

Featured Innovation: Part 2

Bringing Palliative Care Home to Patients Engaged in Clinical Trials:

An Interview with Joan Blais, MPA

The West Coast Center for Palliative Education and Research (WCCPER), established in 1994 at the University of California Davis Health System (UCDHS) in Sacramento, California, has been the catalyst for efforts to integrate palliative care more fully into practice across settings at UCDHS. This institution is one of the few academic medical centers to include a hospice, providing research and education experiences for health care providers as well as for the medical students and residents who receive their training at UCDHS. In 1999, the UC Davis Medical Center received a grant from Promoting Excellence in End-of-Life Care, a national program office for The Robert Wood Johnson Foundation, to design creative interventions to provide care to patients who do not traditionally have access to palliative care. This project had three prongs: a telepalliation program for multidisciplinary rural health care teams; the establishment of a hospice in a women's correctional facility; and Simultaneous Care, an effort to bring hospice-like care upstream to patients enrolled in clinical trials. Joan Blais, MPA, director of WCCPER, describes the design and implementation of the Simultaneous Care program (1999-2002) in the following interview conducted by Innovations Associate Editor Anna L. Romer, EdD. The UC Davis Health System is one of three winners of this year's Circle of Life Award for innovative work in end-of-life care.

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Rationale for the Project

Can you describe the impetus for the original Simultaneous Care program?

The vision for the project was developed by Frederick Meyers, MD, chair of medicine and long-time hospice medical director at the University of California Davis Medical Center. For many years, Dr. Meyers had seen patients who were enrolled on clinical trials referred to hospice when they had only a few days left to live. These patients had very little time to prepare for life's closure, and in most situations their psychological and spiritual needs had never been addressed by a clinical team. The clinical team at UC Davis felt that patients on clinical trials rarely received interdisciplinary palliative care at end-of-life, and thus, in every sense of the words, could be described as an "underserved population". In our response to the call for proposals for the RWJF-funded Promoting Excellence in End-of-Life Care program, Dr. Meyers' idea for simultaneously providing palliative care while patients are enrolled on clinical trials was proposed. The concept was entitled "Simultaneous Care." There were actually three projects undertaken as part of the UC Davis Promoting Excellence in End-of-Life Care grant. Simultaneous Care is the project that I will focus on here. [See the Executive Summary for an overview of the entire project.]

Dr. Meyers developed the project to test the practicality and efficacy of integrating investigational therapy (which most patients frame as a curative model of care) with palliative care. The Simultaneous Care model aimed to move hospice-like care upstream to patients enrolled on Phase I and II clinical trials, at the same time that these patients and their families were still actively pursuing

cures for their cancers.

The situation is ambiguous in some ways for these patients. By definition, phase I and II clinical trials have the same entry criteria as hospice—you only enroll patients for whom all else has failed and whose cancers have progressed to terminal stages. Yet, patients who engage in clinical trials are desperately hoping to vanquish the cancer, and have usually not prepared for death at all. So, many people have felt that it is contradictory to provide palliative services to this group, even though palliative care is appropriate and these patients need these services.

It was the experience of Fred Meyers and his hospice clinical team that led to the development of this intervention. It was his observation that clinical trial patients often fall through the cracks in terms of receiving palliative or supportive care. They are at a point in their disease process where they need to focus on quality of life issues, but the system does not include this perspective. This concept was confirmed by the Institute of Medicine report entitled, "Improving Palliative Care for Cancer."¹

What were your goals?

One of our goals was to transform what was considered "usual" care by focusing on quality of life. We felt that standard care should include attention to the psychosocial concerns of patients and caregivers, provide family support, and attention to quality of life issues.

A second goal was to increase both hospice referral and hospice length of stay for patients enrolled in clinical trials. It has been our experience that these patients usually had the shortest length of stay of any patient, if and when they were referred to hospice.

A third goal was to improve patient and family experience while participating in clinical trials. We supported active participation in clinical trials. Often patients drop out of clinical trials because of the impact on their quality of life. We felt that offering careful pain and symptom management as well as opportunities to explore the meaning of their experience would only enhance these patients' quality of life. We hoped that offering these two kinds of care simultaneously would actually improve retention in the clinical trials as well as have a positive effect on patient and family quality of life.

