Integrating Palliative and Oncology Care for Patients with Advanced Cancer: A Quality Improvement Intervention

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Abstract

Background: Practice guidelines recommend palliative care for patients with advanced cancer, but gaps in access and quality of care persist.

Objective: To increase goals-of-care (GOC) communication for hospitalized patients with Stage IV cancer.

Methods: An interdisciplinary team designed a quality improvement intervention to enhance oncology palliative care, including training in communication skills and triggers for palliative care consults.

Setting/Subjects: All adult inpatients with Stage IV cancer and unplanned admission at an 804-bed hospital affiliated with a National Cancer Institute (NCI) Comprehensive Cancer Center.

Measurements: The primary quality measure was the percentage of patients with Stage IV cancer who had a GOC discussion during hospitalization; secondary measures included screening for pain, dyspnea, spiritual needs, and outcomes of intensive care, hospice, and 30-day readmission.

Results: In the 11-month study period, $n = 330$, Stage IV cancer patients were hospitalized. Comparing the first three months with the final three months, rates of GOC discussion increased from 29% to 48% ($p = 0.013$), and specialty palliative care consultation increased from 18% to 33%, ($p = 0.026$). Rates of symptom screening, intensive care unit transfer, hospice, and 30-day re-admission did not change overall. However, patients with specialty palliative care more frequently had pain screening (91% vs. 81%, $p = 0.020$), spiritual assessment (48% vs. 10%, $p < 0.001$), and hospice referral (39% vs. 9%, $p < 0.001$), and they were less likely to be re-admitted within 30 days (12% vs. 21%, $p = 0.059$).

Discussion: Interdisciplinary quality improvement was effective to increase GOC discussions and palliative care consults for patients with Stage IV cancer.

Keywords: advanced cancer; palliative care; quality improvement

Introduction

THE INSTITUTE OF MEDICINE (IOM) and the American Society for Clinical Oncology (ASCO) endorse early palliative care for high-quality cancer care.¹⁻³ Cancer pa-

tients experience better outcomes with palliative care—less pain and depression, better quality of life, and similar or improved survival.⁴⁻⁸ Palliative care enhances value by shifting care out of hospitals to hospice, thereby improving quality while reducing costs.⁹⁻¹⁵

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Despite proven benefits, palliative care is accessed for <50% of patients with advanced cancer.^{16–18} Only one-third of advanced cancer patients have discussed goals of care (GOC) and end-of-life treatment preferences with their physicians.^{19,20} To address gaps in quality and access, we designed a quality improvement intervention to enhance palliative care for patients with Stage IV cancer. We assumed that primary and specialty palliative care would be necessary to meet patients' needs, and we promoted elements of palliative care provided by either a medical oncologist or palliative care specialist. The primary study objective was to increase GOC communication for hospitalized patients with Stage IV cancer.

Methods

Design, leadership, and context

The study design used quality improvement methods with monthly quality measure data cycles over a study period from July 2015 to May 2016. Project leadership included representation from Medical Oncology, Radiation Oncology, Oncology Nursing, Critical Care, Palliative Care, and Hospital Quality Improvement. Investigators met monthly to respond to quality measures data and to implement practice changes. This team collaborated to gain buy-in from administrative leadership, to communicate the goals of the project to Medical Oncology clinicians, and to refine the intervention in response to monthly data feedback.

Setting and participants

The setting was an 804-bed university hospital with a National Cancer Institute (NCI) Cancer Center. This tertiary medical center has an interdisciplinary inpatient palliative care consult service delivering more than 1000 new patient consults annually. The team includes specialty physicians, nurse practitioners, a social worker, and a chaplain. The eligible population comprised all adult patients who had Stage IV solid tumors and unplanned admissions to the Medical Oncology inpatient unit.

Quality improvement intervention

Two interventions were selected to drive quality improvement: (1) oncology communication skills training beginning in month 2, and (2) use of triggered specialty palliative care consultation beginning in month 4. First, a 45-minute communication skills training session was developed by investigators and provided monthly on the Medical Oncology unit for residents, medical students, nurse practitioners, and physician assistants. Training content included skills for advance care planning, code status decisions, and GOC communication, plus practical information about medical record documentation. Training methods were primarily didactic, with small group discussions at key points during presentation. Second, a study-affiliated social worker screened hospital admissions daily to identify all Stage IV cancer patients with uncontrolled symptoms on admission. When a patient met this trigger condition—Stage IV cancer with uncontrolled symptoms as the reason for admission—the palliative medicine physician then contacted the medical oncology physician for a brief discussion to consider consultation. In keeping with the study assumptions respecting the roles of primary and specialty

palliative care, consultation was not automatically triggered, but only conducted after approval from medical oncology attending physicians.

