The TEAM Approach to Improving Oncology Outcomes by Incorporating Palliative Care in Practice

Marie A. Bakitas, Areej El-Jawahri, Morag Farquhar, Betty Ferrell, Corita Grudzen, Irene Higginson, Jennifer S. Temel, Camilla Zimmermann, and Thomas J. Smith

Abstract

Palliative care (PC) concurrent with usual oncology care is now the standard of care that is recommended for any patient with advanced cancer to begin within 8 weeks of diagnosis on the basis of evidence-driven national clinical practice guidelines; however, there are not enough interdisciplinary palliative care teams to provide such care. How and what can an oncology office incorporate into usual care, borrowing the tools used in PC randomized clinical trials (RCTs), to improve care for patients and their caregivers? We reviewed the multiple RCTs for common practical elements and identified methods and techniques that oncologists can use to deliver some parts of concurrent interdisciplinary PC. We recommend the standardized assessment of patient-reported outcomes, including the evaluation of symptoms with such tools as the Edmonton or Memorial Symptom Assessment Scales, spirituality with the FICA Spiritual History Tool or similar questions, and psychosocial distress with the Distress Thermometer. All patients should be assessed for how they prefer to receive information, their current understanding of their situation, and if they have considered some advance care planning. Approximately 1 hour of additional time with the patient is required each month. If the oncologist does not have established ties with spiritual care and social work, he or she should establish these relationships for counseling as required. Caregivers should be asked about coping and support needs. Oncologists can adapt PC techniques to achieve results that are similar to those in the RCTs of PC plus usual care compared with usual care alone. This is comparable to using data from RCTs of trastuzamab or placebo, adopting what was used in the RCTs without modification or dilution.

INTRODUCTION

The benefits of structured, team-based, multidisciplinary palliative care (PC) concurrent with usual oncology care have now been demonstrated in multiple randomized trials in situations from metastatic lung cancer to hematopoietic stem cell transplantation. These benefits typically include better quality of life and symptom control, less anxiety and depression, greater prognostic awareness, less caregiver distress, equal or better survival, and equal or lower costs. (Table 1) These data are so compelling that ASCO has stated explicitly that “every patient with advanced cancer should be seen by a PC interdisciplinary team within 8 weeks of diagnosis—establishing a new standard of care.”

The data that demonstrate the superiority of PC are derived from trials that compared concurrent PC plus usual oncology care with usual oncology care alone—and usual
### Table 1. Summary of Recent Studies Comparing Usual Care With Usual Care Plus Palliative Care

