

Background

Every year an estimated 1.7 million new cases of cancer will be diagnosed; 439.2 per 100,000 people.¹ Approximately 39.3% of people will be diagnosed with cancer in their lifetime with a median age at diagnosis of 66 years.² Mortality rates vary based on type of cancer and patient characteristics.² 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.² In Washington State, the age-adjusted cancer rate is 451/100,000 people with a mortality rate of 156.7/100,000 people.^{3,4}

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.⁵ 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.^{5,6} Further, these disparities have increased over the past 60 years.⁵ 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.⁷ 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.² In the United States there are over 16.9 million cancer survivors.⁸

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.⁴ 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.⁹

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.¹⁰ Studies show that people with bladder, ovarian and liver cancer have higher acute care admissions when compared to other cancer types.¹¹ 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.¹¹ Patients most commonly present to the emergency department with pain, fatigue, dyspnea, fever, and gastrointestinal problems.¹²

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

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.¹³

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:

	Minimum Standard
Assessment and Risk Stratification	<ul style="list-style-type: none"> • Develop a standard process to assess a patient’s risk of inpatient care use – low/high that determines intensity of care management • Dedicated function of maintaining a registry of patients based on risk including age, comorbidities, type and stage of cancer, treatment intensity • Assess for social determinants of health including housing, food security, patient ability to care for self or presence of a caregiver
Patient-Centered Care	<ul style="list-style-type: none"> • Early conversations on patient goals of care including around inpatient care use and medical interventions • Education on symptom management and how to access care team • Person and caregivers understand signs, symptoms, and complications that may necessitate urgent or emergency care • Access to the care team is available 24/7
Care Management	<ul style="list-style-type: none"> • Standard protocol for management based on risk based on internal clinic resources including at a minimum: <ul style="list-style-type: none"> ○ Post-discharge outreach to those identified as higher-risk ○ Post-discharge provider follow-up appointments • Standard symptom management and triage pathways for common side effects • Telehealth standards built into care pathways
Integrating palliative care alongside life-prolonging and/or curative care	<ul style="list-style-type: none"> • For patients who are higher-risk and/or higher-need, consider referral to interdisciplinary specialty palliative care as outlined in the 2019 Bree Collaborative Palliative Care recommendations

Assessment and Risk Stratification

Stratifying patients by risk for inpatient care use allows for scarce clinical resources to be directed to those who would most benefit. Research into risk stratification is still early, and while no well-accepted standard exists, common risk factors include: the person's age, presence of comorbidities, type and stage of cancer, treatment intensity, and social determinants of health (e.g., having social support, access to transportation, access to computer and/or phone).

Chemotherapy toxicity can be used as a proxy for inpatient healthcare utilization and models predicting toxicity have been developed, predominantly for older populations (e.g., >65, >70 years old).^{14,15} Many risk stratification protocols use a mix of administrative, claims, and clinical data (e.g., lab values, patient patient-reported outcomes, health care utilization).

Patient-Reported Outcomes

Patient-reported assessments include around general health, see MD Anderson's [Symptom Inventory \(MDASI\) Core Items](#). More detailed assessment of common symptoms include on fatigue, see the [PROMIS short form fatigue](#) or the [brief fatigue inventory](#); pain, see PROMIS [pain intensity](#) or [pain interference](#) or the [brief pain inventory](#); sleep quality, see [PROMIS short form sleep quality](#) or the [insomnia severity index](#). Assessment of common mental health issues that can exacerbate symptom severity include anxiety, see the [Generalized Anxiety Disorder \(GAD\) 7-item](#) or the [PROMIS short form anxiety](#) and depression, see the [Patient Health Questionnaire \(PHQ\) 2, 3, or 9 item screener](#).