Data collection on quality measures and outcomes

A trained research assistant with a clinical social work background conducted structured chart reviews to collect all descriptive and quality measure data. She identified all hospitalized patients with Stage IV solid tumor diagnosis with unplanned admissions, and the subset with uncontrolled symptoms on admission. Chart abstractions included patient demographics, cancer type, and diagnoses to calculate the Charlson Co-morbidity Index, commonly used for risk stratification. This index captures 17 comorbid conditions, each of which is allocated a weighted point score.²¹

The primary quality measure was the percentage of Stage IV cancer patients who had a documented discussion of GOC during hospitalization. This measure was adapted from the National Quality Forum (NQF)-endorsed Quality Measure 1641: Hospice and Palliative Care-Treatment Preferences, used to capture discussions of life-sustaining treatment preferences for patients enrolled in hospice or specialty palliative care.²² For purposes of this study, we accepted documented discussions of GOC or life-prolonging treatment if led by clinicians from palliative care, medical oncology, or another service. Documentation had to include communication between the patient or patient surrogate and a treating physician or advanced practice provider, with content covering some of the following elements: treatment goals and values, prognosis, cancer treatment choice, life-sustaining treatment choices, or hospice or comfort care options. Recording an order or decision, such as “Patient is DNR” did not qualify as it failed to record communication leading to this decision. In addition, documentation in an advance care planning note was recorded, since this embedded element of the electronic record is designed to communicate information across settings and providers.

Secondary quality measures included NQF 1634: Pain Screening, NQF 1639: Dyspnea Screening, and NQF 1647: Beliefs, Values Addressed. Pain and dyspnea screening were present if the admitting physician explicitly asked about these symptoms; a negative review of symptoms did not count. Beliefs and values were considered addressed if any clinician—physician, nurse, social worker, or chaplain—documented discussion of religious or spiritual needs, or offered access to a chaplain. These NQF-endorsed quality measures have established operational definitions, and validity and reliability in prior testing.²⁰

Analysis

Primary and secondary quality measures and rates of intensive care unit (ICU) transfer and hospice enrollment were tracked monthly by using run charts to graph the rate of adherence to each quality measure outcome monthly throughout the study period. Pre- to post-intervention change in quality measures was tested by comparing rates in the first three months of the study period with the final three months by using Fisher exact test for equal proportions. As an additional analysis of the temporal change in the primary quality measure, a linear regression analysis using time as a covariate for the best fit line was used to test for a trend in GOC discussions.

A significant coefficient of the time variable indicates that the primary quality measure changes relative to time. The analysis was weighted by the frequency of the outcome to improve the goodness of fit, which is evaluated by R^2 . To examine the effect of specialty palliative care, a secondary analysis compared quality measures and outcomes stratified by use or nonuse of consultations.

Ethical considerations

The University of North Carolina Institutional Review Board determined this quality improvement study to be exempt. Reporting followed Revised Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0).²³

Results

Quality improvement methods

Investigators maintained the same fundamental quality improvement design throughout the study. However, the intervention was adapted in response to interim data and participant feedback. Timing of the communication skills training was adjusted to match residents' schedules, so training occurred within a few days of beginning service. Several opportunities, such as a faculty research retreat, were used to discuss the value of primary and specialty palliative care in cancer care with medical oncology faculty physicians.

Characteristics of Stage IV cancer patients

During the 11-month study period, $n=330$ patients with Stage IV cancer had unplanned admissions. Median age was 61, and common primary cancers included lung (23%), gastrointestinal (18%), breast (16%), and genitourinary (14%). Two-thirds ($n=229$) of these patients were admitted with uncontrolled symptoms. Despite advanced cancer, 80% had full code orders on admission and 62% retained full code orders at the time of discharge (Table 1).

Quality measures

The percentage of patients with Stage IV cancer with a GOC discussion increased significantly over time in temporal trend analysis (Figure 1, $p=0.009$). Rates of GOC discussion increased from 29% (months 1–3) to 48% (months 9–11) ($p=0.013$) (Table 2). The baseline rate was comparable to rates in 2008–2010, indicating absence of a temporal trend before intervention.²⁰ There were no significant changes in screening for pain, dyspnea, or spiritual needs, or in rates of ICU transfer, hospice, and 30-day re-admission.

