

The Power of the Few: Description of a New Outpatient Palliative Care Clinic in a Tertiary Cancer Center

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Although significant advances have been made in cancer treatment, approximately 50% of patients diagnosed with cancer will still eventually die of their disease.¹ The majority of cancer patients (more than 80%) will experience pain and symptoms that increase in prevalence and severity as death approaches.² An aging population will contribute significantly to increased number of patients both being diagnosed with and dying from cancer, and innovative approaches to care delivery will be required to meet the increasing demands within a system already constrained by fiscal and other resource issues.

The preferences of terminally ill patients regarding place of care at the end of life has been a major theme in palliative care research. Studies have consistently demonstrated that the majority of terminally ill patients prefer to receive care at home.³⁻¹² In order to respect terminally ill patients' wishes, multiple interventions have been assessed in an effort to avoid emergency room (ER) visits, admissions to acute care facilities, and subsequent deaths in hospitals. Researchers using retrospective population-based studies have identified several factors associated with place of death. These factors can be classified as clinical, patient, and local healthcare system factors. Clinical factors include type and stage of cancer^{13,14} and presence of comorbidities.^{15,16} Sociodemographic factors include race, socioeconomic status, age, gender, and marital status.¹⁷⁻²¹ Healthcare system factors include number of hospital beds per population, number of hospices, and number of home healthcare services, including physicians making

house calls in the last month of life.^{22,23} Several studies have also noted that home visits, specifically by family physicians or palliative care team members, have a positive effect in reducing the use of acute care services.¹⁸⁻²⁶ Although home visits are necessary for patients who are bed bound, as many palliative patients are in the last days and weeks of life, they are time consuming for healthcare providers.

Oncology care has changed over the last two decades and today occurs primarily in ambulatory settings. Many of the patients seen in cancer clinics cannot be cured and are often receiving "palliative" chemotherapy. These patients most often have better performance statuses and prognoses than patients typically seen by in-hospital palliative care consult services or hospices. In the past several years, leading cancer centers have expanded their palliative care programs to include outpatient clinics. Outpatient palliative care clinics have been reported to improve patients' symptoms and have high levels of patient satisfaction.^{24,25} The effect of these clinics on use of acute care services has not previously been documented. The purpose of this retrospective study is to describe our ambulatory clinic and to begin to characterize the patients seen during the first 6 months of a new outpatient palliative care clinic at a major cancer center.

Methods

Description of Outpatient Palliative Care Clinic

In 2005 our institution identified improving palliative care as a key initiative. A 0.5 full-time equivalent (FTE) palliative care

physician was hired to provide inpatient palliative care consults, develop an inpatient palliative care center, and provide outpatient palliative care clinic visits. Two full-time advanced practice nurses (APNs) previously working in the center as consultants to the primary oncology teams were reassigned to the new palliative care team. The new palliative care team was part of the Department of Supportive Care, which also included full-time staff in the areas of nutrition, social work, and mental health. The palliative care clinics were physically located in shared clinical space with the medical, radiation, and surgical oncology teams.

Beginning in February 2006, half-day palliative care clinics were available 4 days each week for all adult cancer patients with a medical, surgical, or radiation oncologist at the center. Patients seen in the clinic are adults with a cancer diagnosis and a life expectancy of 1 year or less, as determined by an experienced palliative care physician. Patients may be referred by any healthcare provider at the cancer center but are usually referred by their oncologist.

Time from referral to initial appointment varied from same day to 2 weeks and was based on level of acuity as determined by the APN. All patient visits include assessment by the physician and the APN. All patients complete the ESAS Edmonton Symptom Assessment Survey prior to each appointment. Initial patient visits include a complete chart review, medical and psychosocial history, and physical exam. Patients are given palliative treatments, education, and

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Published quarterly by the American Academy of Hospice and Palliative Medicine

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counseling, and referrals are made to other disciplines as needed. Patients are routinely contacted by the APN within 1 week after their initial appointment. Follow-up appointments are scheduled depending on acuity of need as determined by the physician and vary between days to months. Patients are encouraged to contact the team at any time prior to their follow-up appointments should they have unmet needs. In addition to the core components outlined above, we maintain the flexibility to respond to patient and family needs as they arise.

Because of differing needs, we offer primarily consultative support to some patients and their physicians, whereas for other patients we provide more comprehensive services using a shared-care model with oncologists or family doctors. No patients are followed by the outpatient palliative care service alone.

Chart Audit

We retrospectively reviewed the medical records of all patients seen by the ambulatory palliative care team physician between February and June 2006. Charts were reviewed to document sociodemographic information, number of visits, and telephone calls with members of the palliative care team, information relating to diagnosis and clinical complications, and use of acute care services after referral to the palliative care clinic through the end of August 2006. Cases had a minimum follow up of 8 weeks and a maximum follow up of 7 months. Information about admission to any of our three major hospitals was gathered via the electronic medical record. Information about admission to any other acute care facility was gathered via review of that hospital's discharge summary.

Sample

A total of 122 patients were referred to the palliative care clinic over the 5-month accrual period. Of these, 49 were not seen by the physician and were excluded from the study because of failure to attend a booked appointment secondary to death, hospitalization, or patient choice ($n = 27$) or having a nonpalliative diagnosis ($n = 22$). The physician saw a total of 73 patients over the 5-month study period.

Patients seen in the clinic had a mean age of 50.9 years. Of the participants, 52% were female and 68.5% were married.

Results

During the 7 months of the study the 73 patients had

- 212 visits with the palliative care physician
- 113 visits with APNs
- 258 APN phone calls
- 56 social work visits
- 23 social work phone calls.

The average length of follow up was 100 days. A total of 32 patients (44%) died. The average length of follow up for those who died (first visit until death) was 66 days. The average length of follow up for those who survived was 122.5 days. Place of death for the 32 patients who died were as follows:

- 13 patients died at home (41%)
- 7 patients died in a hospice/palliative care facility (22%)
- 12 patients died in an acute care hospital (38%).

A total of 25 patients (34%) seen in the outpatient palliative care clinic subsequently used acute care services, either ER ($n = 7$) or admission to hospital ($n = 18$).

Of those seen in the ER

- 5 patients were seen only once
- 1 patient was seen on 3 separate occasions, with the last visit being a terminal event
- 1 patient was admitted at a later date and died in the hospital 8 days after admission.

Of the 18 patients admitted to the hospital

- 9 patients had a single admission, with 8 patients discharged and 1 dying while hospitalized
- 9 patients used acute care services subsequent to their discharge, including 5 who had an additional admission, 3 who had ER visits, and 1 who had multiple admissions.³

Of those who used acute care services, 14 (56%) had a single use and 11 (44%) used services on more than one occasion. The total use of acute care services by these 25 patients were 12 ER visits and 26 admissions.

Conclusion

At our center, we were able to create an outpatient palliative care clinic without a large donation or a major reallocation of resources. Nevertheless, this initiative