To achieve these goals, we attempted to mimic hospice care for these patients who were not eligible for hospice, even as they continued on to engage in the clinical trials. As such, we hired a nurse and social worker to work as a team one-on-one with these patients. Briefly, the team made home visits, weekly follow-up phone calls, and accompanied patients on their doctor visits to cue them to assure optimal communication. Patients had access to a nurse 24 hours a day, 7 days a week, just as hospice patients do.

Implementation

How long did this program last and to whom did you offer it?

It was a 36-month project from January 1999 through January 2002. We had 44 patients who received the service during that time period. We offered it to patients on clinical trials who met a rather inclusive set of criteria. Patients with brain cancer or any kind of brain metastases or barriers to communication with the team were not eligible. So, if patients had dementia in addition to cancer, we did not offer them the program.

Patients were assigned to the intervention or comparison group and we then measured their quality of life in a variety of ways. The patients enrolled in the Simultaneous Care program were the intervention group. We did not have a randomized control group, however. The comparison group was established based on geographic location. Because the nurse/social worker team could not easily promise 24-hour availability and in-home care to those who lived outside a 25-mile radius of the Cancer Center, patients who lived farther away were placed in the comparison group and received "usual care," i.e., all the care associated with the phase I or II clinical trials, but no home visits or special attention to pain and symptom management, or 24-hour access to a nurse.

How was the program presented to the patients when you recruited them for the program?

We told patients that we had a program that would provide them with the services of a nurse and social worker in their home through home visits, and that they could reach the nurse anytime if they had concerns about symptoms or pain.

How did you persuade the clinical trial leaders of the value of this effort? How did you expand their vision to include supportive care as a valuable part of treatment?

Dr. Fred Meyers and other members of the team engaged in a strategic marketing plan. They met with the physicians and nurses and all the different groups in the Cancer Center to explain the process. Dr. Meyers has been, and continues to be, a leader in the UC Davis Cancer Center. As the former chief of oncology, he led the Cancer Center for approximately eleven years. Although he is now chair of medicine, he has maintained clinic hours at the Cancer Center, so he is a colleague with a great deal of credibility with this group of practitioners. He has a long-term relationship with all of the oncologists, nurses, and social workers involved in cancer care, and is a respected leader and clinician.

When Dr. Meyers would go to staff meetings or nursing meetings and present Simultaneous Care, people listened and responded. In addition, other project leaders spoke at every single educational event we could attend. So, whether it was a grand rounds, nursing research club, or the Cancer Center symposium that is held once a year, we would present preliminary results. And we would just keep presenting our program over, and over, and over. Clinical staff got so used to hearing about Simultaneous Care, they began to think about it as something that they needed to suggest or recommend to every patient that came into the clinic. We definitely had a presence in the Cancer Center. We actually moved a few offices in there, so that people would see our people walking around the hallways.

The first few patients that we enrolled in the project generated a lot of success stories. After a while, interest in the project led to a waiting list. Patients would go back and tell their physicians, "I just wish this was offered to me six months earlier."

Key Features

The key features of our program were:

Home Visits and Telephone Follow-Up

We provided patients with a nurse and a social worker team who would follow their care through home visits, similar to a hospice model of care. The nurse would assess any side effects of chemotherapy the patient might be experiencing, as well as any other symptoms that he or she might

be having. The social worker would work with the patient on end-of-life issues such as advance care planning, completing a will, and attending to other tasks of life closure. The social worker also focused on emotional support issues, and family and interpersonal issues. This clinical team offered guidance and support on how to manage the multiple problems associated with cancer, related treatments, adverse reactions, and rehabilitation. The team also called patients and caregivers to follow up on issues as they came up. They visited the home at least once per week; however, they were available whenever the patient needed assistance. Following the hospice model of care, the team called patients and caregivers on a regular basis, and attempted to return all calls in a timely manner.

Empowering Patients to Speak Up with Physicians

In addition, a member of the team would accompany the patient to physician appointments just to make sure that the communication between the patient and the physician was optimal. We have found that patients go to physician appointments and say that everything is going well. Yet, this does not match what the nurse and social worker who have been in the home have observed. Patients would, in fact, have symptoms that they chose not to discuss with the physician. Our hope was that having a member of the team present would help patients be more candid and so bridge this communication gap, and, in turn, lead to better symptom management.