Effect of palliative care consultation

When patients with Stage IV cancer were admitted for uncontrolled symptoms (229 of 330 Stage IV cancer patients), the Palliative Medicine attending contacted the Medical Oncology attending to offer consultation. Palliative care consultation was accepted for 92 (28% of all Stage IV cancer patients; 40% of those triggered for symptoms). The rate of specialty palliative care consultation for Stage IV cancer patients increased from the initial to the final three months of the study (18% vs. 33%, $p=0.026$) (Table 2). Specialty palliative care led half of GOC discussions, and compared with oncologists they more frequently addressed goals and values (73% vs.

TABLE 1. CHARACTERISTICS OF PATIENTS WITH STAGE IV CANCER

Characteristic	All patients (n=330)
Median age in years [range]	61 [20–91]
Sex: female, n (%)	153 (46)
Race, n (%)	
African American	78 (24)
White	222 (68)
Other	30 (9)
Ethnicity, n (%)	
Latino/Hispanic	10 (3)
Primary cancer, n (%)	
Lung	76 (23)
Gastrointestinal	59 (18)
Breast	54 (16)
Genitourinary	45 (14)
Melanoma	36 (11)
Head and neck	23 (7)
Other	34 (10)
Charlson Co-morbidity Index	
Mean [range]	7 [6–16]
Uncontrolled symptoms on admission, n (%)	
Pain	62 (19)
Dyspnea	108 (33)
Nausea	125 (38)
Code status at admission, n (%)	
Full code	264 (80)
Code with limitations	9 (3)
DNR/DNI	57 (17)
Code status at discharge, n (%)	
Full code	205 (62)
Code with limitations	14 (4)
DNR/DNI	111 (34)

20%), but less frequently addressed cancer-directed treatment choices (19% vs. 46%) (Supplementary Table S1; Supplementary Data are available online at www.liebertpub.com/jpm).

Palliative quality measures and outcomes data differed when comparing patients with and without specialty palliative care. GOC discussions were more frequent with specialty palliative care (92% vs. 16%, $p<0.001$) (Table 3). Physician awareness increased for advance directives (69% vs. 12%, $p<0.001$) and surrogate decision makers (69% vs. 31%, $p<0.001$). Screening for pain was more consistent (91% vs. 81%, $p=0.020$), and spiritual needs were more often assessed (48% vs. 10%, $p<0.001$). Hospice referrals increased (39% vs. 9%, $p<0.001$), and 30-day re-admissions decreased (12% vs. 24%, $p=0.059$).

Discussion

A quality improvement intervention using communication skills training and triggers for specialty palliative care was effective to increase GOC discussions for inpatients with Stage IV cancer. Although use of specialty palliative care consults increased, primary palliative care skills were also emphasized. By the end of the study period, 33% of Stage IV cancer inpatients accessed specialty palliative care and 48% had a documented GOC discussion. Screening for symptom distress was relatively high at baseline, and it did not change

FIG. 1. Percentage of Stage IV cancer patients with GOC discussion. Best fit line equation $y = 0.021x + 0.262$, $R^2 = 0.547$; p -value = 0.009. $\dashrightarrow$ Onset of monthly oncology communication skills training. $\rightarrow$ Onset of prompting for specialty palliative care consultations. GOC, goals of care.

over time. Intervention methods were straightforward, and they were evaluated by using validated and standardized quality measures.

This study adds to the emerging literature on methods to increase access to palliative care. Hospitalization with metastatic cancer is usually triggered by uncontrolled symptoms and is associated with a high risk for death in subsequent months.²⁴ Although randomized clinical trials provide the science defining best practice, quality improvement and implementation research tests methods to fill the gap between practice guidelines and real-world healthcare. One quality improvement study used screening for high-risk patients to triple the use of specialty palliative care consultation.²⁵ Consultation triggers have been applied for the ICU population; one multisite ICU study found that specialty palliative care was associated with decreased direct costs and increased hospice referrals.^{26,27} One study attempted to deliver triggered palliative care consultation for all hospitalized patients with advanced cancer. Rates of consultation increased, whereas outcomes were unchanged.²⁸ The Best Practices for End-of-Life Care for Our Nation's Veterans (BEACON) Trial sought to improve hospital-wide end-of-life care processes by using staff training and a Comfort Order set, with resulting changes in the use of some palliative medications and treatments.²⁹ Our intervention differed from prior studies, promoting primary

palliative care skills while offering, but not requiring, specialty palliative care. This approach may be a more sustainable and effective delivery model of collaborative care. In addition, this design engages diverse clinicians in the shared goal of improving care for patients.

