Integrating Palliative Care into a Medical Oncology Practice

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In recent years, the importance of integrating palliative care into standard oncology care has received increased attention. The 2012 American Society of Clinical Oncology (ASCO) Provisional Clinical Opinion on the integration of palliative care into standard oncology care states that substantial evidence demonstrates "palliative care—when combined with standard cancer care or as the main focus of care—leads to better patient and caregiver outcomes. These include improvement in symptoms, QOL [quality of life], and patient satisfaction, with reduced caregiver burden. Earlier involvement of palliative care also leads to more appropriate referral to and use of hospice, and reduced use of futile intensive care."[1]

Professional societies endorse the incorporation of palliative care services into oncology practice. For example, the National Comprehensive Cancer Network (NCCN) recommends screening every cancer patient for palliative care needs. NCCN recommends palliative care for uncontrolled symptoms, moderate-to-severe distress associated with cancer diagnosis, serious co-morbid physical or psychosocial conditions, life expectancy of less than one year, and/or patient and family concerns about the course of disease and decision-making.[2] ASCO has incorporated supportive care measures into its Quality Oncology Practice Initiative (QOPI®); QOPI measures focus on pain, psychosocial concerns, and end of life (see Table 1, page 22).[3] Finally, the Commission on Cancer has added palliative care requirements into its accreditation standards.[4]

Despite this, as noted in the 2013 IOM report Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis "…many patients do not receive palliative care to manage their symptoms and side effects from treatment. Most often this occurs because the clinician lacks knowledge of how to provide this care (or how to make referrals to palliative care consultants) or does not identify palliative care management as an important component of high-quality cancer care."[5]

Understanding the Role of Palliative Care

Palliative care, as defined by The Center to Advance Palliative Care, is "…focused on providing patients with relief from the symptoms, pain, and stress of a serious illness whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of physicians, nurses, and other specialists who work with a patient's other physicians to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment."[6]

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Cancer patients should receive palliative care concurrently with curative care. Figure 1, page 23, shows how palliative care should be delivered in the community setting. When patients are first diagnosed with cancer (gray area on the far left of the figure),

Table 1. QOPI Measures That Focus on Palliative Care[4]

Core Measure	Description of Core Measure
3	Pain assessed by second office visit
4	Pain intensity quantified by the second office visit
5	For patients with moderate to severe pain, documentation that pain was addressed
6	Effectiveness of pain medication assessed on visit following new narcotic medication
7	Constipation assessed at time of, or at first visit following, new narcotic medication
21	Chart documents patient's emotional well-being was assessed within 1 month of first visit to office
22	For patients identified with a problem with emotional well-being, the chart documents that action was taken within 1 month
End of Life Measure	**Description of End of Life Measure**
35	Pain assessed on the second to last or last visit before death
36	Pain intensity quantified on second to last or last visit before death
37	Dyspnea assessed on second to last or last visit before death
38	Action taken to ease dyspnea on the second to last or last visit before death
39	Patient enrolled in hospice before death
40	Patient enrolled in hospice or referred for palliative care services before death
41	Patient enrolled in hospice within 3 days of death
42	Patient enrolled in hospice within 1 week of death
43	For patients not referred in last 2 months of life, hospice or palliative care discussed
44	Chemotherapy administered within last 2 weeks of life

