From the perspective of older patients, quality of care for serious illness in the primary care setting includes aspects of care such as shared decision making, coordination of care, and a clinician who is knowledgeable, skillful, and compassionate. But the most important aspect, and the one that ties all others together, is patient-centered communication.

“Our results suggest a relationship between communication and all other themes,” write the authors of a report published in the American Journal of Hospice and Palliative Medicine. “These themes demonstrate the essence of patient-centeredness, as patients perceive it.”

Primary care is an increasingly important setting for the care of older patients with serious illness, note the authors. However, recent initiatives to improve such care rarely incorporate the perspectives of seriously ill older patients themselves. Understanding the aspects of care these patients deem important can help improve the quality of care delivery.

Investigators analyzed interview responses of older, community-dwelling patients (n = 20; mean age, 70.6 years; female, 65%; white race, 75%) who were living with or at risk for serious illness in 2016 and had participated in a quality improvement initiative for advance care planning at an academic primary care clinic. Five key themes emerged.

**KEY THEMES OF QUALITY CARE**

**Patient-centered communication.** This predominant theme was deemed most important by all participants, and intersected with all other themes. Patients appreciated detailed explanations regarding their diagnoses, the relevance of tests and treatment, treatment options based on their expressed preferences, and the expected impact of their illness on their quality of life.

**Coordination of care.** Patients felt that their primary care physicians played a central role in coordinating care with specialty and other clinicians. They considered that at the heart of quality integrated care was communication to ensure that all clinicians responsible for their care were informed about each other’s involvement and about the goals of care.

**Shared decision making.** Patients saw decision making as an interactive process, and appreciated when their primary care clinician presented different treatment options to choose from and educated them about their care. Again, communication was the unifying theme.

**Clinician competence.** Patients emphasized the importance of both clinicians’ knowledge of and expertise in treating older persons with serious illness and their use of a compassionate, comprehensive approach to care, treating the patient as a whole person, listening, and responding to their unique needs.

**Access to care.** Older patients found access to care challenging, but were willing to sacrifice convenience of location for access to high-quality care.

Lay Health Worker Intervention Improves Satisfaction and Outcomes Among Advanced Cancer Patients

Use of a lay health worker (LHW) to help patients with advanced cancer consider and document their goals of care not only increased patient-physician discussions of preferences, but also led to improved patient satisfaction, fewer ED visits and hospitalizations, and greater use of hospice, according to a study published in *JAMA Oncology.*

“[L]ess than half of the patients in the United States with terminal illnesses have their end-of-life wishes documented,” write the authors. “We provide evidence that an LHW trained to assist with end-of-life care integrated into usual cancer care can effectively address this deficiency.”

Investigators analyzed results of a randomized clinical trial conducted from 2013 to 2015 among adult patients newly diagnosed with stage III or IV cancer or recurrent disease (mean age, 69.3 years; male, 99.1%; non-Hispanic white race, 77.5%) who were receiving care within a Veterans Affairs (VA) health system.

All patients (n = 213) received usual care, provided by the oncology team, a social worker, and a behavioral medicine practitioner. Half of patients were randomly assigned to receive the intervention, a six-month quality improvement program led by a LHW trained to assist patients with advance care planning (ACP) through in-person and telephone conversations. Although the LHW was supervised by a registered nurse, there was no interaction between the LHW and the clinical team.

The LHW provided assistance by:
- Educating patients on the principles of goals-of-care
- Establishing patients’ care preferences
- Identifying a surrogate decision maker
- Filing an advance directive (AD)
- Encouraging patients to discuss their care preferences with their clinical team

“Lay health workers have been a part of the U.S. healthcare workforce since the mid-1960s,” point out the authors, noting that professional resource shortages and novel payment models have recently reinvigorated interest in the use of LHW programs.

LHWs have demonstrated effectiveness in improving cancer screening and adherence to treatment, but they have rarely been integrated into advanced cancer care, note the authors. “A goals-of-care conversation is not about prognosis,” says lead author Manali Patel, MD. “It’s a holistic approach to understanding the patient’s wishes and how they want to experience their life.

