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Palliative Care Consult Team: Program evaluation over a 15-year period

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INTRODUCTION

The delivery of high-quality palliative care is a priority for the aging Canadian population. Within the health-care system, specialist palliative care providers represent an important clinical resource, with the benefits of palliative care teams being demonstrated across multiple settings (Roberts et al., 2021; Ventura, 2016; Oluyase et al., 2021; O’Mahony et al., 2005; Scott et al., 2020). Outpatient palliative care is associated with favourable outcomes, including improvements in pain and symptom management, patient and family satisfaction, and reduced acute care utilization at end of life (Roberts et al., 2021; Ventura, 2016). The benefits of inpatient palliative care consult teams may include decreased symptom burden, increased patient satisfaction with care, and increased chances of a home death (Oluyase et al., 2021; O’Mahony et al., 2005; Scott et al., 2020).

Hospital-based palliative care consult services have become more common in the past several years. This paper highlights the growth and development of a specialist Palliative Care Consult Team (PCCT) over a 15-year period, from 2006 to 2021. We utilize a logic model (Figure 1) highlighting PCCT resources,

activities, measurable outputs, and outcomes. Program outputs have been mapped to Health Quality Ontario (HQO) palliative care quality standards where possible (Health Quality Ontario, 2018). We describe the various roles of the PCCT within our institution, including clinical care, teaching and education, and quality improvement (Stilos et al., 2021). Our intent in performing a program review was to document the clinical and non-clinical outputs of the PCCT through an evaluative lens, with the goal of monitoring change in a few key quality performance indicators over the 15-year period. The results of our program review will be instrumental in highlighting program successes and gaps, both of which may inform future decisions regarding program development and resource allocation. Our description of the structure, function, and evaluation of our specialist palliative care team illustrates our approach and may serve as a practice model to other teams working in both clinical and academic settings.

PROGRAM RESOURCES

Clinical and administrative staff

Sunnybrook Health Sciences Centre is a tertiary level academic hospital in Toronto, ON, that is associated with a regional comprehensive cancer centre (Odette Cancer Centre). The PCCT began in 1996, as the Palliative Care Initiative (PCI) under the oncology program and represented the first organized palliative care program at SHSC. PCCT human resources have increased significantly over the 15-year period since then. At its inception, the team was comprised of four full-time equivalent (FTE) physicians (MDs), 1.6 (FTE) advance practice nurses (APNs); with each nurse working four days a week, in addition to a social worker (SW), and a chaplain. In addition to providing clinical care, the work of the PCI focused on raising awareness of the program amongst patients and other healthcare providers at our institution. Ambulatory care was limited to oncology patients only.

Figure 1

Palliative Care Consult Team Logic Model

Program Resources	Program Activities	Program Outputs	Outcomes
Clinical Staff	Inpatient Consult Service	Number of New Patients Seen	Provide Patients with Goal-Concordant Care
Administrative Staff	Ambulatory Clinics	Time to New Consult	Support the Development of Primary Palliative Care Competencies in Healthcare Providers
Electronic Database	Teaching and Education	Number of Patients Discharged to Palliative Care Unit or Home Palliative Care Service (Quality Standard 11)	Patients and Families See Value/are Satisfied in the Care Provided by Palliative Care Consult Team
	Data Collection: Quality Improvement and Research	Number of Comfort Measures Order Set Completed for Dying Patients (Quality Standard 11)	
		Number of Advance Care Planning/Goals of Care Documentation in EMR (Quality Standard 4)	

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Over the course of several years, the PCI evolved into the PCCT, with the mandate of providing specialist-level palliative care to patients with both malignant and non-malignant diagnoses throughout SHSC. At the corporate level, the palliative care program has now attained the status of a distinct hospital division. In 2023, the Division further evolved to become the first interdepartmental division encompassing both Family Medicine and Internal Medicine.

