Case conferences between general practitioners and specialist teams to plan end of life care of people with end stage heart failure and lung disease: an exploratory pilot study.

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Abstract:

BACKGROUND: Most people die of non-malignant disease, but most patients of specialist palliative care services have cancer. Adequate end of life care for people with non-malignant disease requires acknowledgement of their limited prognosis and appropriate care planning. Case conferences between specialist palliative care services and GPs improve outcomes in cancer-based populations. We report a pilot study of case conferences between the patient's GP and specialist staff to facilitate care planning for people with end stage heart failure or non-malignant lung disease in a regional health service in Queensland Australia. **METHODS:** Single face to face case conferences about patients with a primary diagnosis of advanced heart failure or respiratory failure from non-malignant disease were conducted between a palliative care consultant, a case management nurse and the patient's GP. Annualised rates of service utilisation (emergency department [ED] presentations, ED discharges back to home, hospital admissions, and admission length of stay) before and after case conference were calculated. Content and counts of case conference recommendations, and the rate of adherence to recommendations were also assessed. A process evaluation of case conferences was undertaken. **RESULTS:** Twenty-three case conferences involving 21 GPs were conducted between November 2011 and November 2012. One GP refused to participate. Ten patients died, three at home. Of 82 management recommendations made, 55 (67%) were enacted. ED admissions fell from 13.9 per annum (pa) to 2.1 (difference 11.8, 95% CI 2.2-21.3, p = 0.001); ED admissions leading to discharge home from 3.9 to 0.4 pa (difference 3.5, 95% CI -0.4-7.5, p = 0.05); hospital admissions from 11.4 to 3.5 pa (difference 7.9, 95% CI 2.2-13.7, p = 0.002); and length of stay from 7.0 to 3.7 days (difference 3.4, 95% CI 0.9-5.8, p = 0.007). Participating health professionals were enthusiastic about the process. **CONCLUSIONS:** This pilot is the initial step in the development and testing of a complex intervention based on a model of integrated care. A single case conference involving the patient's heart or lung failure team is associated with significant reductions in service utilization, apparently by improving case coordination, enhancing symptom management and assessing and managing care needs. A randomized controlled trial is being developed.

Comments:

Strengths/uniqueness:

This manuscript describes a novel concept for improving end of life care for non cancer patients. The process is designed to limit the time burden for Family MDs and the model is well described with a clear plan for future research.

Weakness/Limitations:

The limitations of this relatively small pilot project are well described.

Relevance to Palliative Care:

The need to broaden access to palliative care beyond cancer populations and have this occur earlier in the disease trajectory is an international challenge for palliative care programs. The approach outlined in this manuscript suggests the possibility of significant benefits to Family MD and home care nurse expertise with a major impact on patient care outcomes and savings for the health care system.