Adding Early Palliative Care to Treatment of Non–Small Cell Lung Cancer

KATHLEEN N. CLIFFORD, RN, MSN, FNP-BC, AOCNP®

From St. Luke's Mountain States Tumor Institute, Boise, Idaho

Author's disclosures of potential conflict of interest are found at the end of this article.

Correspondence to: Kathleen N. Clifford, RN, MSN, FNP-BC, AOCNP®, St. Luke's Mountain States Tumor Institute, 100 East Idaho St, Boise, ID 83712. E-mail: cliffoka@slhs.org

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Review of "Early palliative care for patients with metastatic non–small-cell lung cancer," by Temel et al. (2010), The New England Journal of Medicine, *363(8), 733–742. For a discussion of the article and how it relates to the concepts of scientific rigor, complexity science, and positive deviance, please see the related article by Jeannine M. Brant and Elizabeth L. Ciemins on page 204.*

Over the past decade, numerous studies have demonstrated that palliative care interventions improve symptom control, patient and family satisfaction, and overall quality of life for patients with advanced diseases. These findings are nothing new to oncology advanced practitioners (APs), who have long recognized the value of caring for our patients and families regardless of the ability to cure their disease. Many key concepts in palliative care (PC)—such as improved symptom management, skillful communication, caregiver support, and relief of spiritual and existential pain—have their roots in oncology nursing (Brant, 2010; Ferrell & Coyle, 2010).

Oncology experts have led the way in patient-centered care and groundbreaking research that is changing the care of the dying in America. These practitioners developed and implemented programs at major institutions across the country, creating interdisciplinary care models as well as education and training initiatives (Bakitas et al., 2009; Coyne et al., 2007; Ferrell, Virani, Malloy, & Kelly, 2010). Their important leadership supports and influences the advancement of palliative care (National Consensus Project for Quality Palliative Care, 2009).

Despite these valuable contributions, barriers remain to integrating palliative care across the cancer experience. The American Society of Clinical Oncology (ASCO) has identified gaps in care and made recommendations for integrating palliative care throughout the cancer continuum (Von Roenn, Strasser, & von Gunten, 2009). In order to provide high-quality care, it is important for the oncologist to take a primary role in providing an individualized approach to symptom management, interdisciplinary needs, and care planning (Peppercorn et al., 2011).

A study recently published by Temel et al. in *The New England Journal of Medicine* validates this approach, showing for the first time that early palliative care, added to standard therapy, extends survival and improves quality of life for patients with metastatic non–small cell lung cancer. This review of the Temel et al. study will explore the potential implications for oncology APs and present an interdisciplinary model of palliative care in a community cancer program.

Overview of Outcomes

This well-conducted study by Temel et al. is the first large randomized trial to measure the impact of adding early palliative care to standard care in patients with newly diagnosed metastatic lung cancer, the leading cause of cancer death worldwide. The median survival time for patients receiving the concurrent approach was 11.6 months, compared with 8.9 months ($p = .02$) for patients randomized to standard oncologic care alone. Both arms received similar anticancer therapy, including chemotherapy, radiation, oral epidermal growth factor receptor tyrosine kinase inhibitors, or combination therapy. Patients in the PC group survived 30% longer than those in the control group (Dahlin, Kelly, Jackson, & Temel, 2010).

A Closer Look at the Study

This trial was conducted at Massachusetts General Hospital in Boston, which has specialized departments in both thoracic oncology and palliative medicine. The palliative medicine program at Massachusetts General Hospital is well established, with an interdisciplinary team of professionals who are experts in palliative care (Dahlin et al., 2010). Their program has been instrumental in setting national quality standards. It provides a fellowship training program and is associated with the Harvard Medical School Program in Palliative Care Education and Practice (http://www.hms.harvard.edu/pallcare/pcep.htm).