Round-the-clock Access to a Nurse

The nurse would be available via a pager to enrolled patients twenty-four hours a day, seven days a week, for any symptoms or problems that patients experienced. The nurse responded in the same manner that a hospice nurse would respond to a call from a patient. Namely, the nurse would assess the patient's condition, and if necessary, schedule a home visit immediately. The rationale for round-the-clock access was the same as for hospice—patients who are gravely ill and dying need this kind of responsive and immediate care. The Simultaneous Care program hired just one nurse. From the beginning, we realized that we would need to rely on the assistance of the on-call nurse in the UC Davis Hospice Program to keep the promise of round-the-clock availability to patients in the program. So, at times, the UC Davis Hospice nurse who was on call during nights and weekends would take the call from the Simultaneous Care patients and respond to their needs.

Coaching Role of the Nurse/ Social Worker Team

The two clinicians (nurse and social worker) we hired had many years of experience with cancer treatment, hospice, death, dying, and communication issues. They were highly skilled and committed to providing outstanding care to our target population. Their excellent communication skills enabled them to present the patient's point of view to the physician diplomatically, and with the force of experience. They would also work with the patient beforehand to craft language or rehearse the conversations so as to maximize the likelihood of the patient being heard by the physician. One of this team was then at the patient's appointment with the physician to prompt the patient if he or she needed help.

It sounds as though the nurse or the social worker would coach the patient in advance, so as to be more articulate.

Exactly. UC Davis Medical School has been involved in the development of pain coaching models for several years. In developing our intervention we drew upon a coaching model to improve pain control that had been done by medical students and residents here.² In that study, the clinician

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would call the patients the night before their appointments and say: "Tell me about your pain." Patients responded in rather general terms, so she would push them to find more specific words, which would be more likely to elicit a helpful response from the doctor; for example, "When you go tomorrow to see your doctor, what words are you going to use to describe that pain?" Patients might answer, "Well, I'm going to say it's really bad." The coach continued, "Well, 'really bad' is not going to tell the doctor exactly how it is. Can you tell him it is a very jabbing type pain? Or is it a constant pain? Is it a throbbing pain?" As we crafted the Simultaneous Care intervention, we tried to build on the experience of others to understand such questions as: What works for patients? What can we develop that will provide better care for patients? So, we decided to incorporate some of these coaching techniques with patients to articulate their symptoms and concerns.

Communication with Physicians and Clinical Trial Staff

How did the nurse/social worker Simultaneous Care (Sim Care) team keep in touch with the rest of the professional caregivers for the patients in the clinical trials? Did they attend meetings?

The Simultaneous Care (Sim Care) team met with the Clinical Research Associates (CRA) at the UC Davis Cancer Center every Monday morning. The team became integrated as an important part of the care that was offered to the clinical trial patients, and would intervene on behalf of the patients with the physician and other members of the clinical trial care team. The Sim Care team functioned much like the hospice nursing team. They paged the physician to request a change in medications, to report on new or uncontrolled symptoms, or to report on the status of the patient. They were meeting with and calling the physicians, and they were also meeting and consulting with the advice nurses.

Barriers: Institutional and Regulatory

I saw the primary barriers to launching the Simultaneous Care project as regulatory ones. Patients on clinical trials do not traditionally receive any type of palliative care. They cannot be referred to hospice while undergoing clinical trials because of the existing regulations guiding hospice reimbursement. Namely, a patient cannot sign up for the Medicare Hospice Benefit if that person is still pursuing curative treatment.

I believe it is fair to say that fewer institutional barriers exist at the UC Davis Cancer Center than at other cancer centers. Over the course of the last few years, through education and role-modeling, our team of oncologists has seen what can be accomplished when the physical and psychological discomfort of patients and caregivers is addressed. The single-minded focus on cure has been expanded to include recognition of the need to support patients with advanced disease and their families. The barriers that isolated clinical trial patients and their caregivers from having their burdens of stress and suffering addressed are slowly being shattered due to Simultaneous Care and other caregiver research that is being undertaken on our campus.

Impact and Evaluation

Lessening the Burdens on Patients, Families, and Staff

Families and patients are pursuing treatment in these clinical trials. But at the same time, families have psychosocial issues and questions regarding the care of their loved ones. Dr. Meyers always says that even the greatest family on earth, when they get into this end-of-life situation, will run into

conflict. Facing death can breed dysfunction and conflict, so families can all benefit from some outside guidance at this point. Frequently, previously harmonious family members don't agree on the treatment choices. And siblings are going to disagree as to what role each person is playing in this process. These issues emerge before the last days, and it is helpful to address them sooner rather than later. We feel that these issues have a direct correlation with the patient and family's quality of life, and improving quality of life was one of our main goals, as you will recall.

