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Palliative Medicine and Supportive Treatment Clinic – an innovative approach to specialist outpatient palliative care. Organizational Standards of the Polish Society of Palliative Medicine

Aleksandra Ciałkowska-Rysz[1,2*], Michał Graczyk[3,4*], Dorota Kazimierczak[5]

[1]Clinical Department of Palliative Medicine, Department of Oncology, Medical University, Lodz, Poland
[2]The Military Medical Academy Memorial Teaching Hospital in Lodz – Central Veterans' Hospital, Lodz, Poland
[3]Department of Palliative Care, *Collegium Medicum* in Bydgoszcz, Nicolaus Copernicus University in Torun, Poland
[4]Home Hospice of the Marians, Warsaw, Poland
[5]Non-Public Health Care Centre PALIUM, Zielona Gora, Poland
** These authors contributed equally to this work.*

Abstract

As part of the work concerning organizational standards in palliative care, Standards Team for the Polish Society of Palliative Medicine offers an innovative model of outpatient palliative care in the form of the Palliative Medicine Clinic and Supportive Treatment. Such an organizational model can be seen as a response to the increasing demand for palliative care services among patients suffering from cancer, who have been included in palliative care in the earlier stages of the disease and in parallel oncological care, and among patients with other progressive life-threatening diseasesthat do not currently meet the criteria for their palliative care coverage, according to the Regulation of the Minister of Health on guaranteed services in the area of palliative and hospice care. The document presents the organizational chart of the clinic, the requirements for staff qualifications, the scopeof services provided, the procedures performed at the clinic, and home visit conditions.

Key words: organizational standards, specialist outpatient palliative care, Polish Society of Palliative Medicine.

Correspondence address:

Prof. Aleksandra Ciałkowska-Rysz, The Military Medical Academy Memorial Teaching Hospital in Lodz – Central Veterans' Hospital, 1 Hallera Square, 90-647 Lodz, Poland, e-mail: aleksandra.cialkowska-rysz@umed.lodz.pl

INTRODUCTION

Palliative medicine is a distinct field of medicine that fills the gap in the health care system between disease-centered treatment and patient-centered approach. The integration of palliative care with the health care system provides tangible benefits in terms of improving the quality of care for patients with progressive life-limiting illnesses.

From the perspective of patients and their caregivers, the key element is to improve the quality of life. A well-organized health care system ought to provide access to various forms of palliative care in order to optimize meeting patients' needs, which change at different stages of progressive disease. According to Hui *et al.*, the answer to patients' changing needs is personalized palliative care, which should be organized to provide a specific patient with the right level of intervention in the right setting and at the right time [1].

The Polish Society of Palliative Medicine (PTMP), as part of the work concerning Organizational Standards in Palliative Care, has proposed a contemporary definition of palliative care: *palliative care is care for a person with a life-threatening or severely life-limiting illness, requiring treatment of physical and psychological symptoms resulting from the disease or its treatment, providing support to address social and spiritual needs, and taking into accounts culture and sexuality, aimed at relieving suffering and optimizing the quality of life of the person and his or her loved ones, carried out regardless of the disease activity and disease-modifying treatment in the early stages of the disease, in the end-stage, during dying, and after the patient's death for the loved ones* [2].

The World Health Organization and many international scientific societies, including the American Society of Clinical Oncology and the European Society for Medical Oncology, promote the early inclusion of palliative care for cancer patients. In cancer patients, palliative care can be used at any stage of the disease and can be provided in parallel with the disease-modifying therapy [3–5].

There is evidence that in case of oncology patients, earlier referral to an outpatient palliative care facility offers the potential for better control of physical and emotional symptoms of the disease. The authors of a randomized clinical trial concerning the integration of oncology and palliative care pointed to health benefits: longer survival, better symptom control, less anxiety and depression, less use of futile cancer therapies at the end of life, improved family satisfaction and the quality of life, and better utilization of care resources [6].

