

Promoting patient centred palliative care through case conferencing

BACKGROUND

What are the characteristics of case conferences between general practitioners and specialised palliative care services (SPCS)?

METHODS

Study participants were adults (N=461) with pain in the preceding 3 months who were referred to a SPCS and their GPs (N=230). Patients were randomised to case conferences or routine care by SPCS.

RESULTS

One hundred and sixty-seven conferences were held; 46 patients withdrew and 142 died before the conference could be conducted. Medicare payment was requested for 72 (43%) conferences. Median time from randomisation to case conference was 52 days (SD: 55), and from case conference to death/end of study was 79 days (SD: 166). Twenty-five percent of conferences had over three health professionals participant; patients and/or their caregivers participated in 91%. Average conference duration was 39 minutes (SD: 13). Mean conference length did not increase when more health professionals were present (3 vs. >3, 39 [SD: 14] vs. 42 [SD 11] minutes, $p=0.274$), nor when patients/caregivers were present (present vs. absent, 39 [SD: 13] vs. 44 [SD: 14] minutes, $p=0.159$).

DISCUSSION

Case conferencing involving SPCS, the GP, other health professionals and the patient can be an efficient part of routine care.

Palliative care focuses on optimising function and comfort for people with progressive life limiting illness.¹ It incorporates nursing, medical and allied health staff, therefore making the coordination of services crucial. When communication between health care providers is poor, effort may be duplicated.^{2,3} Multiprofessional teams provide better palliative care than practitioners working in isolation,^{4,5} and better coordination of existing services can decrease resource utilisation while still maintaining quality.⁶

Medicare Benefits Schedule (MBS) rebates for case conferencing were introduced in Australia in 1999 with the goal of shifting from short term episodic care to longitudinal planning for contingencies.⁷ Uptake of these case conference rebates has however been poor.⁸

Case conferencing can provide a funded mechanism to enhance coordination between a person with advanced life limiting illness, their general practitioner and the palliative care team. This was demonstrated in The Palliative Care Trial, a randomised controlled trial (RCT) conducted in Adelaide, South Australia.⁹

Methods

The study design and methodology were reported previously.⁹ Recruitment was conducted between April 2002 and May 2004. The case conferencing randomisation was 3:1. Participants were followed until death or the study end (November 2004). Main outcomes were integrated performance status,¹⁰ symptom control, palliative phase,¹¹ and resource utilisation.

Study setting

Trial participants were recruited through a regional multidisciplinary specialised palliative care service (SPCS) with more than 1100 referrals per year, 85% with cancer. The SPCS supports GPs providing primary palliative care in the region. The median time from referral to death for all patients referred to the service was 49 days, mean 121 days.

Study participants

Adult patients referred to the SPCS with any form of pain in the preceding 3 months were eligible; patients who did not live within the region, who were expected to die

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within 48 hours, or who withheld consent were excluded. Patient and GP consent was required.

Case conferences

All case conferences in the intervention arm were organised by SPCS staff in conjunction with the patient's GP. The conference minimally included the patient or their representative, the GP, a palliative care nurse, and a representative from another clinical agency relevant to the person's care. The SPCS doctor usually attended. Other participants were selected based on the patient's current or likely needs. The conference agenda was set by the patient and/or carer in consultation with the GP and palliative care nurse, with emphasis on symptom control and planning for clinical contingencies that might be encountered in the patient's care.

Outcomes and analysis

Data included conference participants, topics discussed, duration, and plans developed. Data were entered onto an Access database (Microsoft Access 2002 version 10.4302.4219, Seattle, Washington, USA) and analysed using SAS (The SAS System, release 8.02, Cary, North Carolina, USA). Between group differences were compared using two-tailed Student t-tests for continuous variables, and χ^2 or Fisher's Exact tests for categorical variables. For time to event endpoints, Kaplan-Meier curves were calculated (proc LIFETEST), with differences between groups tested at the 5% significance level by a two sided log rank test. Documentation of claims were derived from administrative data from Medicare Australia.

Ethics approval

The trial was approved by relevant Research Ethics Committees and registered (ISRCTN81117481).

Results

Patient and GP characteristics

Study patients had a mean age of 71 years (SD: 12), 50% were male and 91% had cancer (Table 1). On referral to palliative care: 90% lived at home, 7% in a residential aged care facility (RACF), 94% had a carer, median performance status was AKPS 60 (range 20–90),¹⁰ 55% were in a stable palliative care phase and 41% were

deteriorating or unstable.¹¹ Four percent of patients were in the terminal phase and required input from the SPCS within 24 hours of referral, 21% within 72 hours, 59% within 1 week, and 11% could access the first available outpatient appointment.

