

Department of Family and
Community Medicine

REPORT OF THE PALLIATIVE CARE CAPACITY BUILDING TASK FORCE

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UNIVERSITY OF TORONTO
FACULTY OF MEDICINE

Department of Family & Community Medicine
Palliative Care Capacity Building Task Force
REPORT & RECCOMENDATIONS

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A sincere thank you to members of the Palliative Care Capacity Building Task Force for the considerable time and effort to develop these recommendations and for ensuring that direct improvements in the experience of people with serious illness and their families remained in focus.

As well, a sincere thank you to DFCM Chiefs and individuals on their behalf for contributing the perspective of teaching sites. The information created an important snapshot for the current activities and was of tremendous value when charting the course of developing the recommendations.

Finally, an important thank you to Dr. Lynn Wilson, Dr. David White and DFCM Executive members for the courage to view the effort to meet the palliative care needs of people with serious illness and their family members as an important population, global and public health issue.

RECOMMENDATIONS AT A GLANCE

-
1. Enhance the postgraduate family medicine primary palliative care (PC) educational experience
-
2. Support postgraduate Teaching Sites (TS) with the necessary resources to achieve the primary PC standards
-
3. Enable TS to adopt a customized model of PC integration that accounts for needs, resources and readiness
-
4. Advance the integration of primary PC into undergraduate medical education
-
5. Optimize alliances with key partners and collaborate on parallel activities that enable, facilitate or align with primary PC integration
-
6. Develop and implement a DFCM wide advance care planning strategy in alignment with the Choosing Wisely Campaign
-
7. Lead a coordinated communications effort to expand awareness of primary PC across the Faculty of Medicine
-
8. Establish a Steering Committee tasked with overseeing implementation of the recommendations as well as further integration of primary PC into existing DFCM structures, programs and initiatives
-

INTRODUCTION

- The profound societal shifts accompanying our aging population have created an urgent need for health system reform and with this an awareness that quality end of life care has become a public health issue.
- The vast majority of Canadians will die from one or more serious illness and strong evidence now exists for the value of palliative care when it is provided from the time a person is diagnosed with serious illness, throughout their illness journey and alongside disease-focused therapies.
- People with serious illness who have unmet palliative care needs comprise a vulnerable population
- Ensuring future generations of family physicians are skilled and confident to provide primary palliative care would uniquely position DFCM as a leader in improving the end of life experience through social responsibility and scholarship.
- An interprofessional task force was struck in early 2015 by Dr. Lynn Wilson and DFCM Executive with the direction of developing a set of recommendations that would build primary palliative care capacity to better meet the needs of patients with serious or life-limiting illness and their family members.

BACKGROUND

PRIMARY PALLIATIVE CARE: WHAT IT IS

Palliative care in Canada is evolving in important ways to meet the needs of an aging population who live with chronic complex illnesses and multiple comorbidities. While originally provided to patients dying of cancer, palliative care is now recognized to be of benefit in all chronic and life limiting conditions and appropriate much earlier in the disease trajectory.

There is strong evidence that palliative care is beneficial to patients living with any life limiting illness.

Quality palliative care results in:

- Better health outcomes:
 - fewer symptoms
 - better quality of life
 - greater patient satisfaction
 - increased longevity possible
 - positive effects on emotional wellness and decreased suffering
- Better use of resources
 - less burden on caregivers
 - more appropriate referrals to palliative care
 - more effective use of palliative care experts
 - fewer ER visits and hospital admissions
 - reduced use of ICU
 - decreased costs of care

Current best practice is to integrate and simultaneously provide palliative care alongside disease-focused care from the time of diagnosis of incurable and progressive i.e. life-limiting illness. To maximize the patient and family experience palliative care is ideally integrated:

- throughout the disease trajectory
- in all settings: home, hospital, long-term care, complex continuing care, residential hospices, shelters etc.
- across professions/disciplines and specialities
- within systems of care including communities

	2007	2010
FPs offering house calls	48.3%	42.4%
FPs age <35 offering house calls	30.8%	32.3%
PGY2s intend to offer house calls	43.6%	34.1%

