General healthcare professionals and specialists in palliative care: do they find each other?

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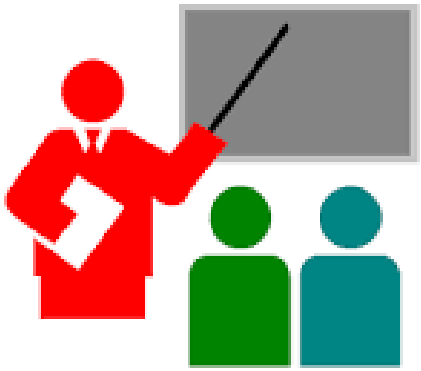
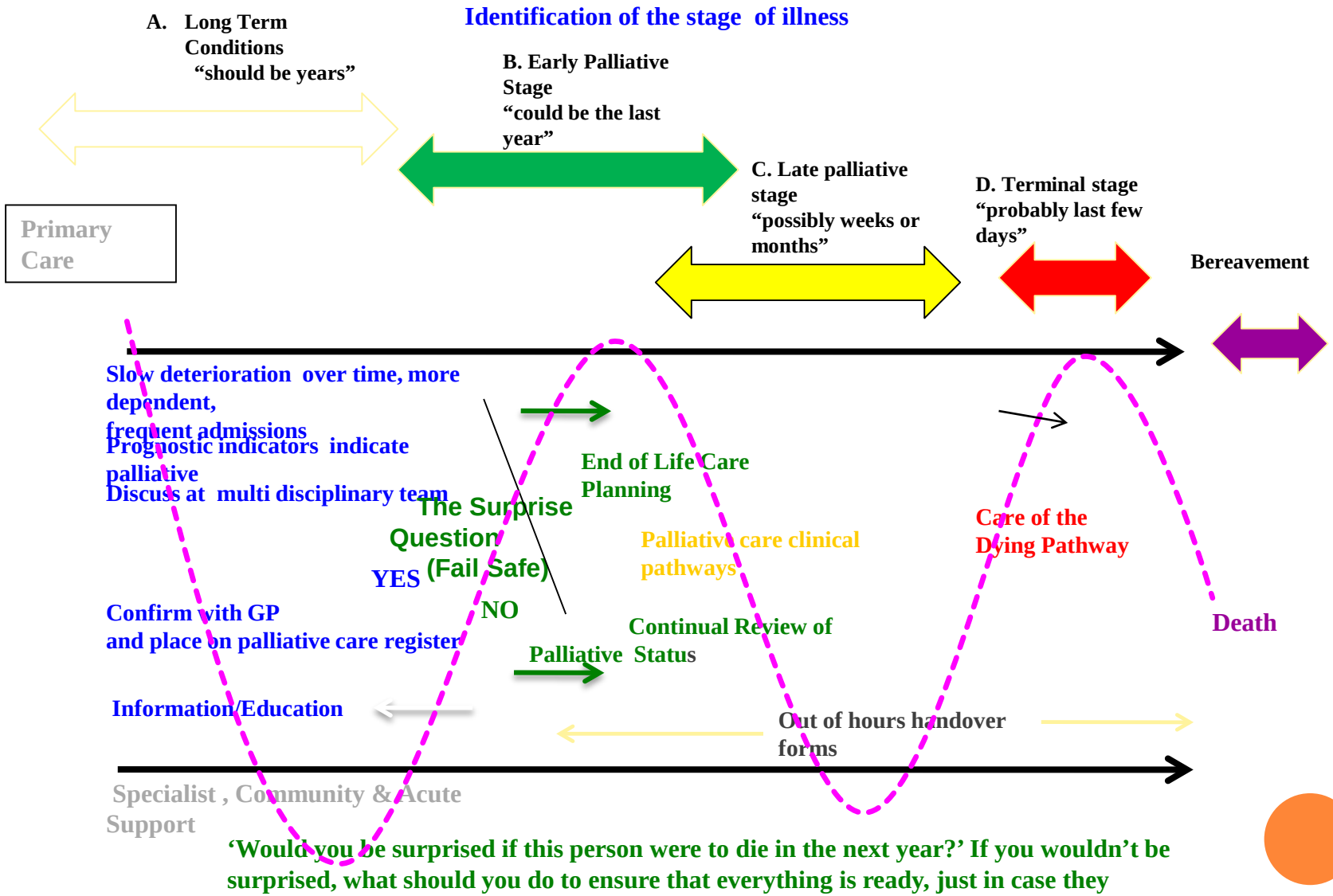
Some questions to address

- What has the generalist-specialist debate taught us?
- Where is the evidence for what works, when and how?
- What needs to happen now for a sustainable future for palliative care?



What has the generalist-specialist debate taught us?

Palliative Care Operational Systems Model



'Would you be surprised if this person were to die in the next year?' If you wouldn't be surprised, what should you do to ensure that everything is ready, just in case they deteriorate quickly?