Table 1. Baseline patient characteristics, including characteristics of those who did and did not receive a case conference

	All participants in the Palliative Care Trial	All randomised to the case conference intervention	Randomised to the case conference intervention and received case conference	Randomised to the case conference intervention and did not receive case conference
N	461	358	167	191
Age				
Mean	71	71	72	71
Median	73	74	74	74
SD	12	12	12	13
Gender N (%)				
Male	232 (50)	189 (53)	90 (54)	99 (52)
Marital status N (%)				
Married/de facto	282 (63)	208 (59)	96 (59)	112 (59)
Widowed	107 (24)	88 (25)	41 (25)	47 (25)
Divorced/separated	45 (10)	38 (11)	20 (12)	18 (10)
Never married	17 (4)	16 (5)	4 (2)	12 (6)
Missing	10	8	6	2
Living arrangements N (%)				
Lives alone	102 (24)	84 (25)	41 (26)	43 (25)
Spouse/family	257 (60)	190 (58)	89 (57)	101 (58)
Other	68 (16)	56 (17)	27 (17)	29 (17)
Missing	34	28	10	18
Caregiver N (%)				
Yes	394 (94)	307 (94)	147 (96)	160 (91)
Accommodation N (%)				
Private residence	410 (90)	319 (91)	153 (93)	166 (89)
Aged care	30 (7)	23 (7)	9 (5)	14 (7)
Hospital	14 (3)	10 (3)	3 (2)	7 (4)
Missing	7	6	2	4
Cancer N (%)				
Yes	420 (91)	327 (91)	153 (92)	174 (91)
LOS (days)				
Mean	144	135	220	61
Median	87	83	178	38
SD	160	152	174	7
Range	1–833	1–757	12–757	1–628
AKPS*				
Mean	63	61	63	59
Median	60	60	60	60
SD	13	14	14	13
Range	20–90	20–90	20–90	20–90

* AKPS = Australian modified Karnofsky Performance Status. A score of <70 equates to the need for a carer to assist with daily living

There were 230 GPs from 105 practices with medians of one patient per GP (range 1–7) and three GPs per practice (range 3–23).

Case conferences

Three hundred and fifty-eight of the 461 study patients (78%) were randomised to the case conferences with 167 conferences conducted (47%); 142 died before the conference could be conducted, 46 study patients withdrew. Study patients randomised to case conferences were similar to the entire study population (Table 1). Those randomised but who did not receive a case conference had significantly shorter time from referral to death ($p < 0.001$) but were otherwise similar to the entire study population. Reasons case conferences were not held included: clinical decline and death before the case conference could be arranged (need for acute intervention at referral vs. no acute need, likelihood of conference being held 38 vs. 51%; $p = 0.027$) or study patients withdrew before a case conference could be arranged (withdrew from the study vs. did not withdraw, 18 vs. 52%; $p < 0.001$).

Of the 167 case conferences conducted, 72 (43%) GPs claimed reimbursement (Table 2). Two claims were filed for case conferences among patients from the usual care arm.

Conference timing

Median time from patient entry into the study to case conference was 52 days (range 6–288, mean 69, SD: 55) and median time from case conference to patient death or end of study was 79 days (range 0–726, mean 152, SD: 166). There was a trend for patients who were deteriorating to have shorter times from referral to case conference (phase at referral: 'unstable or deteriorating' vs. 'stable', mean 64 [SD: 46] vs. 74 [SD: 60] days; $p = 0.255$).

Participants at the conference

Seventy-five percent of conferences ($n = 124$) included three health professionals and 24% ($n = 70$) had four or more. Professional participants were the GP (99% of conferences), palliative care nurse (100%), palliative care doctor (78%), generalist community nurse (15%), social worker (5%) and RACF representative (4%). A patient or carer was

Table 2. Case conferences claimed through the MBS EPC items

MBS rebate item number	Number of claims made
Organises and contributes to a case conference	
740: 15–30 minutes	4
742: 30–45 minutes	1
744: 45+ minutes	1
Contributes to a case conference	
759: 15–30 minutes	9
762: 30–45 minutes	26
765: 45+ minutes	30
Organises and contributes to discharge a case conference	
746: 15–30 minutes	0
749: 30–45 minutes	0
757: 45+ minutes	0
Contributes to a discharge a case conference	
759: 15–30 minutes	0
762: 30–45 minutes	1
765: 45+ minutes	0
Total case conferences claimed	72

present for 152 (91%) of conferences. General practitioners participated by telephone in 21 conferences (13%), the remaining conferences were conducted with participants in the same location, usually the patient's home.