At present, there are two arms to the clinical service, which include an inpatient acute care consultation service and ambulatory palliative care clinics. Given the consistent annual increase in patient volumes over the past 15 years (Figure 2), team composition has changed accordingly to meet clinical demands. In accordance with the Canadian Society of Palliative Care Physicians guidelines (Henderson et al., 2019) and HQO quality standard 12 (Health Quality Ontario, 2018), the PCCT strives to deliver interprofessional care that leverages the competencies of various disciplines to provide high-quality holistic patient care. Current staffing levels include 10 FTE MDs, 1.2 FTE APNs (one working four days a week and the other part-time to two days a week). In addition to two FTE registered nurses, 0.8 FTE SW and 1 FTE patient care manager. Funding for a dedicated SW and chaplain has been withdrawn; therefore, the PCCT routinely utilizes the expertise of the unit-specific interprofessional staff to support the spiritual and psychosocial needs of patients and families.

For operational reasons, management of the PCCT migrated from the oncology program to the Veteran's program in 2017, streamlining the out-patient, in-patient program and palliative care unit under one program. The program is fully affiliated with the Department of Family and Community Medicine, University of Toronto, Faculty of Medicine. Consequently, a core mandate of the PCCT is to provide palliative care clinical teaching rotations to a variety of undergraduate and graduate medical and nursing students.

PROGRAM ACTIVITIES

Inpatient and Ambulatory Services

The PCCT inpatient service provides on-site palliative care consultation seven days a week in addition to providing daily follow-up to its rostered patients. The ambulatory team sees new and follow-up patients on a daily basis in dedicated palliative care clinics, providing both in-person and virtual appointments.

A comprehensive PCCT consultation includes a thorough assessment of various domains relevant to identifying palliative care needs specific to the patient and family. The patient's symptom burden is systematically assessed using the Edmonton Symptom Assessment Scale (ESAS; Hui, 2017) at the time of the initial consult. In addition, a detailed history, comprising the patient's performance status, physical, psychosocial, and spiritual care needs, is unique to the palliative care consult. The PCCT consultation includes specific recommendations for patient management, including opioid and non-opioid analgesia, pharmacologic and non-pharmacologic management of non-pain symptoms, and facilitating transfer to community-based palliative care or PCU, if appropriate, and participating in serious illness conversations/goals of care discussions. Consultations are done independently by a physician or the APN and, at times, performed as a dyad by both,

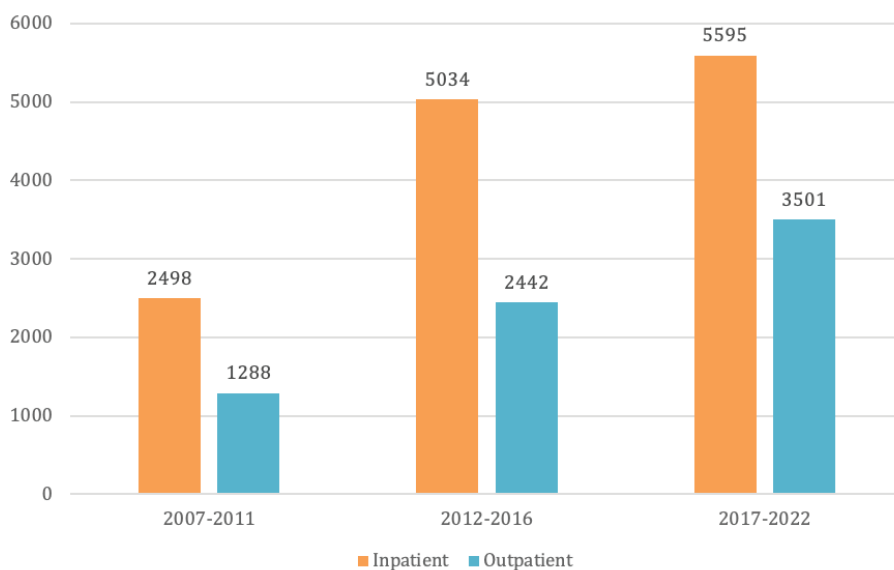
APN-physician, in very complex clinical cases (Stilos et al., 2021).