<table>
<thead>
<tr>
<th>Study and Population</th>
<th>QOL</th>
<th>Symptoms</th>
<th>Anxiety</th>
<th>Caregiver Distress</th>
<th>Survival</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunley et al, 2007</td>
<td>NM, satisfaction increased</td>
<td>NM</td>
<td>NM</td>
<td>NM</td>
<td>=</td>
<td>$7,550 per person, ( P = .03 ) More likely to die at home, less likely to visit ED or be admitted to hospice</td>
</tr>
<tr>
<td>Gade et al, 2008</td>
<td>+, ( P = .04 )</td>
<td>NM</td>
<td>NM</td>
<td>NM</td>
<td>=</td>
<td>$4,885 per person, ( P = .001 ); fewer ICU admissions, ( P = .04 ); longer hospice stays, ( P = .04 )</td>
</tr>
<tr>
<td>Bakitas et al, 2009</td>
<td>+, ( P = .02 )</td>
<td>+, ( P = .06 )</td>
<td>Less depressed mood, ( P = .02 )</td>
<td>Longer, 5.5 months; ( P = .14 ) NS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temel et al, 2010</td>
<td>+, ( P = .03 )</td>
<td>7 lung cancer–specific symptoms better</td>
<td>Less depression, ( P = .01 )</td>
<td>Longer, 2.7 months; ( P = .02 )</td>
<td>Total cost was higher because patients lived longer, but cost per day was $117 lower( ^7 )</td>
<td></td>
</tr>
<tr>
<td>Farquhar et al, 2014</td>
<td>+ Reduced patient distress due to breathlessness, ( P = .049 )</td>
<td>NM</td>
<td>=</td>
<td>=</td>
<td>=</td>
<td>Total costs $354 ($444) less; better QOL; dominates cost-effectiveness</td>
</tr>
<tr>
<td>Zimmermann et al, 2014</td>
<td>+, ( P = .05 )</td>
<td>= at 3 months, ( P = .33 ) + at 4 months, ( P = .05 )</td>
<td>NM</td>
<td>Better satisfaction with care, ( P = .007 ); + QOL( ^5 )</td>
<td>=</td>
<td>NR</td>
</tr>
<tr>
<td>Higginson et al, 2014</td>
<td>+ Mastery of breathlessness, ( P = .048 ); Dyspnea =</td>
<td>=</td>
<td>=</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td>Bakitas et al, 2015</td>
<td>–, ( P = .30 )</td>
<td>–, ( P = .09 )</td>
<td>Mood =</td>
<td>Lower depression and stress, ( P = .02 ) and .01, but not QOL</td>
<td>Longer, 6.5 months; 1-year OS, 63% ν 48%; ( P = .038 )</td>
<td>NR; equal resource use</td>
</tr>
<tr>
<td>Ferrell et al, 2015</td>
<td>+, ( P &lt; .001 )</td>
<td>+, ( P &lt; .001 )</td>
<td>+, ( P &lt; .001 )</td>
<td>; better well-being and less distress, ( P = .001 ); less burden, ( P = .008 )</td>
<td>Longer, 6 months; NS, ( P = .20 )</td>
<td>NR; more ADs, 44% ν 9%, ( P &lt; .001 )</td>
</tr>
<tr>
<td>Grudzen et al, 2016</td>
<td>+, ( P = .03 )</td>
<td>ND</td>
<td>=</td>
<td>ND</td>
<td>Longer, 5.2 months; NS, ( P = .20 )</td>
<td>; note only 25%-28% use of hospice in both groups</td>
</tr>
<tr>
<td>Temel et al, 2016</td>
<td>= at week 12, ( P = .34 ); + at week 24, ( P = .01 )</td>
<td>NR</td>
<td>+, ( P = .048 ) +16</td>
<td>Too early to tell</td>
<td>NR; more likely to discuss EOL wishes, 30% ν 14.5%; ( P = .004 )</td>
<td></td>
</tr>
<tr>
<td>El-Jawahri et al, 2016</td>
<td>+ (smaller decrease), ( P = .005 )</td>
<td>Less, ( P &lt; .03 ) at 2 weeks; = at 3 months</td>
<td>Less, ( P &lt; .001 )</td>
<td>No change in QOL or anxiety; less depression, ( P = .03 ) +18</td>
<td>Too early to tell</td>
<td>NR</td>
</tr>
<tr>
<td>Maltoni et al, 2016</td>
<td>+, ( P = .04 )</td>
<td>NR; FACT-Hep, HCS, and TOI all better with PC</td>
<td>=</td>
<td>=</td>
<td>=; 1-year OS, 32%-37%</td>
<td>NR; improvements in use of chemotherapy in the last 30 days, hospice LOS, place of death</td>
</tr>
</tbody>
</table>

Abbreviations: +, improved; =, equal; AD, advance directive; BMT, bone marrow transplant; Ca, cancer; ED, emergency department; EOL, end of life; FACT–Hep, Functional Assessment of Cancer Therapy–Hepatobiliary; HCS, Hepatobiliary Cancer Subscale; LOS, length of stay; ND, not determined; NM, not measured; NR, not reported; NS, not significant; OS, overall survival; PC, palliative care; QOL, quality of life; TOI, Trial Outcome Index.
Concurrent Palliative Care in Oncology

oncology care alone was bested in all trials. There are ongoing trials to establish whether primary PC that is delivered by the oncology team alone is equal to specialty palliative care. The hypothesis of most of these trials is that oncology teams can do much of the work of specialty palliative care if the same tools and approaches are used that the concurrent PC teams use in clinical trials. Unless we use the same components of PC that are used in trials, usual oncology care remains usual oncology care, as would happen if the oncologist modified R-CHOP (rituximab plus cyclophosphamide, doxorubicin, vincristine, and prednisone) by leaving out vincristine and reducing the dose of cyclophosphamide by 50%.

What, then, is in the PC care team toolkit and how can oncologists adopt these techniques today in their practices?