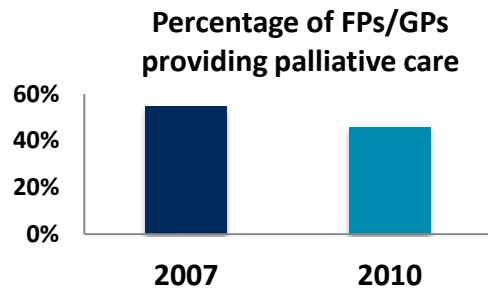
Specialized palliative care clinicians alone could not adequately meet the palliative care needs of any patient population. At the same time, not all patients have needs at a complexity level warranting specialized palliative care. Meeting palliative care needs will **require a cadre of non-specialized palliative care clinicians** (e.g. family health teams, oncology teams, cardiology teams, respirology teams etc.) **to attain and maintain primary palliative care competence**. Applying these competencies would enable system-wide integration of a palliative approach to care. Applying an integrated palliative approach to care means a person's and family's range of physical, psychosocial and spiritual needs will be addressed at all stages of frailty or chronic illness. This should occur in all health care settings and not delayed until the end stage of an illness. It should be applied early in an illness trajectory to provide active comfort focused care and a positive approach to reducing suffering.

WHAT PRIMARY PALLIATIVE CARE MEANS TO FAMILY PHYSICIANS

Multiple quantitative and qualitative studies have confirmed the family physician perspective on palliative care:

- an inherent and important part of the family physician role
- view themselves as potentially providing effective palliative care if adequate knowledge, skills and confidence are acquired along with timely access to specialized palliative care mentors to advise and guide

Family physicians may not view or label as such but a tremendous amount of palliative care is currently provided in the family practice setting. The overall percentage of family physicians who communicate formal provision of palliative care is declining however:



More recently, in 2015 an **Ontario wide survey**¹ **examined the extent to which primary care practices provide palliative care in the community.** All members of the Association of Family Health Teams of Ontario, Association of Community Health Centres and the Nurse Practitioners Association of Ontario were included.

- 78% of practices have clinicians who **provide home visits** for end of life care
- 52% provide care **outside of regular office hours**
- 19% of practices **maintain a registry** of patients who require palliative care
- 15% of practices have clinicians who provide care for patients in residential hospices or palliative care units
- 14% do not have access to specialized palliative care
- 8% of practices did not have a clinician who provides palliative care
- Model of care delivery: 53% – group provides all palliative care; 50% – specialized palliative care provides consultation; 50% – care is shared; 22% care is transferred to specialized palliative care

Enablers to providing palliative care were cited to be communication and education with the key barriers cited to be time, burden and skills.

WHAT PRIMARY PALLIATIVE CARE COMPETENCE LOOKS LIKE

Within the CFPC Accreditation Standards for Family Medicine Residency Training Programs, palliative medicine (end-of-life care) is one of eight care domains for which residents **must have adequate exposure** during training.

These are the two overarching aims and are followed by a brief exploration for each:

A. Residents must gain the competencies to provide care for patients and their families in the home and in institutions at the end of life

B. Residents should acquire competencies in collaborative models that assist with patient management

A. Specific palliative care competencies are not outlined in the CFPC standards however the following list was assembled for the DFCM Postgraduate Competency Based Curriculum project.

- educate patients, families, and colleagues about “palliative care” as an approach
- assess and manage common symptoms
- facilitate advance care planning, goals of care discussions and end-of-life decision-making
- address patients and families’ psychosocial issues and suffering
- manage the care of a dying patient in last days and final hours
- support families and caregivers through grief and bereavement

B. There are several examples of successful shared and collaborative models of care between family medicine

and palliative care clinicians. To support these models, specialized palliative care clinicians must expand competence beyond what is required to care for patients and families who have complex needs. This includes abilities to lead quality improvement efforts, gain comfort with collaborative and shared care models and provide mentorship and support to any colleague providing primary palliative care.