In this study, the medical oncologist in the thoracic oncology clinic approached, recruited, and obtained consent for their patients with newly diagnosed metastatic non–small cell lung cancer with Eastern Cooperative Oncology Group performance status (PS) of 0 to 2. Over 3 years, 151 patients were enrolled and underwent randomization in a 1:1 nonstratified fashion. A total of 27 patients died by 12 weeks, and 86% of the remaining patients completed the 12-week assessments. Patients in the intervention group (PC) met with a palliative care physician or nurse practitioner (APN) within 3 weeks of enrollment (within 8 weeks of diagnosis). The average number of PC visits was 4, with a range of 0 to 8 visits. The assigned provider saw the patient for ongoing care.

This was a longitudinal study that followed patients across their disease trajectory. Patients in the PC group were seen monthly for the first 6 months, then on a regular basis as needed. Over the study period, 70% of the participants had died before the analysis of the end-of-life data was conducted. The PC intervention was shown to be feasible and acceptable, with a low dropout rate of less than 1% at 12 weeks. During the patient encounters, providers paid specific attention to relieving of physical and psychosocial symptoms, establishing goals of care, assisting with treatment decision-making, and coordinating individual care. The study protocol provided for a standardized approach to patient care, utilizing guidelines from the National Consensus Project for Quality Palliative Care (2009). These guidelines were included in the supplemental materials and are summarized in Table 1.

The PC team consisted of six physicians and one APN. The team APN provided interesting insight into this study in a commentary published in the *International Journal of Palliative Nursing* (Dahlin et al., 2010). Dahlin et al. reflected on the experience of interacting with patients early on in their diagnosis, noting that a different approach was needed—careful timing and skillful presentation, working toward nurturing and deepening the relationship. Discussions of goals of care were “gentle and inquisitive,” more open-ended and less directed than those that take place closer to the end of life. The APN role with this group was characterized as that of facilitator of the cancer journey, “to help the patients live well while dying.” While Dahlin et al. acknowledge the contribution of the interdisciplinary team, they point out that the study was not designed to examine any differences in the techniques or processes used by the physicians vs. those of the APN. They emphasized the need for additional research on the role of advanced practitioners (APs) and their impact on patient care outcomes (Dahlin et al., 2010).

Depression and Quality-of-Life Measures

The study group reported 50% less depression symptoms than the standard care group. Approximately 18% of patients in both groups received new prescriptions for antidepressant medication. Commonly available tools were used to assess mood. The Hospital Anxiety and Depression Scale (HADS-D), which consists of two subscales with 14 items, was used to screen for anxiety and depression. Significantly, this showed that only 16% of PC patients had depressive symptoms vs. 38% in the standard care arm (p = .01). The Patient Health Questionnaire 9 (PHQ-9) was used to evaluate symptoms of a major depressive disorder, using the criteria of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). This showed that 4% of PC patients had mood symptoms vs. 17% of patients in the standard care group (p = .04).

The primary outcome of the study was change in quality of life at 12 weeks, as assessed by the Functional Assessment of Cancer Therapy–Lung (FACT-L), the lung cancer subscale (LCS) of the FACT-L, and the Trial Outcome Index (TOI). Quality of life at 12 weeks was significantly higher in the PC group (98.0 vs. 91.5; p = .03 for the FACT-L; 59.0 vs. 53.0; p = .009 for the TOI; 21.0 vs. 19.3; p = .04 for the LCS [changes did not reach significance]). These improvements in the PC group were seen in patients with progressive metastatic disease whose quality of life would be expected to decline over time, as was seen in the standard care group. Patients in the standard care group were referred for palliative care consultation as needed, possibly blunting the difference in scores. See Table 2 for further outcomes data.

