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ORIGINAL ARTICLE

# An investigation of the challenges to coordination at the interface of primary and specialized palliative care services in Switzerland: A qualitative interview study

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**ABSTRACT**

Good coordination of healthcare services is vital for ensuring health cost efficiency and high-quality care for patients. It is especially important in the context of palliative care as services are often highly fragmented due to a combination of diverse professional groups, organizations, and approaches to care. However, the coordination of services in this field is often evaluated as insufficient. Little is known about the challenges to coordination in this sector in Switzerland. The present study addresses this gap in research by investigating the challenges to coordination at the interface of palliative care services in Switzerland. Interviews ($n$ = 24) with 38 healthcare practitioners working in palliative care in four cantons (Basel-City, Lucerne, Ticino, and Vaud) form the basis for this investigation. The selected cantons not only represent French, Italian, and German language regions of Switzerland but also represent diverse rural, urban, and historical contexts. Expert interviews are analyzed using structural content analysis. Three clusters of challenges to coordination were identified in the data: (1) organizational challenges to coordination, which relate to explicit forms of coordination; (2) relational challenges to coordination; and (3) structural challenges to coordination, which relate to implicit forms of coordination. The study reveals a need for better financial support for coordination in palliative care and a stronger focus on interprofessional coordination in educating professionals in palliative care. Future research on how to further foster good team coordination practices between primary and specialized palliative services merits further investigation. Since these findings are indicative of areas for improvement for coordination at the interface of Swiss palliative care services, they are of particular interest for healthcare practitioners, policymakers, and researchers involved in the evolution of coordinative practice.

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## Introduction

Good coordination of healthcare services is essential for ensuring health cost efficiency and high-quality care provision for patients (Albreht, McKee, Alexe, Coleman, & Martin-Moreno, 2008). In the context of palliative care, good coordination requires the effective marshaling of professionals and other resources required to carry out patient care activities and is usually managed by the exchange of information among providers of different aspects of care (Xyrichis & Lowton, 2008; McDonald & McCallin, 2010). Palliative circumstances especially require well-coordinated responses in the face of quickly changing clinical status or patient preferences for location of care (Agar et al., 2008). Yet, the coordination of services in this field is often evaluated as insufficient (Peikes, Chen, Schore, & Brown, 2009).

Previous literature has indicated factors that challenge coordination within palliative care settings. Notably, many challenges to coordination arise from the specific requirements of patient trajectories, which call for the coordination of different palliative care services and combinations of professional competencies (Murray et al., 2015; Turner-Stoke et al., 2007). Patient populations, regional conditions, network characteristics, and availability of resources can also present barriers to coordinative action (Bainbridge, 2010). In Switzerland, further challenges to coordination are attributed to cantonal differences regarding palliative care. Specifically, the federalist organization of the Swiss health system does not allow for uniform standards of palliative practice. Crucially, although the "National Strategy for Palliative Care 2013–2015" provides a general guideline for palliative practice for the 26 Swiss cantons (Federal Office of Public Health, FOPH, 2016), they are free to adhere to or ignore the guidelines where they feel appropriate. Consequently, rather than a cohesive approach to palliative care, provisional structures and implementation are extremely fragmented (Radbruch & Payne, 2011), with differences also found between rural and urban contexts (Alvarado & Liebig, 2015). Moreover, understanding of the challenges to coordination in palliative care in Switzerland is rather limited (Wittenberg- Lyles et al., 2009). The majority of the existing literature regarding palliative services in Switzerland focuses on challenges to interprofessional collaboration rather than coordination (Alvardo & Liebig, 2016; Alvarado & Liebig, 2015) and is limited to outpatient or stationary palliative contexts. Certainly, interprofessional collaboration and coordination are strongly related and are both important for effective team functioning (Evert, Laars & Noordegraaf, 2019; Reeves, Xyrichis, & Zwarenstein, 2018). However, interprofessional collaboration refers to when professions work together to achieve common goals and is often used

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as a means for solving a variety of problems and complex issues (Green & Johnson, 2015). On the other hand, interprofessional coordination specifically describes the managing of tasks, resources, and people (Malone & Crowston, 1994). This suggests that coordination is not only part of a collaboration but can be understood as a specific activity carried out by group members when managing interdependencies.