The outlined strategy also provides an opportunity to improve outcomes regarding the quality of care, including end-of-life hospitalizations, use of emergency departments, and use of intensive care unit stays [7]. Such a model has found justification not only clinically, but also economically. Recently, there have been publications proving that palliative care can significantly reduce health care expenses among patients with advanced cancer. The cost reduction depends on the timing of the inclusion of palliative care consultations [8, 9]. A documented outcome of early palliative care is also a reduction in stress for caregivers [10].

An outpatient palliative medicine clinic may be the optimal place to meet palliative care needs for patients in the early stages of illness. Outpatient care provides adequate conditions for controlling the symptoms of the disease and provides an opportunity to build a trusting relationship with the patient and their caregivers. In outpatient clinics, it is possible to conduct long-term pharmacological and psychological interventions, counseling, education, monitoring and care planning. This type of care can also prevent crisis situations for the patient, such as emergency department visits or intensive care unit admissions.

Palliative medicine outpatient clinics that offer consultations to patients who are able to come to the clinic can be an important part of a comprehensive palliative care program. They are usually associated with other specialized palliative care units.

In 2009, the European Association for Palliative Care (EAPC), in its standards, recommended integration of outpatient palliative care units with other forms of palliative care due to the progressive nature of the conditions of patients under care. Patients with progressive disease and diminished functional status will at some point no longer be able to use outpatient clinics, therefore, they should be integrated with inpatient or home palliative care units [11].

Palliative medicine outpatient clinics can be combined with palliative care units, or be a part of oncology centers as hospital-based outpatient clinics. The model of a palliative medicine outpatient clinic operating together with an oncology outpatient clinic can provide a convenient form of contact for the patient during the oncology treatment, and allow the promotion of the palliative care model within the oncology team [12]. However, this is not an optimal solution for larger centers where palliative care services are organized comprehensively [1].

Outpatient palliative care services can be adapted to different models. A Danish study comparing outpatient palliative care models presented a model in which the primary intervention provided by a physician and nurse practitioner amounted to a consultation or follow-up at a palliative medicine clinic located in a hospital. The scope of the consultation included assessment of the symptoms, psychological distress and social support needs. The time of the first consultation was scheduled for about 1 hour, follow-up consultations for 30 minutes. Follow-up visits were scheduled every 3 weeks or as needed in the form of consultations with a palliative care physician and a nurse, or with a nurse alone. Additionally, regular telephone contact implemented by the outpatient clinic nurse was offered. If the patient's mood or general condition prevented him or her from coming for a follow-up, a home visit was also possible. A telephone hotline for urgent cases was available 2 hours per day. In this model, the patient also had access to a multidisciplinary team as needed, which, in addition to palliative care physicians and nurses, included a physiotherapist, dietician, social worker, psychologist and clergyperson [13].

In Poland, palliative care is integrated with the health care system, and outpatient palliative care is one of the guaranteed benefits. Currently, the document defining the standard of this care is the 2013 Regulation of the Minister of Health on guaranteed services, according to which palliative care provided in a palliative medicine outpatient clinic is a publicly funded service [14].

OUTPATIENT PALLIATIVE CARE IN POLAND – CURRENT STATUS

Access to palliative and hospice care services varies in Poland. Disparities between provinces relate to the number of units, expenditures per capita and accessibility to particular ranges of services. Access to home-based services is the best, while access to inpatient and outpatient services is the least [15, 16].

In 2016, there were only 147 palliative medicine outpatient clinics in our country. By 2018, the number had risen to just 154. During this time, a much larger increase in the number of units of other forms of palliative care could be observed.

Palliative medicine outpatient clinics do not sufficiently address the needs for outpatient care. In Poland, low funding and the lack of differentiation in funding between outpatient counseling and outpatient home visits are barriers to the development of this form of care. An adequate ratio would be one palliative medicine outpatient clinic per county and a correspondingly higher number in large cities [15, 16].