In keeping with best practices (Henderson et al., 2019), the composition of hospital palliative care teams is ideally interprofessional and may include a physician(s), a nurse(s), a social worker, and a chaplain. Some teams also have adopted the inclusion of an APN. An APN is a nurse who holds a master or doctoral degree in nursing and has expertise in patients with complex care needs. Specifically, an APN brings forth specialized knowledge, skills, and leadership to the clinical setting to enhance patient and family care and the decision-making process, and impacting healthcare system outcomes and cost (Canadian Nurses Association [CNA], 2019). APNs have been described as instrumental in the care of high-volume patient populations (Parker & Hill, 2017).

In keeping with HQO quality standard (QS) 1, the PCCT provides 24/7 access to a palliative care consultant (Chakraborty & Stilos, 2023). After hours (from 5pm–8am), the PCCT physicians provide an on-call service offering telephone advice to referring services and patients from both the acute care and ambulatory patient cohorts. It is important to note that the median time from referral to initial inpatient consultation has remained 0 days over the 15-year period (range 0–13 days), with no deviation even during the time of the COVID-19 pandemic. The median time from referral to ambulatory

Figure 2

New Patient Volumes



consultation is 11 days, which is in keeping with provincial cancer care guidelines (Zwicker, 2015). The PCCT has a process to assess same day urgent ambulatory consults if requested.

The PCCT has advocated meeting the palliative care needs of patients living with progressive non-malignant diseases. At its inception, the PCCT was resourced only to provide palliative care consultation for patients with malignant disease only. In 2019, the PCCT expanded ambulatory clinics to include patients living with progressive non-malignant disease (See Figure 3). Current non-malignant disease sites include heart failure, kidney care, and amyotrophic lateral sclerosis (ALS). Of note, SHSC houses the largest ALS clinic in North America.

Teaching and Education

Teaching and education is an essential mandate of any academic specialist palliative care team (Henderson et al., 2019). The majority of PCCT physicians are hired into the academic role of clinician teacher, which mandates that 20% of their practice be dedicated to teaching and education (Laboratory Medicine & Pathobiology – University of Toronto, 2023). The PCCT provides core post-graduate clinical rotations to learners from Family Medicine, Internal Medicine, Medical Oncology, Radiation Oncology, Psychiatry, and Palliative Medicine. In addition, elective experiences are offered to both undergraduate and postgraduate medical trainees. Each academic year, the PCCT trains approximately 50 residents, clinical fellows, and medical students across acute care and ambulatory settings.

Data Collection: Quality Improvement and Research

An electronic patient database was created at the time of PCCT's inception in 1999 and has been maintained consistently since that time. PCCT administrative staff, plus an externally contracted information technology specialist, manage the database. Database information is systematically collected for each new and repeat patient seen by the PCCT. Various data elements are captured, including patient demographics, referring service, primary palliative

care diagnosis, reason for referral, date of consultation, palliative performance scale (PPS; Anderson et al., 1996) and code status at the time of initial consult, and patient disposition.

Regular database review has permitted the PCCT to track various program outputs, including trends in clinical volumes, referral patterns, and patient disposition. Data monitoring is instrumental in optimizing operational aspects of the team, such as human resources planning, but is also critical in informing quality improvement efforts, such as reducing wait times for admission to the palliative care unit (Bottoms et al., 2022). Given that the database was established prior to a formal program evaluation plan, not all outputs of interest are represented. Maintaining a data collection and monitoring system has been highlighted as an essential component of strategic planning and quality improvement (Weissman et al., 2008).

PROGRAM OUTPUTS

Clinical Volumes and Patient Characteristics

PCCT clinical volumes, which are documented as the number of new patient consultations conducted annually, are presented in Figure 2. The data demonstrate a consistent increase in patient volumes in both the inpatient and outpatient settings over a 15-year period. Inpatient consult volumes have more than doubled over the period, while volumes in the ambulatory setting have tripled. Approximately 85% of annual patient volumes represent patients with a cancer diagnosis, and 15% represent non-cancer diagnoses (Figure 3). Table 1 shows the most common cancer diagnoses of our patient cohort.

