

The Evidence Behind Integrating Palliative Care Into Oncology Practice

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Palliative care services provided alongside traditional oncology care have been shown to be beneficial to patients and families. This article provides a brief history of palliative care, a pathway to implementing these services into currently established oncology programs, and a brief discussion of common barriers.

At a Glance

- Palliative care increases quality of life and patient satisfaction and decreases caregiver burden and healthcare costs.
- Palliative care program development requires education, review of population needs and available services, effective screening tools, and participation in quality improvement processes.
- Integration of palliative care into oncology care is expected to increase with the transition to a patient-centered model with value-based reimbursement.

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Changes in cancer prevalence, earlier detection, and advances in treatment during the past four decades have created an estimated 14.5 million cancer survivors in 2014 (National Comprehensive Cancer Network [NCCN], 2016b). For many survivors, cancer has become a chronic condition, with individuals living for many years with progressive debility from the combined effects of disease burden, treatment side effects, and comorbid conditions (Coyle, 2015). The World Health Organization defines palliative care as “an approach to care which improves quality of life of patients and their families facing life-threatening illness, through prevention, assessment and treatment of pain and other physical, psychological and spiritual problems” (Coyle, 2015, p. 4). Studies

have demonstrated that palliative care, alone or in conjunction with antineoplastic treatment, increases quality of life, symptom improvement, and patient satisfaction while decreasing caregiver burden and lowering healthcare costs (Smith et al., 2012). Based on those findings, leading oncology organizations, such as the American Society of Clinical Oncology (Smith et al., 2012), the American College of Surgeons (2016), the NCCN (2016a), and the Oncology Nursing Society (2016), recommend integrating early palliative care services into comprehensive oncology care provided to patients.

Despite these recommendations, a variety of provider and patient barriers exist to the early and extensive use of palliative care services. The process of implementing these guidelines can

be broken into four major areas: (a) educating healthcare providers and the community about palliative care, (b) developing a palliative care program to optimize and match the available palliative care services in the community with the needs of the patient population, (c) developing effective screening tools or referral criteria to identify at-risk patients, and (d) participating in program development and quality improvement processes.

Education on Palliative Care

The biggest barrier to implementation may be the lasting misconceptions by patients and providers of what palliative care entails and the stigma associated with the terms *palliative care* and *hospice*. Abernethy and Currow (2011) described hospice as the “dominant model of palliative care service provision in the United States” (p. 347). Hospice has been an established form of palliative care available as a covered Medicare and third-party payer since the early 1980s. Unfortunately, based on the limiting eligibility criteria of this benefit, including documentable limited life expectancy and the forfeiture of curative treatment pursuits, use of this service remains very late in the illness trajectory, typically when the patient has exhausted all other medical options and end of life is imminent (Parikh, Kirsh, Smith, & Temel, 2013). According to the National Hospice and Palliative Care Organization (2015), 48.8% of patients who were enrolled in hospice had a length of stay of less than 14 days. Because of the stigma and association with hospice and end of life, some providers are reluctant to refer