Relationship Building as a Component of Establishing Continuity of Care in Outpatient Palliative Care Program

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Growth of Palliative Care

- Palliative Care has increased in inpatient setting as large numbers of hospitals have initiated various configurations of interdisciplinary teams
- Culture change in inpatient setting
- Some patients are discharged home with hospice or to inpatient hospice unit and continue to receive the same benefits of focus on holistic symptom management and support to family and caregivers with focus on end of life care
GAP IN SERVICES

• Inadequate follow up for symptom management or emotional support for those not ready for hospice

• Unnecessary or challenging hospital admissions which are distressing and challenging to patients and their families

• Patient and family distress

• Increased costs for further workups that may not be necessary

• Stress of being in the hospital setting-long ED waits
Outpatient Palliative Care

• Provide continuity of care

• Interdisciplinary team to provide holistic care

• Providers may be known from inpatient setting and relationship building has already begun
Outpatient Palliative Care in Oncology

• Significant progress has been made in treating cancer, still approximately half of all patients with cancer eventually die of their disease and one third within 6 months of diagnosis.

• Multiple national and international organizations support early integration of palliative care into oncology practice.

• American Society of Clinical Oncology supports full integration of palliative care as routine part of comprehensive cancer care by 2020. \(^1\)
Palliative Care Outpatient Setting

Temel et al study New England Journal 2010 showed that “early palliative care led to significant improvements in quality of life and mood” in patients with advanced breast cancer.

“Early outpatient palliative care for patients with advanced cancers can alter use of health care services including care at EOL.” and “less aggressive end of life care including reduced chemotherapy and hospital admissions”2
Barriers to Instituting Outpatient Palliative Care

• Poor reimbursement
• Limited resources
• Limited space
• Attitudes towards palliative care
  emotional resistance
  continued focus on cure
  lack of education about goals of palliative care
Building Outpatient Palliative Care Program at New York Presbyterian Hospital – Weill Cornell

- Administrative legwork including ongoing negotiations with Palliative Care Medical Director and Chief of Oncology

- Physician hired 2014-fellowship training in Palliative Care

- Experienced social worker ½ time

- Identify 3 oncology clinics to begin
  - Breast center
  - GI oncology
  - Thoracic/brain (specifically GBM)
Challenges

Limited space

Billing and reimbursement

Appropriate referrals

Data collection to measure outcomes

Oncology buy in
Building Relationships with oncologists and staff in outpatient setting

- MD and SW available during specific time frames in outpatient clinics
- Made effort to get to know RNs, techs, administrative staff
- Present as collaborative, supportive, available
- Guests in their setting
Clinicin Relationship and Attachment Theory

Bowlby’s attachment theory has been useful in understanding the variety of relationships has been defined as an emotional bond between two individuals based on expectation that one or both members will provide care and protection in times of need.
Attachment Theory

- Loss of functioning may all contribute to an increased reliance on others including providers.
- Activated in times of stress
- Altered by response of provider
Case of Mr S

- 88 yo widowed Caucasian man with hx of gastric cancer. Disease progressed on several lines of chemo, now on clinical trial
- Weekly chemotherapy in outpatient setting
- Met weekly in clinic
- 3 daughters involved in care
Relationship Building with Patient and Daughters

- Patient in WWII  Spoke at length about his experiences
- Patient NYPD Detective
- Wife died of cancer
- Spent time with life review
- Discussed advance care planning  Pt completed HCP and DNR
Disease progressing

- Difficulty in coming to NYP. Daughter expressed wanting to transfer to Staten Island Hospital to continue treatment—discussed with oncologist who was in agreement.

- SW spoke to daughter over phone to discuss plan. We talked about his previously expressed wishes and asked if he could come in to meet with oncologist and Palliative Care to discuss options.

- Discussed hospice and patient agreed.
Outcome

• Patient died 1 week later

• Avoided hospitalization

• Family grateful
References

1. Hui et al; Availability and Integration of Palliative Care at US Cancer Centers: JAMA March 17, 2010-Vol 303 No 11 1054-1061

2. Temel et al; Early Palliative Care for Patients with Metastatic Non Small Cell Lung Cancer: New England Journal of Medicine 2010 363: 733-742