Little is known about the challenges to coordination at the interface of primary palliative care and specialized palliative care services. Identifying challenges to coordination at the interface between primary and specialized palliative care is imperative as patients frequently require a transfer from primary to specialized services and the task of navigating through this transition can be demanding (Liebig & Piccini, 2017). The present study aims to explore perceived challenges to coordination at the interface of Swiss primary and specialized palliative services. This insight is needed to inform health policy regarding coordinative practices between palliative services in Switzerland.

## Methods

A qualitative study design was adopted to explore perceived challenges to coordination between primary and specialized palliative care services from the perspectives of healthcare practitioners working in Swiss palliative care services.

### Sample

Results are based on a qualitative study in which semi-structured interviews with a total of 38 professionals working in palliative care in different regions of Switzerland were carried out, namely the following cantons: Basel-City, Lucerne, Ticino, and Vaud. These cantons not only reflect rural and urban regions but also diversly developed policy contexts for palliative care in Switzerland. The sample included 24 interviews with 11 general practitioners (GPs) and 12 nurses working in primary palliative care services, as well as 15 interviews with 9 specialized medical doctors (e.g., oncologists) and 6 specialized palliative care nurses working in hospitals, hospices, mobile palliative care teams (MPCTs), and specialist private practice.

### Data collection

Data were collected between January and June of 2018. The participants were identified in each canton via Internet searches and personal referral. They were recruited via e-mail invitation or telephone call. Those included in the study were interviewed by three researchers in a semi-structured interview format, in the language corresponding to the official language of the canton (Vaud: French, Ticino: Italian, or Lucerne/Basel: German). Interviews lasted between 30 and 45 minutes and were conducted in a location determined by the participant (e.g., clinic or personal office). Interview guidelines were informed by concepts derived from a conceptual framework for the evaluation of integrated palliative care networks (reference 8) and covered key topics to explore challenges to coordination (see Table 1). Demographic data were collected from all participants. Interviews were audio-recorded and transcribed verbatim in their original language, with all personal identifiers removed.

**Table 1.** Excerpt of interview questions.

(1) How are tasks and responsibilities divided in your network/cooperation?
(2) Who, in your opinion, has a key role in your network/cooperation when it comes to coordinating tasks?
(3) Who takes the lead in your network/cooperation?
(4) Who takes the lead in a critical situation
(5) How does the communication work in your network/with other professionals? (with respect to intensity, quality, means of communication)
(6) Do you feel that everybody is as committed to the network/collaboration, as they should be?
(7) Would you say, you work on the basis of common goals and values?
(8) Do you and your team or collaborators do have a trustful and respectful relationship to each other?
(9) How do you solve problems in your network/together with your collaborators?

### Data analysis

The data were analyzed using "structural content analysis" (Kuckartz, 2012) to identify and report patterns within the data. The first stage of analysis involved familiarization of the data, i.e., audio recordings and the transcripts. The second stage was coding the data. The first few transcripts were coded by two researchers, and subsequent codes were grouped into clusters around similar and interrelated concepts. To facilitate clarity in the analysis of the data, a distinction was made between concepts, which differentiated between challenges to *explicit forms of coordination*, which relies on instruments (e.g., electronic tools, schedules, plans) and verbal and written communication (instructions, meetings, feedback), and challenges to *implicit forms of coordination* (i.e., the processes involving non-verbal aspects of communication or actions), including the synchronization of members' actions based on unspoken norms and assumptions (Espinosa, Lerch, & Kraut, 2004; Malone & Crowston, 1994). The researchers cross-checked to compare the codes that were applied to initial transcripts and agreed on a set of codes to apply to all subsequent transcripts. This was done in order to ensure consensus between the researchers regarding the codes and analysis. Codes and themes in the data were constantly discussed and reflected upon among the team of three researchers to ensure rigor in the analysis. On the basis of this, the codes were then grouped together into clusters of challenges which were then clearly defined. The data in the subsequent transcripts were then coded according to these clusters. Data were then re-coded by one of the researchers using a qualitative data analysis software package (MAX QDA) to organize the data efficiently and systematically.