METHODS AND APPROACH

TASK FORCE ACTIVITIES

- Analysis of a focused review of the literature on the evidence for and best practices around palliative care integration
- Review of accreditation standards and recently released directional documents addressing palliative care provision for Ontario
- Conduct an environmental scan of current clinical and educational palliative care activities among DFCM Teaching Sites
- Assess the perceived needs, gaps and barriers related to primary palliative care delivery among DFCM Teaching Sites
- Distill this information in to a draft set of strategic recommendations that outline specific guidance on building capacity within the DFCM
- Develop a model for an approach to implementing the recommendations

KEY FINDINGS

FOCUSED LITERATURE REVIEW UNDERGRADUATE LEARNERS IN FAMILY MEDICINE

Research Web exclusive

Giving curriculum planners an edge

Using entrance surveys to design family medicine education

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Aim:

- Among family medicine PGY1s, assess the exposure to family medicine during medical school and examine the impact on future intentions to practice

Background:

- 2012 National Survey, 41% & 35% of PGY1's & PGY2's in family medicine plan to narrow scope of practice

Methods:

- Survey of family medicine PGY1's about undergraduate experiences in key domains of family medicine

Results:

- Most study participants felt exposure to family medicine in undergraduate was strong overall
- For a number of clinical domains however limited exposure was noted, e.g. 50-55% had minimal or no exposure to home care, LTC settings and palliative care
- Residents also reported a lower likelihood of maintaining these three domains as part of their practice

TAKE HOME MESSAGE:

- Particularly during family medicine experiences, exposure to palliative care during undergraduate medical education likely impacts whether or not family physicians maintain palliative care as part of their practice

POSTGRADUATE LEARNERS IN FAMILY MEDICINE

Web exclusive Research

Are family medicine residents adequately trained to deliver palliative care?

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Aim:

- Assess self-perceived readiness to deliver palliative care among family medicine PGY1s and PGY2s

Background:

- Most family medicine curricula have a one-month core rotation with specialized palliative care clinicians

Methods:

- Mixed methods study conducted at U of T; study population is comprised of DFCM PGY1s and PGY2s

Results:

- Residents expressed feeling the need to transfer dying patients to specialized palliative care programs as these were perceived as providing better care (“more expertise” and “appropriate infrastructure”)

TAKE HOME MESSAGES:

- Despite the aim of improving palliative care skills, the postgraduate family medicine curriculum i.e. block rotation supervised by specialized palliative care clinicians may have the unintended effect of preventing residents from maintaining palliative care as part of their practice
- Family medicine residents highlighted potential curricular enhancements that might serve to mitigate this:
 - **improve access to FM mentors who practise palliative care**
 - improve access to both palliative care CPD and palliative care specialists when needed

2013 DFCM ACCREDITATION DATA

The following data are taken directly from accreditation documents and outline detailed perspectives of both palliative care and maternity care postgraduate experiences.

PALLIATIVE AND END OF LIFE CARE EXPERIENCE

How do Residents learn skills, knowledge and attitudes related to palliative and end of life care?

DFCM Central PSQ Response

“End of life care is learned in palliative care rotations, internal medicine and family medicine experiences. Certain topics relating to palliative and end of life care are delivered during academic half-days. PGCORed™ modules are required for PGY1 & PGY2 Residents. The End of Life Care Module© focuses on preparing the resident for seeing dying patients during their medical practice. Topics include the basics of end of life care, pain management as it relates to its assessment and treatment in end of life care, establishing patient and family goals for care in the last days and hours of care, and how to support families through their grief and bereavement.”

