

## Background

Every year an estimated 1.7 million new cases of cancer will be diagnosed every year with an incidence of 439.2 per 100,000 people.<sup>1</sup> Approximately 39.3% of people will be diagnosed with cancer in their lifetime with a median age at diagnosis of 66 years.<sup>2</sup> Mortality rates vary based on type of cancer and patient characteristics.<sup>2</sup> The five most common types of cancer by new cases in 2019 are 1) breast at 268,600 cases, 2) lung and bronchus at 228,150 cases, 3) prostate at 174,650, 4) colorectal at 145,600, and 5) melanoma and skin cancer at 96,480 cases.<sup>2</sup> In Washington State, the age-adjusted cancer rate is 451/100,000 people with a mortality rate of 156.7/100,000 people.<sup>3,4</sup>

Incidence and mortality rates show disparities based on race and ethnicity as well as socioeconomic status. Black Americans show higher mortality rates and those living in more socially disadvantaged areas show higher cancer incidence and mortality.<sup>5</sup> Socioeconomic differences are due in part to differences in exposures and lifestyle choices such as smoking and those living in poorer neighborhoods being more likely to have cancer diagnosed at a later stage when cancer is more widespread in the body.<sup>5,6</sup> Further, these disparities have increased over the past 60 years.<sup>5</sup> Survival also varies based on insurance status, with those receiving care through Medicaid and those who are uninsured being more likely to die from cancer after a diagnosis than those receiving private insurance.<sup>7</sup> These disparities show opportunities for interventions to advance health equity through better screening or case finding and potentially through parity in treatment and supportive care.

### *Cancer Treatment*

Advances in earlier identification of cancer and in treatment have led to increases in life expectancy and quality of life, although disparities remain as noted above. Overall, approximately 67.1% of people diagnosed with cancer survive for at least five years.<sup>2</sup> In the United States there are over 16.9 million cancer survivors.<sup>8</sup>

Treatment for cancer is either localized, such as with surgery and radiation therapy, or introduced through the bloodstream and therefore systemic, such as with chemotherapy or immunotherapy.<sup>4</sup> Goals of treatment include both improved quality of life and to prolong life. Chemotherapy and radiation to treat cancer can cause a wide variety of side effects from hair loss to pain, nausea, and a decrease in white blood cells leading to infections.<sup>9</sup>

While the majority of oncology care is planned and provided through out- or in-patient services, patients also frequently seek treatment for urgent and emergent issues, often from side effects of treatment through emergency departments, indicating an opportunity for better symptom management throughout the disease course.<sup>10</sup> Studies show that people with bladder, ovarian and liver cancer have higher acute care admissions when compared to other cancer types.<sup>11</sup> Having other comorbidities or diagnoses alongside the cancer diagnosis, being of advanced age, having more advanced or widespread disease, and having a longer initial stay in the hospital are significant predictors of using inpatient care.<sup>11</sup> Patients most commonly present to the emergency department with pain, fatigue, dyspnea, fever, and gastrointestinal problems.<sup>12</sup>

The workgroup's goal is to reduce potentially avoidable emergency department visits and therefore improve patient experience and care outcomes for patients undergoing cancer treatment.

**Recommendation Framework**

*Interventions*

Among oncology patients admitted to the Cleveland Clinic’s palliative and general medical oncology services, 27.4% were readmitted within 30 days.<sup>13</sup> This rate declined by 4.5% after introduction of provider education, post-discharge nursing phone calls within 48 hours, and post-discharge provider follow-up appointments within five business days.<sup>13</sup> Systematic reviews show five strategies for reducing unplanned acute care use among oncology patients including: identifying patients at high risk for unplanned acute care, enhancing access and care coordination, standardizing clinical pathways for symptom management, developing new loci for urgent cancer care, and using early palliative care.<sup>14</sup>

This workgroup developed the following focus areas to spread these best practices identified in the literature and through surveys and report-outs from Washington state-based facilities:

	<b>Minimum Standard</b>
Assessment including of patient satisfaction with oncology care	
Risk stratification mechanisms to better meet patient need(s)	
Wrap-around supportive services through interdisciplinary team-based care	Post-discharge nursing phone calls Post-discharge provider follow-up appointments
Assessing and addressing caregiver need(s)	
Integrating palliative care alongside life-prolonging and/or curative care	See 2019 Bree Collaborative <a href="#">Palliative Care recommendations</a> .