An additional barrier to the development of outpatient care is the social stereotype limiting palliative care to end-of-life care and insufficient knowledge in the oncology community regarding early referrals to palliative care alongside oncology treatment. Currently, most patients are referred to palliative care after completing oncology treatment at a stage of significant disease progression, in a condition that no longer allows free movement. The vast majority of patients referred to palliative care therefore require home or inpatient care.

Outpatient palliative care in Poland requires organizational and funding changes. The Standards Team formed by the Polish Society of Palliative Medicine suggests transforming palliative medicine outpatient clinics into Palliative Medicine and Supportive Treatment (PMST) Clinics. Such an organizational model was proposed by the Ministry of Heath's Team for Palliative Medicine in 2012. However, no action was taken regarding organizational changes at that time [17].

OUTPATIENT CLINIC FOR PALLIATIVE MEDICINE AND SUPPORTIVE TREATMENT – ORGANIZATION

The outpatient clinic for Palliative Medicine and Supportive Treatment should provide palliative care in an outpatient setting from Monday to Friday during selected visiting hours. Outpatient clinic hours should be demand-driven (number of contracted services), with a minimum of twice per week. Outpatient clinics in cancer centers should operate every day on weekdays.

This form of specialized care is dedicated to patients who can come to the outpatient clinics, and in selected situations to patients who remain at home, but do not require palliative home care.

The PMST should implement a model of early palliative care integrated with other medical disciplines (e.g. oncology, pulmonology, cardiology or neurology). This would allow patients to continue causal treatment while providing specialized symptomatic treatment.

In justified cases, a visit to the PMST could be carried out in the home setting. If the clinical condition of patients under the PMST 's care deteriorates as the disease progresses, the patient will require continued treatment and referral to specialized home or inpatient palliative care.

The outpatient clinic should provide assistance in the treatment of pain and other somatic symptoms, as well as psychological support to patients whose health condition allows them to come to the clinic for an appointment, and who are not covered by home care.

The clinic would cover people:

- undergoing disease-modifying treatment,
- not qualified for causal treatment (e.g. due to advancement of the disease, old age),
- after completion of causal treatment, with an unsuccessful prognosis,
- after successful causal treatment, without active features of cancer, with complaints as a consequence of cancer or its treatment.

SCOPE OF THE PROVIDED SERVICES

The Palliative Medicine and Supportive Treatment Clinic should provide:

- medical advice and consultation (also in the form of teleconsultations in justified cases),
- nursing services (also in the form of teleconsultations in justified cases),
- psychological counseling (also in the form of tele/video-counseling in justified cases),
- doctor's home visits,
- home visits by a nurse,
- home visits by a psychologist,
- advice or intervention visits outside of the scheduled clinic hours in case of emergency needs of the patient, if organizational conditions allow,
- performing diagnostic laboratory and imaging tests necessary in the process of symptomatic or supportive treatment,
- referral to other treatment providers – including hospital, outpatient specialized care, rehabilitation, specialized home or inpatient palliative care.

Comment

1. Tele/video-counseling should be a complementary tool in daily clinical practice in situations that do not require direct contact with the patient (e.g. providing advice, clarifying recommendations, doubts or continuation of the treatment/e-prescription, additional psychological support).
2. In the billing system of the National Health Fund, there should be the possibility of billing for a consultation or an emergency visit performed off-schedule, if the need arises and the organizational conditions of the clinic allow it.

CONDITIONS FOR THE IMPLEMENTATION OF HOME VISITS

In justified cases, a visit to the PMST can be carried out at home. Home visits ought to be for patients who cannot come to the outpatient clinic, but do not require home care. This includes patients in stable condition with limited mobility, such as patients suffering from weakness, pathological fractures or other disabilities. Home visits can be carried out as needed by any member of the team employed by the clinic: doctor, nurse, psychologist.

