



**The Integration of Palliative Care into Standard Oncology  
Care: American Society of Clinical Oncology Clinical  
Practice Guideline Update**

# Introduction

- The purpose of this version of the American Society of Clinical Oncology (ASCO) guideline is to update the ASCO Provisional Clinical Opinion (PCO) (2012) on the integration of palliative care into standard oncology care, and transition the content into a guideline.
- Patients with advanced cancer are defined as those with distant metastases, with late-stage disease, cancer that is life-limiting and/or with prognosis of 6-24 months.
- This update includes nine RCTs, as well as one quasi-experimental study, and five secondary publications from previously reviewed RCTs.
- It reviews and analyzes new and updated evidence on early palliative care, including for patients in both inpatient and outpatient settings, the components and triggers for offering patients palliative care, palliative care services for family caregivers, and how oncology professionals and other clinicians can provide palliative care, in addition to palliative care specialists.

# ASCO Guideline Development Methodology

The ASCO Clinical Practice Guidelines Committee guideline process includes:

- a systematic literature review by ASCO guidelines staff
- an expert panel provides critical review and evidence interpretation to inform guideline recommendations
- final guideline approval by ASCO CPGC

The full ASCO Guideline methodology supplement can be found at:

[www.asco.org/palliative-care-guideline](http://www.asco.org/palliative-care-guideline)

# Clinical Questions

This clinical practice guideline addresses six overarching clinical questions:

- (1) What is the most effective way to care for patients with advanced cancers' symptoms?
- (2) What are the most practical models of palliative care?
- (3) How is palliative care in oncology defined or conceptualized?
- (4) How can palliative care services relate in practice to other existing/emerging services?
- (5) Which interventions are helpful for Family Caregivers?
- (6) Which patients should be offered/or referred to palliative care services, when in their disease trajectory, and are there triggers that should be employed to prompt specialty palliative care referrals?

# Target Population and Audience

## Target Population

Patients with advanced cancer and their caregivers

## Target Audience

Oncology clinicians, patients, caregivers, palliative care specialists

# Summary of Recommendations

## CLINICAL QUESTION 1

What is the most effective way to care for patients with advanced cancers' symptoms (palliative care services in addition to usual care, compared with usual care alone)?

### *Recommendation 1*

Patients with advanced cancer should be referred to interdisciplinary palliative care teams (consultation) that provide inpatient and outpatient care early in the course of disease, alongside active treatment of their cancer (Type: evidence based, benefits outweighs harms; Evidence quality: intermediate; Strength of recommendation: strong).

# Summary of Recommendations

## CLINICAL QUESTION 2

What are the most practical models of palliative care? Who should deliver palliative care (external consultation, internal consultations with palliative care practitioners in the oncology practice, or performed by the oncologist her/himself) ?

### *Recommendation 2*

Palliative care for patients with advanced cancer should be delivered through interdisciplinary palliative care teams, with consultation available in both outpatient and inpatient settings (Type: evidence based, benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).

# Summary of Recommendations

## CLINICAL QUESTION 3

How is palliative care in oncology defined or conceptualized?

### ***Recommendation 3***

Patients with advanced cancer should receive palliative care services, which may include a referral to a palliative care provider. Essential components of palliative care include:

- rapport and relationship building with patient and family caregiver(s)
- symptom, distress, and functional status management (i.e. pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation)
- exploration of understanding and education about illness and prognosis
- clarification of treatment goals
- assessment and support of coping needs (e.g., provision of dignity therapy)
- assistance with medical decision making
- coordination with other care providers
- provision of referrals to other care providers as indicated.

For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement, starting early in the diagnosis process and ideally within 8 weeks of diagnosis (Type: informal consensus; Evidence quality: intermediate; Strength of recommendation: moderate).

# Summary of Recommendations

## CLINICAL QUESTION 4

How can palliative care services relate in practice to other existing or emerging supportive care services (including nurse navigation, lay navigation, community and home health care, geriatric oncology, psycho-oncology, and pain services)?

### ***Recommendation 4***

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

# Summary of Recommendations

## CLINICAL QUESTION 5

Which interventions are helpful for family caregivers?