### Ethical considerations

Formal research approval for this study was obtained from the Ethics Committee of Northwestern Switzerland (EKNZ) on 29 August 2018 (Req-2018-00490). At the outset of interviews, participants received and completed an informed consent form for participation in the study and recording of interviews. Before each interview, explanations about objectives, reasons for recording interviews, voluntary participation, and confidentiality of data were given. The anonymity of participants was guaranteed.

## Results

The aim of this study was to identify challenges to the coordination at the interface of primary palliative care and specialized palliative care services in Switzerland. Three clusters of challenges were identified in the data (see Table 2). These were (1) Organizational challenges to coordination, which relate to *explicit forms* of coordination; (2) Relational challenges to coordination; and (3) Structural challenges to coordination, which relate to *implicit forms of coordination*. These challenges are discussed with respect to the perspective from which they derive (i.e., primary and/or specialized service provider perspectives) and are explained as follows.

### Organizational challenges to coordination

The categories of this cluster of challenges include (a) non-standardized use of electronic patient records (EPR), (b) lack of preplanned/regular meetings between primary/specialized palliative care providers, and (c) indirect communication between providers.

#### Use of EPR

As reported by both PPC and SPC service providers, coordination is hampered by non-standardized use of EPR systems. Professionals use systems for the storage and sharing of EPRs that are specific to their own PC institution or practice. However, it is not possible to share patient documents and other relevant patient information across incompatible electronic systems, which is often the case across primary and specialized palliative care services. As one nurse asserted: "We use old fashion methods, because people are not up to date so you can't just send them a file or link online (…) frustrating really!" (Nurse, Ticino). The majority of the respondents thus express a desire for the use of a standardized information transfer systems across institutions: "It would save so much time and would be so convenient for everyone! I don't know why we don't have this already" (Assistant nurse, Ticino).

#### Lack of regular meetings

Interviewees also expressed that the coordination of patient care is harder to achieve, as meetings with members from the other services are mostly "ad-hoc" rather than preplanned or scheduled regularly. Therefore, it is difficult to remain informed about care coordination. To be able to attend meetings, professionals must be extremely flexible when a meeting is called spontaneously, which is difficult to achieve amidst an already busy schedule. As one interviewee argued: "I cannot be expected to drop things and go, this is simply not realistic for me" (GP, Vaud).

#### Indirect communication

Another problem reported for coordinating tasks is the inability to communicate with other service providers directly (i.e., not face to face or on the telephone). Mainly this was attributed to difficulties in reaching other services via telephone or e-mail: "It's so difficult to get hold of the GP when you need them. We all have busy working lives" (Specialist, Luzern). Moreover, having to communicate via a second person such as a colleague or secretary when the relevant professional is not available complicates coordination: "If you reach a voicemail or a secretary, you don't know if the message will really go through. If it's something urgent then you might be stuck" (Head nurse, Ticino). Problems with indirect communication were reportedly worsened by geographical distances between providers. Providers face complications when they are not able to reach others via telephone or e-mail correspondence, a common problem among GPs whose time is in high demand, as they cannot easily meet up with them personally otherwise. As described by a GP: "Within my own team, I can just talk to them directly and Mendrisio is a small area, but if I need to reach a specialist all the way in Lugano (large town in Ticino), it's much more complicated as it's much further away" (GP, Ticino).

### Relational challenges to coordination

The categories of this theme are (a) conflicting understanding of professional roles, (b) conflicting team understanding, and (c) distrust for professional competencies.

#### Professional roles

Respondents describe conflicting understandings of the professional roles of members of the other service. Specifically, with respect to identifying those responsible for the coordination of tasks and decision-making, ambiguity is apparent. Notably, both members of primary and specialized palliative services felt that they were the sole responsible actor for the coordination of tasks. Moreover, there was a lack of understanding of the role of the members of the other team with respect to the coordination of patient care. As one specialist remarked: "I'm not sure why I would need to talk to primary palliative services once I have the patient under my custody" (Specialist, Lucerne).