Comment

1. In the opinion of the Team, this form of service requires an independent valuation taking into account all components of the costs incurred during the visit. When planning the valuation of a home visit, it is necessary to take into account: the time of the visit, the time of the commute, the cost of fuel, the cost of operating the car, the cost of medications used ad hoc, the cost per hour of the member of the consulting team (doctor, nurse, psychologist).
2. In the case of PMSTs operating in a medical entity which has a home care team, the implementation of home visits should not be a problem, but in hospital outpatient clinics, they may pose an organizational problem due to limited staff resources and their form of employment. Therefore, visits to the patient's home ought to be contracted independently of counseling, or there should be flexibility in the type of service provided in accordance with the capabilities of the medical entity.

REFERRALS TO PALLIATIVE MEDICINE AND SUPPORTIVE TREATMENT CLINICS

A health insurance physician may refer to an outpatient clinic any patient who requires symptomatic or supportive treatment regardless of diagnosis and stage. The outpatient clinic physician, depending on the needs, may qualify the patient for specialized palliative care or provide a consultation and with recommendations refer the patient for care to the referring physician, general practitioner or other specialist. A patient diagnosed with a malignant tumor may be admitted to the PMST without a referral on a scheduled date after registration, if the patient feels the need for this form of care.

Comment

Currently, a referral to a palliative medicine clinic is required for all patients.

STAFF OF PALLIATIVE MEDICINE AND SUPPORTIVE TREATMENT CLINICS

The team consists of members from various disciplines: a doctor, a nurse and a psychologist. The head of the PMST is a physician specializing in palliative medicine.

In the PMST there should be employed a palliative medicine specialist or a doctor in the process of specializing in palliative medicine.

A nurse employed by the PMST should either have a specialization in palliative care nursing or be in the process of such specialization, or have completed a qualification course in palliative care nursing.

The psychologist should be a specialist in clinical psychology, but employment without specialization is also acceptable.

The organization of the clinic should allow for the provision of services outside of working hours on weekdays, especially visits to a patient in case of emergency (e.g. severe uncontrollable pain, toxic effects of drugs), if organizational conditions allow.

Comment

The PTMP team believes that rigidly defining the duration of the visit would hinder the fluency of work in the clinic. The more rigid the framework, the less flexible the system will be and the more difficult it will become to adapt it to the needs of the patient at any given time, therefore it will be less favorable to both parties (patient-health care professional). The current hourly system is sufficient to provide quality services. With greater demand, the clinic's working hours can be extended (personnel are employed on a part-time basis resulting from the clinic's working hours) and the contract with the payer can be increased just as flexibly.

PHYSIOTHERAPIST AT THE PALLIATIVE MEDICINE AND SUPPORTIVE TREATMENT CLINIC

In the opinion of the PTMP Team, the services of a physiotherapist in an outpatient palliative medicine clinic are not essential. Patients under outpatient care can receive physiotherapy treatments within the health care system in entities dedicated to this type of service, with an appropriate team and equipment, which gives access to a greater variety of treatments. Alternatively, patients in a worse general condition or with limited mobility requiring physiotherapy treatments can receive home care as part of a home palliative care team.

Comment

Currently, the payer limits the number of services for a patient under the PMST to two per week, which excludes the possibility of performing treatments/services on a regular basis. A physiotherapist requires a separate room –an office in order to perform treatments.

PALLIATIVE MEDICINE AND SUPPORTIVE TREATMENT CLINIC AND PALLIATIVE CARE ORGANIZATIONAL STRUCTURES

It is advisable for the PMST to be located within the structure of a unit specialized in home palliative care, or inpatient of a multispecialty hospital or multispecialty outpatient clinic of an oncology hospital (center).

ON-PREMISES CONDITIONS OF PALLIATIVE MEDICINE OUTPATIENT CLINICS

The outpatient clinic for Palliative Medicine and Supportive Treatment should meet specific requirements similar to other entities performing outpatient services [18].

Comment

In small entities, a single doctor's office, where members of the outpatient team work alternately, may be sufficient. In larger entities, an additional office for a psychologist is needed, as well as a treatment room where, for example, dressing changes or bisphosphonate infusions are performed.