DFCM Teaching Site PSQ Responses – vast majority of data addresses a core palliative care rotation

DFCM Site	4 wk core?	1 st or 2 nd Yr	Spent w/ specialized PC?	Longitudinal FM exp*	Information outlining how the Teaching Site ensures an adequate clinical palliative care experience
A	✓	2 nd	✓	Yes	FHT has a home based PC program
B	✓	2 nd	✓	No	1 FM preceptor has active PC interest & facilitates learning
C	✓	1 st	✓	No	Academic ½ day sessions
D	✓	2 nd	✓	No	LEAP certification
E	<	1 st	✓	For some	If FM preceptor provides home PC then resident gains skill
F	>	2 nd	✓	No	Focus of experience is cancer
G	<	1 st	✓	No	Academic ½ day sessions
H	✓	1 st	✓	No	Academic ½ day sessions
I	✓	2 nd	✓	No	Academic ½ day sessions
J	✓	1 st	✓	No	Academic ½ day sessions
K	✓	2 nd	✓	No	Home visits with rural focus
L	✓	1 st	✓	No	Academic ½ day sessions
M	✓	1 st	✓	No	Home-based Primary Care Program; Fam Med Inpt Service
N	✓	1 st	✓	No	Academic ½ day sessions

* Is there a formal palliative care element in the longitudinal family medicine clinical experience?

Note: 12 of 14 identified the PGCORed™ end of life care module as a core element of the palliative care experience. The module is mandatory for all faculty of medicine, postgraduate learners, regardless of program or department.

MATERNITY CARE

How do Residents learn skills, knowledge and attitudes related to maternity care?

DFCM Central PSQ Response

“All residents are expected to follow some pregnant patients during their Family Medicine experience. This may occur in the course of their regular clinics or as a dedicated high volume Family Medicine-OB clinic supervised by a family physician. Residents generally are expected to attend the deliveries of family medicine patients either using a soft or hard call system. The tracking of family medicine deliveries has been added to the RPP tool to address uniformity of this experience across the program.”

DFCM Teaching Site PSQ Responses – quotes taken directly from PSQ responses of individual Teaching Sites

- FMTU recruited 2 new Family Physicians with obstetrical skills to develop the FMTU Obstetrics program
- With two newly recruited faculty who practice OB...
- Each resident follows approx 16-20 patients over the 2 years of residency, significantly more than the minimum requirement of 6
- # of antenatal patients is reviewed at 6-month review
- Residents manage the intrapartum care of patients registered to family MDs comprising a core call group
- All residents have a FM OB preceptor and overseen by FM OB Lead

TAKE HOME MESSAGE:

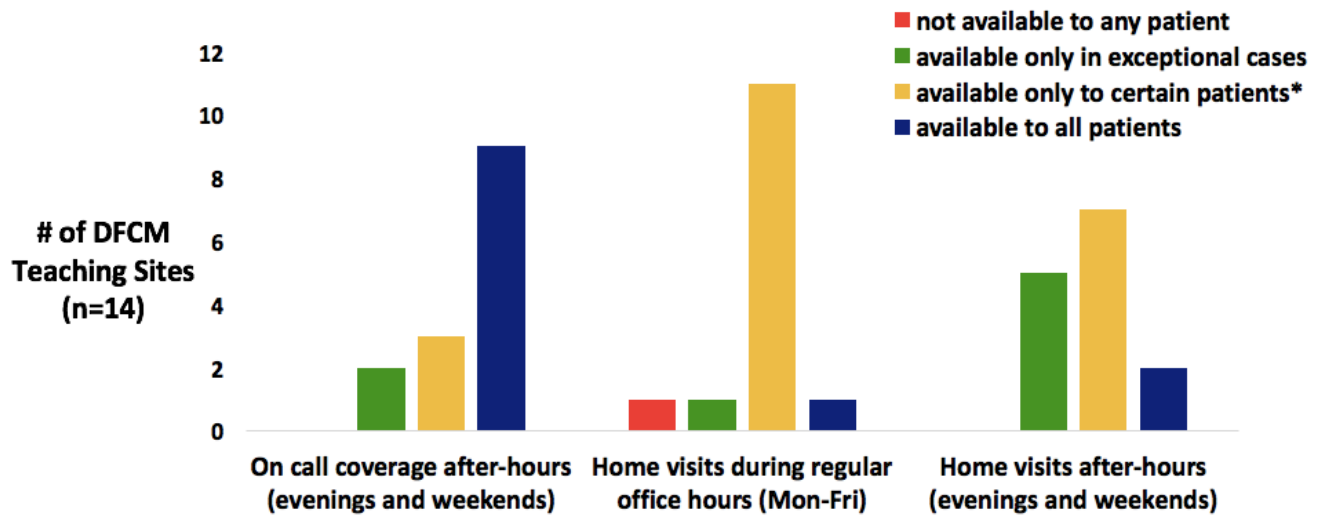
Teaching Sites have successfully met CFPC accreditation standards for Maternity Care through innovation and creative use of a wide range of resources. This warrants the question, **What leadership, teaching and learning strategies could apply to palliative care experiences?**