THE TEAM APPROACH TO PC CONCURRENT WITH USUAL ONCOLOGY CARE

The TEAM approach (Time, Education, Assessment, and Management) components that have been distilled from clinical trials are listed in Table 2 and make it patient and family centered, education centered, and symptom centered. We include here the methods that were used in trials of an interdisciplinary team approach to concurrent PC or, in the case of Massachusetts General Hospital studies, an expert advance practice nurse or doctor backed by an interdisciplinary team if needed.

Time dedicated to identifying the patients’ understanding of their illness, treatment, and prognosis was a consistent factor in the success of all PC randomized clinical trials. Such discussions can take an extra hour per month and may be factor in the success of all PC randomized clinical trials. Such of their illness, treatment, and prognosis was a consistent doctor backed by an interdisciplinary team if needed.

Education was a component of all clinical trials. In the monthly visits with the PC team, patients and families can explore realistic options. Structured topics should include the identification of patients’ specific care goals, values and how to perform value-derived treatment and advance care planning decision-making. Prognostic awareness—understanding the nature of their condition as a life-limiting illness—seems to be key and requires coaching and direct communication by the health care provider. More than two thirds of patients with lung and colorectal cancer thought their palliative chemotherapy, radiation and/or surgery could cure them. An excellent communication guide—a manual to help practitioners increase prognostic awareness—is highly recommended. We have listed the important domains that are usually covered in Table 3.

The value of education is that patients with prognostic awareness, especially if advance medical directives were completed more than 30 days before death, die less often in the hospital (19% vs 50% in Australia) and use more hospice care and for longer duration. In a non–small-cell lung cancer trial by Temel, those in the PC group with greater prognostic awareness received intravenous chemotherapy near the end of life (EOL; ineffective fourth-line and fifth-line treatment; chemotherapy 9% of the time vs 50% in the usual care group).

Those who have EOL discussions—goals of care and/or understanding of illness—are more likely to be satisfied, to die at the place of their choosing, and to have less distressed relatives; however, we, as their oncologists, must start these conversations as people rarely bring it up themselves. Those who had prognostic discussions with their physicians revised their self-reported estimates downward by 17.2 months, more toward reality (months, not years), with no more depression, sadness, or anxiety, more advance directives, and better EOL care. Most PC practitioners use a standardized communication approach to identify what the patient and family knows and wants to know before wading into more sensitive and difficult topics, such as prognostic awareness and delivering bad news. We have found a temporary tattoo on the inner forearm that is visible to the oncologist or advance practice nurse to be helpful in remembering a way to get started with difficult conversations (Fig 1). After reviewing the four questions and getting to know the patient and assessing family understanding and goals, it is easier to do motivational interviewing. “You are doing OK now, but have you thought about a time in the future when you might be sicker, and need an advance directive or living will?”

A simple technique for oncologists to use is to address understanding and prognosis after any scan that shows progressive disease. A new study found that only four of 64 oncologist discussions about scan results had frank prognosis discussions. The authors suggested adding the question, “Would you like to talk about what this means?” to allow the patient some control as well as to obtain permission to disclose crucial information.
Using and responding to formal assessment by using standard tools is usually a first step for the PC team or the oncology team to get to know the patient. Starting with symptoms is safe. Symptom assessment scales were used in nearly all trials and can help identify how the patient and family are coping. The Edmonton Symptom Assessment System is a simple tool that measures nine common symptoms that are experienced by patients with cancer and can be completed in 5 minutes, although all available tools—Memorial Symptom Assessment Scale, MD Anderson Symptom Table 2. The Components of TEAM-Based Palliative Care