In our Cancer Center, we have a clinical trials office staffed by clinical research associates. Each clinical research associate is assigned several protocols and they work with the patients and their caregivers who are on that protocol. So, for example, the clinical research associate would contact patients to reschedule chemotherapy sessions when necessary. If patients were having any problems, or any symptom management issues, then the clinical research associates could refer them to our nurse/social worker team. These clinical research associates were enthusiastic about this program because it lightened their load by providing expertise and time to address patient and family questions and concerns. The Sim Care team worked very well with all the clinical trial associates and became members of that larger team. So, it really strengthened the relationship that clinical trials staff had with these patients.

Some physicians also reported that they felt that some of the burden of care was taken off of them because these other team members were present and available to patients and families. So, the program became a very positive experience for the entire Cancer Center. And when we say that it changed the culture, it really did. Pretty soon we heard people who had never spoken the words "palliative care" talking about the benefits of palliative care and referring patients to our program in order to improve their care.

What kinds of tools did you use to evaluate the impact of this intervention on patients and families?

We used the FACT-G, the Functional Assessment of Cancer Therapy,^{3,4} which measures quality of life using four domains: physical well-being, social/family well-being, emotional well-being, and functional well-being, and "additional concerns." Patients then evaluate the truth of a few statements for each category using a Likert scale that ranges from "not at all" to "very much." In addition, we had a chemotherapy side effects sheet that the nurse used to monitor side effects, and we used the Missoula-Vitas quality of life tool.⁵ Patients in both the intervention and comparison groups completed these tools, so that we could compare them.

We tried to understand family caregivers' perspectives, as well as patients'. We conducted an After-Death Bereaved Family Interview.⁶

How did you collect feedback from physicians about the program and its impact?

Every single one of the oncologists referred patients to our Simultaneous Care program. We gave a questionnaire to all of them inquiring about their satisfaction with the project.

Results

We found that the introduction of palliative care along with disease-directed therapy neither undermined patient participation in clinical research nor adversely affected the patient/physician relationship. To summarize the trends we found using the FACT tool in the "usual care" or control group and the intervention group, we found that quality of life in all four domains varied greatly at

baseline for both groups. Both groups reported substantial variation, and wide swings in the physical and emotional suffering that they were experiencing. Patients in both groups showed quality of life deterioration over time. Some patients were able to maintain their quality of life and could be expected to need less support, while others required much more. In the beginning, the quality of life in all four domains went down for the intervention patients. Interestingly, there was a shift after about six to eight weeks. Then we saw the opposite trend: quality of life went down for the usual care group and improved for the intervention group.

How do you account for these findings?

We can only speculate at this point, but we think that it was the nurse and the social worker going into the home. With the entry into the home of these professionals, the social worker may have brought up issues that the family, the caregiver, and the patient had not really thought about. Patients or families may have been in denial or just preferred not to think about difficult or uncomfortable issues. Having someone from the outside come in and stir these questions up creates an opening that can be disturbing. "Have you thought about what you might want the end of your life to look like? What unfinished business do you have?" But then after talking to the social worker and working through some of those issues, the patients perceived that their quality of life actually improved. We're only postulating here, but we would hope that we'd have helped them come to some resolution on some of those difficult items.

Hospice Referral and Length of Stay

One of our initial goals was to increase the rate of referral to hospice among patients on clinical trials and we did succeed in that area. We're really proud of the referral rate to hospice of the intervention patient versus the control patient. Ninety-two percent (92%) of the Simultaneous Care patients transitioned to hospice, as opposed to 53 percent in the usual care group. Even that number is above the national average!

The length of stay in hospice was longer for Simultaneous Care patients, I think, than even our regular hospice patients. I believe this is because the nurse and social worker were in the home presenting the idea of going into a hospice program, and what the benefit would entail to patients earlier than they may have been presented to other clinical trial patients. The Simultaneous Care patients had a median hospice stay of 54.5 days, compared with a median length of stay of 37 days for the "usual care" patients.

Completing Clinical Trials

We felt that we supported the patient in the clinical trial and that our care probably had some role in the patient staying on the trial. Patients sometimes leave trials, we understand from the literature, due to symptoms that are just uncontrollable. Patients weigh the positive with the negative and without additional support, often decide that they'd probably do better if they quit the trial.

If patients were actually going into hospice sooner and surviving longer, and yet they weren't coming off their trials sooner, do you think they were just surviving longer because they were getting better symptom management and psychosocial care? What do you think is going on here?