**Table 2.** Overview of challenges to coordination at the interface of primary and specialized palliative care services.

| Challenges to coordination at the interface of Swiss primary and specialized palliative care services | | |
|---|---|---|
| Organizational challenges | Relational challenges | Structural challenges |
| Non-standardized use of electronic patient records (EPRs) | Conflicting understanding of professional roles | Lack of time for coordination with other services |
| Lack of preplanned/regular meetings between primary/specialized palliative care services | Conflicting team understandings | Lack of financial remuneration for coordination with other services |
| Indirect communication between providers | Distrust for professional competencies | Lack of awareness of available services |

### Team understanding

Similarly, interviewees clearly showed conflicting team understandings. Specifically, although some primary palliative care practitioners reported feeling part of a larger palliative team, which includes specialized palliative care members, others did not. Notably, some interviewees did not see themselves as working as part of a team at all so they did not see the need to coordinate with others beyond their immediate team of professionals, within their own field. Markedly, a specialist reported how a GP claimed that it was not necessary to pass on their patient to specialized care as "they did a three-month palliative care course, and therefore didn't see the need for the patient to be transferred to a specialist" (Specialist, Ticino). Similarly, the disparity in views concerning team understanding was evident. Interestingly, most primary and specialized palliative professionals considered themselves team members: "Of course I am part of a group of people that work together as part of a palliative care team" (assistant nurse, Basel). Yet GP's responses included remarks that reject the notion of being in a team: "Palliative care team? What palliative care team?" (GP, Vaud) and "no, I am not part of a 'team'" (GP, Basel).

### Trust in competencies

Many interviewees alluded to distrusting the professional competencies of members of the other services. Many attributed this to unfamiliarity of other professionals in the other services. Therefore, where possible, they would rather assign coordinative tasks to members of the same team, rather than another. Moreover, some members reportedly do not trust members of the other services to know how to carry out a task. As one nurse described "I feel a bit embarrassed to explain to a specialist what they should do, but sometimes they don't know because they haven't worked as closely with the patient as we have" (Assistant nurse, Ticino). One or two participants also reported that previous interpersonal conflicts with members from other teams about the disagreement of patient care prevented them from wanting to cooperate with them in the future. For example, "I try to avoid working with that doctor, and if I know he will be there, and I would rather ask for someone else to work with me on a task instead" (nurse, Ticino)

### Structural challenges to coordination

The categories related to this final theme are (a) lack of time for coordination with other services, (b) lack of financial remuneration for coordination with other services, and (c) lack of awareness of available services.

Unsurprisingly, many professionals reported that a lack of personal time prohibited them to commit to coordinating tasks with other services: "Often I really don't have time to take a phone call because I am with a patient, never mind meeting personally" (GP, Vaud). Additionally, interviewees explained that most coordination with the other services goes unpaid so although there might be some opportunities to meet more often, it is not often followed through. One nurse in Ticino recalled that: "At the very beginning, our team, the specialist and the patient meet up and this time is paid, but then after that, that's it." It was also apparent from some interviews that some professionals do not actively coordinate with members of other services as they are not always aware of the services that are available to them. When asked about collaboration with professionals from other palliative services, one specialist in Luzern admitted that they "didn't know that MPCT's were available in the area."

## Discussion

It is unsurprising that the inability to share patient documents electronically presents challenges to coordination at all interfaces between palliative care-related occupations and institutions. The sharing of relevant, timely information across professional boundaries is fundamental for good care coordination (Nancarrow et al., 2013). Patient documents are essential for providers to understand patient requirements and determine appropriate care (Brunner, 2010). Other countries have developed electronic palliative care coordination systems (Hall, Murchie, Campbell, & Murray, 2012). However, Switzerland is not so far advanced as not all cantons and their pertaining palliative care services use electronic patient documents. Notably, the use of EPRs was only enforced in Switzerland in 2017 in nursing homes and hospitals, although it is not yet obligatory in primary care (Bundesamt für Gesundheit (BAG), 2019). Given that patient documents contain vital information for the treatment plan of patients, delays in acquiring patient documents can delay patient treatment, potentially resulting in poorer quality of care.

