Palliative Care & Cancer in Nebraska

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Palliative Care – National Findings

- Palliative care (inpatient, outpatient, and home-based) can not only improve the quality of life for oncology patients, but also decrease symptom burden
- Quality of care an oncology patient receives can be greatly influenced by palliative care
- Substantially reduces the total cost of patient care
- Palliative care provided concurrently with standard oncology care in patients with advanced cancer results in positive outcomes with regard to QOL, symptom relief, mood, patient satisfaction, advance care planning, and survival.

Role of Oncology Provider

1. Ask, tell, ask. Always ask people how much they want to know and what they do know. Then tell them, in understandable words. Then ask: “What is your understanding of your situation?”

1. At each transition point (when changing treatments or prognosis), ask: “What are you hoping for?” and “What is your understanding of your situation?”

Always do a symptom assessment

1. At least some of the time, do a spiritual assessment.

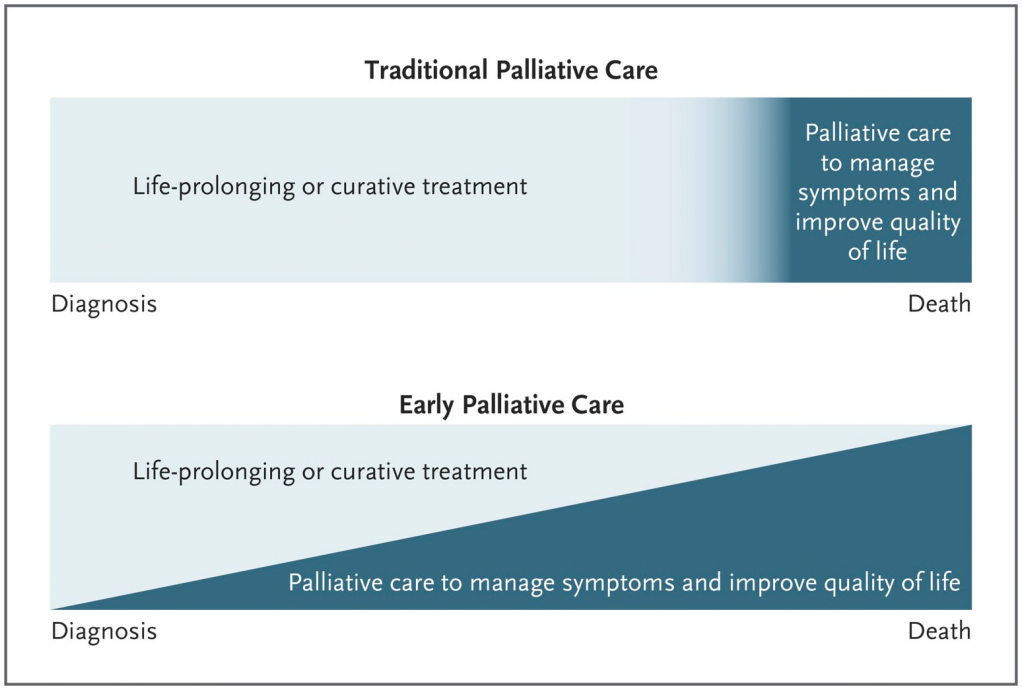
1. Make a “hospice information referral” when the patient still has 3–6 mo left to live.

1. Audit hospice referrals, like quality oncology practice initiative (QOPI) does.

1. Set up “best practices” for seriously ill patients who have less than a year to live.

1. Take advantage of decision aids to help those patients who want to know their prognosis really know their prognosis.

1. Use some “palliative care pearls” in your practice, such as olanzapine for nausea, ginger for nausea, ginseng, or dexamethasone for fatigue and better QOL.