## **Assessment**

- General
  - [MD Anderson Symptom Inventory \(MDASI\) Core Items](#)
- Anxiety
  - [Generalized Anxiety Disorder 7-Item Scale \(GAD 7\): English](#)
  - [PROMIS Short Form v1.0 Anxiety 6a: English](#)
- Depression
  - [Patient Health Questionnaire \(PHQ9\): English](#)
- Fatigue
  - [PROMIS Short Form v1.0 - Fatigue 6a: English](#)
  - [Brief Fatigue Inventory: English](#)
- Pain
  - [PROMIS Scale v1.0 - Pain Intensity 3a: English](#)
  - [PROMIS Short Form v1.0 - Pain Interference 6a: English](#)
  - [Brief Pain Inventory: English](#)
- Sleep Quality
  - [PROMIS Short Form v1.0 - Sleep Disturbance 8a: English](#)
  - [Insomnia Severity Index: English](#)

## **Risk stratification**

### **Wrap-around supportive services**

### **Caregiver need(s)**

### **Palliative care**

Palliative care can be offered alongside curative treatment at any age or stage of illness and can address many of the deficits in our health care system. *“Palliative care focuses on expert assessment and management of...symptoms, assessment and support of caregiver needs, and coordination of care [attending] to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness.”*<sup>15</sup> Palliative care consistently shows improved outcomes for patients in both in- and out-patient settings and has been associated with reduction in symptom burden, higher satisfaction with care, more appropriate referrals to hospice, and fewer days in a hospital.<sup>16,17,18</sup> For oncology patients, early delivery of palliative care has been associated with increased quality of life and with longer life.<sup>19,20</sup> Palliative care reduces caregiver stress and has been shown to reduce caregiver emotional and spiritual needs as well as increasing caregiver confidence.<sup>21,22</sup> For many diagnoses, patients who receive palliative care earlier on in the course of their disease have been shown to live longer and with a higher quality of life when compared to those who start palliative care later in the course of illness.<sup>23</sup>

## Recommendations for Stakeholders

**These recommendations not intended to be used in lieu of medical advice.**

### *Patients and Family Members*

- Know who your care team is and how to reach them.
- Talk about how well your needs and symptoms are being addressed by your provider(s) and whether specialty palliative care may be better able to address your needs.
- Talk about your goals of care with your provider or care team. Your goals of care are typically the aspects of your life that are most important to you such as attending an upcoming wedding or walking around the block.
- If applicable, know who to contact on your care team with questions or urgent issues.
- **Advance Care Planning.** Think about the type of care you would want at the end of life and what aspects of care and your life are most important to you. Have a conversation with your family members or other caregivers about what you would want. You should also have a conversation with your care team about your values, goals and preferences for end-of-life care that includes caregivers and the individual designated as your durable power of attorney for health care.
  - Talk about how family members or other caregivers should implement the care plan if you are unable to express your wishes.
  - We recommend that you complete:
    - An advance directive that stipulates specific treatment preferences (if known and applicable to the situation),
    - A durable power of attorney for health care that names a surrogate and indicates the amount of leeway the surrogate should have in decision-making and/or information on the Washington State hierarchy for surrogate medical decision makers, and
    - A written personal statement that articulates your values and goals regarding end-of-life care.
  - A Physician Orders for Life-Sustaining Treatment (POLST) or similar suitable document may be appropriate. These are completed with your physician and/or clinical team.
- Have conversations early on in disease progression about your wishes for hospital visits and medical intervention. Conversations should include risks and benefits of hospitalization and may include filling out a POLST or similar suitable document. As part of these conversations, think about the type of care that you would or would not want (e.g., feeding tubes). Information from Choosing Wisely and Consumer Reports on feeding tubes can be found [here](https://www.choosingwisely.org/patient-resources/feeding-tubes-for-people-with-alzheimers/) ([www.choosingwisely.org/patient-resources/feeding-tubes-for-people-with-alzheimers/](https://www.choosingwisely.org/patient-resources/feeding-tubes-for-people-with-alzheimers/)).
- Be sure that you and your family or other caregivers understand red flags or warning signs that may mean you need to go to the hospital and under what conditions you may not want to receive care in the hospital setting.
- Talk about the potential need for a higher level of care (e.g., more help at home) if care needs are greater than can be safely managed. Conversations should include financial as well as medical concerns.
- Connect to community resources or state resources that can help plan for future and increasing care needs including respite care.
- **For Caregivers.** Caregiving can be stressful. Talk to your or your partner/family member's

provider about your needs as a caregiver. Resources for caregiving are available [here](http://www.aarp.org/caregiving/local/info-2017/important-resources-for-caregivers.html) ([www.aarp.org/caregiving/local/info-2017/important-resources-for-caregivers.html](http://www.aarp.org/caregiving/local/info-2017/important-resources-for-caregivers.html)).