Failure to schedule regular meetings and indirect communication between providers presents a clear challenge to coordination since in the complex, demanding working environment of palliative care, time constraints are inevitable (Jünger, Pestinger, Elsner, Krumm, & Radbruch, 2007). Specifically, as meetings are frequently arranged informally, it is plausible that professionals cannot find the time to meet spontaneously amidst a busy working schedule.

While a few meetings between services are predetermined, these are often optional and therefore professionals may not be inclined to prioritize them. Opting out of meetings could be indicative of a lack of motivation for attendance. Since individuals are often driven by personal and professional values (Hoffer, Godfrey, & Thistlethwaite, 2013), it could suggest that the value of these meetings is not apparent to those working in the field. If this is the case, this finding alludes to a need for enforcing the value of coordination between teams within palliative services and implementation of regular meetings. The literature strongly supports that structured meetings where attendance is required are more effective for ensuring the cooperation of services (Garcia, 2009). The finding that indirect communication presents challenges to coordination between service providers reflects previous health literature that miscommunication is common where multiple actors are involved (Luckett et al., 2014). This finding is alarming as indirect communication allows for delays in information transfer and potential miscommunication. Since palliative situations can be very delicate, the miscommunication of information regarding a patient or delay in coordination of care (e.g., transfer from primary to specialized palliative care) can have detrimental implications for patient outcomes.

On a deeper level, apparent inconsistencies in understanding of professional roles among providers are identified. Specifically, professionals' opinions about who is responsible for coordination or decision-making differ between services. Notably, many professionals see themselves as the person responsible for coordination, while this opinion is not shared by others. On the contrary, while some specialists believe their role to be central to decision-making and coordination, some specialized palliative care members did not see the need for cooperating with them once patients had been transferred into their care. Some ambiguity concerning professional roles may be attributed to the context dependency of those in the coordinative role. This finding may be explained by the literature which supports that the decision of who takes coordination roles is mostly determined in the context of specific conditions, if not in the individual case (Bainbridge et al., 2010). However, a lack of consensus could have a negative impact on coordination since it can be unclear among the healthcare practitioners who are ultimately in charge of coordination. Practically, this might also hinder interprofessional collaboration because those who believe they are solely responsible for coordinating tasks may not be motivated to collaborate with others. The literature supports that clearly identified professionals who are appointed to coordinate, e.g., case managers, are beneficial for ensuring good coordination (Gomes et al., 2012; Sleeman, Davies, Verne, Gao, & Higginson, 2016). Empirical findings also demonstrate that identifying a key coordinator helps mitigate coordinative issues and facilitates integrated care (Luckett et al., 2014). The data also revealed opposing beliefs about team ideology. Essentially, some professionals identified themselves with being part of a palliative care "team" that included the other service, while others did not. While this result does not seem unusual for professionals across healthcare settings (Harrison, Sampson & Devries, 2019), these findings have some considerable implications for coordination. Notably, if an individual does *not* identify with being part of a wider palliative care team, then the motivation to coordinate service provision with others, or a rationale for needing to do so, is somewhat lacking. This could result in members of palliative services not cooperating with others, where it might be beneficial.

The findings also indicate distrust for professional competencies of those working in other palliative care fields. Crucially, it was suggested that primary palliative care members do not wish to pass on their patients to specialists because they do not believe they need to do so, indicating a lack of trust for specialist services. This result reflects previous reports that some physicians consider palliative care as a rather "naturally given" human competence and therefore not an issue of formal learning (Wollin, Yates, & Kristjanson, 2006). This is significant as the appropriate transition of patients from primary to specialized palliative care is fundamental for ensuring optimal treatment outcomes for the patient (Bainbridge et al., 2010). Failure to do so can result in adverse patient outcomes such as discontinuity of care (Bally, Lingenhel, & Tschudi, 2012). However, fostering an environment where there is mutual trust between actors might help to remedy these negative effects (Hansen, 2009; Wolkowski, 2010)