Social Determinants of Health

Social support is specifically important for people undergoing high-intensity medical interventions such as treatment for cancer, with patients reporting wanting empathy above all but also support at home.¹⁶ Some research shows cancer progression to be inversely related to social support.^{17,18} Social support is considered a social determinant of health, broadly the conditions in which people are "*born, grow, live, work and age*" that include a person's education, employment, the experience of racism, community safety, and many other environmental exposures.¹⁹ These social factors contribute more to overall health than clinical interventions and are linked to chronic disease and obesity.^{20,21} A variety of tools currently exist, from one to 20+ questions (e.g., [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE\)](#), [Franklin County Public Health in Ohio Core 5 questions](#), [OneCare Vermont: Self-Sufficiency Outcomes Matrix](#), [Oregon Family Wellbeing Assessment](#)).

The literature showing an association between patient-specific factors and unanticipated health services use is summarized as follows:

	Population Studied	Predictors	Process	Outcome
Daly R. 2020²²	Antineoplastic therapy included receipt of any intravenous or oral cytotoxic, immunotherapeutic, or biologic agent	<ul style="list-style-type: none"> • Malignancy and treatment characteristics (77 features) • Medications (101 features) • Laboratory values (45 features) 	Machine learning from medical record data	Acute care visit for pre-defined list of preventable symptoms (e.g., nausea) within 6 months of start
Brooks GA. 2015²³	Patients with Advanced solid-tumor cancer Palliative-intent chemotherapy	<ul style="list-style-type: none"> • Age • Charlson comorbidity score • Creatinine clearance • Calcium level • Below-normal white blood cell and/or platelet count • Polychemotherapy (vs monotherapy) • Receipt of camptothecin chemotherapy 	Medical record abstraction	Chemotherapy-related hospitalization adjudicated by the oncology clinical care team
Brooks GA. 2019²⁴	Patients with stage IV or recurrent solid tumor malignancy first chemotherapy treatment	<ul style="list-style-type: none"> • Albumin • Sodium 	Abstracted administrative, EHR, and clinical data	All-cause hospitalization within 30 days of chemotherapy treatment
Grant RC. 2019²⁵	Adult patients with cancer commonly treated on outpatient basis	<ul style="list-style-type: none"> • Combination of cancer type and treatment regimen • Age • Emergency department visits in the prior year 	Population-based administrative and clinical databases	Emergency department visit or hospitalization within 30 days after starting systemic therapy for cancer
Hong JC. 2018²⁶	Patients undergoing chemotherapy or radiation therapy All adult patients who underwent outpatient external-beam RT with or without concurrent systemic therapy (chemotherapy, immunotherapy, or hormonal therapy)	Factors with highest predictive gain: <ul style="list-style-type: none"> • Planned number of radiation fractions • Planned total radiation dose • Time since most recent ED visit • Weight loss • Age 	Machine learning from pretreatment EHR data and treatment data	Any ED visit or hospitalization second day of treatment to completion of treatment

Patient-Centered Care

Education about disease and symptom management and medication use and side effects is paramount to patient-centered oncology care. While surveys of patients show general satisfaction with aspects of their provider-led education, some report wanting more detailed information showing the need for minimum standards for patient education with opportunity for further conversations that may be specific to individuals.^{27,28} Patient education has shown some success at reducing common side effects of oncology treatment including fatigue and is best coupled with nurse-led symptom management as needed as outlined in the following section.²⁹

Similarly, early goals of care conversations about serious illness care are associated with care that better aligns with patient wishes, higher quality of life, and lower family stress among family members.³⁰ Providers should initiate conversations as this is commonly expected by people undergoing episodes of care.³¹ Interventions targeted at clinicians to implement standards around goals of care conversations are often necessary, being associated with a significant increase in goals of care conversations occurring, the conversations being documented in the medical record, a higher-quality conversation, and a higher concordance between a patient's stated goals and the care that a patient actually receives for patients with stable goals when compared with usual care.³² Often these interventions take the form of practice and feedback sessions.³³

