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Editorial

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Models For Palliative Care For Cancer Patients

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Introduction

Palliative care has evolved over the past five decades as an interprofessional specialty to enhance quality of life and quality of look after patients with cancer and their families. Existing evidence supports that timely involvement of specialist palliative care teams can enhance the care delivered by oncology teams. This review provides a state-of-the-science synopsis of the literature that supports each of the five clinical models of specialist palliative healthcare delivery , including outpatient clinics, inpatient consultation teams, acute palliative care units, community-based palliative care, and hospice care. The roles of embedded clinics, nurse-led models, telehealth interventions, and first palliative care also are going to be discussed. Outpatient clinics represent the key point of entry for timely access to palliative care. During this setting, patient care are often enhanced longitudinally through impeccable symptom management, monitoring, education, and advance care planning. Inpatient consultation teams provide expert symptom management and facilitate discharge planning for acutely symptomatic hospitalized patients. Patients with the very best level of distress and complexity may enjoy an admission to acute palliative care units. In contrast, community-based palliative care and hospice care are more appropriate for patients with a poor performance status and low to moderate symptom burden. Each of those five models of specialist palliative care serve a special patient population along the disease continuum and complement each other to supply comprehensive supportive care. Additional research is required to define the standards for palliative care interventions and to refine the models to further improve access to quality palliative care.

Over the past five decades, palliative care has evolved from a philosophy of care that focuses on the last days of life to knowledgeable specialty that delivers comprehensive supportive care to patients with advanced illnesses throughout the disease trajectory. Conceptualized by Dame Cicely Saunders within the 1960s, the primary model of care was community-based hospice care. within the 1970s, Balfour Mount coined the term palliative care and began the primary palliative care unit in an acute care academic hospital in Montreal. This model of inpatient care was widely accepted and contributed to a rapid climb in inpatient palliative care teams worldwide. within the 1990s, several palliative care teams began to see patients in outpatient clinics, which paved the way for patients to realize access to palliative care earlier within the disease trajectory. Over the past decade, multiple landmark clinical trials confirmed the advantages of outpatient palliative care, which stimulated more interest and growth during this field. The model of palliative care continues to evolve to raised serve a growing number of patients throughout the disease continuum while adapting to an aging population and therefore the ever-changing landscape of novel cancer therapeutics. On the idea of the consolidated body of evidence, ASCO has published multiple statements to support the mixing of palliative care, with a vision toward comprehensive cancer care by 2020.

Currently, the five major service delivery models of specialist palliative care, namely outpatient palliative care clinics, inpatient palliative care consultation teams, acute palliative care units (APCUs), community-based palliative care, and hospice care, complement each other to supply comprehensive supportive care from diagnosis to the top of life. These five services differ in their team structures, care processes, patient populations, location of care, and reimbursement models. Specialist palliative care, delivered by individuals with specialized training and expertise, complements and augments primary palliative care, which is basic symptom management and communication provided by nonpalliative care clinicians. during this article, we review the literature that supports each of the five specialist palliative care service delivery models and their variations. Conceptual models and first palliative care are discussed elsewhere.

Elements of Effective Models of Palliative Care

This review identified variety of dynamic elements that are integrated into palliative care models during a range of care settings to enable access to appropriate services, improve communication and coordination between providers, enhance palliative care skills of non-specialist and informal carers, and increase capacity to reply rapidly to individual patient needs and preferences as these change over time.

Case management

Case management may be a recurring feature of the many successful model that seeks to assess and meet the complete range of every individual's palliative care and other needs, including those concerning activities of daily living (e.g. house-work) and social wellbeing. As a result, case management frequently requires coordination of services beyond the healthcare sector, including social services and pastoral care. Case management is informed by the principles of patient-centred care intrinsically , patients and families themselves often play a lively role in determining which services they receive.

Shared care

Whilst definitions of shared care have varied, it's been frequently reported as a component of effective palliative healthcare delivery , utilised by variety of various models. Characteristics of shared care seem to possess commonly included: an identifiable lead clinician working alongside health professionals from other disciplines, attention on communication and coordination, and a rapid needs-based response and navigational strategies.