Finally, many professionals report structural challenges to coordination with other palliative services. Crucially, many respondents reported a lack of time for coordination with others. This is hardly surprising given the extensive literature surrounding healthcare professionals who are overburdened with work (Cassel, Ludden, & Moon, 2000). However, this finding could also be related to the lack of financial remuneration available for coordination between services. The Swiss national tariff system (TARMED) that financially supports these professionals does not extend to crucial tasks such as coordinating further specialized care. Thus, professionals must dedicate time to coordinating tasks across services, with little to no recompense. In view of this, allocating time toward coordination between services is unlikely to take first priority. As the literature shows, adequate financial reimbursement for coordination between services is paramount (Reeves, Schweighoffer & Libeig, 2019). Specifically, financial support has a substantial impact on the time allocated for coordination activities and the quality of care provided (Travis & Hunt, 2001). Sufficient resources, good infrastructure, and continuous funding are integral to achieving sustainable, integrated healthcare delivery, especially in palliative care (Groeneveld et al., 2017). Lack of awareness for available services in palliative care is usually discussed with respect to patient awareness for the availability of care (e.g., Borgstrom et al., 2019). However, the results indicate that professionals' coordination with other services may be restricted as they are not aware of the services available to them. This has potentially adverse effects for patients who might require additional support from other services. Given that awareness of the availability and accessibility of resources is vital for ensuring integrated care (Baxter, Johnson, & Chambers et al., 2018), professionals should be well informed of the range of services available for their use.

## *Limitations of the study*

Limitations of the study are acknowledged. It is unclear how representative are these experiences, attitudes, and beliefs regarding challenges to coordination between primary and specialized services. This may be because people who actively contribute to research around palliative care might have a greater interest in or more pronounced views on the topic. In this study, we did not include palliative patients or their relatives. However, patients and relatives of palliative patients are also key members of palliative care services so their perspectives on challenges to coordination between services may have provided an even richer understanding of these challenges. Other studies that have compared patient perspectives or relatives' perspectives with professional perspectives in this field have highlighted interesting differences in views between professional groups and patient/relative groups with respect to different aspects of care (reference). Future research that could also explore patient and relative perspectives in addition to or in comparison with professional perspectives on this topic would thus provide an interesting insight to inform the development of care coordination between palliative services.

## Conclusions

The aim of this study was to investigate challenges to coordination at the interface of primary and specialized palliative services in Switzerland. The findings not only affirm previous literature that proposes that Switzerland is in need of improving coordination of palliative services but indicate specific challenges to coordination at the interface of these services. Specifically, three key clusters of challenges to coordination at the interface of primary and specialized palliative services were identified. Firstly, organizational challenges included: the non-standardized use of EPRs, a lack of preplanned/regular meetings between primary/specialized palliative services, and indirect communication between providers. These factors were particularly detrimental to the exchange of important patient information necessary for good care coordination. Secondly, relational challenges were conflicting understandings of professional roles and team understandings, as well as distrust for professional competencies. These challenges particularly deterred interprofessional coordination and collaboration. Lastly, structural challenges, including a lack of time for coordination, a lack of financial remuneration for coordination, and a lack of awareness of available services, were identified. These findings clearly indicate barriers to coordination that should be addressed in order to ensure high quality of care provision for palliative patients.

On the basis of these insights, the following recommendations for improvement are proposed. First and foremost, adequate financial remuneration for professionals engaged in coordination at the interface of services must be provided. Additionally, professionals from both primary and specialized services should receive interprofessional education as a part of their palliative formation to foster shared team understandings, values, and trust for professional competencies, as well as to increase awareness for available palliative services. Furthermore, given the difficulty of communication between providers, it would be advisable for palliative services to appoint designated care coordinators at the interface of services in order to facilitate care coordination. Moreover, future initiatives to develop compatible electronic records would be beneficial for mitigating organizational challenges to coordination at the interface of services. The results of this study are of value to healthcare practitioners, policymakers, and researchers involved in the evolution of coordinative practice. Future research to identify further strategies and initiatives for facilitating coordination between primary and specialized palliative services warrants investigation.

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