

EXPANDING COLLABORATION WITH ONCOLOGISTS: A Model and Pathway to the Future

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Recent national meetings, professional society collaborations, treatment guidelines, journal articles, and research initiatives have underscored the growing number of opportunities and challenges for palliative care providers to partner with oncology practices, thereby seeing more cancer patients earlier in the disease trajectory and contributing to their quality of life as they receive cancer treatments.

For many palliative care programs, greater integration with oncology also means moving beyond the hospital walls to community and outpatient settings, where these patients get most of their care. However, advancing these partnerships will raise a fundamental challenge for palliative care, Academy leaders warn. For a field facing serious workforce issues,¹ greater demand for palliative care will stretch capacity further, hastening the emergence of a proposed partnered system in which palliative care specialists teach primary palliative care techniques to primary care physicians and specialists such as oncologists while reserving the palliative care team's direct involvement for more complex or difficult cases.

The devil is in the details, and the new generalist-plus-specialist palliative care model needs to be worked out, but if palliative care can forge strong partnerships with oncology, the experts say, it will provide a model for working with other common diagnoses experienced by seriously ill patients in such areas as cardiology, neurology, and kidney disease.

A Conversation About Quality of Life


On April 3, the American Cancer Society's (ACS) advocacy affiliate, the American Cancer Society Cancer Action Network (ACS CAN), convened a meeting in Washington, DC, for representatives from 40 organizations to discuss how to integrate palliative care into mainstream medicine to improve quality of care and quality of life. This stakeholder meeting began by clarifying what palliative care is, what it offers to patients and families, and what the barriers to its wider application are. Attendees reached consensus on the need to advocate for greater investment in training for

the palliative care professional workforce, support for research to establish a stronger scientific base, and payment and other policy changes that could enhance access to high-quality palliative care.

"The fact that ACS CAN is collaborating in a meaningful way with the Academy is critical to the advancement of our field," observes Timothy E. Quill, MD FACP FAAHPM, director of the Center for Ethics, Humanities, and Palliative Care at the University of Rochester Medical Center in Rochester, NY, and AAHPM's immediate past president. Dr. Quill represented the Academy at the ACS CAN meeting. "This national prestigious organization clearly understands the importance of our skill set."

However, the underlying dilemma, Dr. Quill says, remains an insufficient credentialed hospice and palliative medicine workforce, which was acknowledged by the Academy when it brought the field's leaders together for a Workforce Summit in Chicago last August to explore the field's potential future and possible responses. "The whole concurrent model between oncology and palliative care suggests that every oncology patient needs a consultation with the palliative care team," he observes. "Our biggest barrier is that, although palliative care does offer value to these patients, we simply don't have the workforce to meet that level of need," he observes.

"Thus, the model of 'training up' for oncologists in palliative care has emerged, with palliative care specialists doing the training and taking on the tougher cases. But this is a very tricky issue for our field. As you are growing the specialty, you want to be asked to take more



patients,” Dr. Quill says, but when the demand becomes too great, distinctions about inappropriate or unnecessary referrals become necessary. “It requires some real thought and collaboration at the local level to handle that transition.”

Dr. Quill coauthored a recent perspective piece in the *New England Journal of Medicine (NEJM)*². The article proposes the training of generalists and other specialists in primary palliative care as a practical, cost-effective, and sustainable way to expand the delivery of palliative care without outstripping the specialty’s capacity to respond. Rather than just adding palliative care as another layer of specialized care in an already complex, expensive healthcare environment, he called for clearer distinctions between primary palliative care and specialist palliative care, “so that they can coexist and support each other.”

“The ability to say no—to progressively, more clearly say to oneself and to referrers, ‘This is a case I don’t need to be on,’—is our field’s challenge,” says the coauthor of the *NEJM* perspective piece, Amy P. Abernethy, MD FACP FAAHPM, current AAHPM president and an oncologist and palliative care physician who directs the Center for Learning Health Care and the Cancer Care Research Program at Duke University School of Medicine. In practical terms, that means defining appropriate triggers for referrals to the palliative care specialist and teaching those triggers to oncologists.

“What does the patient who needs to be referred to palliative care look like?” Dr. Abernethy poses. “Oncologists don’t necessarily know when to refer if we’re not telling them how to do it.”

For example, although most oncologists should be able to learn the basics of analgesic pain management, the

more complex challenges of prescribing methadone as an analgesic might benefit from referral to the pain or palliative care specialist.

Dr. Abernethy is principal investigator of a joint research project with ASCO announced in March designed to get the latest palliative care research evidence directly into the hands of oncologists through ASCO’s technology-based virtual learning network. The network, together with ASCO’s Quality Oncology Practice Initiative, will be used to form a continuous quality improvement-based technology for improving clinical practice. The new project, with 3-year funding support from the federal Agency for Healthcare Research & Quality, proposes to share palliative care research and to teach evidence-based palliative care and symptom management to oncologists, starting by recruiting teams from 20 diverse oncology practices to participate in its pilot phase.

“The goal is to take the current evidence base for symptom management and quality of life enhancement within oncology and palliative medicine and transfer that through a distinct toolbox of learning modules containing what every oncologist should know,” Dr. Abernethy says. Oncology and palliative care advisors to the project met in April for the first of many discussions of what ought to be included in a core palliative care skills set.