PROCEDURES PERFORMED AS PART OF THE OUTPATIENT PALLIATIVE MEDICINE AND SUPPORTIVE TREATMENT CLINIC

Procedures performed within the PMST can be divided into diagnostic, therapeutic and psychological support procedures (Table 1).

Comment

As part of the Palliative Medicine and Supportive Treatment Outpatient Clinic, it should be possible to make referrals for all diagnostic laboratory and imaging tests analogous to specialty clinics (which should be included in the funding).

Counseling and education can be provided by a doctor, nurse and psychologist.

The clinic can also provide consultations for patients who are in different wards.

Comment

In order for the PMST to provide effective care for patients at various stages of illness, the specialists it employs ought to have access to a package of necessary diagnostic tests and therapeutic procedures. This means that they must be funded by the payer.

SOCIAL SUPPORT AND PSYCHOLOGICAL CARE FOR THE ORPHANED

According to the definition of palliative care, social support for patients (and often families) is one of the components of palliative care. In the current legislative system in Poland, there is a separation of health care and social care, which is regulated by relevant laws [19].

According to the Article 2 of the Social Assistance Act of 12 March 2004: social assistance is organized by governmental and local administration bodies, cooperating in this regard, on a partnership basis, with social and non-governmental organizations, the Catholic Church, other churches, religious associations and natural and legal persons. In the case of palliative care units, whose founding bodies are church or non-governmental organizations, it is also possible to organize social support, but the dimension and manner of the support has not been standardized. Within the framework of outpatient care, medical personnel should identify places or institutions where the patient or his caregivers can obtain social benefits.

Currently, psychological support of orphans is not covered by the contract with the payer. This results in the inability to bill for services for orphans (adults as well as children). In our opinion, psychological support for families and orphans up to 12 months after the patient's death should be provided as a part of outpatient palliative care.

SUMMARY

Outpatient palliative care is a form of palliative care for all patient groups. Patients with a diagnosis of cancer can benefit most from early inclusion in this form of palliative care.

The Standards Team of the Polish Society of Palliative Medicine proposes an innovative model of outpatient palliative care in the form of the PMST. Effective provision of integrated palliative care requires the inclusion of a patient with advanced cancer in palliative care while still under oncologic care and functionally independent. Supportive care is seen as an essential component of oncology care. However, there is considerable variation among oncologists in the provision of supportive care and referral to palliative care. Increasing therapeutic diversity in oncology makes it increasingly difficult to comprehensively address supportive care needs. According to the Standards Team of the Polish Society of Palliative Medicine, an effective palliative care team should play a separate, but complementary and collaborative role with the oncology team in the care of cancer patients at each stage of the treatment. The level of involvement of each discipline will change over time. In patients with an unsuccessful prognosis, palliative medicine specialists will gradually take the care over. An analogous system should apply to cooperation with other specialists.

Patients previously covered by home palliative care should also be referred to outpatient care if their condition improves or stabilizes and they will only require care from one member of the interdisciplinary team.

The Standards Team formed by the Polish Society of Palliative Medicine believes that outpatient palliative care can also be a response to the growing demand for palliative care among the population of patients with non-cancer conditions who currently do not meet the eligibility criteria for care, according to the current annex to the Regulation of the Minister of Health on guaranteed services in the field of palliative and hospice care. In our opinion, any patient (regardless of diagnosis) can benefit from consultations at Palliative Medicine and Supportive Treatment Clinics if they receive a referral from their attending physician or family doctor. The limitation of both personnel and financial resources prompts us to create models of care in which there will be a personalized approach to covering patients with higher current or anticipated palliative care needs with ongoing care. Patients with cardiac, pulmonary or renal conditions who remain on disease-controlling therapies should be placed under the care of their specialists or family physicians after receiving consultations for symptomatic treatment. Re-consultation will be possible in case of changing needs.

The above document is not a legal act, it is a scientific study, which contains the position and at the same time the proposal of experts from the Standards Team of the Polish Society of Palliative Medicine. The next stage of our activities will be to subject the document to consultation among experts and ambulatory palliative care professionals.

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