<table>
<thead>
<tr>
<th>Component</th>
<th>In the Trials</th>
<th>What Is Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>A structured palliative care visit of at least 1 extra hour per month; repeated at regular intervals (ie, monthly); not once</td>
<td>These assessments can be conducted by a physician or advanced practice nurse with specific training in conducting such assessments</td>
</tr>
<tr>
<td>Education</td>
<td>Structured, prospective, and recurrent discussions about symptoms, goals, and preferences for care, prognosis understanding, advance care planning, and communication with the health care team</td>
<td>Education that is done prospectively and regularly, rather than during a crisis is more effective. Usual topics include, on a recurring basis: Medically appropriate options for treatment; patients should know they have or have not left any medical stones unturned; this is best done by listing the treatments used and their outcomes, especially with recurrent disease; if appropriate, reinforce patient and family work as advocates. Advance care planning; durable power of attorney or proxy is not sufficient to change care patterns; a living will or advance directive is needed. Use of hospice for best possible care, and arranging a hospice information visit once it is evident the disease is going to take the person’s life, with 3–6 months to live or even longer</td>
</tr>
<tr>
<td>Assessment</td>
<td>Formal assessments for: Symptoms (ESAS, MSAS-C, CAPC rounding tool); Spirituality (FICA, or “Are you a religious or spiritual person?”); Distress (Distress Thermometer, others) Psychosocial (PHQ-2) Caregiver strain It is not sufficient to just ask “How are you?”; patients and families are sometimes reluctant to share their problems for fear that nothing can be done, or that it is not in the clinician’s remit, the oncologist will stop treating their cancer or they will be labeled a complainer</td>
<td>After these formal symptom assessments move onto goal setting We use questions such as: How do you like to get medical information? What is your understanding of your disease? What is important to you? What are you hoping for? Have you thought about a time when you might become sicker, such that you would need and advance directive or living will? (some motivational interviewing) We have incorporated this into a temporary tattoo that gives oncologists a script to start the most difficult discussions (Fig 1) If progressive disease is evident, it is time to revisit goals of care, prognosis understanding, and advance care planning</td>
</tr>
<tr>
<td>Management</td>
<td>By set protocols and an interdisciplinary team (APNs, social workers, chaplains, doctors)</td>
<td>Interdisciplinary care and referrals were common elements of all studies Giving people knowledge of their realistic options and a plan of action was shared across all the studies An oncology office that does not have established social work or chaplain ties should develop them, much as we develop ties with surgeons or radiation oncologists</td>
</tr>
</tbody>
</table>

Abbreviations: APN, advance practice nurse; CAPC, Center to Advance Palliative Care; ESAS, Edmonton Symptom Assessment Scale; FICA, Faith and Belief, Importance, Community, Address in Care; MSAS-C, Memorial Symptom Assessment Scale Condensed; PHQ-2, Patient Health Questionnaire-2.
Available from Thomas J. Smith for $0.50 each.

Patory care as calling patients the day after a new chemotherapy meeting to troubleshoot. Such forward thinking and anticipation are at risk for complications and discuss them at a weekly IDT. The IDT in place: Social workers, chaplains, advance practice nurses, and oncology nurses, psychologists, allied health professionals, and physicians. A key step is to identify patients who are needed to guide US cancer care with respect to the most efficient, yet effective, use of nonreimbursable support services.

Management by an interdisciplinary team was also a key component of randomized trials. In one Australian trial for patients receiving PC, a structured regular meeting of the interdisciplinary team (IDT) with recommendations to the primary care physician demonstrated significant improvement compared with practitioner education, with 26% fewer hospitalizations. Most practices will have some components of the IDT in place: Social workers, chaplains, advance practice oncology nurses, psychologists, allied health professionals, and physicians. A key step is to identify patients who are at risk for complications and discuss them at a weekly IDT meeting to troubleshoot. Such forward thinking and anticipatory care as calling patients the day after a new chemotherapy regimen has been a successful technique used by oncology medical home models, which has led to reduced hospitalizations and lower costs.

We do not yet know which components of the multidisciplinary team are essential. When Muir et al delivered PC in oncology offices with just a physician and advance practice nurse, they showed better symptom management with a 21% decrease in symptom burden, an increase in oncologist satisfaction (necessary for them to continue to work with oncologists), and an 87% increase in consultations in 2 years. They saved each oncologist more than 4 weeks of time so that the practice could do more regular oncology, and eased the oncologist’s burden as one strategy to avoid burnout. It is our opinion that these services are essential, and in our experience, providers, patients, and families greatly appreciate them, so we incorporate them within the budget. Most practices have financial counseling available, but psychosocial counseling, such as social workers or chaplains, are uncommon. Some nonreimbursable services, such as chaplaincy or a social worker, may require more formal testing before endorsement. US Oncology has adopted the best practice model of appointing someone in the office—usually a social worker or nurse—to review with a patient advance care planning within the first visits of a diagnosis of a life-limiting illness. Advance care planning was also increased substantially, with some practices having completed advance medical directives in up to 89% of patients. More evidence is needed to guide US cancer care with regard to the most efficient, yet effective, use of nonreimbursable support services.