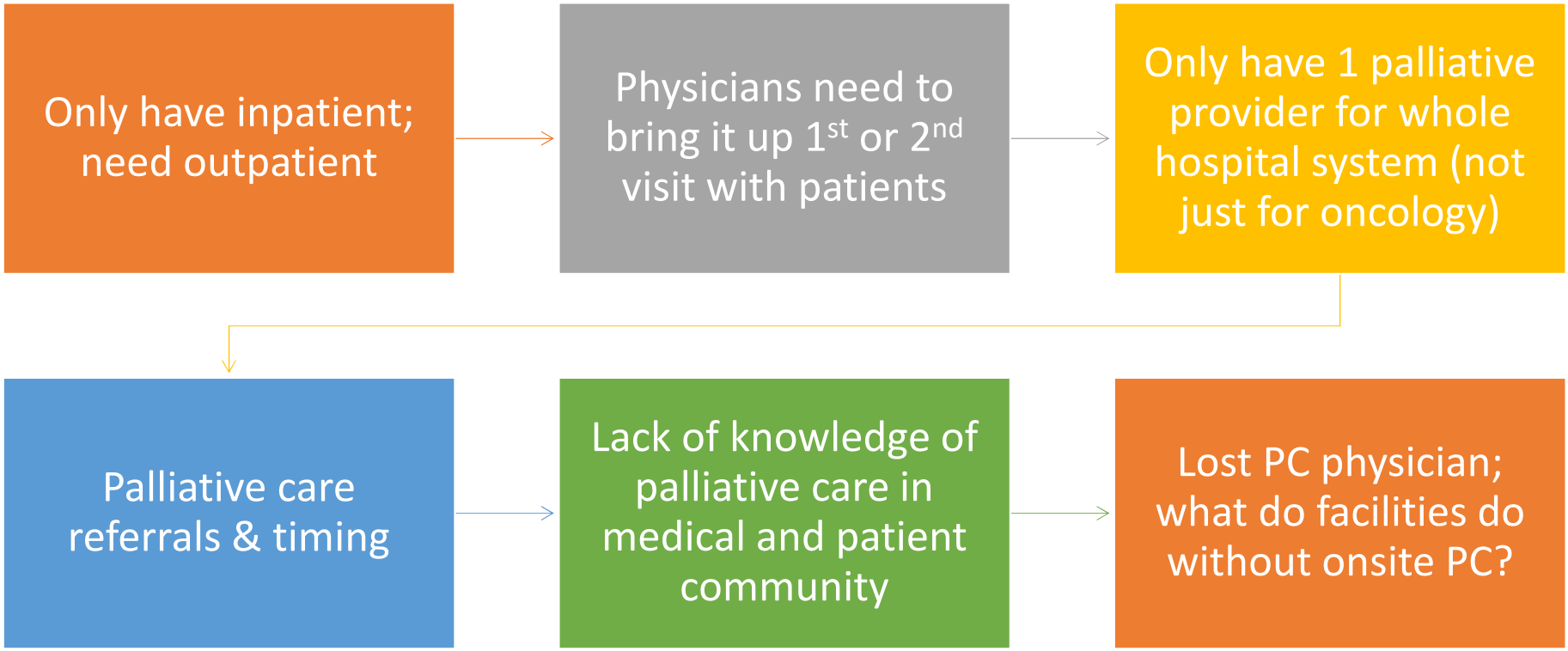
Palliative Care Referrals

- Patients with advanced cancer, whether inpatient or outpatient, should receive dedicated palliative care services, early in the disease course, concurrent with active treatment
- For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement within 8 weeks of diagnosis
- Unfortunately, studies have shown that this is not currently the case

Inpatient Palliative Care - Nebraska

- Staffing varied by location and system
- Majority utilize National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care
- Only 1 utilized a trigger or standardized screening criteria, but it was not integrated with the EMR
- Top reasons given by referring providers for the initial palliative care consult included symptoms and establishing goals of care
- 66% reported using a standardized consult note
- Top funding source for program's budget was financial support from hospital; 50% have fee for service billing

Palliative Care Challenges



Commission on Cancer Standard 4.5: Palliative Care Services

Palliative care is integrated in the continuum of cancer care. Types of palliative care services include, but are not limited to:

- Team-based care planning that involves the patient and family
- Pain and non-pain symptom management
- Communication among patients, families, and provider team members
- Education about illness and prognosis
- Assistance with medical decision making
- Continuity of care across a range of clinical settings and services
- Attention to spiritual needs
- Psychosocial support for patients and families
- Bereavement support for families and care team members

Palliative care services on-site will vary depending on the scope of the program, local staff expertise, and patient population. The cancer committee will define and identify in a policy and procedure the following:

- On-site and off-site palliative care services
- The palliative care team available on-site
- Criteria for referral to a palliative care specialist

Palliative care services not provided on-site at the facility must be provided through a referral relationship to other facilities and/or local agencies.

Commission on Cancer Standard 4.5: Palliative Care Services

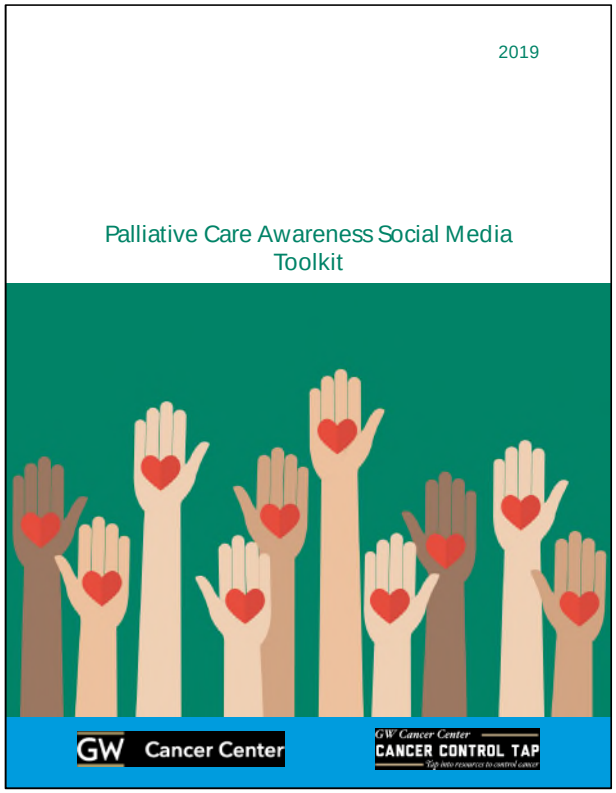
Evaluating Palliative Care Services

Each calendar year, the cancer committee monitors, evaluates, and makes recommendations for improvements to palliative care services. The evaluation is documented in the cancer committee minutes.

During this evaluation, the cancer committee must:

- Assess the approximate number of cancer patients referred for palliative care services and for what services or resources
- Discuss the criteria utilized to trigger referrals to palliative care services
- Discuss areas of improvement
  - Examples include, but are not limited to, barriers to access of palliative care services, addition of palliative care services, decreasing emergency department usage, or improving the timeliness of referrals

If available, it is recommended that a palliative care professional attend the cancer committee meeting to lead the discussion and provide the report.



Updated Resource

Questions/ Discussion

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