“You don’t need higher-level training to have that conversation,” adds Patel, who is assistant professor of medicine at Stanford University School of Medicine, Palo Alto, CA. “You just need a very supportive ear.”

Patients were asked to address the following questions:
- “What is your understanding of your cancer?”
- “What is important to you?”
- “Have you thought about a time when you could be sicker?”
- “How would you want to spend your time in that situation?”

**KEY FINDINGS**

Patients in the intervention group were more likely than controls to have documentation of their goals of care in the electronic health record (EHR) within both six months of enrollment (92.4% vs 17.5%; *P* < 0.001) and 15 months of enrollment (93.3% vs 24.1%; *P* < 0.001).

Intervention patients were also more likely to have completed an AD within six months (67.6% vs 25.9%; *P* < 0.001) and 15 months (74.3% vs 33.3%; *P* < 0.001).

The intervention group rated satisfaction with their providers higher than did controls (9.16 vs 7.83 on a 10-point scale), with a significantly greater positive change in satisfaction from baseline to six months (1.53; 95% confidence interval, 0.67 to 2.41; *P* < 0.001).

Hospice use was higher among patients in the intervention group at both six months (35.2% vs 18.5%; *P* = 0.006) and 15 months (44.8% vs 27.8%; *P* = 0.009), demonstrating the “long-lasting effect” of the six-month intervention, the authors observe.

There was no difference between groups in the percentage of deaths within 15 months of enrollment, indicating that the intervention did not adversely affect survival, note the authors. About one-third of patients died within six months, and just over one-half died within 15 months of enrollment. Also, the use of palliative care did not differ between the groups, a finding that is likely due to the high availability of palliative care within the VA system, the authors point out.

**LESS AGGRESSIVE CARE NEAR DEATH**

Within the final 30 days of life, the intervention group had:
- Less emergency department use (5% vs 45%; *P* < 0.001)
- Fewer hospitalizations (5% vs 43.3%; *P* < 0.001)
- Lower median healthcare costs ($1,048 vs $23,482; *P* < 0.001)
- Greater hospice use (76.7% vs 48.3%; *P* = 0.002)

The authors suggest several possible reasons for the effectiveness of the LHW intervention. These include:
- The information regarding ACP may have been conveyed in a way that was easier for patients and their families to accept.
- The LHW may have spent more time than many clinicians are able to in explaining goals of care and encouraging patients to keep assessing their preferences over time and to communicate these to their care teams.
- The improved documentation of treatment preferences in

*Continued on Page 3*
Cirrhosis Patients Have Poor Understanding of Advanced Disease, Desire More Information

Patients with liver cirrhosis often have limited disease understanding, unmet support needs, dissatisfaction with the quality of information they receive, and are unfamiliar with the benefits of palliative care, according to a report published in the Journal of Hepatology.

Nevertheless, healthcare professionals caring for these patients, although not always confident about their ability to discuss the seriousness of the disease and palliative options, all recognize the important role of palliative care in improving patient care.

“Health professionals need support to improve their communication with patients, to address patients’ broader needs beyond medical treatment, and to develop new models to improve palliative care coordination between different medical specialties,” write the authors.

Investigators analyzed results of a systematic literature review of both qualitative and quantitative studies from nine developed nations that focused on the perspectives of patients with cirrhosis (age, 46 to 61 years; male, 65%) and their healthcare professionals. Most of the 19 studies were from the U.S. and U.K., with the majority of these originating from the U.S. Nearly all were published after 2013.

For most patients, the underlying etiology of cirrhosis was alcohol-related liver disease or hepatitis C. Healthcare professionals were mainly general practitioners (GPs), hepatologists, or palliative care specialists.

PATIENT PERSPECTIVES
- Most patients lacked understanding of their disease or its prognosis, and were unaware of its likely progression.
- Patients were also unclear about how their symptoms related to their cirrhosis, or about the implications of many of their care aspects.
- Patients felt that the information they received was too “medicalized,” and yearned for more time during medical visits to receive understandable explanations and practical suggestions.
- Patients also felt stigmatized during clinical encounters by the association of their disease with alcohol misuse.