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The electronic health record may assist oncology practices with some aspects of incorporating PC and oncology care. For example, formal goals of care discussions can be formatted in the note template to capture some of the practical parts of these difficult conversations. This is similar to bringing up laboratory values or radiographs on the computer screen; we bring up the EPIC SmartPhrase to help remind and guide us in critical conversations, then type in the answers and print for the patient information part of meaningful use. Notes that contain this crucial information are easy to send to referring health care practitioners so that all can be on the same page (Table 4). Such an approach is now being used in a phase I study of patients receiving concurrent care and seems to be a useful work-simplifying tool.

WHAT ARE SOME OF THE CHANGES IN CARE THAT PC INVOLVEMENT BRINGS?

In addition to the changes in symptoms and quality of life noted in Table 1, PC involvement changes the course of care near...
EOL. As a matter of course, we discuss the goals of care and set up a hospice information visit when the patient has an estimated prognosis of 6 months, the current timeframe suggested by ASCO University. If the PC team sees the patient as an inpatient, the 30-day readmission rate is cut from 15% to 10%. If, during that consultation, we have the goals of care discussion, the 30-day readmission rate is decreased from 10% to approximately 5%. Similar results were observed in a hospital–hospice partnership with a five-fold reduction in 30-day readmission (1% v 5%).

PC involvement gets more people to hospice and for longer. If the PC team saw patients who were eligible for hospice, 57% went home with hospice. If the PC team did not see them because the consultation was blocked by the

### Table 3. Palliative Care Intervention Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Elements</th>
<th>Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic relationship</td>
<td>Introducing the role of palliative care</td>
<td>Develop a strong therapeutic relationship with patients and caregivers</td>
</tr>
<tr>
<td></td>
<td>Understanding the patient and caregiver experience</td>
<td>Learn about the values, life goals, and experiences of patients and their caregivers, both before and after cancer diagnosis</td>
</tr>
<tr>
<td></td>
<td>Building trust with the patient and caregiver</td>
<td>Develop trust and credibility with patients and caregivers by providing reassurance and outlining parameters of communication</td>
</tr>
<tr>
<td>Assessment and treatment of patient symptoms</td>
<td>Preparing for symptoms</td>
<td>Clarify the symptoms the patient will likely experience and offer reassurance about the methods for reporting and treating symptoms</td>
</tr>
<tr>
<td></td>
<td>Assessing and treating symptoms</td>
<td>At every visit, elicit existing and new symptom concerns with emphasis on common symptoms (nausea, pain and mucositis, fatigue, sleep disturbances, constipation, diarrhea, anxiety, and depression)</td>
</tr>
<tr>
<td></td>
<td>Coordinating symptom management with the primary team</td>
<td>Maintain ongoing, effective communication with other clinicians to define mutual collaboration and work within their preferred practice patterns</td>
</tr>
<tr>
<td></td>
<td>Providing referral for symptom management</td>
<td>Emphasize a team approach to care by referring to specialty care, mental health, alternative medicine, and spiritual support as needed</td>
</tr>
<tr>
<td>Managing patients and caregivers expectations</td>
<td>Reviewing in detail the expected illness trajectory during the illness</td>
<td>Address early on patients and caregivers’ concerns about the trajectory of illness and treatment adverse effects</td>
</tr>
<tr>
<td></td>
<td>Ensuring accurate expectations throughout treatment</td>
<td>Recognize that illness acceptance involves cognitive, emotional, and behavioral elements and offer a safe venue for patients and caregivers to ask questions about their disease and treatment options</td>
</tr>
<tr>
<td></td>
<td>Enhancing patients’ and caregivers’ understanding and acceptance of the illness</td>
<td></td>
</tr>
<tr>
<td>Coping with illness and treatment</td>
<td>Reviewing and validating prior coping efforts</td>
<td>Recognize that patients and caregivers bring their own expertise in coping with the current circumstance on the basis of prior experiences</td>
</tr>
<tr>
<td></td>
<td>Discussing and advocating for different methods of coping</td>
<td>Introduce strategies to help improve adjustment (eg, behavioral, cognitive, and spiritual approaches; accepting illness while maintaining hope; social support)</td>
</tr>
<tr>
<td></td>
<td>Supporting caregiver coping</td>
<td>Bolster caregiver coping by assessing burden, enhancing their communication with patients, and recommending additional support</td>
</tr>
<tr>
<td></td>
<td>Providing referral for additional support</td>
<td>Involve other members of the team for patients and caregivers who may be experiencing severe distress (eg, social work, psychology, chaplaincy)</td>
</tr>
</tbody>
</table>