Study findings should be interpreted in the context of certain limitations. Success of this quality improvement intervention may be specific to this site. Thus, study findings may generalize to other academic medical centers with relatively well-developed specialty oncology and palliative care services but may not apply to other healthcare settings. The team chose to focus on two major interventions, and did not complete multiple cyclical innovations. Clinician training did not include attending physicians, and did not attempt direct communication skills training. Although this makes methods easier to replicate, it may limit impact. Finally, this intervention focused on GOC communication skills and on triggering palliative care consultation. When specialty palliative care was accepted, nearly all elements of palliative care quality were addressed. Additional intervention components or wider acceptance of specialty palliative care may be necessary to improve care for all Stage IV cancer patients.

Despite these cautions, the use of communication skills training combined with triggers for specialty palliative care

TABLE 2. PALLIATIVE CARE QUALITY MEASURES AND OUTCOMES

Measure	Total (n = 330 patients)	First 3 months (n = 108 patients)	Last 3 months (n = 64 patients)	p
GOC discussion, n (%)	123 (37)	31 (29)	31 (48)	0.013
Palliative care consultation, n (%)	91 (28)	19 (18)	21 (33)	0.026
Symptom screen, n (%)				
Pain	276 (84)	90 (83)	50 (78)	0.422
Dyspnea	199 (60)	52 (48)	36 (56)	0.345
Nausea	207 (63)	66 (61)	32 (50)	0.202
Constipation	188 (57)	65 (63)	28 (44)	0.041
Spiritual beliefs, values assessed, n (%)	67 (20)	20 (19)	13 (20)	0.842
30-Day readmission rate, n (%)	61 (18)	21 (19)	11 (17)	0.840
ICU transfer, n (%)	20 (6)	7 (6)	5 (8)	0.763

GOC, goals of care; ICU, intensive care unit.

TABLE 3. COMPARING QUALITY MEASURES AND OUTCOMES FOR PATIENTS WITH AND WITHOUT SPECIALTY PALLIATIVE CARE

Characteristic	Patients with PC consult (n = 92)	Patients without PC consult (n = 238)	p
Median age (range)	58.5 (20–83)	62.0 (22–91)	0.040
Sex: female, n (%)	45 (49)	108 (45)	0.623
Race, n (%)			
African American	18 (20)	60 (25)	0.555
White	65 (71)	157 (66)	
Other	9 (9)	21 (9)	
Cancer diagnosis, n (%)			
Lung	30 (32)	46 (19)	0.216
Breast	10 (11)	44 (18)	
Gastrointestinal ^a	18 (20)	41 (17)	
Genitourinary	9 (10)	36 (15)	
Melanoma	10 (11)	26 (11)	
Head and neck	5 (5)	18 (8)	
Other	9 (10)	25 (11)	
Charlson Score mean [range]	6.77 (6–16)	6.77 (6–11)	0.953
GOC discussion, n (%)	84 (92)	39 (15)	<0.001
Physician aware of advance directives, n (%)	61 (67)	30 (9)	<0.001
Advance care planning note, n (%)	44 (48)	16 (7)	<0.001
Surrogate contact, n (%)	63 (69)	74 (31)	<0.001
Screen for pain, n (%)	83 (91)	193 (81)	0.020
Screen for dyspnea, n (%)	58 (63)	141 (59)	0.616
Screen for nausea, n (%)	50 (55)	157 (66)	0.099
Screen for constipation, n (%)	57 (63)	131 (55)	0.267
Spiritual beliefs, values assessed, n (%)	44 (48)	23 (10)	<0.001
ICU transfer (after PC), n (%)	5 (5)	6 (3)	0.188
Hospice, n (%)	36 (40)	22 (9)	<0.001
DNR/DNI, n (%)	57 (63)	68 (28)	<0.001
LOS median [range]	7 (1–46)	3 (1–30)	<0.001
30-Day readmission, n (%)	9 of 72 eligible (12)	50 of 212 eligible (24)	0.059

^aColorectal/gastric/liver/pancreas.

consultation was an effective method to increase GOC communication for hospitalized Stage IV cancer patients. The quality improvement intervention was well accepted, and monthly training and higher rates of specialty palliative care engagement have been sustained since ending the formal intervention. Specialty palliative care consultation improved quality of care, whereas GOC communication also improved by enhancing primary palliative care in medical oncology. Intervention strategies may be useful to other hospitals to improve the quality of oncology palliative care.

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Author Disclosure Statement

No competing financial interests exist.

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