Palliative care needs a reality check

What is the future for palliative Care?

- Proposed annual death rise internationally of 17% by 2030 (Gomes and Higginson 2008)
- For most people, palliative care is not delivered by specialists
- The purpose and scope of specialist palliative care means different things to different people
- Where are the next generation of palliative care practitioners?

Who is looking for Whom?

What is the challenge with current models of service delivery?

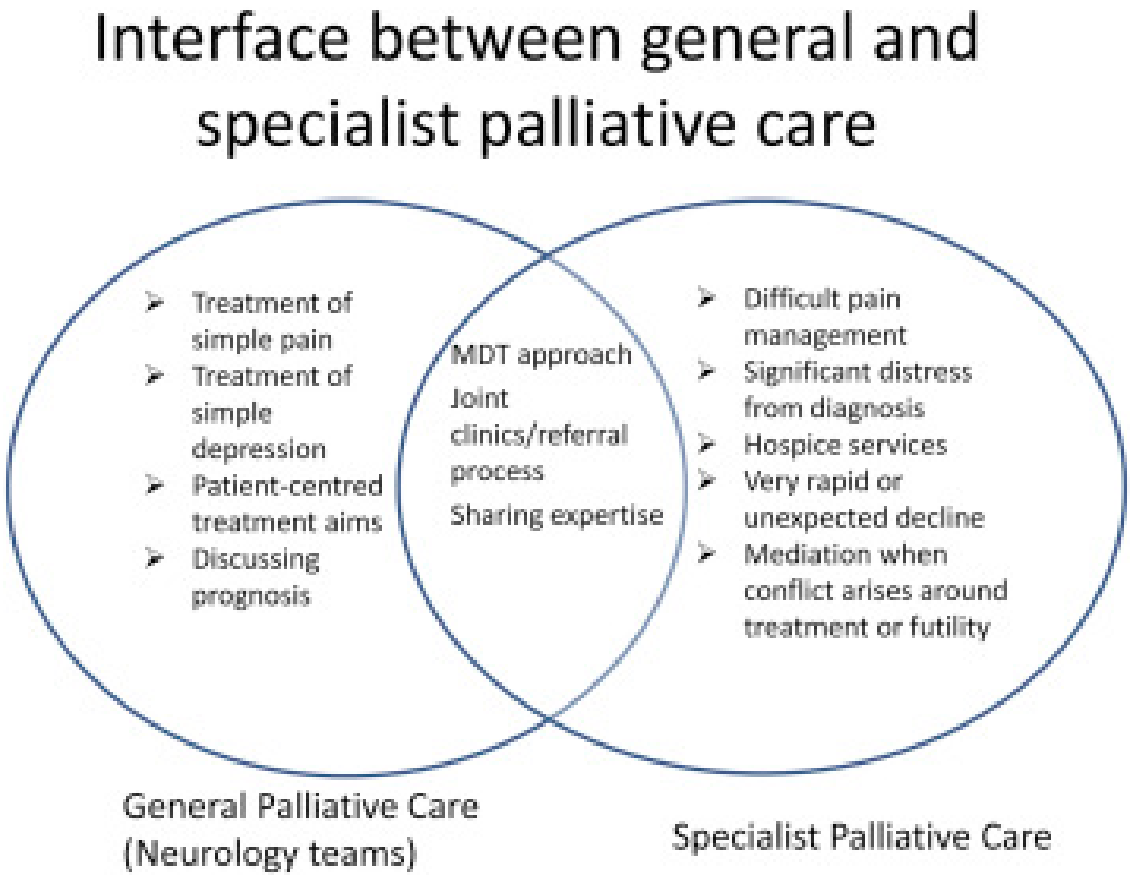

Research

Factors supporting good partnership working between generalist and specialist palliative care services:

a systematic review

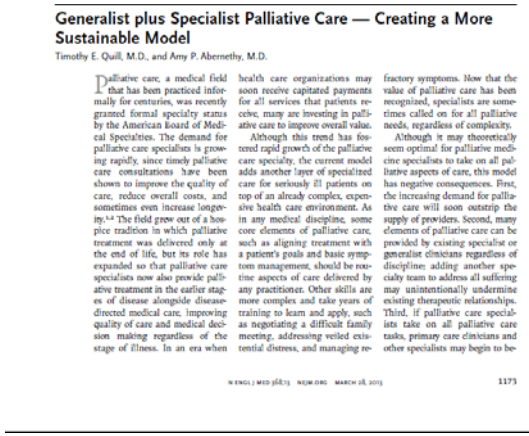
- Lack of definition on generalist palliative care
- No well-defined international best practice models
- Adding another layer of specialist care to an already complex situation
- Risk of undermining or devaluing existing therapeutic relationships
- From the evidence, little consistency in the way models are developed and evaluated.