### *Recommendation 5*

For patients with early or advanced cancer for whom family caregivers will provide care in outpatient, home, or community settings, 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 FCGs who may live in rural areas and/or unable to travel to clinic and/or longer distances, telephone support may be offered (Type: evidence-based; Evidence quality: low, Strength of recommendation: weak).

# Summary of Recommendations

## CLINICAL QUESTION 6

Which patients should be offered/or referred to palliative care services, when in their disease trajectory, and are there triggers that should be employed to prompt specialty palliative care referrals?

### *Special Commentary*

Interventional studies support early specialty palliative care referrals among patients with cancer and their caregivers (FCGs) with advanced stage malignancies. However, additional triggers should be considered among all patients with cancer to ensure prompt referrals to specialty palliative care services for patients at high risk for specialty palliative care needs. Furthermore, oncologists should be educated in primary palliative care competencies and regularly assess triggers for palliative care specialty services as part of their care to patients with cancer and their FCGs. Further studies are needed to better define triggers for meeting unmet specialty palliative care needs in the population of patients with cancer.

# Patient and Clinician Communication

- A key component in retrospective analyses has been the performance of a “goals of care” discussion that entails asking about:
  - Knowledge of the illness
  - Realistic options for treatment
  - Planning for the future
- If such discussions are held, care at the end of life improves, and is more consonant with what most people want.
- The stage IV NSCLC guideline also suggests inquiry about psychological and spiritual care, social support, assessing FCG needs, and physician self-care. Please see the Palliative Care and Patient and Clinician Communications sections of the 2015 guideline, as well as its Data Supplement, which includes Sample Talking Points at [www.asco.org/guidelines/nsclc](http://www.asco.org/guidelines/nsclc)

# Health Disparities

- Clearly, further research involving people of color and/or with low socio-economic status and/or participants from other underrepresented groups is needed.
- It is not within the scope of this guideline to examine specific factors contributing to disparities; however, given the relatively recent publication of research and guidelines on palliative care, it is likely that dissemination is occurring slowly, especially in populations already experiencing health disparities and/or populations with cultures differing from those in research to date.
- Awareness of the disparities in access to palliative care should be considered in the context of this clinical practice guideline, and health care providers should strive to deliver the highest level of cancer care to these vulnerable populations.

# Multiple Chronic Conditions

- It is important to note that elderly patients most often have multiple chronic illnesses and with the aging population it is expected that this problem will increase.
- In addition, the best available evidence for treating index conditions, such as cancer, is often from clinical trials whose study selection criteria may exclude these patients in order to avoid potential interaction effects or confounding of results associated with MCC.
- As a result, the reliability of outcome data from these studies may be limited, thereby creating constraints for expert groups to make recommendations for care in this heterogeneous patient population.
- As many patients for whom guideline recommendations apply present with MCC, any treatment plan needs to take into account the complexity and uncertainty created by the presence of MCC and highlights the importance of shared decision making regarding guideline use and implementation.

# Cost Implications

## *How is palliative care reimbursed?*

- Palliative care is reimbursed as a medical specialty comparable to oncology or hematology. Hospice and Palliative Medicine was made an official medical subspecialty in the U.S. in 2006 and received a Medicare billing identifier in 2008. The physician and advance nurse practitioner can bill for Medicare professional time and palliative care services, but the other members of the inter-disciplinary team such as the chaplain and social worker cannot bill for palliative care services directly, so some other provision must be made for them.

## *What other resources are available to support palliative care, such as cost-avoidance to the practice and health system? What is the business case for palliative care?*

- The primary impetus for hospice and subsequently palliative care was to improve quality of life and symptom management. Hospice has been proven over many years to improve symptoms, reduce patient and caregiver distress, produce equal or even better survival compared to those who do not use hospice, and improve the chance of dying where one desires, usually at home.

# Guideline Implementation

- ASCO guidelines are developed for implementation across health settings.
- Barriers to implementation include the need to increase awareness of the guideline recommendations among front-line practitioners and patients with cancer and their caregivers, and also to provide adequate services in the face of limited resources.
- In addition, there are not enough palliative care providers to do the needed consultations, so oncologists will have to adopt the practices of palliative care and implement primary palliative care in their offices.
- This guideline will be distributed widely through the ASCO Practice Guideline Implementation Network. The guideline Bottom Line Box was designed to facilitate implementation of recommendations.