## Health Care Delivery Organizations and Systems

### Providers

- **Initial Assessment.** Assess and manage physical, functional, psychological, practical, and spiritual consequences of a serious illness. Our workgroup prioritizes the following domains: goals of care, advance care planning, cognitive impairment, functional needs, medical care, caregiver needs, behavioral health/psychosocial, and spiritual needs as listed:
  - Explaining diagnoses, prognosis and talk about setting expectations.
  - **Goals of care.** For all patients, discuss goals of care. Document in the medical record. Goals of care should be reassessed regularly as they may change over time.
    - Clarify patient goals around hospitalization and the potential for need for long-term care. Discuss possible red flags that may necessitate admission to an acute care setting as well as risks and benefits of hospitalization.
    - Discuss how to plan and prepare for a potential inpatient stay including risks and benefits of a hospitalization and when the patient may want to be hospitalized and when they may not want care in a hospital setting.
  - **Advance care planning.** Conduct advance care planning conversations as outlined in the 2014 Bree Collaborative [End-of-Life Care Report and Recommendations](#).
    - Document advance care planning discussions with easily understandable and culturally appropriate advance directives that include: a living will (also called a health care directive) that stipulates specific treatment preferences (if known and applicable to the situation), a durable power of attorney for health care that names a surrogate and indicates the amount of leeway the surrogate should have in decision-making, and a written personal statement that articulates the patient's values and goals regarding end-of-life care. Use the following codes (which can be added to the Medicare Annual Wellness Visit).<sup>24</sup>
      - CPT Code 99497 *“Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.”*
      - CPT Code 99498 *“Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure).”*
  - **Cognitive impairment.** Assess for and address cognitive impairment, if present, using the recommendations outlined in the 2017 [Bree Collaborative Alzheimer's Disease and Other Dementias Report and Recommendations](#).

- **Functional needs.** Discuss practical consequences of a serious illness such as difficulty with activities of daily living. Connect with community resources, as needed.
- **Symptom management/Medical care.** Assess and manage symptoms of serious illness that impact quality of life. Communicate with the patient’s primary care provider and/or specialty care.
- **Pharmacy management.** Assess medication list in conjunction with pharmacist, if possible.
- **Caregiver needs.** Assess caregiver stress, capacity, and support. Offer support, as available.
- **Behavioral health/psychosocial.** Assess and manage behavioral health symptoms related to serious illness.
  - Explain to patients the purpose of screening for depression, suicidality, and anxiety including the safety and security of the information. Screen for the following using a validated instrument:
    - Depression (e.g. Patient Health Questionnaire-2, PHQ-3 and/or PHQ-9) and anxiety (e.g., Generalized Anxiety Disorder-2). Follow guidelines within the 2017 [Bree Collaborative Behavioral Health Integration Report and Recommendations](#), or more recent if available.
    - Suicidality (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts). If suicide risk is detected, follow guidelines within the 2018 [Bree Collaborative Suicide Care Report and Recommendations](#), or more recent if available.
- **Spiritual care needs.** Assess and discuss spiritual care needs. Ideally this is done through a board-certified chaplain with specific training in palliative care, when available.
- **Other needs.** Discuss other patient needs that may not be described above.
- **Ongoing management.** Assess the above domains, as needed. Goals of care discussions and advance care planning may need to be reassessed due to changes in symptoms and/or diagnosis or prognosis.

### *Health Plans and/or Professional Liability Carriers*

#### *Employers*

- Incorporate shared decision making requirements as standards for value-based contracting (e.g., Centers of Excellence, Accountable Care Organizations).
- Talk to your health plan about the importance of shared decision making and how to report on use of shared decision making including how to ensure appropriate reimbursement.

## Measurement

Colorado, Illinois, and Rhode Island have included the National Committee for Quality Assurance (NCQA) metric [Care for Older Adults](#) in contracting and tied to gainsharing. Definition: The percentage of adults 66 years and older who had each of the following during the measurement year reported separately and cumulatively.