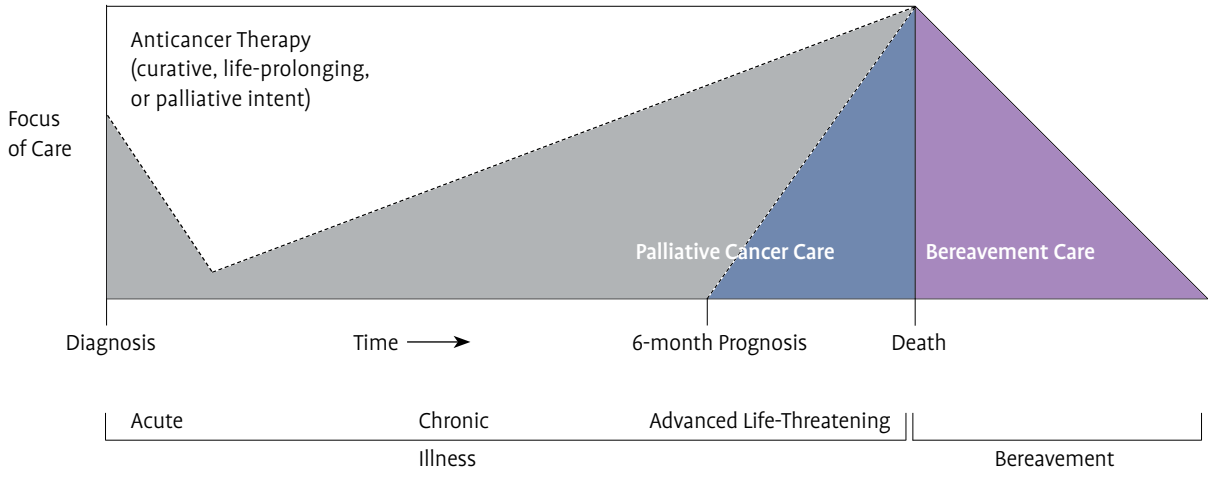
they may have a number of palliative care needs, including symptom-related issues. Once these patients enter into active or curative treatment (represented in white), their palliative care needs often decline. But, as Figure 1 illustrates, curative and palliative care are provided together, based on specific patient needs. If the disease progresses and if there is not a cure, the life-prolonging treatments diminish and palliative care treatment increases until a patient may need hospice care (represented in blue) and/or the patient passes away and the family members and caregivers enter into bereavement (represented in purple).

Our Supportive Care Clinic

The development of our Supportive Care Clinic began in 2012 when the Cancer Care Committee identified implementation of an outpatient palliative care clinic as a quality improvement initiative. The committee recognized that an outpatient palliative care clinic that followed a patient from the moment of diagnosis until the time of an appropriate hospice referral offered opportunities to improve patient care and quality of life—especially for patients diagnosed with late-stage disease. (Prior to 2012, Spartanburg Regional's palliative care program consisted only of inpatient consultation services.)

Medical and administrative leadership from Gibbs Cancer Center & Research Institute met with members of Spartanburg Regional's palliative care program to discuss how the two departments could collaborate on an innovative design for the new outpatient Supportive Care Clinic. The clinic name was carefully chosen based on MD Anderson data that reported

Figure 1. How Palliative Care is Delivered in the Community Setting



that use of the name "Supportive Care" resulted in increased and earlier referrals to palliative care, as well as decreased clinician distress.[7] After much discussion, it was also decided that the marketing materials of the new Supportive Care Clinic would mirror the look and feel of the Gibbs Cancer Center. The results are an innovative design for the outpatient Supportive Care Clinic.

Planning the Clinic

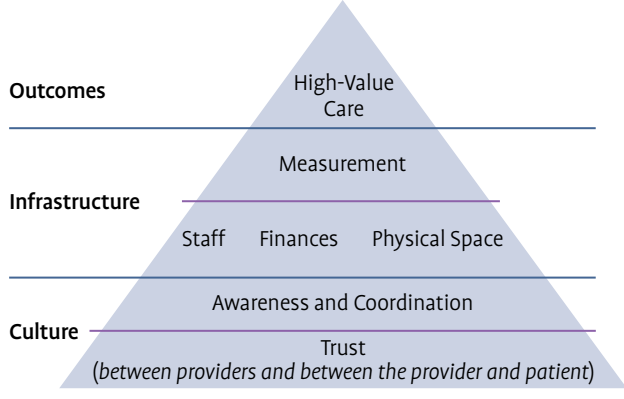
The next step was to put together a multidisciplinary development team whose members included a licensed clinical social worker, a registered nurse, two nurse practitioners, and a palliative care physician. The team's design process used a conceptual model of a successful palliative care program that incorporated culture, infrastructure, and outcomes (see Figure 2, right).[7]

The decision was made to embed the Supportive Care Clinic right into the private medical oncology practice at Gibbs Cancer Center & Research Institute. The practice agreed to provide physical space for the Supportive Care Clinic and to staff the clinic with two of its experienced Advanced Practice Registered Nurses (APRNs). The clinic would be held one half-day each week on Friday during the practice's regular business hours. The Supportive Care Clinic would use the practice's EMR for registration, documentation, and billing, which would allow all providers to access the most current medical record.

