

## Brief Report

# Comparing Unmet Needs to Optimize Quality: Characterizing Inpatient and Outpatient Palliative Care Populations

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## Abstract

**Context.** Palliative care (PC) consultation services are available in most hospitals; outpatient services are rapidly growing to meet the needs of patients at earlier stages of the disease trajectory.

**Objectives.** We aimed to compare the unmet needs of PC patients by location of care to better characterize these populations.

**Methods.** This cross-sectional secondary analysis examined patients receiving hospital and outpatient-based PC across 10 community and academic organizations in the Global Palliative Care Quality Alliance. We identified unmet symptom, advance care planning, and functional needs within our database from October 23, 2012 to January 22, 2015. Kruskal-Wallis, chi-square, and Fisher exact tests were performed.

**Results.** We evaluated 633 unique patients. Inpatients ( $n = 216$ ) were older than outpatients ( $n = 417$ ; 73 vs. 64 years,  $P < 0.0001$ ). Seventy-six inpatients (38%) had a Palliative Performance Scale score  $\leq 30\%$ ; no outpatients did ( $P < 0.0001$ ). More inpatients rated their quality of life as poor compared with outpatients (39% vs. 21%,  $P = 0.0001$ ). We found that outpatients presented with more unresolved pain than inpatients (58.5% vs. 4.1%,  $P < 0.0001$ ). Conversely, more inpatients presented with unresolved anorexia (52.3% vs. 35.8%,  $P = 0.002$ ) and dysphagia (28.1% vs. 5.4%,  $P < 0.0001$ ) than outpatients. We found that inpatient setting was independently associated with lower performance status (odds ratio = 0.068, 95% confidence interval = 0.038–0.120,  $P < 0.0001$ ).

**Conclusion.** Compared with inpatients, outpatients are more burdened by pain at first PC encounter yet experience higher quality of life and better performance status. These findings suggest different clinician skillsets, and assessments are needed depending on the setting of PC consultation. *J Pain Symptom Manage* 2016;51:1033–1039 © 2016 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

## Key Words

Palliative care, health care delivery, health care resources, outpatient clinics, symptom assessment

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## Introduction

Consultative palliative care (PC) is expanding as more health systems incorporate services to address quality-of-life (QOL) needs in patients with serious illnesses at earlier stages in the disease course. Part of this expansion is the delivery of PC services beyond

residential or hospital settings to ambulatory settings, such as the emergency room (ER)<sup>1</sup> and outpatient clinics.<sup>2,3</sup>

This evolution toward increased PC presence upstream and outside of acute care settings reflects growing evidence of the benefits of nonhospital PC,

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including potentially improved survival,<sup>4,5</sup> fewer ER visits, hospital admissions, intensive care unit admissions, hospital deaths, and briefer hospital stays in the last 30 days of life.<sup>6</sup> Compared with late or no referral, early PC referral has been found to result in greater hospice utilization<sup>7</sup> and less aggressive end-of-life care.<sup>4,6–8</sup> Together, these efforts constitute the movement in the field toward true community-based PC.<sup>9</sup>

The limited evidence to date suggests that the patient populations served by clinic-based PC services differ from hospitalized populations in terms of disease progression and care needs. At a large tertiary care academic center, Hui et al.<sup>6</sup> found that cancer patients who were initially seen by a PC team as hospitalized inpatients were further along the disease trajectory than patients who were first seen in outpatient clinics. Specifically, they found cancer patients who were initially seen by a PC as hospitalized inpatients lived a shorter amount of time than patients who were first seen in outpatient clinics.<sup>6</sup>

We hypothesize that inpatients have worse performance status, poorer QOL, and more uncontrolled symptoms than outpatients on initial PC consultation. Intuitively, we recognize that the characteristics of patients receiving PC consultation in the hospital are different than those referred to an outpatient clinic. However, we have not examined these differences using large-scale registry approaches that emphasize nonacademic, community-based PC delivery. To our knowledge, no studies have directly compared the needs of inpatient and outpatient PC populations outside of tertiary-care, single-institution settings. A better understanding of the differences between these groups will allow for the specialty to more appropriately tailor interventions and services to the location of PC delivery.

## Methods

### Overall

We conducted this cross-sectional descriptive study using a registry of PC patient encounters within the Global Palliative Care Quality Alliance, a novel consortium of academic and community organizations studying quality of care in usual delivery environments.<sup>10</sup> The study was approved by the Duke University Institutional Review Board.

### Patient Population

We included data from all initial PC consultations at participating sites entered into our database using our software system, the Quality Data Collection Tool (version 2, Duke Cancer Institute, Durham, NC).<sup>11</sup> Clinicians interviewed patients or their surrogates and

input data at the point of patient care. Patients were asked to rate symptoms, QOL, well-being, and more items on multipoint Likert scales. We excluded patient data if they were from a follow-up PC appointment or if they were obtained in a setting outside of a hospital or outpatient clinic, such as a nursing home, assisted living facility, long-term care facility, or home care. Note that the inpatient cohort included pre-operative and ER consultations. We excluded the intensive care unit setting from the analysis, as we felt this setting served a population distinct from the general hospital. This baseline population consisted of 963 patients.

To obtain clinically meaningful data, we additionally excluded patients if they did not respond to any of the 10 items in the Edmonton Symptom Assessment Scale.<sup>12</sup> Nonresponses included the responses “unknown,” “patient unable to respond,” “other (write-in),” or having no response recorded. We chose to narrow our analysis to this population (“responders”) given the significant disparity in symptom responses between inpatients and outpatients; only 9.5% of outpatients had no response to any of 10 symptoms (“nonresponders”), whereas more than half (57.0%) of inpatients did (see [Supplementary Material](#), available at [jpsmjournal.com](#)).

We collected data at the beginning of the initial consult (i.e., before care by the physician is provided). Survey information was collected from October 23, 2012 to January 22, 2015.

### Data Elements and Statistical Analysis

We evaluated demographic and clinical variables such as patient age, gender, and race/ethnicity, and primary diagnosis. Patients rated QOL on a 10-point Likert scale, and we categorized ratings as poor (0–3), fair,<sup>4–7</sup> or good.<sup>8–10</sup> Performance status was assessed by the Palliative Performance Scale.<sup>13</sup> Patient-reported symptoms were evaluated by the Edmonton Symptom Assessment Scale, and those symptoms rated as “moderate” or “severe” in intensity (4 or greater) were considered clinically significant and unresolved by care before consultation. Other outcomes collected include advance care planning activities, expected prognosis, and psychosocial factors. For example, patients rated their social activity on a 5-point Likert scale ranging from 1 (poor) to 5 (great). For social and emotional well-being, patients were asked to rate their well-being from 1 (best possible well-being) to 10 (worst possible well-being).

We categorized the patients by their care setting and calculated descriptive statistics for their demographic and clinical characteristics. We used a Kruskal-Wallis test for continuous variables and a chi-square and Fisher exact test for discrete variables. We performed a multivariable ordinal logistic

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