Over the 15-year period, the median age of patients seen by the PCCT was 68 (range 10–103) years, with the proportion of females (54%) being slightly

Figure 3

Malignant and Non-Malignant Clinical Volumes

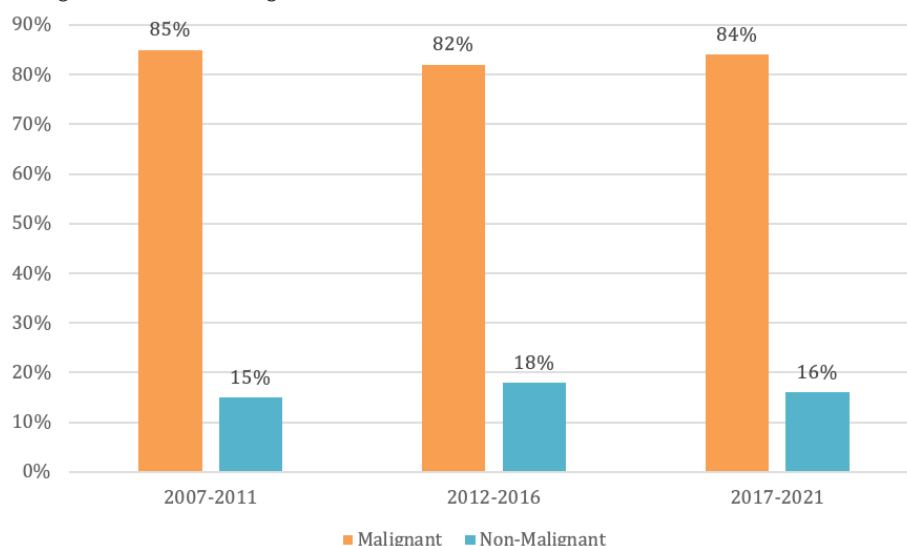


Table 1

Most Common Malignant Diagnoses for Inpatient Consults

INPATIENT Top 5 Common Malignant Diagnosis (Total = 4084)	#	%
Gastrointestinal (include Gastric Ulcer, GI Other, intestine)	1512	21.3%
Gynaecological (include uterine, endometriosis)	773	10.9%
Lung	693	9.7%
Genitourinary (include genito-urinary system)	606	8.5%
Breast	500	7.0%

higher than for males (46%). Median PPS at time of initial palliative care consultation was 40% for inpatients and 60%–70% for ambulatory patients, which respectively corresponds to patients in the “transitional” and “stable” stages of the disease trajectory (Seow et al., 2011). As expected, the ambulatory population generally represents those patients who are earlier in the disease trajectory, who have a better functional status, and are often receiving anti-cancer treatments. Approximately half of all new inpatients had a clinician estimate of survival documented as three months or less at the time of initial palliative care consultation (Figure 4). In the ambulatory setting, the vast majority of patients had an estimated prognosis of greater than six months (Figure 5). This pattern highlights the potential for early palliative care involvement, the benefits of which have been identified by large-scale clinical trials (Sullivan et al., 2019; Temel et al., 2010; Maltoni et al., 2016).

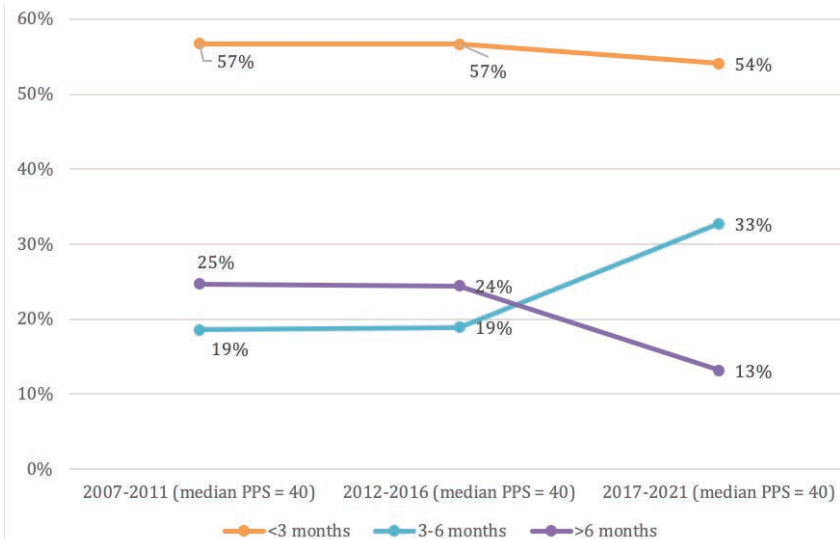
Figure 6 shows the most common reasons for referral to the PCCT in both the inpatient and ambulatory settings. Pain management was consistently the primary reason for referral over the 15-year period. Of particular interest is the number of referrals received to facilitate advance care planning (ACP) and goals of care (GOC) conversations. These referrals increased from essentially none in 2007–2016 to 30% of all new consultation requests in 2017–2022. This profound shift may reflect SHSC’s focus on a “Quality Living and Dying” initiative at the corporate level (Stilos & Wynnchuk, 2021), as well as growing awareness of the benefits of early palliative care involvement and patient-centred decision-making (Sirianni & Torabi, 2020).

