**Palliative Care and Oncology Partnerships in Real Practice**

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This article addresses the practical application of palliative care (PC) in the outpatient oncology setting.

**Introduction**

Palliative care (PC) within oncology is a topic of much interest because of the accumulating evidence that it may lead to better symptom management, improved patient and caregiver quality of life (QOL), better survival outcomes, and reduced cost to society. In this article, we will use the definition of palliative care most commonly applied in clinical practice today (see sidebar).

We will describe the current published evidence regarding optimal ways to integrate PC into practical oncology care, given that so much of cancer-care costs are controlled or influenced directly by oncologists.[1] We will state up-front that there is minimal published evidence of best-practice approaches to PC cancer patients in the outpatient setting. This is not surprising: less than 1% of the National Cancer Institute research budget funds PC studies, and the American Board of Medical Specialties established the new subspecialty certificate in hospice and palliative medicine just 5 years ago, so training programs in PC are just beginning. PC in US hospitals has expanded dramatically in the past decade, however; the number of hospitals with a PC team grew from 658 (24.5%) to 1,568 (63.0%)—a steady 138.3% increase from 2000-2009.[2] Given the growth of inpatient services in PC, we anticipate that outpatient services will develop rapidly.

**What Is the Evidence for Concurrent Care in Practice?**

Only a few published studies describe concurrent PC and oncology care, as shown in Table 1. This section of our article describes models for integrated outpatient PC and oncology care, from the literature and at our own institution.

**The palliative care program at Princess Margaret Hospital, Toronto**

The Princess Margaret Hospital (PMH) palliative care program in Toronto, Canada, began in 2001, starting with an inpatient PC consultation service which later expanded into an acute care inpatient unit, as well as daily PC clinics and a separate cancer pain clinic.[3] Each clinic is staffed by a PC physician and a registered nurse case manager, who evaluate patients and make referrals to psychiatrists, psychologists, social workers, and dieticians, as needed. Follow-up occurs in the PC clinic and by telephone. For patient convenience, the clinic makes an effort to schedule PC follow-up visits in conjunction with other appointments, such as chemotherapy, radiation, transfusions, or other tests. This PC program offers comprehensive clinical and support services, which might not be feasible in institutions with limited clinic space and time.

As mentioned, PMH has a weekly cancer pain clinic, which represents a more integrated model of PC and oncology. It is staffed by an oncologist, a PC physician, and an advanced practice nurse (APN). The clinic’s services are limited to patients with cancer and, as described by Zimmerman et al, typically those with a relatively long prognosis (months to years).[3] Patients are followed in the clinic once every 1 to 2 months, but the majority of medication adjustments are handled by the APN via telephone follow-up. With clinics offered only weekly and the majority of follow-up handled by phone, this particular model is more feasible for institutions with limited clinic resources.

The PMH system also has a method to address urgent outpatient consultations. These patients are seen by a member of the PC team either at the referring clinic itself or in the PC clinic, depending on availability of space and patient convenience. After the urgent consultation is complete, the patient is scheduled into the clinic of the PC physician who performed the urgent consultation. Additionally, clinic patients have access to a 24-hour on-call service staffed by PC physicians. This unlimited
physician availability may be difficult to provide in many settings.[3]

A partially integrated outpatient palliative care service at Cleveland Clinic

**Definition of Palliative Care**

Palliative care is specialized medical care for people with serious illnesses. This type of 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 doctors, nurses, and other specialists who work with a patient’s other doctors 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.

— Diane Meier, MD, Director, Center to Advance Palliative Care, July 1, 2011

Another model for a partially integrated outpatient PC service is at Cleveland Clinic, as described by Walsh.[4] Cleveland Clinic began their program in 1987, based on the program at Royal Victoria Hospital in Montreal, Quebec, Canada. After Cleveland Clinic began their inpatient PC consultation service, the need for outpatient follow-up of these patients was met by starting a PC outpatient clinic. The PC clinic patients are seen in the oncology clinic during 5 half-days each week. This system uses a nurse-manager model in which each patient is followed by a particular nurse manager as an inpatient, in the clinic, or at home. The nurse manager serves as the patient's main contact and helps to coordinate services for the patient. Besides offering patients continuity of care, the service provides a nurse-manager directed 24-hour on-call service.

**The US Oncology national Capital Region Hospice and Palliative Care model**

One business-centered model of integrating PC into the outpatient oncology setting was recently demonstrated by Cameron Muir and colleagues at a US Oncology site in Northern Virginia.[5] An independent PC consult practice was embedded into the private oncology clinic and received referrals from the eight oncologists within the group. The consult practice consisted of a PC attending and fellow who saw patients during 1 half-day period per week. Clinic space was rented by the PC team at fair-market value. To avoid billing for the same diagnoses, the oncologists coded for cancer-related diagnoses (eg, pancreatic cancer) and the PC physicians coded for symptom diagnoses (eg, abdominal pain). By the end of the 2-year study, referrals from the oncologists increased by 87%, patient symptom burden decreased by more than 20%, and the oncologists' overall satisfaction with the PC consult practice was rated at 9 out of 10.