# Limitations of the Research

Research to date has made great strides, but some of the studies faced limitations, for example:

- The field of palliative care research began relatively recently.
- Research funding for palliative care has been limited, therefore outcome data are very limited (90% of hospitals have funding for palliative care services, but few have funding for research).
- The majority of the research has been in patients with solid tumors and more research is needed across tumor types and in hematology.
- Research in health disparities in palliative care is lacking.
- Some studies were single site, which can limit generalizability, and/or small sample size and/or short follow-up.

# The acronym T-E-A-M describes the common attributes of successful palliative care used in the clinical trials.

- Time: at least an extra hour a month with the patient and family.
- Education: about prognosis, options, advance care planning, use of hospice.
- Assessments: formal symptom, spiritual, and distress assessments.
- Management: by an interdisciplinary team.

Sources: Leong, Shah, and Smith, JOP 2017//TS PPT 23 May 2016, JHU

[www.asco.org/palliative-care-guideline](http://www.asco.org/palliative-care-guideline)

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Time:  $\geq 1$  hour/month. Does not have to be oncologist, but with someone. Can be over the phone.

Education: to address difficult issues.

**Assessment Tools - Pain and Symptom**

**Management tools – Measure and Evaluation**

**Tools - National Palliative Care Research**

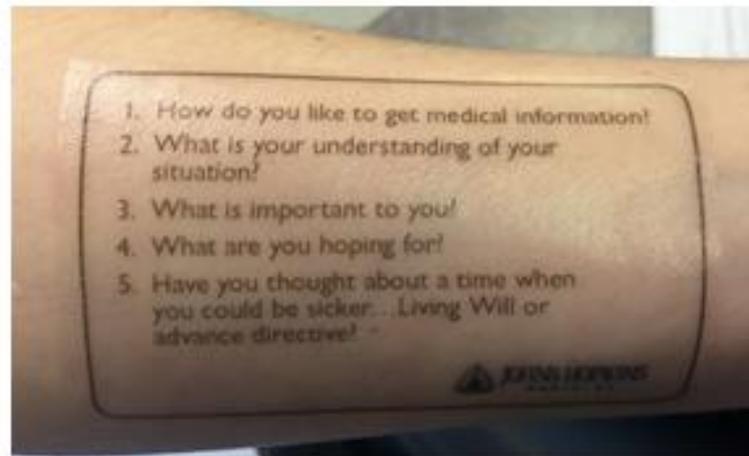
**Center - <http://www.npcrc.org/content/25/Measurement-and-Evaluation-Tools.aspx>**

JHU clinicians may use this palliative care temporary tattoo to remember to address the important issues that may not be covered by the oncologist in a routine visit. This temporary tattoo is available from Tom Smith at a minimal cost and lasts about 10 days.

## TEAM Concept in Palliative Care

### Assessment: Start with Communication Prompts

1. How do you like to get medical information?
2. What is your understanding of your situation?
3. What is important to you?
4. What are you hoping for?
5. Have you thought about a time when you could be sicker...Living Will or advance directive?



# Limitations of the Literature and Future Directions

To enhance and strengthen the evidence base on palliative care, the dissemination of research results, and the quality and equity of palliative care, more research is needed; specific areas include:

- Identifying the specific elements, such as skills and personnel that make the difference seen in research
- Identifying triggers for palliative care
- Including patients with cancers of types not represented in earlier trials, especially hematologic cancers
- More research on the role of palliative care for patients with early stage disease.
- Elucidating health disparities specific to palliative care, for purposes including to: identify disparities, barriers, determinants in receipt and quality of palliative care, and on evidence-based interventions to address disparities
- On family caregivers
- Including patients with advanced cancer in early phase clinical trials

# Additional Resources

More information, including a Data Supplement, a Methodology Supplement, slide sets, and clinical tools and resources, is available at

[www.asco.org/palliative-care-guideline](http://www.asco.org/palliative-care-guideline)

Patient information is available at [www.cancer.net](http://www.cancer.net)

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