Criteria for Referral: Standardizing Palliative Care Referral with Automatic Triggers

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  – Institutional Research Grant
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  – Insys Therapeutics
  – Teva Pharmaceutical
  – Depomed Inc
Outline

• Why do we need referral criteria?

• What criteria to trigger referral?

• How to apply criteria?

• Summary
Timely Palliative Care Referral is Associated with Improved Outcomes

- **Improved symptom control**
  - Pain control (OR 0.38) and Other symptoms (OR 0.51) (Higginson et al. JPSM 2003)
  - ESAS (Kavalieratos et al. JAMA 2016)

- **Improved quality of life**

- **Improved quality of end-of-life care**
  - ER visits, hospitalizations, ICU in last days (Dudgeon et al. JPSM 2008; Hui et al. Cancer 2014; Jang et al. JNCI 2015)
  - ICU stay and intubation/ventilation (Wright et al. JAMA 2008)
  - Chemotherapy use in last days (Temel et al. NEJM 2010; Jang et al. JNCI 2015)

- **Improved communication**
  - Prognostic understanding (Temel et al. JCO 2011)
  - Advance care planning (Temel et al. NEJM 2014)

- **Improved patient satisfaction**
  - Satisfaction (Zimmermann et al. Lancet 2014)

- **Improved caregiver outcomes**
  - Better mood (Dionne-Odom et al. JCO 2015)
  - Less complicated bereavement (Wright et al. JAMA 2016)
  - Caregiver satisfaction (Zimmermann et al. JAMA 2008)

- **Improved oncologist related outcomes**
  - Saves consultation time (average 170 minutes) (Muir et al. JPSM 2010)

- **Reduced healthcare cost**
  - Estimated savings of $4 billion/yr if 5% of all hospitalized patients have PC access
Currently, palliative care referral occurs in a haphazard manner.

Some oncologists refer some patients, sometimes on a timely fashion.

Access to Palliative Care
By Oncologist

Of 1,642 patients who died of advanced thoracic malignancies, 444 (27%) had an outpatient palliative care referral.

Hui et al. Oncologist 2018
Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update

Betty R. Ferrell, Jennifer S. Temel, Sarah Temin, Erin R. Alesi, Tracy A. Balboni, Ethan M. Bosch, Janice L. Finn, Judith A. Paice, Jeffrey M. Peppercorn, Tanyanika Phillips, Ellen L. Stovall, † Camilla Zimmermann, and Thomas J. Smith

For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement within 8 weeks of diagnosis (type: informal consensus; benefits outweigh harms; evidence quality: intermediate; strength of recommendation: moderate).

Among patients with cancer with high symptom burden and/or unmet physical or psychosocial needs, outpatient cancer care programs should provide and use dedicated resources (palliative care clinicians) to deliver palliative care services to complement existing program tools (type: evidence based; benefits outweigh harms; evidence quality: intermediate; strength of recommendation: moderate).

For patients with early or advanced cancer for whom family caregivers will provide care in the outpatient setting, nurses, social workers, or other providers may initiate caregiver-tailored palliative care support, which could include telephone coaching, education, referrals, and face-to-face meetings. For family caregivers who may live in rural areas and/or are unable to travel to clinic and/or longer distances, telephone support may be offered (type: evidence based; evidence quality: low; strength of recommendation: weak).
A. Selective referral (current practice)
- Variable degree of palliative care referral

Pros
- Some patients can benefit

Cons
- Referral often delayed
- Inconsistent care
- Missed opportunities to improve care

B. Universal referral (clinical trials)
- All patients receive early palliative care referral

Pros
- Improved outcomes for many patients

Cons
- Overwhelming limited resource
- Some patients may not need PC yet

C. Targeted referral
- Patients with greater needs receive timely palliative care referral

Pros
- Improved outcomes, likely greater benefit because of enriched population
- Appropriate matching of resources to care needs

Hui et al. CA: Cancer J Clin 2018
Referral Criteria for Outpatient Palliative Care

Who and When?

1. Severe physical symptom(s)
2. Severe emotional symptom(s)
3. Request for hastened death
4. Spiritual or existential crisis
5. Assistance with decision making/care planning
6. Patient request
7. Delirium
8. Brain or leptomeningeal metastases
9. Spinal cord compression or cauda equina
10. Within 3 months of diagnosis of advanced/incurable cancer for patients with median survival 1 year or less
11. Diagnosis of advanced cancer with progressive disease despite second line systemic therapy

Severe distress
Additional support
Proper timing
Neurologic complications

Major Referral Criteria
Performance in Real World

- 200 consecutive consultations at Supportive Care Clinic
- Median survival 14 (95% confidence interval 9.2, 17.5) months
- A majority (85%) met at least 1 major criteria
- The median duration from patient first meeting any criterion to palliative care referral was 2.4 (interquartile range 0.1, 8.6) months