I think what happened was that we transitioned these patients from their clinical trials to hospice right away-- the day that the trial ended. So, these patients did not experience the more typical gap of

a week, two weeks, or a month.

Lessons Learned: Value and Replicability of the Original Program

Anytime a patient is provided with the care of a nurse on a 24-hour basis you are going to have better results in terms of a comprehensive plan of care, effective pain and symptom management, and patient and family satisfaction. Continuity of care improves with constant access to a known professional caregiver. In addition, the program addressed a weak point in cancer care: Patients often do feel frustrated by the communication that they have with cancer center systems. The Simultaneous Care model really worked on correcting or improving that communication.

What led you to end what sounds like a successful program?

We decided to make a transition to a more well-defined intervention that we can disseminate to other cancer centers. The original intervention was fairly costly in that we had to fund the clinical time that was not covered by the Promoting Excellence in End-of-Life Care grant. The grant paid for the development and administration of the Simultaneous Care project, and for the collection and analysis of the data. The grant also funded two other projects: working with three medically underserved rural areas using the UC Davis telemedicine network, and with the California Department of Corrections to establish a hospice in the women's correctional system.

What are the other lessons learned from the original Simultaneous Care program? How has the new Simultaneous Care project evolved out this experience or any of the initial project's limitations?

The Robert Wood Johnson Foundation gave us the opportunity to develop and test the model. What we found was that the model was too costly for it to be replicated by the vast majority of cancer centers. We would go to annual meetings and many of the people on other cancer centers' advisory boards, preeminent people in the United States in palliative care, would all want to talk to us about the Simultaneous Care program. Both they and we thought what we had done was of great interest to the fields of palliative care and cancer care. But we kept coming up against the financing and reimbursement question. Successful models have to be replicable. So, in the end, we decided to try another approach.

The Current Simultaneous Care Model

We went on to something new. We knew that we wanted to find a viable system to provide better care for patients enrolled in clinical trials. We wanted to work with them on their symptom control, psychosocial issues, and decision making, all of which affect one's quality of life. We decided to go with an education model. That's what the *new* Simultaneous Care program is all about. It is a randomized controlled trial of multi-site design with UC Davis Cancer Center, City of Hope Medical Center, and John Hopkins Oncology Center. The program provides three educational sessions to the patient and the caregiver. (We will schedule more if that is the desire of the patient and the caregiver.) We teach them the COPE model, which stands for Creativity, Optimism, Problem-solving, and Expert information.^{7,8}

The current Simultaneous Care project combines two previously successful strategies for intervention—the COPE problem-solving model and the concept of Simultaneous Care, palliation during clinical trial participation—in a population of patients personally or systematically denied access to similar care during participation in disease-directed therapy. The impact of this

psychosocial intervention on the overall quality of life of the cancer patients and their families will be measured and evaluated. The educational intervention teaches patients and caregivers a problem-solving approach for dealing with issues that usually occur with advanced disease, and sets up a system for coaching the patient and caregiver in order to reinforce the teaching.

In this current research, we have found that more than half the patients really need work on their problem-solving skills. They need help with communication with their physician and their caregiving team as well as help with their relationships with family members. Coordinating care from one treatment setting to another is difficult, not to mention coping with all the anxiety and depression that comes with advanced cancer treatment.

Patients and families don't seem to understand when the transitions in their disease trajectory and care are taking place. At one point, patients are receiving active treatment, then the physician says, "This is what I have to offer now: it's a clinical trial." Patients don't really understand that the goals of care have now shifted. Physicians need to be educators at this point. To ensure that the patient's best interests are met, it is incumbent on the oncologist to assess carefully the emotional, intellectual, and physical state of the patient and his or her family, and their capacity to comply with a particular protocol.² Information about potential benefit must be balanced by a careful assessment of the potential costs of participation.

Misconceptions about the potential benefits of participating in a cancer clinical trial are frequent among trial participants. Although patients perceive that they understand the consent form that they are required to sign, their perceived understanding may or may not correlate with actual understanding.¹⁰

All of these challenges are related to Dr. Meyers' point about the stress of terminal illness on family systems, even ones that are highly effective in the best of times. In the face of death, most patients and families can use some additional support or bolstering of their existing skills.

Does the new education model seek to empower patients to ask questions about goals of care, for example?

Yes. Engaging more fully in this conversation will also lead patients and families to understand more clearly what the clinical trials are about, what they can and can't promise.