Does specialist palliative Care make a difference?



Skill set for generalist and specialist palliative care providers

Generalists	Specialists
Management of symptoms	Management of complex refractory symptoms
Discussion on prognosis	Complex psychosocial-spiritual dimensions
Goals of treatment	Conflict resolution
Addresses suffering	Addresses issues of futility
Code Status (DNR, AND)	



Generalist plus Specialist Palliative Care — Creating a More Sustainable Model

Timothy E. Quill, M.D., and Amy P. Abernethy, M.D.

Palliative care, a medical field that has been practiced informally for centuries, was recently granted formal specialty status by the American Board of Medical Specialties. The demand for palliative care specialties is growing rapidly, since timely palliative care consultations have been shown to improve the quality of care, reduce overall costs, and sometimes even increase longevity.[1,2] The field grew out of a hospice tradition in which palliative treatment was delivered only at the end of life, but its role has expanded so that palliative care specialists now also provide palliative treatment in the earlier stages of disease alongside disease-directed medical care, improving quality of care and medical decision making regardless of the stage of illness. In an era when health care organizations may soon receive capitated payments for all services that patients receive, many are investing in palliative care to improve overall value.

Although this trend has fostered rapid growth of the palliative care specialty, the current model adds another layer of specialized care for seriously ill patients on top of an already complex, expensive health care environment. As in any medical discipline, some core elements of palliative care, such as aligning treatment with a patient's goals and basic symptom management, should be routine aspects of care delivered by any practitioner. Other skills are more complex and take years of training to learn and apply, such as negotiating a difficult family meeting, addressing veiled existential distress, and managing refractory symptoms. Now that the value of palliative care has been recognized, specialists are sometimes called on for all palliative needs, regardless of complexity.

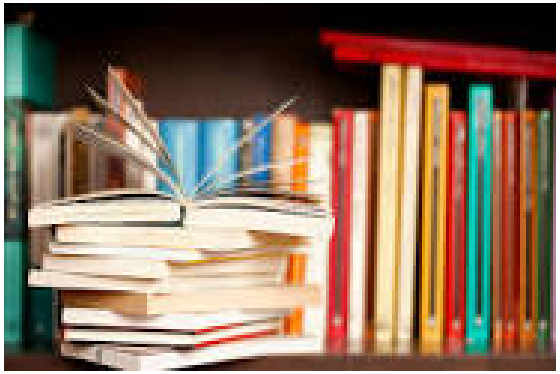
Although it may theoretically seem optimal for palliative medicine specialists to take on all palliative aspects of care, this model has negative consequences. First, the increasing demand for palliative care will soon outstrip the supply of providers. Second, many elements of palliative care can be provided by existing specialist or generalist clinicians regardless of discipline; adding another specialty team to address all suffering may unintentionally undermine existing therapeutic relationships. Third, if palliative care specialists take on all palliative care tasks, primary care clinicians and other specialists may begin to be-

Effect of specialist palliative care on QoL in Hospital, Hospice and Community patients with advanced disease

- Systematic review and meta-analysis (N = 11)
- Small effect in favour of specialist palliative care
- No evidence that patient need triggered integration
- Impact on life quality better for those with cancer and/or where palliative care was introduced early
- Moderate evidence to support benefit of specialist palliative care
- Marked heterogenity in studies, design, instruments and outcomes


Effect of specialist palliative care services on quality of life in adults with advanced incurable illness in hospital, hospice, or community settings: systematic review and meta-analysis

Where is the evidence for what works, when and how?



Some perspectives – General Practice

- How general practitioners and specialist palliative care view their working relationship
- Partnership is based on a sound understanding of their respective identities
- Rules of engagement maintained
- Considerable commitment to the partnership
- Avoiding restrictive language and culture
- A strong belief in sustainability

Some perspectives – hospital care


Organization and evaluation of generalist palliative care in a Danish hospital

- Investigating the organization and integration of generalist palliative care in a large general hospital
- Triangulation of data from evaluations to identify concordance and discrepancies
- No overall policy direction – all localized
- Limited understanding of the impact of palliative caregiving on generalist staff
- Lack of (willingness for) quality indicators

Communication Skills Training

- Systematic review of RCT on effectiveness in relation to improved patient outcomes (1°) and staff behaviours (2°) in generalist palliative care providers who focus on end-of-life care (EoLC)
- Meta-analyses of 11 trials
- Training appears to be effective – at the time
- No evidence of training influencing behaviours
- Heterogenity in outcomes and measures challenges true representation
- Poor reporting in studies
- The question is…what works?