CLINICIAN PERSPECTIVES
- Clinicians were often aware of patients’ lack of understanding of their disease and its severity. However, there was little concordance concerning whose role it was to conduct discussions on these topics. While GPs felt it was the responsibility of hepatologists, many liver specialists felt they lacked both the confidence and skills to hold such conversations.
- All health professionals felt they provided suboptimal care. Liver specialists recognized patients’ concerns about symptom management and lack of adequate information, their fears of losing functional ability, thoughts about dying, and uncertainty about the future, yet most did not raise quality-of-life issues or palliative care options unless asked by the patient or family.
- All healthcare professionals recognized a lack of coordinated care for cirrhosis patients.
- All practitioners wanted an increase in provision of palliative care and to have a collaborative approach earlier in the illness trajectory.

Based on their findings, the authors offer several recommendations for improving communication and palliative care delivery for cirrhosis patients.

RECOMMENDATIONS
- The use of written material and communication aids, such as question prompt lists, to improve patients’ understanding of their disease and palliative care
- Expanded awareness of the broader needs of cirrhosis patients and their families
- Development of strategies for reducing the feeling of stigmatization among patients with alcohol-related disease
- Improved coordination of care among different medical specialties

Source: “Supportive and Palliative Care in People with Cirrhosis: International Systematic Review of the Perspective of Patients, Family Members, and Health Professionals,” Journal of Hepatology; Epub ahead of print, September 20, 2018; DOI: 10.1016/j.jhep.2018.08.028.

Lay Health Worker Intervention (from page 2)

the EHR, including such choices as a DNR order, may have prompted oncologists to discuss the option of hospice earlier.

The authors view LHW integration as a promising approach to improving the quality of end-of-life care delivery for patients with cancer, adding that further research is needed among more diverse populations and settings to assess the generalizability of the LHW approach.

Source: “Effect of a Lay Health Worker Intervention on Goals-of-Care Documentation and on Health Care Use, Costs, and Satisfaction Among Patients with Cancer: A Randomized Clinical Trial,” JAMA Oncology; October 1, 2018; 4(10):1359–1366. Patel M, Bundorf MK, et al; Division of Oncology, Stanford University School of Medicine; Medical Services, Veterans Affairs Palo Alto Health Care System, Palo Alto, California; Clinical Excellence Research Center; Center for Primary Care and Outcomes Research; and Department of Health Research and Policy, Stanford University School of Medicine, Stanford, California.
A Lack of Training in Palliative Care Linked to More Aggressive Treatment Recommendations by Surgeons

Physicians with no training in palliative care (PC) were significantly more likely than those with such training to recommend major surgical interventions for patients with advanced cancer, a recent survey has found. Further, surgeons in the survey had the fewest hours of PC training and the highest percentage (20%) of no training, according to a report published in Surgery.

“Surgeons must weigh the surgical risks with the potential palliative benefits, knowing that operative complications may impact patients’ quality of life profoundly,” write the authors.

Investigators analyzed questionnaire responses of surgeons, medical oncologists, and intensivists (n = 102; median years in practice, 14) treating advanced cancer patients with symptomatic surgical conditions in a diverse number of hospitals and physician practices within a large urban area in 2017.

Participants reported the extent of their PC training, including structured training during residency and fellowship as well as continuing medical education and self-directed learning. Participants were then presented with four clinical vignettes involving patients with stage IV cancer, and asked to select and justify their treatment decisions.

**KEY FINDINGS**

- Surgeons reported fewer hours of PC training (median, 10 hours) compared with medical oncologists (median, 30 hours) and medical intensivists (median, 50 hours).
- 20% of surgeons had no PC training at all. All medical oncologists reported some PC training; only one intensivist reported no PC training.
- In the four clinical scenarios, respondents with no PC training recommended major surgical interventions significantly more frequently compared with those with ≥ 40 hours of PC training (1.6 ± 0.8 vs 0.7 ± 0.7; P = 0.01).

“These findings highlight the need for greater efforts system-wide in palliative care education among surgeons, including incorporation of a structured palliative care training curriculum in graduate and continuing surgical education,” conclude the authors.

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