A model of care that comes with case management and shared care and has been recommended by policy in Australia within the absence of evaluation data is that the 'pop up' model. This model was originally developed to increase palliative care to rural/remote adult

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services and has since been recommended for paediatric palliative care. The model develops a rapid-response team round the patient and their family drawn from primary, community-based and SPC services as needed to deal with each client's care plan. The model relies on excellent coordination, established networks and a system of triggers for referrals, re-assessments and re-referrals to supply intensive support over brief periods. In the UK, a coordinating role for an identical model has been assigned to paediatric oncology outreach nurse specialists to support children dying from cancer The outreach nurse role is described as 'empowering the first healthcare team through advice and direct patient care; providing an interface between primary, secondary, and tertiary care services; and coordinating services.

Specialist outreach services

Internationally, specialist outreach services are widely adopted to enhance care outcomes for underserved populations through the establishment of: i) specialist clinics in urban medical care practices; ii) specialist clinics in rural hospitals where no specialist services exist; and iii) sub-specialist clinics in regional centres. A Cochrane review examined efficacy of specialist outreach services in medical care and rural hospital settings implemented together element of complex multifaceted interventions involving collaboration with medical care , education or other health services. This review concluded that specialist outreach services can improve health outcomes, ensure delivery of more efficient and consistent evidence-based care, and reduce the utilization of inpatient services. the extra costs related to the supply of specialist outreach appear to be balanced by improved health outcomes. None of the studies within the review included comparisons of palliative care specialist outreach services; their widespread use raises a requirement for evaluation.

Managed clinical networks and/or health networks (clinical networks)

Across the world , clinical networks are integrated into many healthcare systems as a part of a wider reform agenda to make sure that underserved populations and people with poorer outcomes have better access to quality, clinically-effective health services. Clinical networks facilitate the formal linking of groups of health professionals and organisations from primary, secondary and tertiary care to figure during a coordinated manner, unconstrained by existing professional and organisational boundarie. Many of those boundaries are driven by funding models and geographical boundaries. Although conceptually appealing, few empirical studies are undertaken to guage the effectiveness of clinical networks. A literature review identified eight empirical studies, including comparative and observational designs. The review concluded that clinical networks - when formally established, with governance and guidelines in situ - facilitated access to worry for people in underserved communities.

Integrated care

Numerous studies identified the crucial role of integrated care. Integration refers to coordination of disparate services centred on the requirements of every individual patient and family with the aim of ensuring continuity of care. Integrated care requires that patients and families are involved in informed decision-making and goal setting. it's supported principles of advocacy and respect that provide seamless, continuous care from referral through to bereavement and across organizational boundaries. Positive effects of integrated care in paediatrics are demonstrated not just for patient and family outcomes, but also on organisational efficiencies and staff satisfaction.

Integrated care is particularly important when supporting adults or children within the community, the enablement of which is increasingly prioritised by policy in many countries. While the role of medical care at the top of life is vital everywhere, palliative care support for primary healthcare is most essential in rural and regional areas, where the burden for coordinating and providing medical aid falls predominantly on general practitioners (GPs) and medical care to community nurses. Data suggest that in some jurisdictions, including Australia, many GPs want to be involved in palliative healthcare delivery but have decreasing capacity to undertake visits to homes or aged care facilities thanks to workload, time constraints and inadequate remuneration. Whilst there are not any evidence-based models for palliative care within the primary healthcare setting, there's emerging evidence that the UK's Gold Standards Framework (GST) has improved communication, collaboration, assessment and planning since its introduction in 2001. It should be noted, however, that the UK's National Health Service has unique drivers not readily transferrable to countries like Australia with different healthcare funding models and multiple jurisdictions. Increasing complexity in commission configuration warrants consideration by future research of the roles played by contextual factors like funding and policy so as to tell planning at the population level. Research should ideally test the impact of changes over time both within and between regions using standard measures of process and outcomes.

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