

**NORTHWEST CANCER SPECIALISTS (NCS)
CARES: COORDINATED, ADVOCACY, RESOURCES,
EDUCATION, AND SUPPORT: A PALLIATIVE
CARE PROGRAM IN AN OUTPATIENT
ONCOLOGY PRACTICE*[†]**

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ABSTRACT

A large community-based oncology practice developed a pilot project to enhance staff and patient awareness of the benefits of palliative care, advance care planning, and earlier intervention with patients with advancing disease. The results were ongoing implementation of palliative care conferences at all sites, greater numbers of referral to hospice, lessened chemotherapy given in the last 2 weeks of life, and the hiring of two social workers as a result of needs identified. Staff reported greater satisfaction with inter-professional communication.

BACKGROUND

The *Northwest Cancer Specialists (NCS)* (now *Compass Oncology*) is the largest community-based practice of oncologists in Portland, Oregon and Southwest Washington. Affiliated with *US Oncology*, the practice has over 40 medical and radiation oncologists.

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OBJECTIVES

The objectives of this program was to develop a series of skill-building, educational seminars for physicians, nurses, and all office staff to become more aware of and competent in providing palliative and end of life care. A further objective was to develop interdisciplinary rounds to discuss patients at “transitions in care” and to clarify goals of care.

METHODS

A committee of interested physicians to advise us was created. History tells us that team collaboration improves patient care and is linked to patient satisfaction (Junger, Pestinger, Elsner, Krumm, & Radbruch, 2007). At *Northwest Cancer Specialists*, there was no systematic way of meeting as an interdisciplinary team. Nurses often expressed frustration that they were unclear about the goals of care, and frustrated by the lack of communication between team members. An internal survey of the practice concluded that, despite the intuitive sense of the practice, they were no better in terms of foregoing chemotherapy in the last 14 days of life than the national average. A focus group was conducted for women in an advanced cancer support group. Their input was extremely valuable as they described the frustrations of waiting for test results, follow-up phone calls, etc. “We’re the ones who are sick” became the project’s vision. Education was provided at three pilot sites on clinical decision-making, communication skills, advance care planning, boundaries, self-care, and bereavement. One of the goals was to challenge every employee at every site to complete their own advance directives, based on an assumption that the more familiar they were with the process, the more comfortable they would be in broaching the subject. One employee invited her family to a “family dinner” in which she instructed every family member to complete an advance directive. An unexpected bi-product was the *UPS* delivery person requesting advance directives to take to his family. We uncovered access issues, such as, no one knew where the advance directives were kept in the clinics, or the only ones found were not in English. This issue was immediately attended to.

Two grants were provided: one from the *Portland Inter-hospital Physician Foundation* and another from *CareOregon*, a state insurance program for low-income Oregonians to develop educational materials. One of the grants allowed the development of a guide for advance care planning to give to each patient receiving care at the clinics. Coinciding with *National Advance Care Planning Day* (April 19), a series of advance care planning seminars was provided in each of the pilot sites. In addition to talking with patients about advance care planning, a “campaign” was rolled out which included posters in each clinic lobby of the oncologists doing activities of daily life: fishing, at the beach, bicycling, baking with their children, etc. Each poster had the tag line, “I have a plan, do you?” and staff members wore “stickers” with this same question.

The intention was to “normalize” advance care planning vs. the insinuation that advance care planning was just for people with cancer. In addition to having a positive response from staff, many of the patients already had completed advance directives, but the oncology clinics did not have copies of them. This resulted in better coordination with primary care physicians, and communication with patients about obtaining copies of the advance directives.

Clinical care conferences were implemented at the three pilot sites. The staff identified patients at transition, or those with complex symptom management. A “planning tool” was created to assist in identifying key issues that needed to be addressed. All clinic staff was invited, including MDs, RNs, MAs, and schedulers. What resulted was more thoughtful planning and support for the patient and family, goal identification, and symptom management. What also resulted was improved communication and empathy across disciplines (Speck, 2006). One physician remarked “I didn’t realize that this would be so helpful!” An MA suggested that she now understood what a difficult job the oncologist had. Of note, two of the three sites were successful in implementing the care conferences, which continue today. Also note, the third site, which at the time was not continuing to utilize the care conferences, has now begun to do the same, with more than 80% of their staff participating. However, a fourth clinic, after seeing the success and positive response from the first two sites, asked to be included, and has remained one of the stronger champions of the care conferencing model.

RESULTS

In the review of this project, 75% of *NCS* nurses and physicians reported increased access to support and resources for their patients; 54% of the nurses reported greater confidence in their skills with patients at the end of life. Only 3% of patients discussed at the clinical care conferences received chemotherapy in the last 14 days of life. Advance directives in the electronic medical record increased by 3% from the beginning to the end of the project, with 53% of patients discussed at care conferences having advance directives in the electronic medical record at the time of their deaths. The numbers of people receiving hospice at the time of death did not increase significantly, nor did time on hospice appear to increase (see Figure 1).