Aggressive Care at the End of Life

The study was not powered to adequately examine indicators of aggressive care at the end of life, but it did review data from the electronic medical records to analyze rates of hospitalization, emergency department visits, chemotherapy administration near the end of life, duration of hospice care, and location of death. Aggressive end-of-life care was defined as chemotherapy within 14 days of death, no hospice care, or admission to hospice 3 or fewer days prior to death. Palliative care patients received less aggressive end-of-life care than the standard care patients (33% vs. 54%; p = .05), yet had an improvement in overall survival of approximately 2 months. The median duration of hospice care for the PC patients was 11 vs. 4 days (p = .09) in the standard care group. The national average duration for hospice is 12.5 days (Goodman et al., 2010). The authors reported that of resuscitation preferences were documented in the medical record more frequently for the PC group (53% vs. 28%, p = .05). This is seen as an important element in clarifying patients' wishes for interventions at the end of life.

The findings of Temel et al. reinforce the importance of integrating palliative care into ambulatory oncology settings soon after diagnosis for patients with metastatic lung cancer. Palliative care practitioners believe these results can be replicated in other advanced cancer diagnoses.

Table 1. Ambulatory Palliative Care Guidelines

Illness understanding/education
- Inquire about illness and prognostic understanding
- Offer clarification of treatment goals

Symptom management—inquire about uncontrolled symptoms with a focus on:
- Pain
- Pulmonary symptoms (cough, dyspnea)
- Fatigue and sleep disturbance
- Mood (depression and anxiety)
- Gastrointestinal (anorexia & weight loss, nausea and vomiting, constipation)

Decision-making
- Inquire about mode of decision-making
- Assist with treatment decision-making, if necessary

Coping with life-threatening illness
- Patient
- Family/family caregivers

Referrals/prescriptions
- Identify care plan for future appointments
- Indicate referrals to other care providers
- Note new medications prescribed

Note. Adapted from Temel et al. (2010).

Potential Limitations

Temel et al. identified limitations of the study that might affect its ability to be generalized to other settings. The study was conducted in a tertiary care center with specialty physicians. The study group was primarily white (95% in the control arm and 100% in the PC group), and all

Table 2. Outcomes Data: Temel et al. Study

Outcome		PC	STD	*p* value
Median survival		n = 77 11.6 mo	n = 74 8.9 mo	.002
Depression	HADS-D	16%	38%	.01
	PHQ-9	25%	30%	.04
Anxiety	HADS-A	4%	17%	.66
Change in QOL scores	FACT-L	4.2	-4	.09
	LCS	0.8	0.4	.5
	TOI	2.3	-2.3	.009
EOL care	Aggressive care	33%	54%	.05
	Resuscitation preferences documented	53%	28%	.05
	Days in hospice	11 d	4 d	.09

Note. PC = palliative care; STD = standard; HADS-D = Hospital Anxiety and Depression Scale; PHQ-9 = The Patient Health Questionnaire 9; FACT-L = Functional Assessment of Cancer Therapy-Lung; LCS = Lung Cancer Subscale; TOI = Trial Outcome Index; EOL = end-of-life. Adapted from Temel et al. (2010).

patients spoke English. Using the recruitment approach to enroll patients based on diagnosis and performance status rather than waiting for them to meet traditional palliative care triggers allows these results to be generalized to a broader group of patients. However, the high level of expertise and resources of the investigators cannot be easily replicated across care settings.

While PC patients elected less aggressive end-of-life care, they still had improved survival. It is noted that this trial was not powered for survival as the primary outcome and warrants a larger study (Currow, Foley, Zafar, Wheeler, & Abernethy, 2011). Alternative explanations for the improved survival benefit may be the amount of attention patients in the intervention arm received, effective treatment of depression, improved symptom monitoring and control, or a reduced need for hospitalization. Increased support may have facilitated the optimal use of anticancer therapies. Early hospice enrollment also may have affected survival.

