for optimal palliative care



APN—advanced practice nurse, CAM—Confusion Assessment Method, CCAC—Community Care Access Centre, EOL—end of life, ESAS—Edmonton Symptom Assessment System, PPS—Palliative Performance Scale.

for communication between team members, clinical coordination of care, and overall patient care. The psychosocial-spiritual advisor provided counseling support, while the bereavement counselor provided bereavement risk assessment and support. The CCAC palliative care case manager was part of the team to ensure effective resource allocation consistent with care needs.

The APN, the bereavement counselor, and the psychosocial-spiritual advisor were funded by an Ontario Primary Health Care Transition Fund (PHCTF) grant (**www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index_e.html**). The CCAC covered the case manager's salary, and the PMP continued in her previous fee-for-service model but received a stipend from the PHCTF for educational sessions with the participating family physicians. Stipends for the on-call roster were also supported by the PHCTF grant.

Access and assessment. Case finding and screening ensured that family physicians and patients received timely access to the EPCT. Using triage methods supported by health systems planners,[17] the following screening questions were developed for the family physicians to consider:

1. Would you be surprised if this patient died in the next 12 months?
2. If no, does this patient have pain, symptom issues, or supportive care needs?

Family physicians and their staff were encouraged to refer patients who met these criteria to the shared-care team. The EPCT provided consultations and visits to the patients and families according to the needs expressed by the family doctors or community nurses. Care plans were made and implemented as a group. The EPCT involvement was flexible and was dictated by the needs of the patients, the families, and the family physicians. The family physicians remained the ones most responsible for their patients, with the EPCT involved as collaborators in care and second-line support. The family physicians could request any member of the EPCT for joint visits. A "case navigation" binder was created for each patient, for the patient to take home, and contained a list of contacts, clinical assessment schedules, and various assessment tools. The EPCT created and used an interprofessional documentation form (**Figure 2**) based on the "Square of Care"[18] to assess patients' needs and develop care plans that enabled all team members to contribute their expertise. Patient assessment tools included the Edmonton Symptom Assessment Scale,[19] the Confusion Assessment Method,[20] the Palliative Performance Scale,[21] and the National Comprehensive Cancer Network's patient and caregiver distress scale.[22]

Coordinated, continuous care. Communication between members of the EPCT and the family physicians was a priority. Referred patients were discussed

Figure 2. Palliative care interprofessional team documentation

Date/Time: _____ Name: _____

Duration of contact: _____ ID#: _____

Contact ☐ Visit ☐ TPC

Accompanied by _____
Name/relationship of caller

☐ Incoming ☐ Outgoing

Place: ☐ Home ☐ Office ☐ Other, specify _____

Domains of Care

- ☐ Disease management: care coordination
- ☐ Physical issues: symptoms
- ☐ Psychological issues: emotions
- ☐ Social issues, financial, WSIB, POA
- ☐ Spiritual: values, beliefs, ethical
- ☐ Functional: ADL, roles
- ☐ EOL/goals of care
- ☐ Loss/grief

White — Patient chart Yellow — Health Professional Copy Pink — Research Office

at weekly EPCT meetings to ensure optimal documentation, communication, and coordination of care. The integration of family physicians as team members, using the APN as a link to family practice offices, and the communication mechanisms such as weekly updates to family physicians were critical elements of the model. The APN in particular was the key point of contact among the family physicians, patients, and families, and the other EPCT members across care settings. Strong foci for the APN included helping all providers with early symptom identification and leading clinical problem solving.

Education and decision support. The APN and the PMP identified educational needs of physicians and community nurses and coordinated practice-based, evidence-based strategies ("just in time" case-based teaching, chart reviews, academic detailing) to improve the knowledge, skills, and confidence required to deliver optimal care. **Table 2** summarizes the topics covered during the 15 clinical and educational multidisciplinary sessions held in all 3 practices. These sessions were open to the physicians' practice teams (nurses, pharmacists, students), the EPCT, and community nurses. The Physician Practice Leaders assumed leadership for these sessions as the project progressed.