- Advance care planning
- Medication review
- Functional status assessment
- Pain assessment

The [Palliative Care Outcome Scale](#) (IPOS) includes 10 items that assesses physical symptoms, psychological, emotional, and spiritual needs, is available in multiple languages, and can be completed by either a patient or with a provider. This tool is being used by New York State as a screening tool for palliative care.

## Appendix C: Guideline and Systematic Review Search Results

	Year	Title	Summary
AHRQ: Research Findings and Reports	2017	<a href="#">Assessment Tools for Palliative Care</a>	We identified more than 150 assessment tools addressing most domains of palliative care, but few tools addressed the spiritual, structure and process, ethical and legal, or cultural domains, or the patient-reported experience subdomain. While some data on the psychometric properties of tools exist, the responsiveness of different tools to change has largely not been evaluated. Future research should focus on: (1) developing or testing tools in palliative care populations for domains with few or no tools, (2) evaluating responsiveness of tools for all domains, and (3) further studying the use of palliative care tools in clinical care and as quality indicators.
	2012	<a href="#">Closing the Quality Gap Series: Improving Health Care and Palliative Care for Advanced and Serious Illness</a>	We found that evidence was strongest (moderate strength of evidence) for interventions for pain, and for the targets of communication and decision making and continuity for selected outcomes. While a few high- and medium-quality, well-designed health care and palliative care interventions have been conducted to improve outcomes for patients with advanced and serious illness, this report highlights the continued presence of variable findings, quality deficiencies, vaguely defined interventions, and variable outcome measurement tools and reporting in much of this intervention literature. The evidence has a number of gaps, including few studies in the hospice setting or pediatrics.
	2010	<a href="#">A Review of Quality of Care Evaluation for the Palliation of Dyspnea</a>	Systematic reviews identified only 3 existing quality measurement sets that included quality measures for dyspnea care. The existing dyspnea quality measures reported by retrospective evaluations of care assess only 4 aspects: dyspnea assessment within 48 hours of hospital admission, use of objective scales to rate dyspnea severity, identification of management plans, and evidence of dyspnea reduction...The panel recommended that dyspnea assessment should include a measure of intensity and some inquiry into the associated bother or distress experienced by the patient. A simple question into the presence or absence of dyspnea would be unlikely to help guide therapy, as complete relief of dyspnea in advanced disease would not be anticipated.
	2010	<a href="#">A Framework for Assessing Quality Indicators for Cancer Care at the End-of-Life</a>	The framework describes five steps for developing and assessing a quality indicator for end-of-life care, defining the (1) population of focus; (2) broad quality domains; (3) specific target areas; (4) steps of the care process; and (5) evaluation criteria for quality indicators. The defined population includes seriously or terminally ill cancer patients, who are unlikely to recover or stabilize, and their families. Domains include the structure and processes of care; physical, psychiatric, psychosocial, spiritual, and cultural aspects of care; as well as the care of the imminently dying, ethical legal issues, and the delivery of care. Evaluation criteria include importance; scientific acceptability, including validity, evidence to improve outcomes, reliability, responsiveness, and variability; usability; and feasibility, including ready data sources.
	2010	<a href="#">Cancer Quality-ASSIST Supportive Oncology Quality Indicator Set:</a>	We successfully evaluated 78 indicators across the domains; results were similar in the two settings. We could not feasibly evaluate 3 indicators because of low prevalence; 22 indicators had significant interrater reliability issues, 9 had significant validity issues, and 3 had both reliability and validity issues, leaving a set of