NOTE. Modified from El-Jawahri et al17 and Temel et al.4 These were used by the palliative care specialist to guide the intervention. The oncologist can adapt as needed.
attending physician or came too late, only 27% went home with hospice.\textsuperscript{45} Patients who received a PC team consultation were 3.24 times more likely to be discharged to hospice (\(P\), .001), 1.52 times more likely to be discharged to a nursing facility, and 1.59 times more likely to be discharged home with services (\(P < .001\)).\textsuperscript{46} In New York Medicaid patients, referrals to hospice increased more than 10-fold if the PC team saw them.\textsuperscript{47} Going home with hospice means a 5%

### Table 4. Goals of Care Discussion Template for EPIC, Cerner, or Other Electronic Medical Records

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you like to get medical information?</td>
<td>Full or something else?</td>
</tr>
<tr>
<td>How about prognosis?</td>
<td>What is your understanding of your situation?</td>
</tr>
<tr>
<td>What is important to you?</td>
<td>What are you hoping for?</td>
</tr>
<tr>
<td>If the disease is growing, acknowledge that not all things have a medical fix</td>
<td>Ask if the patient would like to discuss what the scan findings mean?</td>
</tr>
<tr>
<td>List the prior treatments and response to give the patient a record of what was done; it may be important for families to leave no medical stones unturned</td>
<td>Explore if the patient is eligible for clinical trials</td>
</tr>
<tr>
<td>Advance care planning</td>
<td>Do you have a will? (safe starter question)</td>
</tr>
<tr>
<td>Do you have a living will, advanced directive, or portable orders for life-sustaining treatments? (eg, POLST)</td>
<td>Are all of your providers aware of the wishes and proxy for your medical care that are stated in these documents?</td>
</tr>
<tr>
<td>Are documents readily available in your electronic health records and for all of your health care providers?</td>
<td>What does it say about CPR? (For patients imminently dying in the hospital of their cancer, the success rate of CPR is zero.)</td>
</tr>
<tr>
<td>Who do you want to make medical decisions, if you cannot?</td>
<td>Have you discussed this with her/him?</td>
</tr>
<tr>
<td>Are there spiritual issues to be settled?</td>
<td>Have you thought about where you would like to be for your death, if and when?</td>
</tr>
<tr>
<td>Are there family issues to be settled?</td>
<td>Explore if the patient is eligible for clinical trials</td>
</tr>
<tr>
<td>Are there financial issues to be settled?</td>
<td>Advance care planning</td>
</tr>
<tr>
<td>Have you met with hospice yet? (Plan for at least 3-6 months before death, which for most diseases is predictable; this really helps the transition if and when hospice is needed.)</td>
<td>Have you discussed this with her/him?</td>
</tr>
<tr>
<td>Have you thought about where you would like to be for your death, if and when?</td>
<td>Advance care planning</td>
</tr>
<tr>
<td>Let’s start doing a life review—what you want people to remember about you.</td>
<td>Advance care planning</td>
</tr>
<tr>
<td>And, what’s important to you?</td>
<td>Have you discussed this with her/him?</td>
</tr>
<tr>
<td>What are you hoping for?</td>
<td>Have you thought about where you would like to be for your death, if and when?</td>
</tr>
<tr>
<td>What do you want to accomplish in the time you have?</td>
<td>Live day to day</td>
</tr>
<tr>
<td>Exercise</td>
<td>How to call or reach me</td>
</tr>
<tr>
<td>Diet</td>
<td>Office</td>
</tr>
<tr>
<td>Other instructions</td>
<td>Days</td>
</tr>
<tr>
<td></td>
<td>Nights</td>
</tr>
<tr>
<td></td>
<td>Cell</td>
</tr>
<tr>
<td></td>
<td>E-mail</td>
</tr>
</tbody>
</table>