Staffing the Clinic

An APRN from the medical oncology practice and a palliative care registered nurse (RN) from Spartanburg Regional's palliative care team coordinate the weekly clinic, with oversight from the medical director of Spartanburg Regional's Palliative Care Program. A medical social worker (MSW) from the Gibbs Cancer Institute & Research Clinic rounds out the clinic staff. Two APRNs from

Figure 2. Conceptual Model of a Successful Palliative Care Program[7]



the medical oncology practice were asked to fill the APRN role at the Supportive Care Clinic, and they alternate weeks staffing the clinic. Involving two APRNs from the oncology practice has been key to building a trusting relationship between the medical oncologists and the Supportive Care Clinic. The APRNs are available for immediate consultation at the medical oncology practice and help facilitate referrals to the Supportive Care Clinic. Both the Palliative Care medical director and an APRN attend site-specific multidisciplinary planning conferences with a focus on identifying appropriate referrals to the Supportive Care Clinic.

Training Clinic Staff

In June 2012, approximately three months before the opening of the Supportive Care Clinic, the Palliative Care and Hospice Program medical directors provided 32 hours of palliative care education for the two APRNs who would help to staff the clinic. In addition to completing a communication workshop, the APRNs worked with the inpatient palliative care team and a hospice RN. Didactics included:

- Prognosis
- Palliative care theory
- Advanced symptom management
- Outpatient palliative care
- Spiritual care
- Palliative care billing.