Growing Signs of Collaboration

Trends in the larger system, including an aging population with multiple comorbidities and a growing focus on bending the healthcare cost curve, and in oncology practice itself have made the job of oncologists much more complicated in recent years. “The complexity of things I have to know day by day is escalating logarithmically, with more and more personalized therapy pathways and genomics,” Dr. Abernethy says. “That’s important for palliative care



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practitioners to know.” Other illustrations of the expanding interface between palliative care and oncology include

- ASCO’s participation in the American Board of Internal Medicine Foundation’s *Choosing Wisely*[®] campaign. Its list of five common treatments that should be questioned by patients and doctors leads off with a palliative care-friendly recommendation: “For patients with advanced solid tumor cancers who are unlikely to benefit, do not provide unnecessary anticancer therapy, such as chemotherapy, but instead focus on symptom relief and palliative care.”³
- ASCO’s 2012 “Provisional Clinical Opinion: The Integration of Palliative Care into Standard Oncology Care”⁴ urged concurrent palliative care with standard oncologic care from initial diagnosis for patients with metastatic cancer or high symptom burden.
- The National Comprehensive Cancer Network’s (NCCN) “Guidelines for Supportive Care: Palliative Care,” version 2.2012,⁵ states that institutions should develop processes for integrating palliative care into cancer care, with appropriate screening, educational programs, and quality monitoring.
- The American College of Surgeons Commission on Cancer’s “Cancer Program Standards 2012: Ensuring Patient-Centered Care,”⁶ includes a standard on palliative care, which should be available to patients either onsite or by referral.

“To say that palliative care is the standard of care—meaning that if you’re not doing it, that’s substandard—is huge,” Dr. Quill notes. Emphasizing that standard in their outreach gives palliative care advocates an opportunity to help oncologists meet the standard.

Clarifying Language

One of the key challenges for these kinds of collaborations, says Rebecca Kirch, director of quality of life and survivorship for ACS, is to overcome the language barriers separating the two fields. “Many oncologists were taught that palliative care was end-of-life care, so they have to relearn what it means,” she says. Based on public opinion research done in 2011 by the Center to Advance Palliative Care and ACS, patients and families may not know what the term means, but they know what they need, and palliative care meets that need.

“At the national level, we need to agree across clinical specialties to talk about quality of life as our common denominator, using consistent language to explain palliative care and its benefits to help people understand what we do and who we do it for,” Kirch says. “What we’re talking about is building a quality of life workforce that cuts across diseases and disciplines. Our collective responsibility is to give patients and families the words to get the care they need supporting the quality of life they want.”

Dr. Quill agrees with this focus on quality of life and avoiding an “either/or trap” for palliative care. “That’s why the studies showing that palliative care enhances quality of life while patients live longer are so important. That doesn’t preclude the need for hospice care for patients as their disease advances, but it may not be the message we lead with.”

These connections are of necessity locality- and institution-specific, he adds. “You can’t do training up for oncologists if you only have a one- or two-person staff, but you can make people aware of the issues and establish concurrent palliative care within the limits of your resources, asking yourself: ‘How are we going to do this? Who needs to be seen by the palliative care specialists in this institution?’ In other

settings, primary care providers stay involved in their patients' care, and that's a very good model."

Jennifer Temel, MD, an oncologist at Massachusetts General Hospital, is lead author of the landmark 2010 study demonstrating the benefits of early palliative care involvement in the care of lung cancer patients—not just outcomes such as better quality of life, but also longer survival.⁷ However, this kind of early involvement requires integration, Dr. Temel says, and integration starts with relationship building between palliative care clinicians and oncologists.

"Collaboration between palliative care and oncology has been one of the main keys to our success at Massachusetts General Hospital," Dr. Temel says. "We forged strong relationships between the two services to ensure that they provided consistent and integrated care. I recommend that palliative care clinicians who are attempting to provide earlier care for patients with cancer participate in meetings with oncologists and try to integrate themselves into the day-to-day structure of the cancer center and learn how the cancer team works." Palliative care practitioners can benefit from putting themselves in the oncologist's shoes to understand the challenges of cancer care today, when treatments are changing so rapidly.

The palliative care program at the University of Alabama-Birmingham (UAB), which is an NCCN-accredited cancer program, has been working on this kind of integration, says Elizabeth Kvale, MD, medical director of palliative and supportive care outpatient services at UAB. "We bring the palliative care team to the outpatient setting—including the chaplain, psychologist, counselor, physical therapist, and nutritionist. We have an outpatient palliative care clinic that shares space with the Breast Health Center."

Growing palliative care in the outpatient setting is much the same as in other environments, Dr. Kvale says. She recommends attending oncology grand rounds every week and making follow-up phone calls back to referring oncology providers. One difference in the outpatient setting is a different cost avoidance equation, "forcing us to understand which elements of our program are revenue generating. Here we place greater emphasis on rehabilitation, with billable physical therapy visits to help patients with limitations in activities of daily living."

Another Academy past president, James Cleary, MD, oncologist and palliative care physician at the University of Wisconsin, Madison, also emphasizes the importance

of language in relationship building with oncologists. "I say I'm a very aggressive palliative care physician—not passive." He uses tools such as ASCO's guidelines and encourages other palliative care physicians to take an evidence-based approach. "What does the patient want?" he says. "Does this treatment fit with current ASCO guidelines? Doing chemotherapy in the last two weeks of life is not good practice. We should be making oncologists aware of these things, which reflect the voice of oncology."

An oncology colleague recently consulted with Dr. Cleary for tips on how to present poor prognoses to patients. "I said, 'I don't tell patients they are dying.' I say, 'I'm concerned that you're not going to make it.' Just using that word changes things and conveys empathy. So often in my palliative care consultations, I ask questions, instead of just telling them." 🍷

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