Place of death (Quality Standard #11)

Hospice Palliative Care Ontario (HPCO) identifies place of death as a palliative care quality indicator (statement #11; Health Quality Ontario, 2018). Place of death is often recognized as a proxy for a “good” death, with preference being given to death in the home or in a PCU setting. Over the last 15 years, an increasing number of patients who have been followed by the PCCT die either in the palliative care

Figure 4

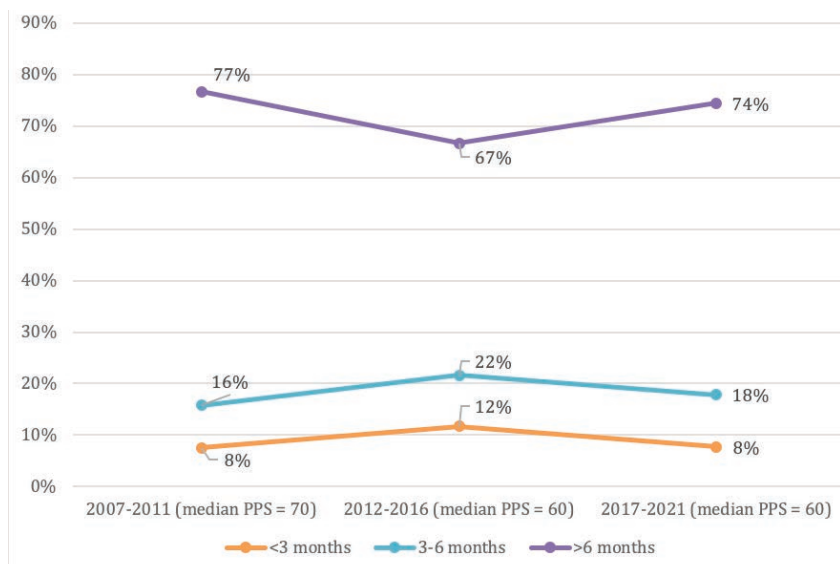
Clinician Estimate of Survival for Inpatients



Note. PPS = palliative performance scale

Figure 5

Clinician Estimate of Survival for Ambulatory Patients



Note. PPS = palliative performance scale

unit (PCU) or home setting, with a corresponding decrease in the number of acute care deaths (Figure 6). Specifically, the PCCT has recently reviewed the process of transfer from acute care to the PCU through a quality improvement lens (Bottoms et al., 2022), with a goal of increasing the efficiency of transfers and improving the patient and family experience. Most recently, Bonares et al., (2023) found that patients with non-malignant disease were referred to specialist palliative later in their illness trajectory and were more likely to die in

hospital, as compared to those patients with a malignant diagnosis.

Comfort Measures for Dying Patients (Quality Standard #11)

Building on SHSC’s corporate “Quality Living and Dying” initiative, in 2012, the PCCT created and disseminated the “Comfort Measures Order Set (CMOS)” for inpatients at the end-of-life. The order set was developed with the intent to support the development of primary palliative care competencies amongst non-palliative care clinicians at SHSC (Lau et al., 2018). Figure 7 shows

the number of CMOS completed by PCCT clinicians since 2012. However, this likely represents a gross underestimation of CMOS utilization, given that the PCCT database does not capture orders completed by non-palliative-care physicians.