DISCUSSION

It was important to identify practice leaders to help champion the work. While overall hospice referrals did not increase, the reduction in numbers of patients receiving chemotherapy at the end of life was significant, as well as staff satisfaction in communication and enhanced clinical skills in patients with advanced disease. It is noteworthy that the success in the initial clinics led to the interest from other practice sites to implement similar care conferences. Including staff

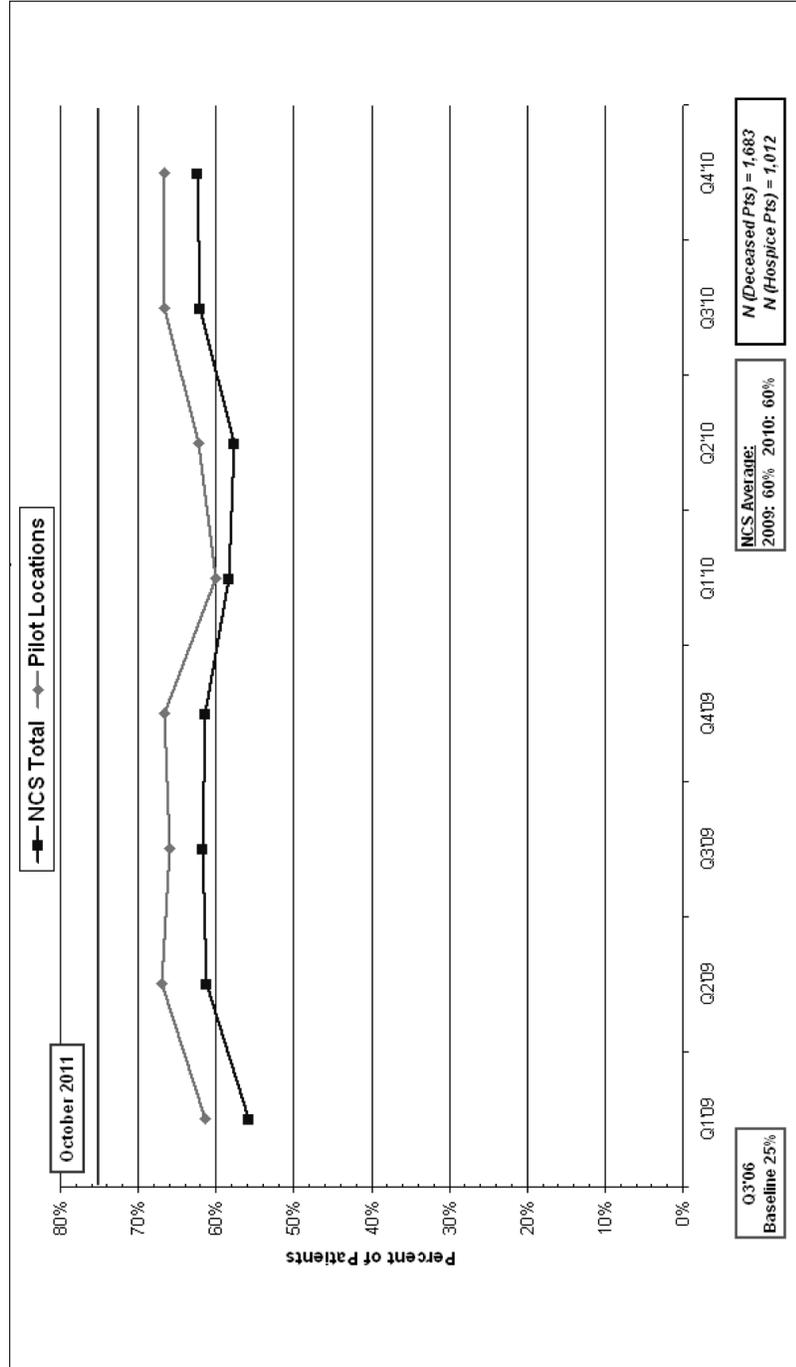


Figure 1. Percent of deceased patients enrolled in hospice at time of death.

from all disciplines also appeared to increase overall morale, and improved communication across disciplines. The care conferences helped to “level the playing field” and increase empathy across disciplines (Hall & Weaver, 2001).

IMPLICATIONS FOR PRACTICE

This project shows that offering educational sessions for both clinical and non-clinical staff increases awareness and confidence in skills pertaining to planning for care in patients with advanced diseases. Additionally, staff morale and communication seemed to improve as a result of creating care conferences for patients at transitions. Of note, in part due to these efforts, the practice, for the first time, has hired two social workers to attend to the psychosocial needs of patients and to support patients and staff. By tracking the amount of psychosocial needs that became evident at the care conferences, the practice determined the value added benefit that would exist by enhancing their psychosocial support services. They report greater patient and family satisfaction, particularly for patients facing end of life (Rabow, Hauser, & Adams, 2004).

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