Goals of care conversations should include clear discussions of information on prognosis and certainty of prognosis as accurately as possible, preferences for decision-making including designating a durable power of attorney for health care, understanding the person's fears related to the cancer diagnosis and treatment, understanding the patient's specific goals as they relate to quality of life and social events discussing the impact of impaired function with trade-offs, and involving family members or others in treatment and management.³⁴

Questions to ask include:³⁵

- Patient understanding: What is your understanding now of where you are with your illness?
- Information preferences: How much information about what is likely to be ahead with your illness would you like from me?
- Goals: If your health situation worsens, what are your most important goals?
- Fears: What are your biggest worries about the future and your health?
- Trade-offs: If you become sicker, how much are you willing to go through for the possibility of gaining more time?
- Family: How much does your family know about your priorities and wishes?
- Resources: What is available in your community?

Care Management

Among oncology patients admitted to the Cleveland Clinic's palliative and general medical oncology services, 27.4% were readmitted within 30 days.¹³ 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.³⁶ These care management approaches are key to the strategies outlined in The American Society for Clinical Oncology's Best Practices for Reducing Unplanned Acute Care for Patients With Cancer that calls for "enhancing access and care coordination, standardizing clinical pathways for symptom management, [and] developing new loci for urgent cancer care."¹³ While nurse-led patient navigation programs have had mixed impacts on quality of life and patient distress, they are associated with patient satisfaction.³⁷

At a minimum, the workgroup recommends a standard protocol for management based on risk based on internal clinic resources including post-discharge outreach to those identified as higher-risk, and post-discharge provider follow-up appointments coupled with standard symptom management and triage pathways for common side effects, and telehealth standards built into care pathways.

Telephone follow-up after treatment for cancer, typically done by a nurse who is part of the oncology care team, can be proactive or serve as an as-needed resource accessed by the patients. Remote symptom management does not occur in all cases, depending on the resources available at the delivery site.³⁸ Barriers to remote symptom management include lack of time, obtaining accurate patient information over the telephone, high workload, and lack of knowledge or training.³⁵

Proactive telephone follow-up has shown to be effective at meeting patient psychosocial and informational needs, with studies showing patients receiving the calls to have shorter hospital visits and to ask more informed questions at those visits.³⁹ Telephone follow-up has been shown to provide continuity of care, be seen as more convenient, feel more normal than a clinic visit, and benefit from structure.⁴⁰ Further, telephone follow-up has been successful across multiple cancer types including colorectal, breast, and endometrial cancer.^{41,42}

The Pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) program, an evidence-based telephone practice guides for 15 symptoms (i.e., anxiety, appetite loss, bleeding, breathlessness/dyspnea, constipation, depression, diarrhea, fatigue/tiredness, febrile neutropenia, mouth dryness/xerostomia, mouth sores/stomatitis, nausea and vomiting, pain, peripheral neuropathy, skin rash, skin reaction, and sleep changes) common among oncology patients is being used in multiple delivery sites across Canada and also within the United States to improve the consistency and quality of remote nursing symptom management.^{43,44,45} Review of the COSTaRS program found the practice guidelines to be used only 33% of the time and among those a higher score on a symptom management scale, more complete assessments, and functioning more within their full nursing scope of practice rather than referral to an oncologist. The majority of people reported satisfaction with the COSTaRS telephone-based cancer treatment symptom support.⁴⁶

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.”*⁴⁷

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.^{48,49,50} For oncology patients, early delivery of palliative care has been associated with increased quality of life and with longer life.^{51,52} Palliative care reduces caregiver stress and has been shown to reduce caregiver emotional and spiritual needs as well as increasing caregiver confidence.^{53,54} 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.⁵⁵

Many of the aspects of palliative care, including the patient needs described above, can and should be managed within oncology care with referrals to specialty palliative care when patient need increases beyond the capacity of primary palliative care.⁵⁶ This primary palliative care can meet many of the physical, functional, psychological, practical, and spiritual consequences of a serious illness. The oncology care team should refer to specialty palliative care when a patient’s needs can no longer be met within the oncology setting due to increases in symptom burden, including pain, nausea, delirium, fatigue, anxiety, and/or depression.