Supporting ACP/GOC Conversations (Quality Standard #4)

In an effort to promote the development of primary palliative care competencies amongst all clinical hospital staff, in 2018, a unique type of ACP and GOC conversation note was created in the hospital’s electronic medical record (EMR). The novel note type was developed with hospital and PCCT leaders to encourage communication of ACP and GOC conversations between clinicians and patients, and to ensure that documentation of conversations was visible and easily accessible to all medical providers using the EMR. Figure 8 shows the total number of ACP and GOC notes completed for both inpatients and outpatients across the organization. Data indicate an upward trend in the number of completed notes since the launch of the novel note type in 2018. However, these data likely represent a gross under-estimation of the actual number of ACP and GOC conversations that occurred between clinicians and patients, given that many clinicians documented the conversations in a regular EMR note type.

In tandem with the launch of the ACP and GOC note type, the PCCT created and delivered palliative care professional development materials for staff members, which focused on improving communication skills at end of life. PCCT staff created and facilitated an in-person simulated communications workshop and online video resources to support the development of primary palliative care skills amongst hospital staff. Professional development activities were targeted to an interprofessional audience, including nurses, physicians, and allied health staff including social workers. To date, approximately 100 healthcare professionals and learners at our institution have been trained in ACP and GOC communication skills (Torabi, manuscript in progress). Our experiences at SHSC

Figure 6

Reason for Referral to Palliative Care

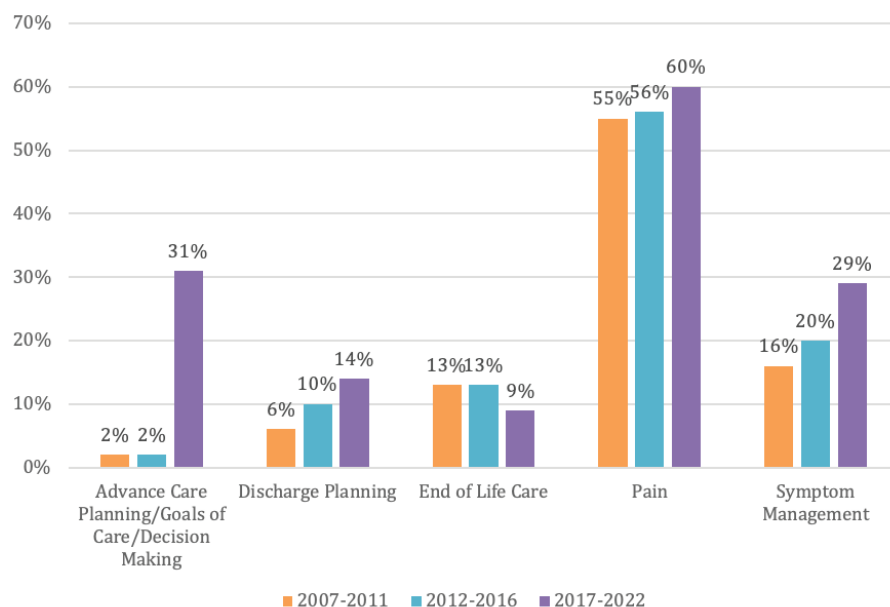
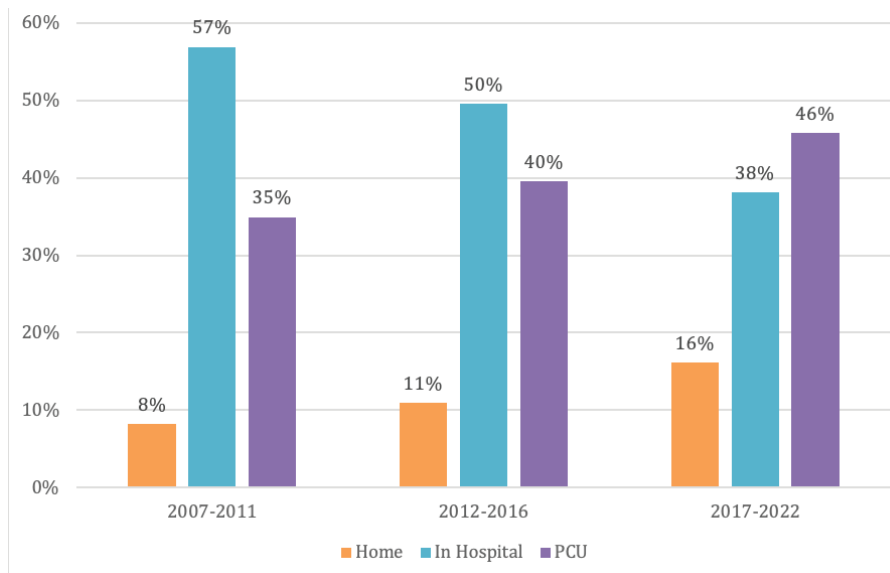