	<a href="#">Feasibility, Reliability, and Validity Testing</a>	41 indicators most promising for further testing and use in this population, with an overall kappa score of 0.85 for specified care.
2019	<a href="#">Psychosocial interventions for informal caregivers of people living with cancer</a>	Psychosocial interventions do not impact to a clinically meaningful degree outcomes for caregivers irrespective of patient cancer stage or type. Perhaps, other outcomes (e.g. relationship quality) or other psychosocial interventions (e.g. meditation) may be more helpful for caregivers. Interventions should be subjected to better conducted trials. Intervention development should involve caregivers and pay particular attention to individual personal needs.
2017	<a href="#">Early palliative care for adults with advanced cancer</a>	This systematic review of a small number of trials indicates that early palliative care interventions may have more beneficial effects on quality of life and symptom intensity among patients with advanced cancer than among those given usual/standard cancer care alone. Although we found only small effect sizes, these may be clinically relevant at an advanced disease stage with limited prognosis, at which time further decline in quality of life is very common. At this point, effects on mortality and depression are uncertain. We have to interpret current results with caution owing to very low to low certainty of current evidence and between-study differences regarding participant populations, interventions, and methods. Additional research now under way will present a clearer picture of the effect and specific indication of early palliative care. Upcoming results from several ongoing studies (N = 20) and studies awaiting assessment (N = 10) may increase the certainty of study results and may lead to improved decision making. In perspective, early palliative care is a newly emerging field, and well-conducted studies are needed to explicitly describe the components of early palliative care and control treatments, after blinding of participants and outcome assessors, and to report on possible adverse events.
2017	<a href="#">Psychosocial interventions for fatigue during cancer treatment with palliative intent</a>	We found little evidence around the benefits of psychosocial interventions provided to reduce fatigue in adult patients with incurable cancer receiving cancer treatment with palliative intent. Additional studies with larger samples are required to assess whether psychosocial interventions are beneficial for addressing fatigue in patients with incurable cancer.
2016	<a href="#">Educational interventions for the management of cancer-related fatigue in adults</a>	The review found that education may have a small effect on reducing the intensity of fatigue, its interference in daily activities or relationships, and general (overall) fatigue. It could have a moderate effect on reducing distress from fatigue amongst people with non-advanced cancer. There may also be beneficial effects on anxiety and overall quality of life, although it is unclear whether it reduces depression. It is unknown if this result might differ between types of cancer treatment or if the education is provided during or after cancer treatment. Not enough is known about the type of education that is most effective, when it is best provided, or whether it is effective for people with advanced cancer.
2015	<a href="#">Interventions to enhance return-to-work for cancer patients</a>	Results suggest that multidisciplinary interventions involving physical, psycho-educational and/or vocational components led to more cancer patients returning to work than when they received care as usual. Quality of life was similar. When studies compared psycho-educational, physical and medical interventions with care as usual they found that similar numbers of people returned to work in all groups.

<p>Health Technology Assessment Program</p>	<p>2013</p> <p><a href="#">Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers</a></p>	<p>The results provide clear and reliable evidence that home palliative care increases the chance of dying at home and reduces symptom burden in particular for patients with cancer, without impacting on caregiver grief. This justifies providing home palliative care for patients who wish to die at home. More work is needed to study cost-effectiveness especially for people with non-malignant conditions, assessing place of death and appropriate outcomes that are sensitive to change and valid in these populations, and to compare different models of home palliative care, in powered studies.</p>
	<p>2011</p> <p><a href="#">Interventions for improving palliative care for older people living in nursing care homes</a></p>	<p>We found few studies, and all were in the USA. Although the results are potentially promising, high quality trials of palliative care service delivery interventions which assess outcomes for residents are needed, particularly outside the USA. These should focus on measuring standard outcomes, assessing cost-effectiveness, and reducing bias.</p>
	<p>2011</p> <p><a href="#">Non-invasive interventions for improving well-being and quality of life in patients with lung cancer</a></p>	<p>Nurse follow-up programmes and interventions to manage breathlessness may produce beneficial effects. Counselling may help patients cope more effectively with emotional symptoms, but the evidence is not conclusive. Other psychotherapeutic, psychosocial and educational interventions can play some role in improving patients' quality of life. Exercise programmes and nutritional interventions have not shown relevant and lasting improvements of quality of life. Reflexology may have some beneficial effects in the short term.</p>
	<p>None</p>	
<p>Centers for Disease Control and Prevention</p>	<p>Nothing specific, 2016 Opioid Prescribing Guidelines for Chronic Pain</p>	
<p>Institute for Clinical and Economic Review</p>	<p><u>2016</u></p> <p><a href="#">Palliative Care in the Outpatient Setting</a></p>	<p>Overall, the evidence describing outpatient palliative care's benefit is stronger for QoL, resource utilization outcomes, patient satisfaction, and mood outcomes, with more limited evidence suggesting benefits on survival, symptom burden, psychosocial, and caregiver outcomes. These observations are consistent with the fact that outpatient palliative care programs are designed to increase patient social support, patient self-advocacy, and coordinated medical care; while palliative care is not focused on improved survival as an indicator of effectiveness, the survival benefit may be mediated by the other more directly influenced outcomes of interest (e.g., mood, QoL).</p>

2017

[Integrated  
Outpatient  
Palliative Care in  
Oncology](#)