Conference length

Average conference duration was 39 minutes (SD: 13, median 40, range 15–90). Conference length did not increase with more professional participants (3 vs. >3, mean 39 [SD: 14] vs. 42 [SD: 11] minutes; $p = 0.274$) nor did it increase when patients and/or carers were present (present vs. not, mean 39 [SD: 13] vs. 44 [SD: 14] minutes; $p = 0.159$).

Main issues discussed

Symptom control (other than pain) was the predominant issue raised at the conferences. Other issues are outlined in Table 3.

Discussion

In this study, case conferences were successfully conducted for about half the patients randomised to this intervention. Conferences were brief, multidisciplinary, and patient centred – consistent with the principles of palliative care. Inclusion of multiple health

professionals and patients/carers did not add to the conference length.

Uptake of case conferencing has been relatively poor across the health care system.⁸ By contrast, this study had excellent participation from consenting GPs. Implementation of case conferencing was facilitated by: having SPCS staff organise the conference, using a patient defined focus, developing an agenda based upon current and anticipated needs, assisting the GP to gain remuneration by providing instructions and MBS claim numbers, and including the specialist palliative care nurse and doctor in the conference. Deriving the conference agenda directly from patient needs was considered to be a vital aspect of the conference.

Barriers to conducting the conferences

Organisation of case conferences can be difficult.^{12,13} In this study, conferences were organised by the SPCS in consultation with the GP. This required training in the principles of case conferencing, their conduct, and engaging GPs. Administrative personnel skilled in scheduling appointments needed to work closely with clinical staff. The average time to organise the case conference was estimated at 15 minutes. General practitioners reported satisfaction with

Table 3. Issues discussed at the case conference (each conference had up to six problems that could be addressed within the agenda)*

Agenda item	1	2	3	4	5	6	Total number of times discussed
Pain control	49	12	9	4	3	1	78
Other symptom control*	89	99	67	42	23	12	332
Functional issues	12	26	23	14	17	5	97
Psychological distress	3	7	11	11	5	3	40
Social issues	11	10	21	21	14	14	91
Spiritual concerns			1	1	2		4

* More than one symptom could be discussed during the conference

the organisation of the conferences; consistent with previous reports that GP participation was enhanced when the conference was organised by SPCS.¹⁴

Another anticipated difficulty was getting conference participants together at one time. However, objective assessments of the relationship between the number of participants and timing of the conference do not necessarily support this perception. Inadequate reimbursement has been cited as a barrier to case conferences,¹⁵ however a reimbursement claim was only made in 43% of conferences held during this study. It is possible that GPs may not have been aware that they could claim reimbursement as part of the study. Alternatively they may have used alternative MBS item numbers to make claims. Study staff provided explicit documentation to GPs regarding how to make a claim. However, the number of case conferences undertaken by GPs may be underestimated for this study and in Australia more generally, if calculated only from current claims data.

Methods to ensure sustainability of the model

For sustainability in palliative care, the role of palliative care staff in organising and managing conferences is critical. For wide uptake of this intervention there need to be resources for the increased administrative support required to organise case conferences. Education of palliative care providers is also needed for better uptake. All clinical staff need to be trained in case conference documentation, agenda setting, and facilitation.

The model studied here encouraged patient centred case conferences with patient participation whenever possible. Almost all

conferences were attended by the patient, their carer or both. Even with no patient/carer present, the palliative care nurse still consulted with the patient/carer in order to define their agenda. The resulting discussion focused on social as well as medical issues. This reflects similar positive experiences for both patients and health professionals participating in case conferences.¹⁶⁻¹⁸

Telephone participation for GPs (rather than face-to-face participation) was a successful strategy used in other studies of case conferencing in palliative care.¹⁴ It was particularly useful in this study, given that GPs are not reimbursed for travelling time to a patient's home.

A common criticism of the Australian MBS payment process for case conferencing has been the complexity of the paperwork.¹⁹ This study specifically addressed this issue by developing appropriate documentation that was completed during the conference by the palliative care nurse and served as the basis for an agreed management plan.

Conclusion

Case conferences can be incorporated into the routine practice of a SPCS. All conference participants valued the inclusion of the patient whenever possible. Organisation and documentation of the conference by the SPCS reduced the burden on GPs and increased their participation in the conferences.

Conflict of interest: none declared.

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