

# Integration of oncology and palliative care

## - findings from the PALLiON pre-study survey

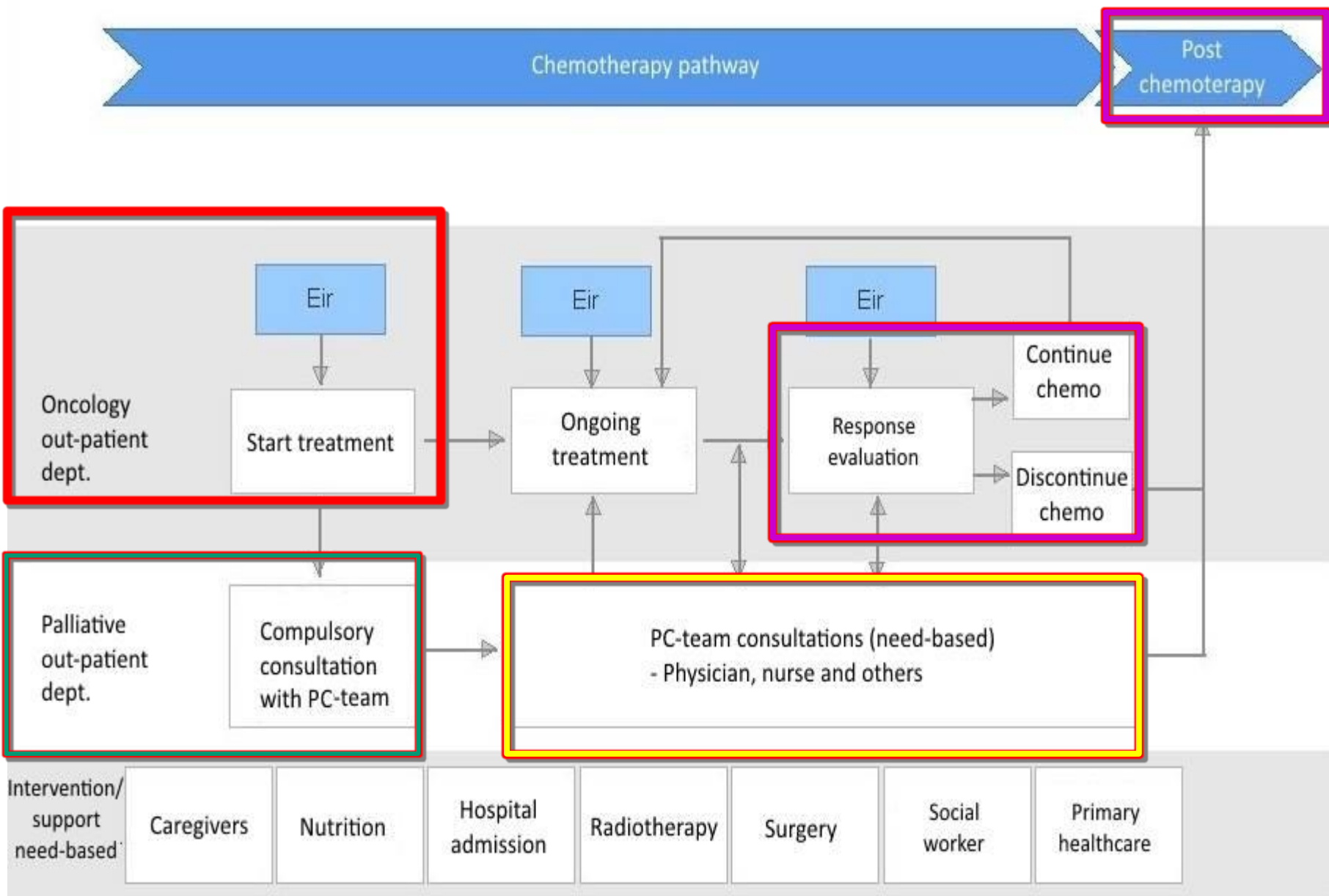
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# Why PALLiON?

- Integration of oncology and PC is a topical issue
  - Earlier referrals; positive outcomes for patients and caregivers
    - QoL, depression, satisfaction with care, symptom mgmt., survival
      - Temel, Zimmermann, Bakitas, Maltoni, Dionne-Odom a.o.
    - differences in methods and outcomes– small effect sizes
      - Kavalieratos; JAMA 2016, Haun; Cochrane 2017
- Overtreatment / aggressive treatment is a problem
  - questionable medical benefit, expensive, less time spent at home, etc.
  - PC referrals occur too late
- Time has come to rethink and reorganize

# What is PALLiON?

- A national cluster-randomized trial
  - 12 hospitals; oncology + specialized PC service; team +/- inpatient units
  - 3 strata: no. of inhabitants in the local catchment area
  - 2 clusters; control; practice as usual and intervention
    - 300 patients per cluster
- The three-tiered intervention consists of
  - structured educational program for oncologists and PC physicians
  - SCPs; as the backbone of the clinical intervention
    - compulsory PC consultation upon start of last line of chemotherapy
    - compulsory, regular systematic symptom assessment
- Patients are not randomized
  - consent to filling in questionnaires, PROMs, QoL etc., in both arms



# Study outcomes; PALLiON

- Primary study outcome
  - Use of chemo last 3 months before death
    - no./ proportion of pts, no of cycles, start/end of last cycle in relation to time of death, other medical treatment after discontinuation of chemo
  - Secondary outcomes
    - PROMs, caregiver QoL, satisfaction with care