<table>
<thead>
<tr>
<th>Major criteria</th>
<th>Present (%)</th>
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<tr>
<td>Severe physical symptom(s)</td>
<td>140 (70)</td>
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<td>Severe emotional symptom(s)</td>
<td>36 (18)</td>
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<td>Request for hastened death</td>
<td>1 (0.5)</td>
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<tr>
<td>Spiritual or existential crisis</td>
<td>2 (1)</td>
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<tr>
<td>Assistance with decision-making/care planning</td>
<td>26 (13)</td>
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<td>Patient request</td>
<td>4 (2)</td>
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<tr>
<td>Delirium</td>
<td>0 (0)</td>
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<td>Brain or leptomeningeal metastases</td>
<td>25 (12.5)</td>
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<tr>
<td>Spinal cord compression or cauda equine</td>
<td>3 (1.5)</td>
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<tr>
<td>Within 3 months of diagnosis of advanced/ incurable cancer for patients with median survival 1 year or less</td>
<td>54 (27)</td>
</tr>
<tr>
<td>Diagnosis of advanced cancer with progressive disease despite second line systemic therapy (incurable)</td>
<td>63 (31.5)</td>
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</table>
We propose a model of routine symptom screening coupled with triggers for referral.

All oncologists refer all appropriate patients, always on a timely fashion.

This requires (1) consensual referral criteria, (2) systematic screening, (3) triggers, (4) palliative care clinic availability.
Process of Integration
Complex Machinery

Outpatient PC clinic resources

Defined referral criteria

Routine screening

Automatic triggers

Increased early palliative care access
Applying the Referral Criteria
Standardizing the Referral Process

**Clinician-Based Referral**

- **Step 1: Recognizing patient needs**
  - Clinician assessment
    - Clinician recognizes patients’ care needs

- **Step 2: Criteria for referral**
  - Clinician judgement
    - Clinician decides if patient requires a referral or not
      - Highly heterogeneous criteria
      - Selective by nature

- **Step 3: Initiating referral**
  - Clinician-based referral
    - Clinician discusses with patient and makes a referral

- **Outcome**
  - A proportion of patients get referred, often late in the disease trajectory

**System-Based Referral**

- **Universal screening**
  - Patient care needs are regularly assessed with validated questionnaires

- **Standardized referral criteria**
  - Care needs matched against a checklist
  - Homogeneous but may be customized for each center
  - May be universal (all patients) or selective (some patients)

- **System-based automatic referral**
  - If patient meets criteria, a referral is automatically made (unless patient refuses)

- **Outcome**
  - All patients who meet criteria are referred in timely manner
## Applying the Referral Criteria

### Delphi Consensus

<table>
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<th>Statements</th>
<th>Level of agreement N (%)</th>
<th>First round</th>
<th>Second round</th>
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<td>Outpatient palliative care referral should be based on <strong>both</strong> automatic referral and clinician-based referral.</td>
<td>50 (86)*</td>
<td>48 (86)*</td>
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<td>Outpatient palliative care referral should be based on automatic referral <strong>instead of</strong> clinician-based referral.</td>
<td>16 (28)</td>
<td>4 (7)</td>
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<td>Outpatient palliative care referral should be based on clinician-based referral <strong>instead of</strong> automatic referral.</td>
<td>10 (17)</td>
<td>10 (18)</td>
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<td>Automatic referral criteria need to be institution specific.</td>
<td>34 (59)</td>
<td>31 (55)</td>
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<td>Automatic referral criteria need to be tumor type specific.</td>
<td>30 (52)</td>
<td>25 (45)</td>
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<td>Automatic referral criteria may increase the number of outpatient palliative care referrals.</td>
<td>56 (95)*</td>
<td>55 (98)*</td>
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<td>Automatic referral criteria may facilitate earlier palliative care access for cancer patients.</td>
<td>55 (93)*</td>
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<td>Automatic referral criteria may help administrators to set benchmarks for quality improvement.</td>
<td>46 (79)*</td>
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<td>Automatic referral criteria may result in greater collaboration between oncologists and palliative care specialists.</td>
<td>35 (60)</td>
<td>32 (58)</td>
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<td>Automatic referral criteria may decrease the autonomy of clinicians to deliver primary supportive/palliative care.</td>
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<td>29 (52)</td>
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<td>Automatic referral criteria may hinder clinicians’ ability to refer patients to palliative care.</td>
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<td>5 (9)</td>
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<td>5 (9)</td>
<td>1 (2)</td>
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<td>Automatic referral criteria may result in conflicts between oncologists and palliative care specialists.</td>
<td>30 (52)</td>
<td>24 (43)</td>
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<td>Automatic referral mandates routine screening in the oncology clinic which is too burdensome to conduct regularly.</td>
<td>21 (36)</td>
<td>13 (23)</td>
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</table>

Hui et al. *Supp Care Cancer* 2017
Applying the Referral Criteria
Standardizing the Referral Process

Parallel referral

Clinician-Based Referral

- Clinician assessment
- Clinician judgement
- Clinician-based referral

System-Based Referral

- Universal screening
- Standardized referral criteria
- System-based automatic referral