Table 2. Summary of topics covered

TOPIC	DISCUSSION POINTS
Pain	• Pain management • Adjunct therapies • Pain scales • Use of steroids
Other symptoms	• Nausea and vomiting • Constipation, bowel troubles • Depression
Emergent issues	• Increased calcium and sodium levels • Cancer clinic treatment • Respiratory depression • Respiratory distress
Management issues	• Pharmacology of palliative care • Alternative therapies • Increased personal comfort level with managing care • Checklists or approaches to management • Home setting resources
Prognostication	• End-stage symptoms • Medications
Communication	• Delivering bad news • Difficult emotions, situations, and families (in anger or denial) • Communication regarding spiritual aspects of the end of life • Balance between needs of patients and families
Team	• Interaction with other health professionals • Role of team members and how to access • When to refer

Results

The project recruited 100% of family physicians from 3 family health teams (N=21) who, in a 12-month period, referred 114 patients to the EPCT for shared care. This represented a 40% increase in yearly referrals compared with referrals to the West Lincoln Memorial Hospital Palliative Care Team. Office chart reviews indicated 775 contacts made by the physicians: 236 office visits, 242 home visits, and 297 telephone calls or e-mails. Recipients of contact were predominately the EOL patients or their families (59%), followed by nurses (30%) and PMPs (5%). A total of 22 physicians and 36 nurses or other practice staff attended the 15 practice-based educational sessions during the project. Four physicians from the 3 practices elected to be Physician Practice Leaders. The on-call roster was used mostly on weekends, with calls from community nurses; on-call clinicians received an average of 1 to 2 calls per day. Most calls were to discuss escalation of symptoms or to obtain new orders or care plans. Actual visits to patients occurred less than once weekly (when on call).

Patients' preferences for place of death were able to be accommodated much more frequently during this project. In total, 93% of the patients who expressed a preference for a place of death stated they wished to die at home; 59% of these patients did die at home, compared with 28% of palliative patients before the project. Mean length of patient participation in the program was 145.14 days (range 5 to 445 days). Sixty-six percent of patients referred to the project died by the end of the study period.

Provider perceptions of the project were evaluated through surveys, interviews, and focus groups. A survey was developed and mailed to the 21 physicians and 6 community nurses involved with the project to ascertain their views in 4 areas: roles and value of team members; team interaction; changes in practice; and effects on care quality. Of the 27 surveys sent, 4 nurses and 12 physicians replied, for a 60% response rate. Physicians felt that the most imperative component of the care model was having access to palliative care consultations around the clock. Practice-based education was felt to be the next most important component. Most physicians valued the personal contact with the EPCT. Physicians also felt that patients greatly benefited from access to a more comprehensive palliative home care team and from the coordinated, seamless integration of services. In general, physicians felt that the project improved quality, communication, coordination, continuity, and integration of care and allowed them to maintain their role as the primary care providers.

The community nurses most valued the improved trust and working relationships between themselves and

family physicians, whom they now felt were more confident and available to discuss treatment plans. They also felt less alone in handling complex issues that arose in the home setting. Support from the APN enhanced their problem-solving skills, which in turn improved their confidence in decision making.

Five physicians also participated in a qualitative, semistructured telephone interview after the project, and 4 community nurses participated in a focus group guided by a semistructured interview. Audiotapes from interviews and focus groups were transcribed and themes were identified using content analysis techniques.[23] These findings are summarized in **Tables 3** and **4.**

Discussion

This study of the shared-care model established that family physicians can provide ongoing care to their palliative care patients and families if supported through integrated and collaborative models of shared, interprofessional, specialist palliative care. This is particularly useful for physicians in limited-support practice communities, such as large rural areas. The family physicians and the community nurses participating in this program felt more confident and capable with such supports. The APN appears critical to the facilitation of the shared-care process by modeling best practices, identifying patients early, and enhancing family physician and community nurse involvement. Presumably by enhancing the efficiency and quality of physicians' time with EOL care patients, the EPCT truly supported the family physician and allowed them to be more effective in their work.