Figure 7

Place of Death



demonstrated good uptake by interprofessional staff, including positive evaluations of the interactive sessions. However, implementation of communication workshops proved to be very resource intense, both in terms of time and human resources, which may pose a barrier to long-term implementation.

COMMENTARY

The program review indicates that the PCCT has successfully changed its structure and function over the past 15 years to meet the growing demand for specialist palliative care services at our institution. Human resources have decreased over the 15 years, specifically for nursing and spiritual care, despite

an increase in patient volumes, but has increased in physician support. Outputs related to key palliative care quality indicators have shown improvements over a 15-year period. Specifically, we have seen a decrease in the number of deaths in acute care and have systematically incorporated high-quality end-of-life care into clinical care pathways at our institution. We also demonstrated an increase in ACP/GOC conversations and documentation in the EMR. The PCCT electronic database is critical to ongoing program monitoring, evaluation, and quality improvement. It was developed specifically to capture the clinical workload of PCCT clinicians. These numbers then get reported to the various channels, such as the program director and the Ministry of Health for ongoing program and funding planning. However, the database fails to capture the complex needs of patients and families, or their satisfaction with the care provided by the PCCT. In addition to the routine database elements, capturing rich, qualitative data represents an opportunity to begin assessing important outcomes of the program (Figure 1), such as satisfaction with care, which cannot be measured solely through a quantitative lens.

FUTURE DIRECTIONS

This paper describes the successful growth and operation of a specialist palliative care consultation service at a tertiary-level hospital over a 15-year period. Based on database review and program evaluation, PCCT program visioning over the next five years is focused on several diverse foci:

1) Standardization of ACP/GOC documentation within our EMR

Building primary palliative care capacity, including communication skills related to end-of-life discussions have emerged as an important focus of care in our healthcare context. Supporting patients and families in achieving goal-concordant care is reflected in ACP and GOC conversations. As our program evaluation indicates, ACP and GOC conversations represent a major focus of the care provided by the PCCT. With the support of

