

Michigan 2007 Quick Palliative Care Survey: Results

Purpose	The purpose of this project was to gather information from hospital-based palliative care teams on 1) barriers to optimal palliative care and 2) sources of referral. These two items were included in the 2006 palliative care census, but the results were corrupted by a software glitch.
Sponsors	This project is a collaborative effort of the Michigan Hospice and Palliative Care Organization and the Michigan Department of Community Health. It supports the end-of-life priority of the Michigan Cancer Consortium.
Methodology	<p>A two-item online survey (see Appendix A) was e-mailed to the contact persons for 24 active (rather than developing or launching) programs that responded to the 2006 census. Twenty (20) programs returned one completed questionnaire each.</p> <p>Of the nonresponders, one program had been discontinued due to closure of the facility; one was a physician-only consult model; one was a nurse consult model; and the other was a primarily community-based consult model.</p>
Findings: Barriers to Palliative Care	<p>Respondents were asked to check the five (5) most important barriers to optimal palliative care in their hospital. Answers were distributed as follows (sorted by number of responses):</p> <ol style="list-style-type: none">17 Physician believes that he or she is providing palliative care.14 Physician believes that palliative care interferes with aggressive treatment.13 Patient and/or family is unaware of prognosis or treatment choices or both.9 Patient and/or family is reluctant to accept prognosis.7 Health care team members believe that the palliative care team will dilute or displace their role in patient care.6 Non-beneficial treatment is provided.6 Physicians resist prescribing palliative doses of opioids and other drugs.6 Inadequate supply of clinicians with palliative care expertise.4 Health care team and patient/family have conflicting needs.3 Patient and family have conflicting treatment goals and preferences.3 Funding is lacking to create or maintain a palliative care service.2 Nurses are reluctant to administer palliative doses of opioids and other drugs.1 Question is not applicable ~ very minimal barriers.

Observations: **Barriers to optimal palliative care are commonly experienced.** Fourteen respondents (70%) selected five barriers and five (25%) indicated only four. On an encouraging note, one respondent (5%) indicated that there are few barriers to palliative care in her facility.

Barriers to Palliative Care

Issues related to physician resistance dominate as barriers; 95% of the 20 respondents selected one or both of the two top-ranked items:

- Believes palliative care interferes with treatment (n=2; 10%)
- Believes s/he provides palliative care (n=5; 25%)
- Both of the above (n=12; 60%).

Six respondents (30%) also indicated that physicians resist prescribing palliative doses of opioids and other drugs.

Patient and family issues related to awareness and acceptance of prognosis are the second most commonly reported barriers. Fourteen respondents (70%) checked one or both of these items:

- Unaware of prognosis and/or treatment choices (n=5; 25%)
- Reluctant to accept prognosis (n=1; 5%)
- Both of the above (n=8; 40%)
- Neither of the above (n=6; 30%).

Three respondents (15%) also ranked patient/family conflict about treatment as a top barrier.

Provision of non-beneficial treatment was selected as an important barrier by six respondents (30%). In all cases, these individuals also noted a combination of issues related to physician resistance and patient/ family awareness and/or acceptance of prognosis.

Issues related to the health care team ranked third in frequency of selection. The 13 respondents (65%) chose only one item each:

- Belief that palliative care team will dilute or displace role of health care team (n=7; 35%)
- Team and patient/family have conflicting needs (n=4; 20%)
- RN reluctance to administer palliative doses (n=2; 10%).

Resource issues rank lowest as a barrier to optimal palliative care.

Six respondents (30%) selected these items:

- Inadequate supply of clinicians (n=3; 15%)
- Inadequate supply of clinicians plus lack of funding (n=3; 15%).

These findings should not be interpreted to suggest that resources are not a critical issue for palliative care teams. Rather, funding and adequate staffing are necessary but not sufficient elements for success.

Findings: Respondents were asked to check the five (5) most common sources of referral to the palliative care service from July 1, 2006 through June 30, 2007. An alphabetical list of possible referral sources was provided, with an option to specify other sources. Answers were distributed as follows (sorted by number of responses).

- 16 Hospitalists
- 14 Critical care
- 12 Oncology
- 9 Case management / discharge planning
- 9 Primary care
- 9 Pulmonary medicine
- 6 Cardiology
- 3 Family or patient
- 3 Nephrology / renal dialysis
- 2 Neurology
- 1 Ethics committee or ethicist
- 1 Long term acute care
- 1 Spiritual care
- 0 Emergency medicine
- 0 Pediatrics
- 9 Other:
 - Nursing home / longterm care
 - Nursing home and community
 - Community nursing homes
 - Internal medicine
 - Internal medicine
 - Academic internal medicine – interns & residents
 - Family practice; social work department
 - Social workers, palliative care interdisciplinary team rounding
 - Screening tool for palliative care needs; nursing

Observations: **Referral sources are diversified for most palliative care teams**, regardless of program tenure. Fifteen respondents (75%) selected five referral sources, four (20%) indicated four sources, and one (5%) indicated three.

Hospitalists and critical care dominate as referral sources; 95% of the 20 respondents selected one or both of these two top-ranked items:

- Hospitalist (n=5; 25%)
- Critical care (n=3; 15%)
- Both of the above (n=11; 55%)

Oncology and primary care specialties are the next most frequently selected referral sources.

- Oncology was chosen by twelve respondents (60%).

- Primary care, internal medicine, and/or family practice were indicated by eleven respondents (55%).

Non-physician practitioners rank third as a category of referral sources.

- Case management, social work, nursing, spiritual care, and/or ethics committee were indicated as common referral sources by ten respondents (50%).

Other medical specialties rank fourth as a category of referral sources.

- Nine respondents (45%) indicated pulmonary medicine as a top referral source.
- And nine respondents (45%) indicated one or more other medical specialties (cardiology, nephrology, neurology).
- No one chose emergency medicine as a common referral source.

This question does not assess the relative number of referrals from each specialty. One respondent indicated a substantial difference in volume of referrals among the top sources. In that facility, the palliative care service receives more oncology referrals from hospitalists (when they are attendings) than from oncologists (when they are attendings).

Conclusion

Barriers to optimal palliative care are commonly experienced by the majority of programs regardless of size of facility, tenure of program, number of patients served, or composition of the palliative care team. Physician resistance to palliative services and patient/family lack of awareness of prognosis dominate as the top two barriers in most settings.

Certain referral sources are common to most programs, also with no particular patterns of variation related to program characteristics. Hospitalists, critical care, oncology, and primary care specialties stand out as the most often cited sources of referral to palliative care services.

While resource issues ~ availability of funding and qualified staff ~ rank lowest as barriers to optimal palliative care, they remain critical concerns for many programs. Resources are necessary but not sufficient for success.

It may be helpful for palliative care teams to discuss their similarities and differences regarding barriers and referrals and exchange learnings and successes related to both issues.