DFCM CURRENT STATE: SITE SELF-ASSESSMENT

The following is a data summary from a survey that was designed, tested and completed for each of the 14 DFCM Teaching Sites:

- 11 Chiefs completed themselves
- 3 delegates completed on Chief's behalf

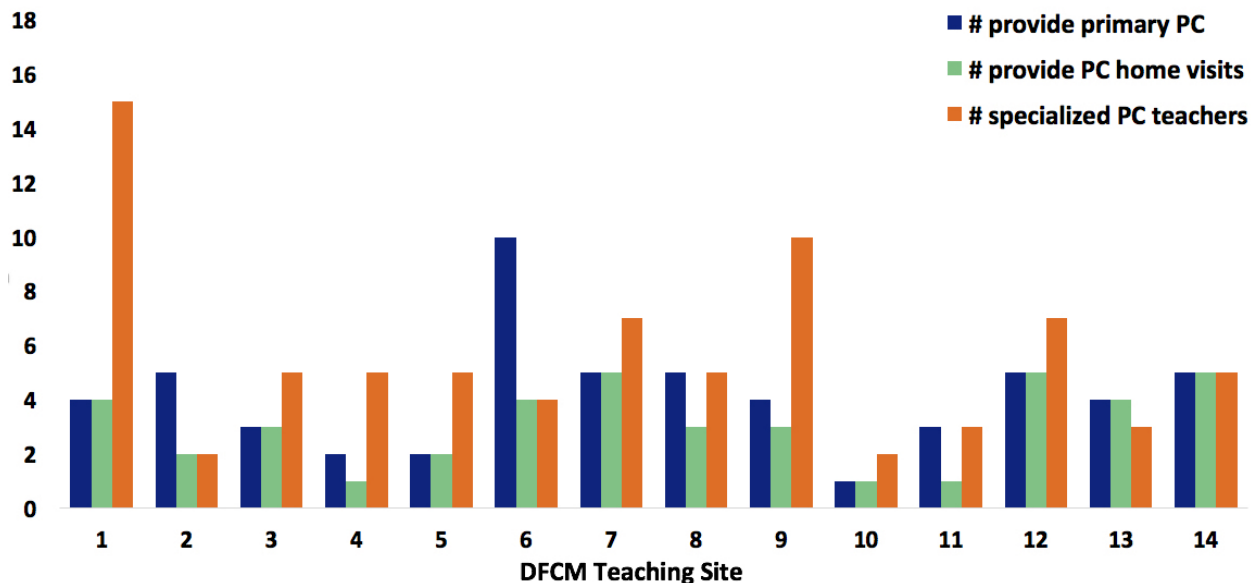
The following is a **summary of clinical services that may or may not be available to all, some or no patients**. Chiefs were asked to consider all patients within the site, not only palliative care patients:



*E.g. as part of a program or initiative, because practices differ etc.

Note: 1 of 14 DFCM Teaching Sites indicated all three clinical services available to all patients

For each Teaching Site the following is: **# of family medicine resident preceptors who provide primary palliative care** and **# who make palliative care home visits**. Also included is the **# of specialized palliative care clinicians** at the site available to teach family medicine trainees.



How often are specialized palliative care clinicians available to family medicine resident preceptors for clinical or educational matters at your site?

Always	5
Often	4
Sometimes	4
Rarely	1
Never	0

How often are specialized palliative care clinicians available to provide direct care at your site?