NOTE. Fill in as you interview on the screen, then print for the patient and family. It can be done on several visits and updated as the situation changes. Abbreviation: POLST, Physician Orders for Life-Sustaining Treatment.
30-day readmission rate versus a 25% rate for matched patients who did not go home with hospice.\textsuperscript{48}

If PC is provided with an outpatient evaluation in the clinic, the length of stay in regular hospice is increased from 15 to 24 days ($P < \cdot .001$).\textsuperscript{49} In one cancer center, if the PC team saw the patient more than 1 month before death, the patterns of care changed, with fewer EOL hospitalizations and $6,687$ in lower health system costs.\textsuperscript{50} From the pioneering study in lung cancer by Temel, PC was associated with increased hospice length of stay, lower daily costs, and equal costs despite living 2.7-months longer.\textsuperscript{5}

Hospice, in turn, improves care\textsuperscript{51} and likely improves survival.\textsuperscript{52,53} In one study, longer survival was associated with a 3.74-fold-lower likelihood to have high EOL care costs,\textsuperscript{54} and Medicare data show that hospice saves $8,700 per patient.\textsuperscript{55}

Oncologists can improve their performance with hospice length of stay by making it a quality assurance issue. Constructive feedback to oncologists that compares them with their peers and national averages for hospice length of stay led to a doubling of hospice length of stay within 1 year, from 19.7 days to 39.6 days.\textsuperscript{56}

**DISCUSSION**

Specialist-based PC—initiated soon after a cancer diagnosis—demonstrates improvements in quality of life, mood, symptoms, and, at times, survival. These data are strong for beginning such care as an outpatient, although the introduction of PC principles in the emergency department or as an inpatient has demonstrated positive outcomes as well. An oncologist would not wait to use trastuzumab in patients with human epidermal growth factor receptor 2–positive breast cancer until the eighth randomized trial showed exactly which regimen was absolutely the best. Immediately after those landmark studies, we adopted the methods used in these clinical trials that demonstrated so much benefit and have been modifying our protocols as new data become available. It is time to do the same with concurrent PC.

It is critical to distinguish PC from hospice care, the most common subtype of PC familiar to most oncologists (Box 1). We are still surprised how frequently we hear, “Oh, she’s not ready for palliative care yet.” Hospice care is administered to those who have no curative options and who have less than 6 months to live, if the disease process runs its natural course, with proven benefits as described above. PC can and should be provided with concurrent cancer-directed treatment on the basis of need rather than prognosis. Despite the well-established benefits, only approximately one half of all patients who are dying of cancer are comanaged by hospice, and at least one third use hospice for less than 1 week, a marker of poor quality of care.

A compelling business case—outlined in the ASCO guidelines—can be made for the incorporation of PC to reduce costs by improving the quality of care that people receive near EOL to what they actually want, if those wishes are discerned. Every study, to date, has shown that inpatient PC consultations

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### BOX 1. Distinguishing Hospice From Palliative Care

**Hospice Care**

Hospice is a type and philosophy of care that focuses on the palliation of a terminally ill patient’s symptoms by providing care, not curing.

It is used when there are no longer curative options or reasonable options.

In the United States, hospice care is generally restricted to those who have less than 6 months to live, and must cover all expenses with per diem payment of about $150.

**Palliative Care**

“Palliative care is specialized medical care for people with serious illness. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of palliative care doctors, nurses, and others who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.”

– Diane Meier, MD, Director, Center to Advance Palliative Care\textsuperscript{57}
improve care and with equal or lower costs. Such strategies will be essential to make room in the current system for ever-increasing care costs but that were never the intent of PC.

In summary, oncologists can and must learn to adopt the techniques used in the trials of specialty PC concurrent with usual oncology care, just as we learned to administer nivolumab when the clinical trial evidence was compelling. The TEAM approach is a good way for oncologists to start incorporating these techniques.

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References
18. VanDusen H, LeBlanc TW, Traeger L, et al, Inpatient integrated palliative and transplant care to improve family caregiver (FC) outcomes of patients hospitalized for hematopoietic stem cell transplantation (HCT). J Clin Oncol 34, 2016 (suppl 26s; abstr 235)
56. Van Gunten CF. A quality improvement approach to oncologist referrals for hospice care. J Clin Oncol 34, 2016 (suppl 26s, abstr 45)
57. Center to Advance Palliative Care: About palliative care. https://www.capc.org/about/palliative-care/
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