This study also demonstrated that a home-based, shared-care model can accommodate patients' preferences for place of death more often than more traditional models. There was a strong sense from participants that a care model was finally in place that created confidence in communicating by knowing "who to call for what" and how to build capacity within their own system.

Some success of this project could be attributed to the previously established relationships between the preexisting palliative care team and some family physicians. This situation might not be as readily generalizable to other communities, which is a limitation of the study.

Future direction

The model has great relevance to the primary health care transformation agenda, as it focuses on building and enhancing the capacity of family physicians to deliver effective primary palliative care and supports integrated interprofessional teams. It is now the care model exemplar for the Local Health Integration Network in the Niagara West region. Dissemination of the project indicates interest at a systems planning level for this model. Sustainability of such models, however, hinges on changes in policy and funding that will allow for partnerships in true shared-care models customized at the community level.

Table 3. Themes from interviews with physician participants after the project

FOCUS OF INTERVIEW QUESTIONS	KEY IDEAS SHARED BY PARTICIPANTS	KEY QUOTE SUPPORTING THEME
Most valued component	• Support of team • On-call access to physician specialist interdisciplinary team	"[H]aving access to the palliative physician ... because I never worked with a palliative care person before ... that was a new experience for me ... having that access was really expert, was really valuable"
Effects on role or practice	• Confidence in decision making • Sustained involvement	"[M]y load is less. And that is very good, but I still feel I am involved in the sense that I don't feel like I am abandoning my patient and I am still involved in terms of what's going on, and in feeling part of it, and certainly looking after palliative patients is an important part of family medicine and very rewarding one .... it actually makes it go easier"
Coordination of care	• Ease of access • Comprehensiveness of support • Quality of communication	"[I]t was easier to get more support into the home. I would say it ... happened faster and was more comprehensive ... in terms of getting more individuals involved with varying levels of expertise ... and during duration of [the patients'] journey through palliative care ... they were getting more hours of support. The dialogue with various team members was increased and ... of a higher quality"
Effects on quality of care	• Anticipation of needs • Averted crises • Enabled home death • Reduced fears of suffering	"I think it was fabulous ... because, you know, when all the people have so much anxiety, can I handle this? What is the next crisis going to be? And I really get a sense from most of my families that everything that would come would be dealt with right ... the patients knew they were not going to be suffering; they knew they weren't going to be in pain. Anything that happened, there was a solution for it"

Table 4. Themes from interviews with nurse participants after the project

FOCUS OF INTERVIEW QUESTIONS	KEY IDEAS SHARED BY PARTICIPANTS	KEY QUOTE SUPPORTING THEME
Most valued component	• Access to palliative experts • Interdisciplinary team support • Access to on-call services	"[M]ade a huge difference. Even just, you know, even though I didn't have to access it very often, you know it's there .... You know that, okay, this guy is really sick, if I get called there in middle of the night ... I've got somebody else I can call instead of sitting there and thinking, okay well, I've done what I can but ..."
Effects on role or practice	• Confidence in decision making • Better anticipation of needs	"To pick somebody's brain ... when you're in a situation and you're thinking, okay ... I don't know what else to do here .... We've done everything we can do, and it was just nice to have that one person that you could just access and say ... okay [refers to Advanced Practice Nurse] what do I do now? .... She opened up different options, okay, maybe go this way instead of ... you're leaning too far that way, or she just gave you more insight"
Coordination of care	• Trust and respect between nurses and physicians • Quality of communication • Access to home services	"[T]he network has been amazing ... even in the daytime. If the family doctor was on the project ... I could phone in and ... we were put right through to the doctors, and things were dealt with right away. And if the doctor wasn't working there was always someone covering. And you were just put right through, and ... I mean it was amazing. I've worked in [refers to town], and it's like road block, STOP! Can't go any further. It's just horrible .... This was like [a] highway"
Effects on quality of care	• Enabled home death • Adjustment support	"[W]e would never have gotten to the place before death that we were at ... one situation was a single mom ... teenage kids ... the psychosocial counselor ... did a huge amount in getting things in order ... helping them work out finances ... preparing to get a minister in place ... she wanted to stay at home [and] the teens couldn't care for her ... to be able to provide that care and have her stay home ... she was able to accomplish everything she wanted before death ... it involved shift nursing ... visiting nursing ... chaplain"