The authors responded to questions regarding specific elements of this study in the Letters to the Editor section of *The New England Journal of Medicine* (2010; *363*, 2263–2265). One question was about the potential group differences in treatments and performance status (PS), which are well known to impact survival rates. Temel et al. noted that the two study groups did not differ significantly with respect to the number of chemotherapy regimes received (the variety of treatment modalities is listed in the original article). The baseline PS was similar between the groups and was not followed longitudinally. However, patient-reported measures of health status, including quality of life, were collected and analyzed. A potential variation in coexisting diseases may have contributed to the survival difference between the groups. This was not specifically measured but was minimized by randomization with a balance in the baseline patient characteristics and disease stage. Applying the seventh edition of the TNM staging system, published after the study started, all patients enrolled had stage IV disease (Groome et al., 2007).

The primary outcome of significant differences in quality of life at 12 weeks was met in two of the three measures analyzed. The statistical differences between groups on the lung cancer subscale (LCS) of the FACT-L scale, which measures seven symptoms specific to lung cancer, were less significant but did show a benefit for the PC group. There may have been less difference in this symptom scale because 14% of the standard care group had a palliative care consultation (Dahlin et al., 2010). Several patients did not complete the study, which required additional patients to be enrolled so that the study would have 80% power to detect a significant difference between the groups. It is also possible that the influence of the palliative care team in the institution increased the attention to symptom management in the standard care group, which may have varied more in other settings.

This approach needs further investigation in larger patient numbers, as well as in other diagnoses and settings to determine if the survival benefit can be replicated. The improved quality of life from a concurrent care approach has been demonstrated in other studies (Bakitas et al., 2009; Peppercorn et al., 2009). The survival benefits seen here challenge the perception of palliative services as an alternative to life-prolonging care, shifting it instead into a valuable adjuvant care plan that benefits patients regardless of stage of disease (Sanft & Von Roenn, 2009). Palliative care principles are now widely supported as a standard of care in quality cancer programs (Bakitas et al., 2010; Cherny, 2010; Peppercorn et al., 2011). The important question is how the results of this study can be adopted in the community oncology setting, where approximately 85% of Americans' receive their cancer care? (Association of Community Cancer Centers, 2011).

Translating Research Into Practice

Palliative medicine board certification was established in 2006, increasing the availability of these specialized physician services (Von Roenn et al., 2009). Inpatient palliative care services are available in over 80% of hospitals with 300 beds or more and in 53% of hospitals with 50 or more beds (Center to Advance Palliative Care, 2010), but access for ambulatory patients remains limited (Meier & Beresford, 2008). Few community cancer centers provide outpatient palliative care. Use of palliative medicine consultation remains low among oncologists, as does the early referral to hospice (Goodman et al., 2010). Advanced practitioners are increasingly utilized; they play a valuable role in providing patient-centered care, managing symptoms, and decreasing suffering across the cancer continuum (Brant, 2010; Dahlin et al., 2010; Hospice and Palliative Nurses Association, 2011; Oncology Nursing Society [ONS], 2011). Both ASCO and ONS have long supported the integration of palliative care practices across the continuum of care, regardless of stage or need for other therapies. They, and other oncology organizations, have published guidelines and quality standards of care (Zafar, Currow, Daugherty, & Abernethy, 2010). The National Comprehensive Cancer Network has published palliative care guidelines (NCCN, 2011) that endorse concurrent care.

Barriers to the Use of Palliative Care

Identified barriers to integrating palliative medicine in oncology often point to limited physician training in communication and lack of appreciation of symptom burden. The issues are complex, and are becoming increasingly more so in this era of health-care reform (Ferris et al., 2009; Dalhin et al., 2010). Different perspectives between specialties exist. The very term "palliation" is somewhat confusing. Palliation has traditionally been used in the context of anticancer treatments to relieve cancer symptoms and increase survival. Palliative medicine specialists are seen as focused on advanced symptom management and preparation for death. This has contributed to the perception among physicians and patients that palliative medicine is end-of-life care. A recent study evaluating barriers to palliative care use found that physician and AP use of palliative services increase when they come under the heading of "supportive care" or "symptom management" clinics (Bruera & Hui, 2010).