Did the appeal of the COPE model come out of what you learned in the first Simultaneous Care project?

We first learned about the COPE model from two well-respected researchers and clinicians who were at Johns Hopkins Oncology Center. Matthew Loscalzo, ACSW, who is now an associate dean at Eastern Virginia Medical School, and Jim Zabora, ScD, dean of the School of Social Service at Catholic University, had worked extensively with the model when they were at Johns Hopkins. They came out to California to meet with us, and together with the phenomenal expertise and guidance of Betty Ferrell, PhD, from the City of Hope Medical Center, we developed this new Simultaneous Care program. In developing the project we attempted to answer the questions, "What can we provide patients that will address psychosocial issues experienced at end-of-life by both patients and caregivers? How can we improve quality of life for patients and caregivers?" The COPE model seemed to hold great potential for helping patients and caregivers. After spending almost one year planning the various aspects of the project, the group submitted a grant proposal to the National Cancer Institute. The grant received an outstanding score, and we have just started our second year

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of the five-year grant period.

So it wasn't a direct outgrowth of what you had learned in this other, earlier version?

We decided to continue calling our program "Simultaneous Care" because the name had such a positive connotation in the minds of the nurses and physicians at our cancer center. As the grant writer on the project, I thought this particular problem-solving, educational intervention for family caregivers and cancer patients seemed like one of the most interesting, well-defined interventions that I had ever read about. Jim and Matt educated our team about the model, worked with us on the identification of measurement tools, and remain on the grant team as valued contributors. This particular problem-solving intervention has all of the necessary qualities of an intervention that is cost-effective and sustainable. We are using numerous validated tools, and are following both the patient and the caregiver for 180 days. Under the guidance of Laurel Beckett, PhD, chief of biostatistics at UC Davis, we know that we will have a comprehensive analysis of the data that is collected. We believe this study is well designed, and that we will be able show evidence that we are improving care of the patient and the caregiver; in addition, we will better understand what it is that makes a difference for patients and families.

Were there any lessons from the original program that you have been able to incorporate into the new program?

In the original program, nurses and/or the social worker called the patient every couple of days to see how they were doing. In this project, besides providing the three educational sessions, the educator calls the patient and caregiver to discuss problems, problem-solving, and family dynamics. The educator makes a separate call to the caregiver; to talk to them about any issues that have come up that week, as well as whether they have been able to use the COPE problem-solving model. The educator inquires about any issues in the problem-solving arena, and if there is anything we can do to support the caregiver and patient.

Is there any inherent tension in doing this life closure work with patients who are engaged in clinical trials? Is that a tension that can even be resolved in terms of getting people to enroll in clinical trials? Many times patients, family members, and sometimes even physicians talk about the promise of clinical trials in ways that are a little disingenuous.

Well, I think that is absolutely true. I think that many patients want to go on clinical trials and they actually push the doctors to tell them about the clinical trials that are available to them. I've met with patients and caregivers who want to know what sites they can go to on the Internet to find out what trials are out there for their particular cancer. So, they actually feel short-changed if they are not presented with every alternative possible for curing their cancer.

In Sum

Developing a palliative care model is challenging. We want to create an integrated program, and we feel that we're providing services that patients and caregivers desperately need. So, we will continue to develop the model into something that the Cancer Center will see as the standard care that they need to provide. At the end of the project, we hope to have a dissemination conference for all of the cancer centers in the United States to describe what we're doing, and to train them to implement the COPE model in their facilities.

Ongoing Questions

What are your current burning questions about providing the best possible care for patients on clinical trials?

We want to contribute in a meaningful way to answering the question: "How can we support cancer patients and families to resolve the difficulties that they face during critical transition points in their care?" We know that patients and their families require support in how to manage the multiple problems associated with cancer. We feel that caregiver support is often overlooked in cancer care. So, that is something that we are very interested in addressing. If psychosocial issues for family are resolved prior to the death of the patient, we feel that the grief process of the caregiver and the family members should be lessened. We're going to find that out through our after-death survey, which we are going to be using with caregivers after the death of the patient.

The second question that we are working on is: "How do you institutionalize palliative care to be part of the care that's offered to all patients at the Cancer Center?" It seems that recruiting the expertise of clinicians from the fields of social work and nursing is one crucial element. We are also exploring how to provide patients and caregivers with skills to address the types of problems one faces at the end of life. Undoubtedly, part of the answer will come from measuring the impact of our efforts, and then using that evidence to modify our process as well as advocate for this kind of care.

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