From a business perspective, Muir et al estimated that each PC referral saved approximately 170 minutes of the referring oncologist’s time. Presumably, the time gained could be used by oncologists to see additional patients and focus on the oncologic aspects of their patients' care. To compensate for the clinic space and time used by the PC consultants, as well as their salaries, Muir and colleagues estimated that the PC consultants needed to evaluate at least two new patients and provide four to six follow-up consults per clinic half-day. In their current practice model, the physician and an APN have 4 new patient consultations and follow-up visits with 10 to 14 patients in a half-day session.

Muir et al concluded that the embedded PC consult practice was feasible from both a clinical and business perspective. The PC consultants improved patient symptom burden and garnered high approval by the oncologists in the practice. They drastically decreased the amount of time that oncologists spent in managing symptoms and discussing care goals, allowing the opportunity for increased productivity and a higher quality of cancer care. According to the authors, having the palliative practice embedded into the oncology practice was advantageous because the shared physical space and close contact of physicians facilitated integration of the two practices. Although the study demonstrated successful integration of PC and oncology in the outpatient setting, it did have limitations. The PC consultation service lacked an interdisciplinary team to optimize the PC delivered, which raises questions about the feasibility of integrating an entire interdisciplinary team into an outpatient oncology practice. By focusing on the business aspects of integrating the two practices, the study provided limited data about the impact of the intervention on patients in the oncology practice. The authors later noted that the number of referrals could have been facilitated by identifying certain diagnoses or clinical situations that would trigger PC consults, such as malignant pleural effusion, intractable pain, or an Eastern Cooperative Oncology Group (ECOG) performance status of 3 or higher. In addition, the authors are left with the question of how to make their integrated model scaleable and reproducible in other settings.
Virginia Commonwealth University–Massey Cancer Center palliative care services

At Virginia Commonwealth University (VCU), there is a similar PC pain clinic in addition to the inpatient palliative acute care unit and inpatient consultative services. This clinic utilizes space in the oncology clinic for 1 half-day per week and is staffed by a PC attending and fellow. Patients are referred for assistance with cancer pain management and are ideally managed long-term by their primary oncologists once a stable regimen has been reached. Patients are generally referred from their outpatient oncologist’s clinic, but many patients have been seen as inpatient palliative consults. Nursing support is provided by the oncology department for the clinic as well as for triage calls. Social work support also is included in the oncology department services. To create a more interdisciplinary team, the most recent addition to VCU’s services has been to provide psychology resources during clinic time. Our psychologist is part of the inpatient oncology and PC teams, is in-house during the day, and can be paged to the clinic if needed. A similar system is in place for chaplaincy services. We (authors ERA, DF) have noticed that the integration with oncology via the social worker and nurse from their department provides continuity for these patients with often-complicated needs. However, we believe more active involvement of the palliative physicians with the patient’s oncologist in terms of face-to-face discussion during clinic time would further enhance continuity of care and facilitate development of more comprehensive care plans for each patient.

To improve the interface between palliative and oncology providers in the outpatient setting, the palliative fellows at VCU have begun to attend the oncology fellows’ pre-clinic conference each week. During the discussion about scheduled oncology clinic patients, the PC fellow identifies palliative concerns and suggests ways to improve how these concerns are addressed. As a consultant, the PC fellow then sees patients during their oncology clinic visit, to address any PC issues. The oncology fellow either stays in the room during the consultation or sees other patients during that time and then discusses the care plan with the palliative fellow. In the 5 months of this collaboration, the shared time and space of the oncology clinic with the palliative consultant has not negatively impacted clinic flow. In addition, the palliative and oncology fellows believe this integration of services has enhanced the quality of cancer care in the clinic. Thus, we have found that incorporating PC into the oncology fellows' clinic is both feasible for the clinic and convenient for the patient. This integration could serve as a model for other institutions that have established palliative and oncology services.

The financial sustainability of this program is now under evaluation. The chaplain and the psychologist do not bill for their visits, and their salary is contributed by the Massey Cancer Center. An oncology social worker is available at VCU’s safety net institution, to help patients meet the many emotional and practical challenges of cancer.

What Is the Impact of Integrated PC Programs on Patients?

Integrating PC into the outpatient oncology setting introduces palliative medicine and the PC team earlier in the course of a patient’s illness, allowing for a smoother transition from curative to palliative goals of care when needed. Patients also will benefit from expert symptom management in the outpatient setting, which may result in fewer hospital admissions for severe symptoms, such as intractable pain or vomiting. The PC team can help to coordinate outpatient services, such as home health agencies and hospice services, or other resources available based on the patient’s needs.[4] As a result of this combination of palliative and oncology efforts into cancer care, patients will have the opportunity to receive the highest quality of care possible.