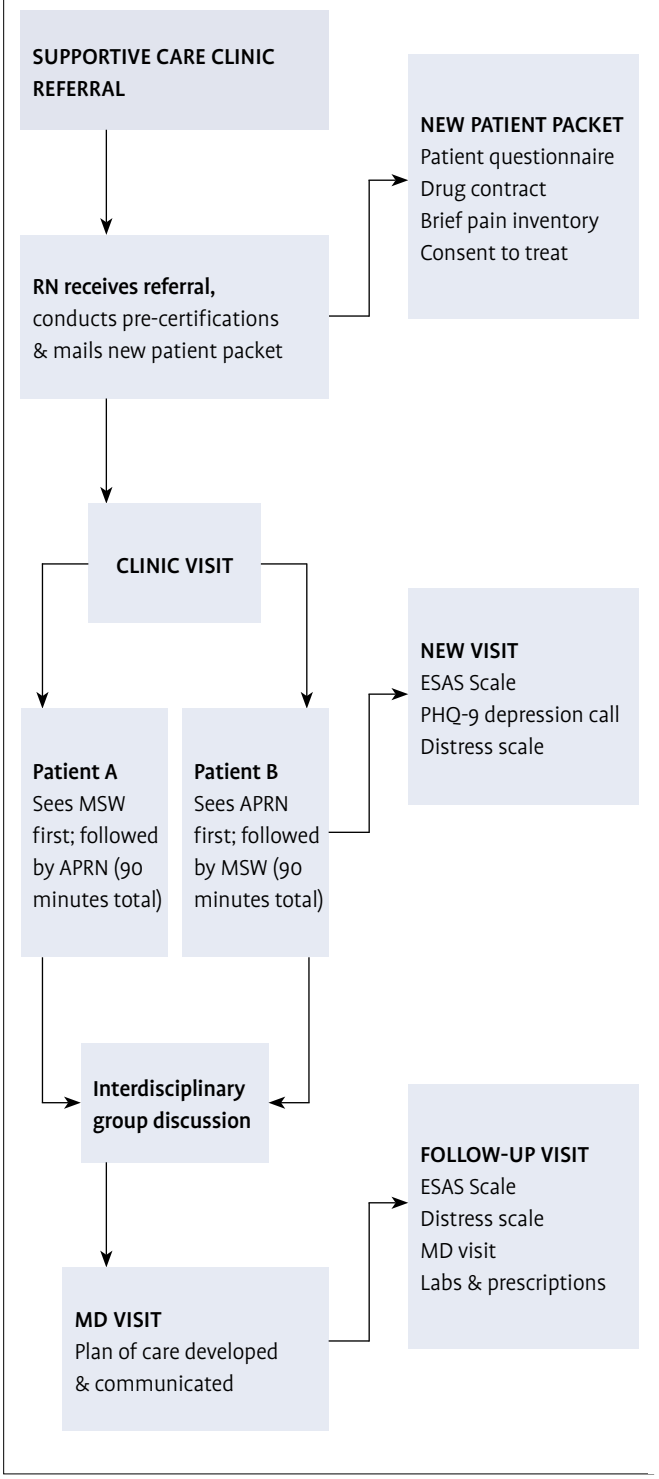
Patient Visit Flow Process

Our Supportive Care Clinic saw its first patient in September 2012. The clinic is structured so that the palliative care RN sees patients first, interviewing them and updating and completing their history and medication profile. The medical social worker follows, gathering additional information from patients and family members. Next, the APRN sees the patient and dictates the history and physical. Then the team huddles to discuss the patient and plan next steps. The appointment concludes with the patient seeing the Palliative Care medical director who performs a medical assessment and then discusses the care plan with the patient. The palliative care physician dictates the assessment and the plan, based on the following five domains:

- Prognosis
- Domain 1: Understanding Goals of Care & Prognosis
- Domain 2: Physical Symptoms
- Domain 3: Psychosocial & Practical Issues
- Domain 4: Spiritual & Cultural Issues
- Domain 5: End of Life, Advanced Care Planning & Hospice.

The palliative care RN closes the patient's clinic appointment by reviewing any medication changes, providing copies of signed paperwork, and making follow-up appointments. In three days,

Figure 3. Supportive Care Clinic Workflow



(Left to right) Supportive Care Clinic Team: Amy Sanders, NP; Chad Dingman, LISW-CP, OSW-C; Ashleigh Pintoff, RN; Brian Bell, MD; and Melissa McCarter, NP.

the palliative care RN follows up by phone with patients with excessive symptoms (symptoms with a score of four or above on the Edmondton Symptom Assessment Scale [ESAS]). All patients are given a phone number that they can call to contact a palliative care provider, seven days a week, through the Spartanburg Regional Call Center. Figure 3, left, illustrates the clinic's patient visit flow process.

Outcome Measures

The first nine months of the Supportive Care Clinic saw 71 patient referrals. Of these, a total of 49 patients were seen in the clinic. Of all appointments scheduled during this period, 22 percent resulted in no shows. Many of the "no show" patients reported later that they felt too poorly to attend the clinic. To help improve this no-show rate, the palliative care RN now contacts each referred patient by phone to initiate the relationship with the Supportive Care Clinic staff and to encourage patients to keep their appointments. Patients receive a second phone call two days before their clinic appointment, encouraging them to keep the appointment. The average age of clinic patients has been 56.7 years, and 53 percent have been male. Eighteen percent of the clinic patients have made three or more visits to the Supportive Care Clinic.

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We have realized enormous benefits from our staffing model. Palliative care staff has learned from the medical oncology APRNs' cancer care expertise; the APRNs now serve as enthusiastic liaisons for the Supportive Care Clinic. In turn, the APRNs have been receptive to palliative care principles and philosophy, and the hope is that they will now be able to share this information within their medical oncology practice.

During the first nine months of the Supportive Care Clinic, patients have demonstrated a 13 percent decrease in pain scores from the first visit to the last visit, and a 17 percent decrease in ESAS scores during the same time frame.

Supportive Care Clinic goals for the next six months will measure:

- Volume: 80 new patients total for the 12-month period.
- Productivity: 8 patient visits per half-day clinic (2 new and 6 follow-up visits).
- Quality: A 15 percent decrease in pain scores from average first visit score to average last visit score.
- Quality: A 25 percent decrease in distress scores in the highest distress group from average first visit score to average last visit score.
- Quality: A 20 percent decrease in total ESAS score from average first visit score to average last visit score.

Palliative care in both inpatient and outpatient care settings is integral to high-quality patient-centered care.

Business Plan

In our model, the new Supportive Care Clinic used existing staff and space. The clinic generated only minimal additional expenses, e.g., fees related to additional licensure and billing services. Our team secured a grant from Spartanburg Regional Foundation to underwrite planned expenditures for patient and family educational materials and to host a Palliative Care Regional Medical Conference, which was held in Spartanburg, S.C., May 1–2, 2014. Future plans include expansion of the half-day Supportive Care Clinic from once a week to twice a week; the medical oncology practice has agreed to continue to provide the APRN, MSW, and clinic space.

Palliative care in both inpatient and outpatient care settings is integral to high-quality patient-centered care. Currently, our clinic is the only outpatient Supportive Care Clinic in the region. We continue to evaluate the success of the Supportive Care Clinic and plan to replicate this model to address similar needs for other chronic diseases. OI

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