Always	3
Often	8
Sometimes	1
Rarely	0
Never	2

How important is each of these POTENTIAL BARRIERS to family medicine resident preceptors maintaining primary palliative care as part of their practice? (Scale: 1=Not at all, 5=Very)

Mean	TOP 2 (Greatest potential for being a barrier)
3.86	Potential need to provide home PC visits during office hours
3.79	Low comfort and familiarity levels with PC knowledge or skills among preceptors
	Bottom 2 (Least potential for being a barrier)
2.36	Poor access to acute PC unit beds to admit patients with complex needs, not necessarily those at the end of life but those that need palliation (e.g. symptom control)
2.36	Inconsistent or unreliable access to specialized PC physicians

What is the ONE greatest POTENTIAL BARRIER to family medicine resident preceptors maintaining primary palliative care as part of family practice? (number of responses)

- Low comfort and familiarity levels with PC knowledge or skills among preceptors - 5
- Limited opportunity to maintain PC as part of practice because of the current model for PC delivery - 2
- Low interest levels in palliative care among preceptors overall - 2
- Amount of time required to provide palliative care in the home - 2
- Potential need to provide home PC visits after-hours (evening and weekends) - 1
- Poor flow of patient information from other settings - 1
- Inconsistent or unreliable access to specialized PC physicians - 1

Does your DFCM teaching site maintain a registry for palliative care patients?

Yes = 2
 No = 11
 Not sure = 1

TAKE HOME MESSAGES:

Each site has enough primary palliative care activity to begin with small scale pilot projects. As well, levels of comfort and familiarity with palliative care knowledge or skills are elements that with focused attention to faculty and professional development they can be improved.

RECOMMENDATIONS

PRIMARY PALLIATIVE CARE: DFCM CONTEXT

The following points are a synthesis of the data and key findings:

- DFCM prepares future family physicians for comprehensive primary care, which includes the provision of primary palliative care for patients and their families.
- The capacity building focus should be the educational experience of postgraduate family medicine learners.
- Similar to primary maternity care **not all family medicine preceptors could be expected to maintain primary palliative care competence and practice.**
- Also similar to primary maternity care, a cadre of family medicine preceptors maintaining primary palliative care clinical and academic skills should serve as role models for undergraduate and postgraduate learners.
- **DFCM Teaching Sites should consider applying existing models and strategies that ensure residents achieve competence in maternity care to achieving competence in palliative care.**

GUIDING PRINCIPLES & STANDARDS

The following guiding principles served as foundational in the development of the recommendations and the Task Force suggests adoption for all associated initiatives and activities during the Implementation Phase.

Guiding principles for teaching and learning about the primary PC of patients and their families

- High value is placed on maintaining therapeutic relationships
- Access to quality PC is a social responsibility issue as patients who have unmet PC needs comprise a vulnerable population
- Primary PC is provided and taught by family medicine preceptors to patients in the context of their families and communities

In receiving and accepting this report, the DFCM Executive is endorsing the following standards. These can also serve as long term measures of success and impact for this initiative:

Primary PC standards for postgraduate family medicine residency training

- CFPC accreditation “Red Book” standards for the palliative medicine (end of life care) domain are met
- Primary PC is modeled by family medicine preceptors
- Specialized PC clinicians are accessible and available for mentorship

DFCM'S PALLIATIVE CARE CAPACITY BUILDING TASK FORCE: RECOMMENDATIONS

PC = Palliative Care ✓ = primary responsibility to oversee + = supportive/ mentorship role (full legend below)

		Implementation Responsibility	
		DFCM	DPC
1. Enhance the postgraduate family medicine primary PC educational experience			
1.1	Revise postgraduate “palliative and end of life competencies” to reflect CFPC Red Book standards	+ -PG	✓ -Ed
1.2	Develop learner experience standards for primary PC	✓ -PG	+ -Ed
1.3	“Care of dying person at home” is added to residency practice profile	✓ -PG	+ -Ed
1.4	Outline standard PC content for the postgraduate academic ½ day curriculum	+ -PG	✓ -Ed
1.5	Determine need and consider developing a set of PC “clinical one pagers”	+ -PG	✓ -Ed
1.6	CFPC accreditation “Red Book” standards for the palliative medicine (end of life care) domain are met	✓ -PG	+ -Ed
1.7	Primary PC is modeled by family medicine preceptors	✓ -TS	+ -TS