With the increase in availability of clinical palliative care services, organizations have tested and implemented varying degrees and types of integration with oncology care. These can be evaluated using common instruments, like the Integrated Practice Assessment Tool based on the health care integration framework by Heath et al. Adapted from this framework, levels of integration across palliative care and oncology have recently been proposed in the Collaborative Care Continuum framework by Kaufmann et al. In addition to levels of integration, leaders have described various methods of integration of services, including co-rounding models for hospitalized patients, embedded or co-located outpatient clinical services, and standalone clinics or services. Further, organizations have had positive experiences with integrated services limited to particular disease or conditions, types of therapy (e.g., investigational agents or novel immunotherapy drugs), or by embedding palliative care experts into non-patient-facing case discussions such as multidisciplinary oncology team meetings (“tumor boards”). In addition to other types of integration, much focus has been on the outpatient setting, which is where the majority of cancer care is delivered. For palliative care, the outpatient realm has been considered the “next frontier” of community-based palliative care services, and although growth is robust, many communities do not have access to non-hospital services.

2013

[Effectiveness of  
Family and  
Caregiver  
Interventions on  
Patient Outcomes  
among Adults with  
Cancer or Memory-  
Related Disorders](#)

All included studies were RCTs, with the majority being fair or poor methodological quality (9 good, 32 fair, 15 poor). Most studies reported multiple outcomes, though few reported data on most of our outcomes. The duration of the intervention and follow up periods varied. Many studies reported a large number of comparisons, including findings from multiple subscales, few of which showed significant differences between treatment groups. Some of the significant intervention effects were found in single trials, subscales from larger quality of life, depression, or symptom indices, and may be due to chance or reporting bias. The reproducibility and broader applicability should be viewed with caution.

National  
Consensus  
Project for  
Quality  
Palliative Care  
National  
Coalition for  
Hospice and  
Palliative Care

2018

[Clinical Practice  
Guidelines for  
Quality Palliative  
Care, 4th edition](#)

The NCP Guidelines, 4th edition, are organized into 8 domains:

Domain 1: Structure and Processes of Care The composition of an interdisciplinary team is outlined, including the professional qualifications, education, training, and support needed to deliver optimal patient- and family-centered care. Domain 1 also defines the elements of the palliative care assessment and care plan, as well as systems and processes specific to palliative care.

Domain 2: Physical Aspects of Care The palliative care assessment, care planning, and treatment of physical symptoms are described, emphasizing patient- and family-directed holistic care.

Domain 3: Psychological and Psychiatric Aspects The domain focuses on the processes for systematically assessing and addressing the psychological and psychiatric aspects of care in the context of serious illness.

Domain 4: Social Aspects of Care Domain 4 outlines the palliative care approach to assessing and addressing patient and family social support needs.

Domain 5: Spiritual, Religious, and Existential Aspects of Care The spiritual, religious, and existential aspects of care are described, including the importance of screening for unmet needs.

Domain 6: Cultural Aspects of Care The domain outlines the ways in which culture influences both palliative care delivery and the experience of that care by the patient and family, from the time of diagnosis through death and bereavement.

Domain 7: Care of the Patient Nearing the End of Life This domain focuses on the symptoms and situations that are common in the final days and weeks of life.

Domain 8: Ethical and Legal Aspects of Care Content includes advance care planning, surrogate decision-making, regulatory and legal considerations, and related palliative care issues, focusing on ethical imperatives and processes to support patient autonomy.

2018

[Best Practices for  
Reducing  
Unplanned Acute  
Care for Patients  
With Cancer](#)

We identified five strategies to reduce unplanned acute care for patients with cancer: (1) identify patients at high risk for unplanned acute care; (2) enhance access and care coordination; (3) standardize clinical pathways for symptom management; (4) develop new loci for urgent cancer care; and (5) use early palliative care. We assessed each strategy on the basis of specific outcomes: reduction in emergency department visits, reduction in hospitalizations, and reduction in rehospitalizations within 30 days. For each, we define gaps in knowledge and identify areas for future effort. These five strategies can be implemented separately or, with possibly more success, as an integrated program to reduce unplanned acute care for patients with cancer. Because of the large investment required and the limited data on effectiveness, there should be further research and evaluation to identify the optimal strategies to reduce emergency department visits, hospitalizations, and rehospitalizations. Proposed reimbursement changes amplify the need for cancer programs to focus on this issue.

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