# A pre-post PALLiON study

- The three-tiered intervention implies an organizational change
- Need to know something about baseline status
- Study aims were to
  - map the collaboration, organizational and care issues in participating hospitals

# Methods

- A Questback® survey, based on
  - experiences as a regional advisory unit
  - leading documents on the Norwegian way of organizing oncology/PC
  - literature reviews, esp. published indicators on integration
    - administrative, clinical, educational aspects (*Hui et al 2015 x 2*)
  - web-based, sent to heads of oncology and heads of PC
- Categorical answers; 3/4/5 or Y/N plus free comments

# Results – administrative aspects, 1

- 19 responses received, data from 11 hospitals analyzed
  - 4 heads of oncology, 5 heads of PC section, 2 heads of both
- Eight hospitals had PC in-patient units (3-12 beds)
  - one had designated PC beds in a general oncology unit
- Eight hospitals had PC out-patient units
  - from based on need referrals to full time 5 days/week
  - all had PC teams; as required
  - all PC teams served other hospital departments
  - all PC teams had extra-mural activities



# Results – administrative aspects, 2

- Composition of PC teams - multidisciplinary
  - all teams had nurses and certified PC doctors (1-4)
  - most frequent medical specialties were
    - oncology 45%, GP 73%, anesthesiology 36%
  - social workers and priests part of 5 teams
  - psychiatrist/psychologist and dieticians part of 3 teams
- No standardized procedures / SCPs for referral/contact to PC
  - need-based or ad-hoc
- PC doctors rarely participated at MDT meetings with oncologists

# Clinical aspects, causes for referral

- Major causes; rarely, quite often, very often
  - complex symptomatology; *very often* (n=11)
  - terminal care and psychosocial issues; *quite often* (n=9)
  - coordination of care outside hospital; *very often* (n=4), *quite often* (n=5)
  - family relations; *very often* (n=4), *quite often* (n=5)
  - decisions and discussions about care; *rarely* (n=6)
- Four hospitals confirmed SCPs for PC patients on chemo
  - none provided information about its content
- Common PC/oncology rounds; *rare* (36%) or *quite often* (64%)

# Clinical aspects, symptom assessment

- ESAS was used more often in PC out-patient units
  - *very often (n=7), quite often (n=3), rarely (n=1)*
- than in oncology out-patient units
  - *very often (n=2), quite often (n=2), rarely (n=5), never (n=1)*

and

- more often in PC in-patients
  - *very often (n=8), quite often (n=2)*
- than in oncology in-patients
  - *very often (n=1), quite often (n=4), rarely (n=3), never (n=1)*

and

- PC teams used ESAS frequently
  - *very often (n=8), quite often (n=3)*

# Palliative chemotherapy, 1

- Never administered by the PC units in 7 hospitals
  - may be related to organizational issues?
- Patients quite often get written information about pall. chemo
- Contact with PC doctor during palliative chemo;
  - never, rarely, quite often, very often
    - upon start; *rarely* (n=9)
    - if progressing on treatment; *quite often* (n=6)
    - upon end/discontinuation; *quite often* (n=6), *very often* (n=5)
    - based on needs; *very often* (n=7)

# Chemotherapy, start and stop

- Decisions to start pall chemo; *to a small extent, some extent, a large extent*
  - Blood values; *to some extent: n=4, to a large extent: n=5*
  - Imaging; *to a large extent: n=8*
  - Performance status; *to a large extent: n=8*
  - Symptom burden; *to a large extent: n=8*
  - Patient's wishes; *to a large extent: n=7*
- Decisions to continue or discontinue pall chemo;
  - Blood values; *to some extent: n=3, to a large extent: n=5*
  - Imaging; *to a large extent: n=8*
  - Performance status; *to a large extent: n=9*
  - Symptom burden; *to a large extent: n=9*
  - Patient's wishes; *to a large extent: n=7*

# Results, educational aspects


- Rotation
  - from PC to oncology; confirmed by 4 hospitals, but infrequent
  - the other way round; confirmed by 8 hospitals, infrequent in 4
- Communication training took place in 5 hospitals
- Specialized PC education took place in 6
- Common PC/oncology education was reported by all
  - but seldom happened (n=10)

# What can be inferred from this?

- Not a scientifically developed survey
- Small sample, no statistics
  - in some cases, perceptions of oncology and PC heads differed
  - no correct answers - interpersonal variations
  - difficult to report poor clinical routines?
  - also «true» organizational variations, e.g. use of ESAS etc.



# Maybe, the most important question

- Are these aspects of integration suited for measuring what we want to achieve in and with a study like PALLiON?
- PALLiON's primary objective; use of chemo last 3 months
  - study period probably too short
  - preponderance of pts for whom last line of chemo is their first line
  - maybe differences between arms on the secondary outcomes?
    - PROMs, QoL, symptoms, satisfaction
- PALLiON aims to be more than a study
  - a profound change; organizational, professional and personal level;
  - affecting clinical practice and mind-set
- This implies research challenges beyond studies (Zimmermann, 2017)
  - design, methodology, recruitment and patience...



# Conclusion

- A post-study survey will be conducted
- PALLiON outcomes; use of chemo, PROMs etc. in both groups
  - complement each other
- More hard-core, administrative data give important information
  - Countable, can be retrieved from electronic patient records, chemotherapy-registries etc., also historical data;
    - No. of patients in contact with PC upon start of last chemo
    - Why?
    - When, in relation to time of death?
    - Systematic symptom assessment, performance status documented in EPR?
    - Use of advance care planning and advance directives?