Many patients get referred from both sources

Augmented referral

Clinician-Based Referral

- Clinician assessment
- Clinician judgement
- Clinician-based referral

System-Based Referral

- Universal screening
- Standardized referral criteria
- System-based automatic referral

Clinicians make the final decision and selected patients will be referred
Automatic Referral
Challenges Ahead

• Buy in from oncology team
• Fine tune referral criteria
• Integrate in electronic health records
• Funding for palliative care services
• Demonstrate improved outcomes
Routine Symptom Distress Screening

General Oncology Clinic

ESAS screening at oncology clinic (consult or followup)

“High Distress Level”
≥3 ESAS symptoms with 7/10
Nursing staff page social worker
Social Work Triage (within 48 hours)

Significant distress detected by clinician regardless of screening or patient/caregiver request

Admission if indicated

Resolved or Manageable
Continue to monitor over time

Low Distress Level
Continue to monitor over time

Significant Distress
Arrange referral/timely followup with
1. Palliative Care (if multiple symptoms and advanced cancer)
2. Psychiatry or psychology (if predominantly emotional distress)
3. Oncology team

Hui et al. Oncologist 2017
Routine Symptom Distress Screening

Defining Cutoff

Hui et al. *Oncologist* 2017
## Routine Symptom Distress Screening
### Referral Outcomes

<table>
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<tr>
<th>Screening</th>
<th>Pre-Implementation N (%)</th>
<th>Training N (%)</th>
<th>Post-implementation N (%)</th>
<th>P-value</th>
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<tr>
<td>ESAS completed</td>
<td>316/379 (83)</td>
<td>299/328 (91)</td>
<td>447/465 (96)</td>
<td>&lt;0.001</td>
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<td>Severe symptom distress</td>
<td>34/316 (11)</td>
<td>35/299 (12)</td>
<td>58/447 (13)</td>
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<td>Social work referral</td>
<td>7/34 (21)</td>
<td>25/35 (71)</td>
<td>46/58 (79)</td>
<td>&lt;0.001</td>
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<td>Palliative care referral</td>
<td>4/34 (12)</td>
<td>7/35 (20)</td>
<td>15/58 (28)</td>
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<td>Hospice care referral</td>
<td>0/34 (0)</td>
<td>2/35 (6)</td>
<td>2/58 (6)</td>
<td>0.54</td>
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<td>Psychiatry or psychology referral</td>
<td>3/34 (9)</td>
<td>2/35 (6)</td>
<td>4/58 (7)</td>
<td>0.82</td>
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Hui et al. *Oncologist* 2017
Implementation Flowchart

ESAS completion
- Patient care coordinators give out ESAS forms
- Enter ESAS data to EPIC in real time

ESAS review
- If any ESAS >=7
  - RNs conduct assessment, education, etc
  - Document management plan in EPIC
  - Put “MD Notified” if symptoms not address

Best Practice Alert
- If any ESAS >=7 AND “MD Notified”
  - Physicians to assess symptoms further

Physician assessment
- Discuss with patient the plan
  - Complete BPA note in EPIC
  - Order referral if appropriate
ESAS Review
Best Practice Alert
Template Note for Physicians
# Report Card

## Performance Indicators

- **Meets Goal ≥75%**
- **Needs Improvement 70-74%**
- **Unsatisfactory <70%**

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<tr>
<th>Loc -&gt; Dept -&gt; Month -&gt; Visit Type -&gt; Visit Provider</th>
<th>Unplanned Patient-Screened</th>
<th>Visits</th>
<th>ESAs Ensured</th>
<th>ESAs Ensured %</th>
<th>ESAs Complete</th>
<th>ESAs Complete %</th>
<th>Severe Symptom %</th>
<th>Severe Symptom 7%</th>
<th>All Lab Doc Entered By RN</th>
<th>All Lab Doc Entered By RN %</th>
<th>RN Int Lab Complete</th>
<th>RN Int Lab Complete %</th>
<th>MD Notify</th>
<th>MD Notify %</th>
<th>MD Int Lab Complete</th>
<th>MD Int Lab Complete %</th>
<th>MD/RN Int Lab Complete</th>
<th>MD/RN Int Lab Complete %</th>
<th>BPA Filled</th>
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<td>3,562</td>
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<td>2,147</td>
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<td>2,186</td>
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<td>2,345</td>
<td>66%</td>
<td>1,689</td>
<td>77%</td>
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</tbody>
</table>
Bridging oncology and palliative care
- Careful design
- Commitment of resources
- Team work
- Both communities can prosper
Thank You!

- MDA Palliative Care
  - Dr. Eduardo Bruera
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  - Dr. Rony Dev
  - Dr. Daniel Epner
  - Dr. Ali Haider
  - Dr. Yvonne Heung
  - Dr. Kevin Madden
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  - Dr. Suresh Reddy
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  - Dr. Kimerson Tanco
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  - Dr. Paul Walker
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  - Dr. Sriram Yennu
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