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

Patients and Family Members

- Make sure that you understand your diagnosis (what type of cancer you have and how far the cancer has spread in your body, often called stage). The [American Cancer Society](#) has many resources.
- Know who your care team is and how to reach them especially with urgent issues.
- 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.
- Have conversations early on in disease progression about your wishes for hospital visits and medical intervention.
- 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](#) (www.aarp.org/caregiving/local/info-2017/important-resources-for-caregivers.html).

Oncology Care Practices and Other Delivery Systems

- Develop a standard process to assess a patient's risk of inpatient care use – low/high that determines intensity of care management
- Dedicated function of maintaining a registry of patients based on risk including age, comorbidities, type and stage of cancer, treatment intensity
- Assess for social determinants of health including housing, food security, patient ability to care for self or presence of a caregiver
- Early conversations on patient goals of care including around inpatient care use and medical interventions
- Education on symptom management and how to access care team
- Person and caregivers understand signs, symptoms, and complications that may necessitate urgent or emergency care
- Access to the care team is available 24/7
- Standard protocol for management based on risk based on internal clinic resources including at a minimum:
 - Post-discharge outreach to those identified as higher-risk
 - Post-discharge provider follow-up appointments
- Standard symptom management and triage pathways for common side effects
- Telehealth standards built into care pathways
- For patients who are higher-risk and/or higher-need, consider referral to interdisciplinary specialty palliative care as outlined in the 2019 Bree Collaborative Palliative Care recommendations

Health Plans

Employers

- Cancer is a costly and complex condition needing dedicate coordination of care. For most people, this is incredibly stressful episode of care and is often overwhelming, leading to or exacerbating anxiety and/or depression and other issues. Employer groups can design benefits or talk with benefits vendors to seek out benefits that include the components recommended in this document that lead to lower inpatient care use and higher quality of life including:
 - A standard process to assess a person's risk of seeking inpatient care
 - Comprehensive education
 - Standard protocols for risk management
 - Nurse care management protocols
- Cancer screenings rated as an A or a B by the US Preventive Services Task Force are provided with no co-pays. Claims? Education?
- Consider designing a cancer-specific online portal to review health benefits relevant to oncology care and any relevant policies.
- Return to work

Hlávka JP, Lin PJ, Neumann PJ. Outcome measures for oncology alternative payment models: practical considerations and recommendations. *Am J Manag Care*. 2019;25(12):e403-e409. Published 2019 Dec 1.

Domains

Clinical Care:

Care Coordination:

Emergency Department and Hospital Utilization:

Palliative Care:

- 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	Assessment Tools for Palliative Care	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	Closing the Quality Gap Series: Improving Health Care and Palliative Care for Advanced and Serious Illness	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 Review of Quality of Care Evaluation for the Palliation of Dyspnea	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 Framework for Assessing Quality Indicators for Cancer Care at the End-of-Life	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	Cancer Quality-ASSIST Supportive Oncology Quality Indicator Set:	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

	Feasibility, Reliability, and Validity Testing	41 indicators most promising for further testing and use in this population, with an overall kappa score of 0.85 for specified care.
2019	Psychosocial interventions for informal caregivers of people living with cancer	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	Early palliative care for adults with advanced cancer	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	Psychosocial interventions for fatigue during cancer treatment with palliative intent	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	Educational interventions for the management of cancer-related fatigue in adults	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	Interventions to enhance return-to-work for cancer patients	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>Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers</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>Interventions for improving palliative care for older people living in nursing care homes</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>Non-invasive interventions for improving well-being and quality of life in patients with lung cancer</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>Palliative Care in the Outpatient Setting</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.

References

- ¹ <https://www.cancer.gov/about-cancer/understanding/statistics>
- ² <https://seer.cancer.gov/statfacts/html/all.html>
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