Patients and families also associate palliation with hospice care. The American public has long heard of the "War on Cancer," a term still in use today. Studies confirm that patients often choose to continue anticancer treatment in the face of multiple side effects and may be reluctant to accept care presented as an alternative to continuing treatment. Clear communication of the goals of care is needed to improve understanding (Von Roenn et al., 2009; Peppercorn et al., 2010). Today the cost of cancer care in the United States has increased to the point of causing a serious financial burden to patients, families, and society. There is a need for more transparent discussions with patients regarding cost as well as quality of care (Meropol et al., 2009). Intensive resources utilized at the end of life significantly contribute to escalating costs (Morrison et al., 2011). It has been suggested that the Temel et al. article has defined a new standard of care to be applied in randomized clinical trials comparing the benefit of new agents against "best supportive care" (Currow et al., 2011).

The Role of the Oncology AP in Palliative Care

The community oncologist is called on to integrate many quality care aspects into patient visits, with limited time and increasing demands across the disease trajectory. Survivorship care, complex diagnostics, and evolving treatment options require more resources (Peppercorn et al., 2011).

The main impact is from the aging population; those over age 65 will double by 2030, increasing the need for oncology services 48% by 2020. A shortfall of oncologists is projected over the next 20 years (Erikson, Salsberg, Forte, Bruinooge, & Goldstein, 2007). This shortage extends to many physician specialties. The palliative medicine and hospice physician workforces are already faced with a shortage, without considering the potential increase in outpatient care (Lupu, 2010). The health-care workforce shortage is in part being addressed by increasing use of APs: clinical specialists, nurse practitioners, and physician assistants, as well as the increased participation of other oncology certified specialists. As the need for services expands in the coming years, the interdisciplinary team will be increasingly important, including in palliative care (Ferris et al., 2009; Dahlin et al., 2010; Peppercorn et al., 2011).

While hospitals are establishing programs led by board-certified palliative medicine physicians, APs have led the way in outpatient cancer care (Bakitas et al., 2009; Bakitas et al., 2010; Follwell et al., 2009; Griffith, Lyman, & Blackhall, 2010; Higginson & Evans, 2010; Mintzer et al., 2009; Pantilat et al., 2006; Prince-Paul, Burant, Saltzman, Teston, & Matthews, 2010). With increasing physician shortages, institutions will look to APs to adapt models to best fit their care settings. The oncology AP is well suited to provide the palliative care role in the outpatient cancer clinic, acting as a coordinator of the interdisciplinary team and as a resource to the cancer program (Bakitas et al., 2010; Brant 2010; Dahlin et al., 2010; Meier & Beresford, 2008; Peppercorn et al., 2011). Advanced practitioners address suffering in multiple settings across the care continuum: as navigators, in acute and chronic care, for survivorship and long-term follow-up, and in palliative care and hospice. With the increasing body of evidence supporting the financial viability of palliative care, APs can call on administrators and physician colleagues to embrace it as integral to quality care rather than an alternative when other treatment fails.

A Supportive Care Clinic in a Community Cancer Center

St. Luke's Mountain States Tumor Institute (MSTI) in Boise, Idaho, is a community cancer program that services the state's major urban center and a large rural area. In 2010, MSTI implemented a nurse practitioner (NP)-led interdisciplinary Supportive Care Clinic, based on the concurrent care approach (Bakitas et al., 2010; Griffith et al., 2010; NCCN, 2011; Meier & Beresford, 2008). This service expanded on a longstanding registered nurse–based telephone triage system with NPs utilized for symptom management and urgent care (Clifford, Erlandson, & Mills, 2008). The cancer program has oncology-certified supportive professionals that are utilized on a referral basis.

