The Evidence Behind Integrating Palliative Care Into Oncology Practice

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Palliative care services provided alongside traditional oncology care have been shown to be beneficial to patients and families. This article provides a brief history of palliative care, a pathway to implementing these services into currently established oncology programs, and a brief discussion of common barriers.

At a Glance

- Palliative care increases quality of life and patient satisfaction and decreases caregiver burden and healthcare costs.
- Palliative care program development requires education, review of population needs and available services, effective screening tools, and participation in quality improvement processes.
- Integration of palliative care into oncology care is expected to increase with the transition to a patient-centered model with value-based reimbursement.

-changing in cancer prevalence, earlier detection, and advances in treatment during the past four decades have created an estimated 14.5 million cancer survivors in 2014 (National Comprehensive Cancer Network [NCCN], 2016b). For many survivors, cancer has become a chronic condition, with individuals living for many years with progressive debility from the combined effects of disease burden, treatment side effects, and comorbid conditions (Coyle, 2015). The World Health Organization defines palliative care as “an approach to care which improves quality of life for patients and their families facing life-threatening illness, through prevention, assessment and treatment of pain and other physical, psychological and spiritual problems” (Coyle, 2015, p. 4). Studies have demonstrated that palliative care, alone or in conjunction with antineoplastic treatment, increases quality of life, symptom improvement, and patient satisfaction while decreasing caregiver burden and lowering healthcare costs (Smith et al., 2012). Based on those findings, leading oncology organizations, such as the American Society of Clinical Oncology (Smith et al., 2012), the American College of Surgeons (2016), the NCCN (2016a), and the Oncology Nursing Society (2016), recommend integrating early palliative care services into comprehensive oncology care provided to patients.

Despite these recommendations, a variety of provider and patient barriers exist to the early and extensive use of palliative care services. The process of implementing these guidelines can be broken into four major areas: (a) educating healthcare providers and the community about palliative care, (b) developing a palliative care program to optimize and match the available palliative care services in the community with the needs of the patient population, (c) developing effective screening tools or referral criteria to identify at-risk patients, and (d) participating in program development and quality improvement processes.

Education on Palliative Care

The biggest barrier to implementation may be the lasting misconceptions by patients and providers of what palliative care entails and the stigma associated with the terms palliative care and hospice. Abernethy and Currow (2011) described hospice as the “dominant model of palliative care service provision in the United States” (p. 347). Hospice has been an established form of palliative care available as a covered Medicare and third-party payer since the early 1980s. Unfortunately, based on the limiting eligibility criteria of this benefit, including documentable limited life expectancy and the forfeiture of curative treatment pursuits, use of this service remains very late in the illness trajectory, typically when the patient has exhausted all other medical options and end of life is imminent (Parikh, Kirch, Smith, & Temel, 2013). According to the National Hospice and Palliative Care Organization (2015), 48.8% of patients who were enrolled in hospice had a length of stay of less than 14 days. Because of the stigma and association with hospice and end of life, some providers are reluctant to refer
patients to palliative care services (Hui et al., 2015). Parikh et al. (2013) reported that “greater than 90% of Americans react favorably to a definition of palliative care that emphasizes it as an extra layer of support that is appropriate at any stage in a serious illness” (p. 2349). Some cancer centers are attempting to overcome this stigma by changing their service line names from “palliative care” to “supportive care” (Hui et al., 2015) and by using language perceived as less negative, such as “serious illness” as a replacement for “advancing disease” (Coyle, 2015, p. 5). Kumar et al. (2012) noted that a significant percentage of patients self-reported lack of knowledge about available services and lack of physician referral as barriers to obtaining palliative care services at one outpatient treatment facility. Bedside oncology nurses functioning as patient advocates and nurse navigators have an obligation to advise and guide patients to all services that may benefit them throughout their illness.

Optimizing Available Services

Nurses are frontline caregivers tasked with assessing patients’ needs and conditions, educating patients and families, advocating for patients, and assisting with navigating the healthcare system (Dahlin, 2015). According to Coyle (2015), “generalist level palliative care is appropriate as a therapeutic approach for all nurses to practice” (p. 5), with opportunities to specialize with additional credentialing beyond general licensure, such as becoming an Oncology Certified Nurse (OCN®) or Certified Hospice and Palliative Care Nurse (CHPN®) (Dahlin, 2015). In addition to the practice of generalist palliative care, a role for specialist palliative care consultation exists in conjunction with the treatment team realm. Parikh et al. (2013) reported that initiating a specialist palliative care consultation at diagnosis improved patients’ understanding of their prognosis because patients often feel that their treating physicians are not always providing complete treatment and prognostic information. The availability of specialized palliative care services varies drastically by geographic location across the United States and may include dedicated inpatient units, inpatient-only services, outpatient services (freestanding or embedded in cancer centers), home visits, telemedicine, and insurance-sponsored palliative care providers as possible options for palliative care service delivery. The key to optimizing these services and to determining feasibility is dependent on knowing what is locally available for a particular patient population and the monetary (e.g., co-payments) and nonmonetary (e.g., travel time, loss of time from work for patient or caregiver, gas) costs of use.

Screening Tools and Referral Criteria

The NCCN (2016a) recommends that all patients should be screened at every visit for unmanaged symptoms, moderate or severe distress, serious comorbid conditions, life expectancy of less than six months, metastatic solid tumors, patient or family concerns, need for assistance with decision making, and desire to be seen by a palliative care specialist. Although the guidelines recommend screening all patients, they do not provide a specific screening tool or questionnaire to implement this recommendation. Few studies in limited populations have been done in attempting to develop a fast but effective screening tool to identify patients who would benefit from a specialist palliative care referral. The consensus from these studies appears to be that this is an area amenable to further study (Glare, Semple, Stabler, & Saltz, 2011).

Program Development and Accreditation

Palliative care became a recognized nursing specialty in 1999 (Hospice and Palliative Credentialing Center, 2016) and a medical specialty in 2006 (Abernethy & Currow, 2011). Since then, the recognition of the benefit and value of palliative care services in the medical community has slowly grown. Over time, position statements have changed from recommending the integration of palliative care into comprehensive oncology care (Oncology Nursing Society, 2016; Smith et al., 2012) to allowing proactive institutions the opportunity to showcase their excellence in palliative care by obtaining an Advanced Certification Program for Palliative Care from the Joint Commission (Coyle, 2015). The American College of Surgeons (2016) also added a required palliative care standard into its guidance document for the 2016 Cancer Program Standards as an integral part of comprehensive oncology care that should be offered to all patients.

Conclusion

As the trend in healthcare moves from a fee-for-service model to a patient-centered, value-based model, the expectation is that an increase will occur in the integration of palliative care into comprehensive oncology care. Nurses are in an ideal position to offer patients generalized palliative care education and guidance in their roles as direct caregivers and patient advocates. They also have the capacity to direct patients to specialist providers should patient need extend beyond their training and scope of practice. The field of palliative care has serious, but not insurmountable, barriers to access, including patient and provider perception and options for patient access. Although research has been done and communication techniques and symptom management have been developed, a great deal of opportunity remains to research best practices for delivering palliative care and identifying individuals most likely to benefit from these services.

References