2. Support postgraduate Teaching Sites (TS) with the necessary resources to achieve the primary PC standards			
2.1	Clarify the primary PC role of the family physician around Medical Assistance in Dying (MAID)	✓ -CPD	✓ -CPD
2.2	Design a primary PC toolkit	+ -Qu	✓ -Qu
2.3	Ensure the needs of both DFCM and DPC faculty members at TS are understood and aim to develop primary PC related teaching, mentorship and collaborative skills	✓ -CPD ✓ -TS	✓ -CPD ✓ -TS
2.4	Develop and implement a plan for LEAP delivery	✓ -CPD	✓ -CPD
2.5	Specialized PC clinicians are accessible and available for mentorship	+	✓ -TS

3. Enable Teaching Sites to adopt a customized a model of PC integration that accounts for needs, resources and readiness			
3.1	Draft a role profile for site-based FM PC Faculty Lead (modeled after FM OB Lead role)	+	✓
3.2	Support local DPC members at TS with a primary PC integration toolkit	+ -Qu	✓ -Qu
3.3	Build on existing TS initiatives and integrate a primary PC element e.g. home bound seniors program	✓ -TS	+ -TS
3.4	Build on existing collaborations and relationships with local DPC members	✓ -TS	✓ -TS
3.5	Leverage current approach or model at TS addressing Maternity Care competence as well as lessons learned from FM OB preceptor model to establish/enhance primary PC model	✓ -TS	+ -TS
3.6	Primary PC competence is considered when recruiting new faculty	✓ -TS	+

4. Advance the integration of primary PC into undergraduate medical education			
4.1	“Modeling primary PC to undergraduate students in family medicine rotation” is endorsed as a formal teaching activity	✓ -UG	✓ -Ed, ✓
4.2	Partner with UME to establish an Undergraduate PC Lead role who should maintain leadership responsibilities for primary PC integration into undergraduate curricular and assessment experiences	✓ -UG, +	✓ -Ed, ✓
4.3	Advocate for palliative care to be a theme within UME’s Foundations Curriculum as one of priority population groups	✓ -UG, +	✓ -Ed, ✓
4.4	Coordinate and plan for the delivery of PC content within undergraduate family medicine experiences	+ -UG	✓ -Ed

5. Optimize alliances with key partners and collaborate on parallel activities that enable, facilitate or align with primary PC integration			
5.1	Collaborate with Dalla Lana School of Public Health to adopt a public health approach to primary PC	✓	✓
5.2	Align with the related activities at the sub-LHIN (e.g. HealthLinks) and relevant LHIN levels	✓ -TS, ✓	✓ -TS, ✓
5.3	Advocate for revised and strengthened language addressing the PC domain within CFPC’s Red Book	✓	✓

6. Develop and implement a DFCM wide advance care planning strategy in alignment with the Choosing Wisely Campaign		
6.1	Leverage existing advance care planning initiatives within DFCM and facilitate spread among TS	Cross Program & Division collaboration

7. Explore a coordinated communications effort to expand awareness of primary PC across the Faculty of Medicine	✓	✓
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8. Establish a Steering Committee tasked with overseeing implementation of the recommendations as well as further integration of primary PC into existing DFCM structures, programs and initiatives			
8.1	Identify opportunities to embed primary PC integration content within CPD curricula	✓-CPD	✓-CPD
8.2	Integrate PC content and philosophy into activities with international partners and Global Health	✓-GH	✓

LEGEND

✓ = primary responsibility for overseeing (joint responsibility if ✓ indicated in both DFCM and DPC columns)

✚ = additional mentorship or support is likely to be of value

(No letters after ✓ or ✚ represents primary responsibility rests with either DFCM central or DPC Head)

TS = DFCM Teaching Site or DPC Teaching Site

PG = DFCM Postgraduate Program

GH = DFCM Global Health Program

CPD = DFCM Continuing Professional Development Program or DPC Continuing Professional Development Committee

Ed = DPC Education Committee

UG = DFCM Undergraduate Program

Qu = DFCM Quality Program or DPC Quality Leads

CONCLUSION

The clinical aim of palliative care is to meet physical, psychosocial, practical and information needs of people with serious or life limiting illness and their family members, irrespective of age, diagnosis and prognosis. This set of recommendations, when taken collectively, serve as a scholarly road map to building primary palliative care capacity.