LAUNCHING THE CENTER

Palliative care requires proactive coordination of team members, including social workers, dietitians, pharmacists, nurses, and rehabilitation services, with effective use of psychosocial resources including chaplains, support groups, and volunteer programs (Higginson & Evans, 2010; Weibe & Von Roenn, 2010). A team met monthly to operationalize the clinic as a designated specialty clinic, which requires administrative commitment and the involvement of stakeholders. The Center to Advance Palliative Care was accessed for valuable resources on program development, which include leadership training with a participating center of excellence. To encourage participation and support, the NP met with physicians individually and attended leadership councils and staff meetings. An open house was held to acknowledge the impact that caring for people with cancer has on everyone at the center, and to celebrate the "culture of caring" everyone wants patients to experience. To trigger referrals, fliers were placed in the clinic work areas listing the NCCN screening criteria (NCCN, 2011), and a mechanism was added to patients' electronic medical records. A brochure was developed to introduce the program to patients.

ESTABLISHING PROTOCOL AND ASSESSMENT MEASURES

To demonstrate the benefit of NPs in providing quality care, chart audits were completed that demonstrated high compliance with symptom management measures. These results were shared at clinical practice meetings (National Quality Forum, 2006; Peppercorn et al., 2011). The Quality Oncology Practice Initiative through ASCO includes measures for symptom management, psychosocial assessment, and end-of-life care (Jacobson, 2008). The Center to Advance Palliative Care has established a set of tools that assist in data collection and outcomes reporting in palliative care domains. They have been complied in an easy to use toolkit found at www.capc.org (Weissman, Morrison, & Meier, 2010).

To avoid duplication and minimize staff time, each discipline uses their existing assessment forms with a simple designation added for supportive care that can be tracked electronically. To establish a supportive care screening tool, the NP provided a review of the literature on tools, and then worked with oncology-certified RNs to develop and trial the screening tool. While several excellent, validated tools are available (Weissman, Morrison, & Meier, 2010), none of them met the needs of the team, so questions were added regarding understanding of treatment/care plan, medications, and available resources. The team has found these questions to be very helpful in assessing the informational needs of the patient and family, and introducing discussion of the goals of care and advanced care planning.[1] The concept of illness understanding was based on the Temel et al. tool that was developed to measure patient/family understanding of illness (see protocol Appendix G, available at www.nejm.org). This tool uses three questions to assess patient and family understanding of their prognosis, the goals of therapy, and their self-reported health status.

THE PATIENT EXPERIENCE

The supportive care clinic sees patients for a comprehensive and time-intensive assessment and education session with the interdisciplinary team. The patient is informed that this often requires a 2-hour appointment. Care is taken to not schedule this session on a treatment day. The NPs who participate in the clinic have extensive oncology experience and practice collaboratively with the oncologists, which facilitated the integration of this clinic into the cancer center. The NP is able to bill for services and has prescriptive authority.

The team includes an oncology pharmacist, who reviews medications, including vitamin and herbal supplements, for interactions and possible dose adjustments and updates the medical record; a social worker, who sees each family for psychosocial and financial needs; and a dietitian, who provides education and counseling and performs nutritional evaluations. Based on patient needs, additional team members can include a physical therapist, a chaplain, and an integrative medicine specialist. The RN, who is the primary coordinator of the clinic flow, provides extensive documentation that includes a written summary of instructions given to the patient and family.

The interdisciplinary team members meet with the patient and family separately or in pairs and each discipline documents the time spent. They interact closely to develop a care plan and provide recommendations that are reviewed with the NP, who addresses individual symptom management with adjustments of medications and referrals for additional care. The NP plays a key role in reviewing diagnosis, prognosis, and the treatment plan, discussing and documenting goals of care. The oncologists at MSTI are updated on their patients and continue to see them for medical issues and treatments. Standard follow-up is provided monthly by the supportive care NP, with 1-week visits if pain medications are adjusted, and in 2 weeks if antidepressants are added or changed. Other disciplines provide follow-up care as needed, often in association with other clinic appointments. Rarely are patients seen more than once in the team setting. Advanced care planning is introduced, but is not a focus. As Dahlin et al. (2010) found when meeting patients early in the cancer experience, these discussions are open ended. The intention is to develop relationships based on palliative principles that will assist patients and families in decision-making over time.

