



Palliative Care in the Home (an Expansion of *Care That Never Quits*®)

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Statement of the Problem

Our clinicians see cancer patients whose complex care needs often delay transitions to the next appropriate level of care. These delays can negatively impact lengths of stay, health care expenditures and readmission rates.

Background/Literature Review

- Early palliative care improves quality of life, symptom burden, advance care planning and survival for advanced cancer patients.¹
- Traditionally, palliative care is delivered in in-patient and out-patient settings.²
- Recently, there is interest in providing specialist palliative care in the home.³

Purpose/Aims or Objectives

The purpose of this program is to deliver palliative care services in the homes of recently discharged SRMC patients living in the greater Tulsa metropolitan area.

Specific Aims/Objectives:

1. Improve symptom management for enrolled patients.
2. Increase completion rate for advance directives.
3. Demonstrate a lower hospital readmission rate for enrolled patients.
4. Examine feasibility of continuing the program.

Methods

Design or Project Type:

Quality Improvement Project

Sample: 5 patients

Setting: patient's home

Evaluation (Measures):

- ESAS-R for symptom assessment and trending
- Advance care directive completion rate
- Hospital readmission rate compared to historical cohort of patients

Data Collection/Analysis:

Excel spreadsheet (password protected)

Timeline:

Feb 2018 – May 2018.

Edmonton Symptom Assessment System: (revised version) (ESAS-R)	
Please circle the number that best describes how you feel NOW:	
No Pain	0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain
No Tiredness (fatigue + lack of energy)	0 1 2 3 4 5 6 7 8 9 10 Worst Possible Tiredness
No Nausea (discomfort + feeling sick)	0 1 2 3 4 5 6 7 8 9 10 Worst Possible Nausea
No Shortness of Breath	0 1 2 3 4 5 6 7 8 9 10 Worst Possible Shortness of Breath
No Depression (downcast + feeling sad)	0 1 2 3 4 5 6 7 8 9 10 Worst Possible Depression
No Anxiety (nervous + being worried)	0 1 2 3 4 5 6 7 8 9 10 Worst Possible Anxiety
Best Wellbeing (how you feel overall)	0 1 2 3 4 5 6 7 8 9 10 Worst Possible Wellbeing
No Other Problem (for example constipation)	0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Completed by (check one):
 Patient
 Family caregiver
 Health care professional/caregiver
 Caregiver-assisted

Edmonton Symptom Assessment System – Revised (ESAS-R)⁴

Conclusions/Implications

1. Objectives # 1-3 were clearly met with improved symptom management, completion of advanced directives, and decreased readmission rate.
2. Program was well received by patients and caregivers.
3. When patient's goals of care are weighed against burdens of treatment, all 5 patients elected hospice.
4. This program could be further expanded to include other patients within our institution.

Limitations

This project was designed for a single cancer care institution. The results and the implications may not be reproducible in another setting.

Findings/Results

Demographics:

5 patients

mean age – 61.4 years

60% male, 40% female

Diagnosis: Tongue cancer, Large B-Cell Lymphoma, Hepatocellular Carcinoma, Breast Cancer, Cholangiocarcinoma

Advance Directive

Completion: 100%

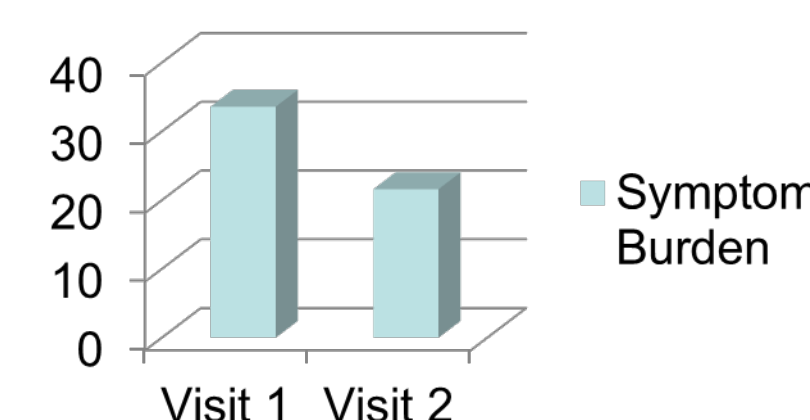
Readmission Rate: 0%*

Admission to Hospice: 100%

*Historical cohort – Readmission rate: 6.7%



Symptom Burden



Visit 1 – mean of 33.6 (ESAS-R)
Visit 2 – mean of 21.6 (ESAS-R)

Acknowledgements/References

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References:

1. Temel J, Greer J, Muzikansky A, et al. Early palliative care for patients with metastatic non-small cell lung cancer. *N Engl J Med.* 2010;363(8):733-742.
2. Wiencek C, Coyne P. Palliative care delivery models. *Semin Oncol Nurs.* 2014;30(4):227-233.
3. Deitrick L, Rockwell E, Gratz N, et al. Delivering specialized palliative care in the community: A new role for nurse practitioners. *Adv Nurs Sci.* 2011;34(4): E23-E36.
4. Edmonton Symptom Assessment System - Revised found at <http://palliative.org/NewPC/pdfs/tools/ESAS-r.pdf>. Accessed 10/1/2017.