What Is the Impact on Healthcare Providers?

Having PC available in their outpatient practice allows oncologists the option of allocating symptom-management and goals-of-care discussions to their palliative colleagues, thereby enabling oncologists to focus on evaluation, staging, and management of cancer. In essence, this collaboration allows the oncologist to focus on oncology and the PC team to focus on the palliative aspects of cancer care. Several Quality Oncology Practice Initiative (QOPI) measures developed by the American Society of Clinical Oncology (ASCO) involve palliative oncology issues and are areas of care in which integration of PC into the outpatient oncology realm can be an indispensable asset. Thus, adding palliative expertise to the care of oncology patients enhances the overall quality of cancer care that the oncologist delivers, increasing the satisfaction of patients and providers. Challenges of integrating PC into oncology care include lack of an appropriately sized workforce and
lack of appropriate financing. There are both an acute and chronic workforce shortage of nurses, physicians, social workers, chaplains, and certified nursing assistance—essentially all members of the interdisciplinary team. Lupu and her expert panel[6] noted that there are about 4400 hospice and palliative medicine (HPM) physicians in the US, but most practice part-time. They estimated that 10,810 full-time palliative and 4487 full-time hospice physicians were needed, translating to a shortage of 6000 to 18,000 palliative doctors. According to the current need, medical oncologists are also facing a 40% shortfall in personnel, so PC professionals may be able to make up for some but not all of the workforce deficits.

There are important clinical issues to be discussed before starting an integrated PC program. When doctors disagree on the treatment plan (eg, the oncologist wants to continue chemotherapy in accordance with patient and family wishes but the PC doctor believes the chemotherapy should be stopped), how will the conflict be managed? We strongly suggest that such problems be addressed beforehand.

What Is the Impact on the Healthcare System?

Generally, the impact on the healthcare system of integrating PC into oncology care appears to be positive; however, it is important not to make assumptions about benefits. Passik et al described the consequences of “moving upstream” to capture PC patients early, before referral to hospice.[7] This “PC-to-hospice” group was more complicated to manage and more costly to the hospice ($413.15 vs $332.05 per patient in the direct-to-hospice group), and yielded less money in charitable donations than the “direct-to-hospice” group.

At most institutions, cognitive specialties such as palliative medicine are not self-sustaining financially, and require subsidy from cost-savings or downstream revenue. PC suffers from low reimbursement for taking care of complex cases (ie, patients with a high symptom burden, patients and families confused about prognosis and goals of care, and lack of communication among multiple specialists already involved in care). This situation has led to the decline of other specialties similar to PC. As one example, the number of medical geneticists has declined from a high of 252 in 1993 to 135 in 2009.[8] Geriatrics is barely surviving as a specialty because of poor reimbursement; about one-third of all fellowship slots are unfilled, and 66% of the fellows are international medical graduates.[9] such that there are not enough practitioners, leaders, or researchers to sustain the field. This poor level of reimbursement affects APNs as well, as the money earned from usual billing is not sufficient to support their salaries. A PC nurse practitioner model program generated less than half the income needed to support salaries from “fee for service”; it could be self-sustaining if it generated program revenue by increasing hospice referrals, and if the hospice in turn supported the APN (but this may violate Starke regulations). Regardless of increased referrals, the program was closed after 2 years.[10] More models of integrated PC–oncology programs and comprehensive assessment of best practices in this context are clearly needed.

Cassel et al described the impact of a PC outpatient clinic on a small rural health system.[11] In general, the PC physician could cover her salary as an internist. The hospital saved $80,000 to $120,000 a year on Medicare admissions by the shorter patient length of stay (about 0.5 days) and fewer daily costs of the diagnosis-related groups (DRGs). Figure 1 shows the reduction in daily cost. The PC patients cost less to society, as shown in Figure 2, while in-hospital mortality did not change, as shown in Figure 3.

Conclusions

Several programs in cancer centers offer successful models of concurrent PC and oncology care. The most readily applicable one is the US Oncology model, which provides a PC physician or APN within an oncology practice. This appears to have a good effect on symptom scores, and it benefits the practice. Truly interdisciplinary care including a chaplain, social worker, and psychologist is difficult given the medical reimbursement model in the US.

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Table 1: Randomized Trials of Palliative Care — Population, Sample Size...

Figure 1: Impact of a PC outpatient clinic on a small rural health sys...

Figure 2: Impact of a PC outpatient clinic on a small rural health sys...

Figure 3: Impact of a PC outpatient clinic on a small rural health sys...

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