

Original Article

A Quantitative Study of Triggered Palliative Care Consultation for Hospitalized Patients With Advanced Cancer

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Abstract

Context. Unplanned cancer-related hospital admissions often herald entry into the final phase of life. Hospitalized patients with advanced cancer have a high symptom burden and a short life expectancy, which may warrant palliative care intervention.

Objectives. To identify the impact of implementing triggered palliative care consultation (TPCC) as part of standard care for patients admitted to the solid-tumor oncology service with advanced cancer.

Methods. We conducted a prospective, sequential, three-cohort study to evaluate TPCC feasibility and impact using patient-reported outcomes, electronic medical records to identify resource utilization, and surveys of oncologists' perspectives on TPCC.

Results. Sixty-five patients were evaluated before TPCC implementation (Cohort 1). Seventy patients (Cohort 2) were evaluated after initiation of TPCC, and 68 patients (Cohort 3) were evaluated after modifications based on implementation barriers identified in Cohort 2. The percentage of patients correctly identifying their cancer as incurable increased from 65% in Cohort 1 to 94% in Cohorts 2 and 3. TPCC had minimal impact on hospice utilization, cost of care, survival, patient-reported symptoms, and patient satisfaction, likely because of the limited nature of the intervention. Implementation was challenging, with only 60% of patients in Cohort 2 and 62% in Cohort 3 receiving TPCC. Overall, the intervention was viewed favorably by 74% of oncologists.

Conclusion. Although TPCC was viewed favorably, implementation was logistically challenging because of short stays, high-acuity symptoms, and individual provider resistance. TPCC improved patients' understanding of their cancer. This population demonstrates high palliative care needs, warranting further research into how best to deliver care. *J Pain Symptom Manage* 2015;50:462–469. © 2015 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

Key Words

Triggered palliative care consults, oncology, implementation

Introduction

Unplanned cancer-related hospital admissions often herald the beginning of functional decline and entry into the final phase of life. In our institution, most

cancer-related admissions result from uncontrolled symptoms, are unplanned, and are associated with a median survival under four months.¹

Palliative care (PC) provides an extra layer of support alongside cancer care at any stage of disease. It

This project was completed while Dr. Rocque was a fellow at the University of Wisconsin.

The results of Cohorts 1 and 2 were presented at the 2014 Annual Assembly of the American Academy of Hospice and Palliative Medicine (AAHPM) and the Hospice and Palliative Nurses Association (HPNA).

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focuses on identifying and meeting the patient's goals of care, including alleviation of physical, emotional, social, and spiritual suffering.² Referral-based models integrating PC and routine oncology care have demonstrated improvement in quality of life, symptom control, and earlier hospice utilization.³⁻⁶ Despite benefits, PC services are underused, and referrals are often late in the course of a patient's disease, thus depriving patients of services from which they may receive great benefit.^{7,8} Given the high symptom burden and short life expectancy of patients with advanced cancer, we believe that hospitalization should be viewed as an opportunity to introduce PC services.¹ The National Comprehensive Cancer Network guidelines provide PC screening criteria for oncologists, which include the presence of metastatic solid tumors.⁹ Screening tools have been used,¹⁰ but the implementation of triggered consults has not been described.

We tested the implementation of triggered palliative care consultations (TPCCs) in patients admitted to our oncology service. We focused our evaluation of this quality improvement project on feasibility, patient outcomes, resource utilization, and oncologist perceptions.

Methods

Ethical Concerns

Given our previous demonstration of high symptom burden and short survival in our population,¹ the participating oncologists were uncomfortable with the concept of a randomized controlled trial in this population. Therefore, we elected to use a prospective, pre-post, sequential cohort study to evaluate implementation of TPCC as part of standard care for patients admitted to the solid tumor Oncology Service.

Setting

The study was conducted in an academic medical center on the solid tumor Oncology Service. Patients with hematologic malignancies, including lymphomas, are admitted to a separate service. At the University of Wisconsin (UW), there is a well-established inpatient PC team, which consists of a PC physician, advanced practice nurse, a social worker, pharmacist, chaplain, and one to three trainees. This team provides consultation services and staffs a 10-bed PC unit. During Cohort 2, the inpatient PC physician staffed the triggered oncology consults in addition to the inpatient unit and any PC consults requested throughout UW hospital. In Cohort 3, staffing was increased such that one physician was responsible for the TPCC and the inpatient unit, whereas a second physician staffed nononcology consults.

Planning the Intervention

A description of our inpatient oncology population with documentation of high PC needs¹ was presented at a cancer center grand rounds to generate discussion. This discussion was followed by review at an oncology divisional faculty meeting in which the attendees unanimously approved a quality improvement initiative to implement TPCC for patients with advanced cancer and an unplanned admission, regardless of performance status. Advanced cancer was defined as having incurable disease or distant organ-based metastases. The primary intent of the consultation was to assess the patients' and families' awareness of prognosis. Consultants also were prepared to conduct a goals-of-care discussion, facilitate advanced care planning, and address any uncontrolled symptoms. We hypothesized that TPCC would increase the hospice lengths of stay and improve symptom burden, quality of life, disease understanding, patient satisfaction, and resource utilization.

Cohort 1 included patients admitted to the inpatient oncology service from April 1, 2012 to May 22, 2012. A waiting period elapsed before implementation of triggered consults on August 1, 2012 to minimize the number of patients in Cohort 1 who were readmitted during collection of Cohort 2 data. Data were collected for Cohort 2 on consecutive patients from August 10, 2012 to October 24, 2012. After analysis of the initial two patient cohorts, barriers to implementation were identified and the consultation process was modified. Data from a third cohort of consecutive patients were collected from May 20, 2013 to July 15, 2013.

The inpatient oncology team initiated consults by placing an order. Consults were seen within 24 hours of receiving the order. Any member of the team could lead the consult, but all consults were staffed with an attending physician. The medical oncology team requested PC consultation during the preimplementation period as per their usual practice, typically for complex symptom management. In contrast, TPCCs were conceptually an abbreviated consultation focused on illness understanding, prognostic awareness, physical symptoms, and goals of care. On completion of TPCC, the lead physician on the PC team provided an abbreviated written summary of the discussion to both the patient and the patient's primary outpatient oncologist.

We modified the consult process between Cohorts 2 and 3 to target identified barriers. In Cohort 3, one staff member, typically the attending physician, performed the consults. This staff member attended oncology multidisciplinary rounds with nursing staff, social workers, and case managers when available to assist in identification of eligible patients and enhance routine communication between the oncology and PC teams.

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