The majority of patients are seen soon after diagnosis with metastatic or advanced disease such as pancreatic or lung cancer. The Temel et al. data did result in an increase in early referrals for metastatic non–small cell lung cancer. No attempt is made to limit this service to advanced disease patients. Patients needing complex symptom management and those with psychosocial distress are seen, including those with sexual concerns that are poorly addressed elsewhere. Several survivors with long-term side effects have been seen with their families.

Patients and families have expressed satisfac-

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[1] Contact corresponding author Kathleen N. Clifford at cliffoka@slhs.org for more information about this screening tool.

tion with the visits, and their enthusiasm has led to increased physician referral and support. One oncologist encouraged his peers to refer "the 10% of patients who take 90% of your time."

STAFF EDUCATION AND SUPPORT

The development of communication skills to effectively address the difficult issues facing our patients is important to this process. The basics of palliative care are included in the education of the AP, but are often inadequate when addressing the profound existential distress encountered in cancer care. Expanding skills and knowledge can decrease the risk of compassion fatigue and professional burnout (Bakitas et al., 2010; Ferrell et al., 2010). The use of interdisciplinary teams improves care (Higginson & Evans, 2010) but requires attention to the team dynamics (O'Connor & Fischer, 2010; Weibe & Von Roenn, 2010). Staff education programs focusing on communication and self-care strategies have been offered and more are planned. A team building session is scheduled to strengthen the interdisciplinary process.

FUTURE GOALS

Goals for the future include measuring various outcomes, including customer satisfaction and resource utilization over time. Plans are being developed to expand the Supportive Care Clinic to other clinics in the St. Luke's Mountain States Tumor Institute system. This model will require adaptation in rural areas where additional challenges include transportation issues and limited support services.

Conclusion

The Temel et al. study is seen as a landmark trial that has received widespread attention beyond the oncology and palliative care communities, prompting a broader discussion among the public, policymakers, and health-care providers regarding quality care (Dahlin et al., 2010). In the setting of escalating health-care costs, this study importantly noted a decreased utilization of care resources. While no financial data were included by Temel et al., the authors did conclude that early introduction of palliative care for cancer patients may serve to "mitigate unnecessary and burdensome personal and societal costs." The financial benefit was better defined in a recent review of Medicaid beneficiaries that found that patients receiving palliative care had significantly lower hospital costs while getting additional supportive services. The projected savings in the state of New York's Medicaid program alone was estimated to be in the millions of dollars (Morrison et al., 2011). These cost savings are increasingly recognized.

Oncology APs represent a growing group of cancer service providers. To offer palliative care as an adjuvant or concurrent care approach, APs must provide a leadership role. We can reach across disciplines to learn from and collaborate with palliative specialists, and encourage referrals for secondary palliative needs (Peppercorn et al., 2010; HPNA, 2011; AAHPM, 2011). Recognizing oncology's rich heritage can inspire APs to take the responsibility for primary palliation to improve their practice and transform modern cancer care (Dahlin et al., 2010; Brant, 2010). Ira Byock, an early physician advocate of palliative care, cautioned against a provider-centric approach to palliative care: "As valuable as our special training, knowledge, skills and experience all are, we ultimately become specialized one patient and family at a time. At the end of the day, it is not our segmented programs and specialties that matter, but the special expertise we bring to the collaborative process of patient and family care" (Byock, 2009). Oncology APs are in the right position to develop and promote this expertise in whole-person care, to implement a concurrent care approach across oncology settings—one patient and family at a time.

DISCLOSURE

The author has no conflicts of interest to disclose.

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