Figure 8

Number of ACP and GOC notes

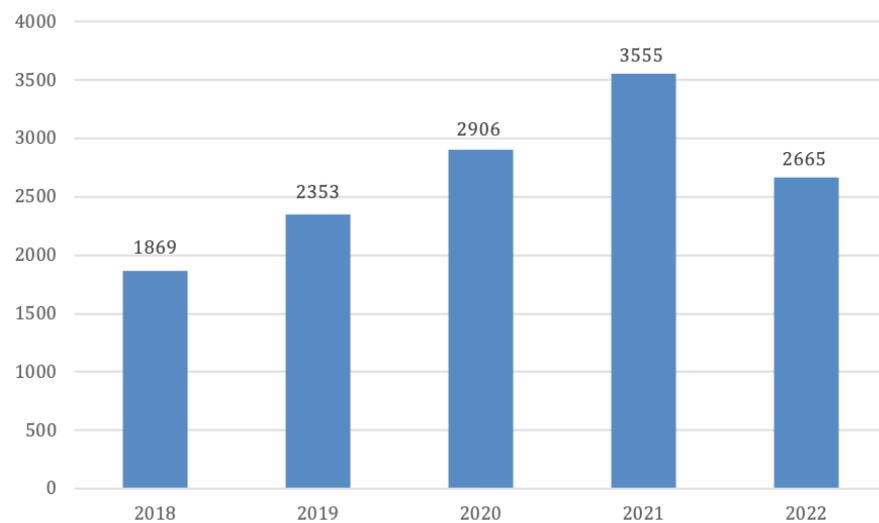
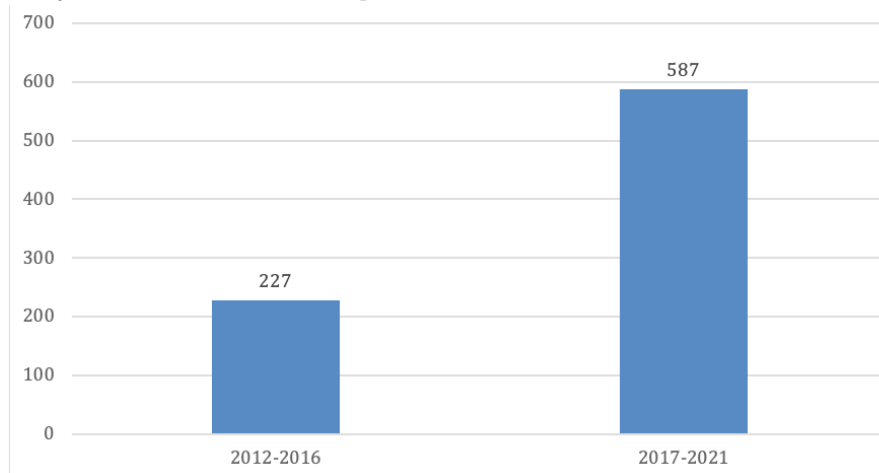


Figure 9

Comfort Measures Order Sets Completed



hospital leadership, the PCCT has led and advocated for the implementation of a standardized electronic ACP and GOC conversation guide (Kaya et al., 2019). A QI study is underway to explore the quality of templated GOC notes, including barriers to use as identified by stakeholders.

2) Increasing capacity for non-malignant clinics (ALS, CHF, nephrology)

While the PCCT's ambulatory practice in the oncology setting has been in operation since the service's inception in 1996, the delivery of non-malignant palliative care clinics has lagged behind. However, evidence supporting palliative

care in non-malignant populations is emerging. Benefits appear to manifest via reduced acute care usage and hospital presentation (Quinn et al, 2020; Maqsood et al., 2021). In our institution, historical barriers have included limited human resources and clinic space, as well as unclear models of care between specialist teams and PCCT consultants. In the last five years, there has been a renewed effort to build dedicated palliative care clinics for the ALS, heart failure and renal populations. Three FTE MDs currently staff non-malignant clinics. Challenges for the future include meeting clinical demand and building capacity for non-malignant palliative care. Ongoing program evaluation

will inform human resources planning, including appropriate allocation of additional APN and MD resources to accommodate for the demonstrated growth in the non-malignant cohort.

3) Identifying barriers to PCU transfer

The number of patients dying in an acute care setting in our organization has consistently decreased in the last 15 years. Dying in acute care does contribute to increased healthcare costs (Alali et al., 2019). The PCCT continues to

advocate for optimal EOL experiences by reducing barriers to timely transfers from acute care PCU (Kingburgh et al., 2023). Building upon a retrospective chart review (Bottoms et al., 2022), the PCCT is now conducting a prospective study to explore further all the nuances of delayed transfers to the PCU.

CONCLUSION

The PCCT has grown substantially over the past 15 years, with a continued increase in patient volumes and team

human resources staffing. The electronic patient database has been instrumental in capturing program outputs and providing direction for program expansion. There continues to be a high demand for PCCT expertise in the settings of both malignant and non-malignant disease, education, and corporate quality improvement. Program evaluation reveals an important lack of rich, qualitative data from patients, families, and referring services related to satisfaction with the care provided by the PCCT.

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