Review Article

The Effect of Communication Skills Training for Generalist Palliative Care Providers on Patient-Reported Outcomes and Clinician Behaviors: A Systematic Review and Meta-analysis

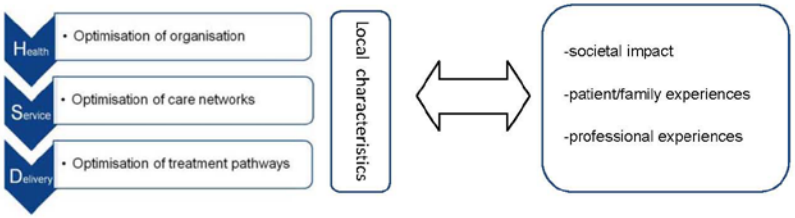
What needs to happen for a sustainable future for palliative care?

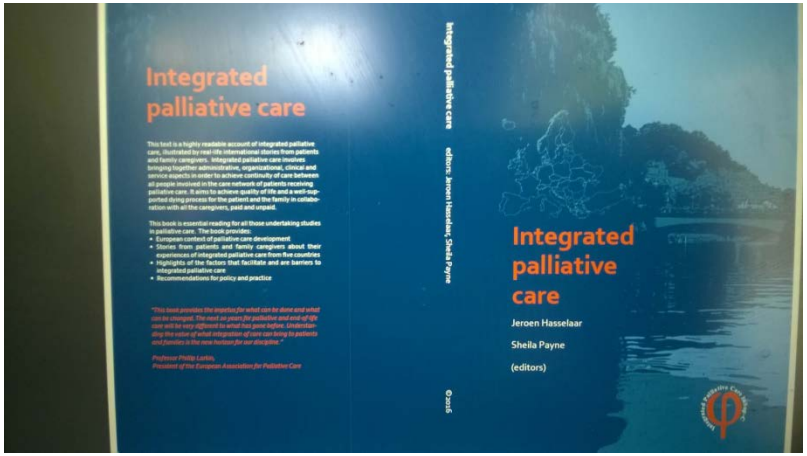
What can we do to ‘ bridge the gap’

- Quality research that looks at factors which mediate partnership working
- What is the direct impact of collaboration on patient outcomes?
- Conscious of cost-effectiveness in collaboration for the system and service provider?

InsupC : integrated palliative care

Figure 2: Identification of best practices in integrated palliative care delivery





Integrated Palliative Care

Are You Ready for Change?

Symposium

Friday 30th September 2016 | 0900 - 1600

Museum of Natural Sciences, Brussels, Belgium

Keynote speakers

Professor David Currow - Professor of Palliative and Supportive Services (Flinders University, Adelaide, Australia)

Professor Phil Larkin - President, European Association for Palliative Care (University College Dublin, Ireland)

Registration

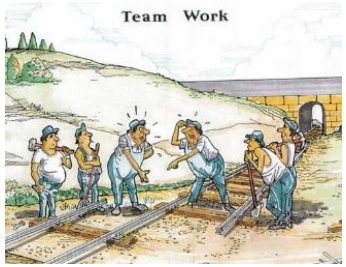
Early Bird Rate: 100 Euros (before 10th August 2016)
Regular Rate: 150 Euros (10th August 2016 onwards)
Online registration: *http://goo.gl/RVWeC6*

Call for Abstracts

Online submission: *https://no.surveymonkey.com/r/eapcinsupc*
Submission deadline: 30th June 2016
For more information: *Maaike.Dautzenberg@radboudumc.nl*

European Association for Palliative Care Research Network (EAPC RN) & Integrated palliative care in advanced cancer, heart disease and COPD project (InSup-C)

EAPC Research Network



Integrated Palliative Care – a vision for the future (Insup-C)

"Integrated palliative care involves bringing together administrative, organizational, clinical and service aspects in order to realise continuity of care between all actors involved in the care network of patients receiving palliative care. It aims to achieve quality of life and a well-supported dying process for the patient and the family in collaboration with all the care givers (paid and unpaid)".

Key messages for integrated palliative care

- One of the most important messages for the transformation of our health care systems
- Changing hearts and minds
- Value the equality and respect of all persons
- Integrated palliative care speaks to reality of living and dying in society
- Underpinned by the elements of collaboration, cohesion and compassion.
- One small step….

Conclusions

"I thought I was on to something but I can't figure out how to move it."

- Communication and dialogue
- Development of a systematic process not personal liaison
- Responsive models of education which include partnership developments
- Clarity on roles and responsibilities
- Appropriate and timely access to specialist palliative care when necessary
- Coordinated Care – Continuous Support

Strength through partnership: Enabling better end-of-life care

What unites us?

What divides us?

Generalist **WITH** Specialist palliative care will find each other **IF**:

- Identity of the team supersedes personalities
- Shared information
- Working together for *the same* goals
- Leadership is held by the patient
- Consultative co-opt of experts

'Ar scáth a chéile a Mhairimíd'

We live in the shadow of each other

Thank you