Conclusion

This project has demonstrated that willing family physicians can successfully deliver effective care to their palliative home care patients on a full-time basis if supported by a collaborative practice and integrated models of care delivery. All of the family physicians approached participated in the project and were willing to use best practice screening criteria to identify palliative care patients early on in the advanced disease and dying trajectory. The role of a small but accessible consultation team was invaluable, as it allowed the physicians to share the load, grow in skill, and maintain their important primary role in the care of the patients. High-quality EOL care in Canada is achievable with this shared-care model of palliative primary care.

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Contributors

Drs Marshall, **Howell, Brazil, Howard**, and **Taniguchi** contributed to concept, design, and implementation of the program; data gathering, analysis, and interpretation; and preparing the manuscript for submission.

Competing interests

None declared

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EDITOR'S KEY POINTS

- Family physicians often wish to participate in the end-of-life care of their dying patients, but there are substantial challenges to the delivery of this complex care. This program aimed to enhance family physician capacity to deliver palliative home care through collaboration in an interprofessional shared-care model.
- Specific goals of the program included improving access to palliative care through the use of screening criteria and case finding in family practice offices; improving primary care physicians' knowledge, skills, and confidence in providing palliative care through practice-based education and shared clinical care with palliative care experts; and improving the quality of palliative home care through specialist team enhancements.
- Physicians felt that the most helpful component of the program was having access to palliative care consultations around the clock. The community nurses most valued the improved trust and working relationships between themselves and family physicians. Both nurses and physicians felt increased confidence in their decision making.
- Physicians felt that patients greatly benefited from access to a more comprehensive palliative home care team and from the coordinated, seamless integration of services. The program was also able to accommodate the patients' preferences for place of death more often than more traditional models.

POINTS DE REPÈRE DU RÉDACTEUR

- Le médecin de famille désire souvent prendre part aux soins des patients en fin de vie, mais cette tâche complexe comporte d'importantes difficultés.. Ce programme a pour but d'améliorer la capacité du médecin de famille de prodiguer des soins palliatifs à domicile en collaborant avec une équipe interdisciplinaire de soins partagés.
- Les buts spécifiques du programme sont entre autres: améliorer l'accès aux soins palliatifs en établissant des critères de dépistage et en dépistant les cas dans les bureaux de médecine familiale; améliorer les connaissances et les habiletés du médecin de première ligne, et sa confiance en sa capacité de prodiguer les soins palliatifs grâce à une formation fondée sur la pratique et en partageant les soins cliniques avec des experts en soins palliatifs; et améliorer la qualité des soins palliatifs à domicile grâce à l'appui de l'équipe de spécialistes.
- L'accès en tout temps à des consultations en soins palliatifs était la composante la plus utile du programme d'après les médecins. Les infirmières communautaires privilégiaient une confiance accrue et de meilleures relations de travail avec les médecins de famille. Les infirmières comme les médecins se sentaient plus confiants pour prendre des décisions.
- Les médecins croyaient que l'accès à une équipe élargie de soins palliatifs à domicile et à des services intégrés de façon transparente était grandement avantageux pour les patients. Le programme permettait aussi de respecter plus souvent que les modèles traditionnels le lieu où le patient désirait mourir.

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