Although the recommendations were designed to be synergistic, a customized approach to any part of any one recommendation will lead to meaningful improvements in the end of life experience for individual patients and family members served by DFCM's academic community of clinicians.

By ensuring future generations of family physicians are skilled and confident to provide primary palliative care, the DFCM is positioned to be an important and socially responsible partner in addressing this public health issue.

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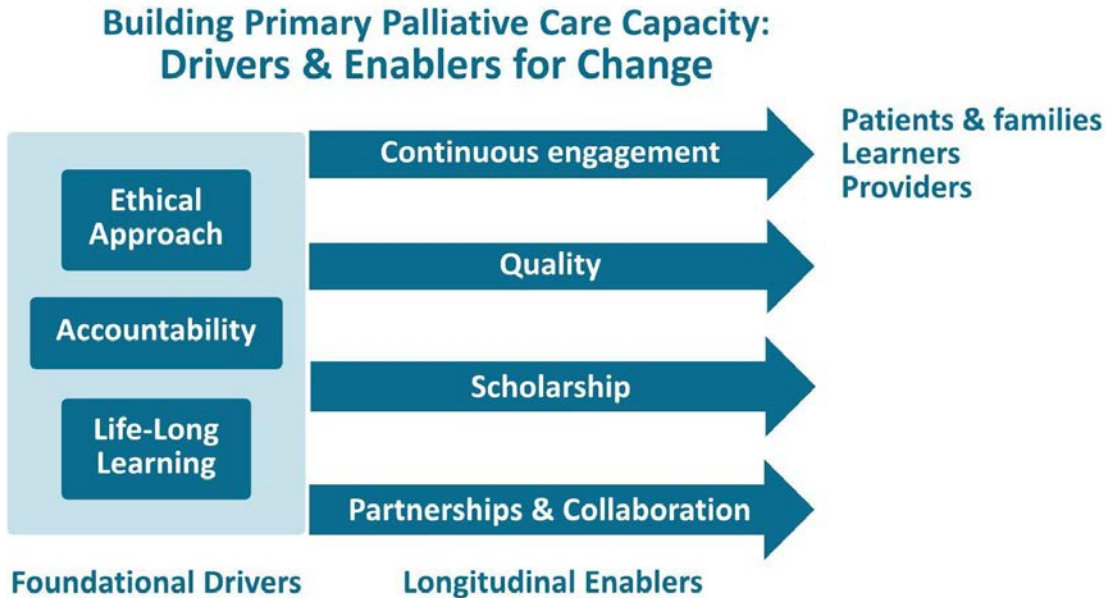
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APPENDIX

ENABLING FRAMEWORK



FOUNDATIONAL DRIVERS

Ethical approach: to guide all aspects of integration

Accountability: overarching metrics to be determined by DFCM Chair and DFCM Executive

Life-long learning: principle for all aspects of education among all learner types and settings

LONGITUDINAL ENABLERS

Continuous engagement: adequate and timely information exchange and continuous engagement of internal DFCM partners is necessary to ensure effective implementation and long-term sustainability

Quality: scalable and measurable QI projects to guide the process of site-based implementation

Scholarship: multiple levels of opportunity for scholarship, including Department wide

Partnership & Collaboration: strategic partnerships with external DFCM partners to collaborate on current or future activities that are in alignment; aim is to avoid duplication and maximize engagement and impact and the sub-region and regional levels

IMPLEMENTATION FRAMEWORK



FOUNDATIONAL ACTIVITIES

1-3 are the antecedent conditions and considerations likely to be necessary to enable long term sustainability

LONGITUDINAL ACTIVITIES

4-8 outline the key activities that serve to support the local Teaching Site change