

A Program for Palliative Care Led by Nurses for Individuals Living with Advanced Cancer

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Abstract

A 6 month program was conducted for individuals living with advanced cancer to address their symptoms and psychosocial requirements, which frequently lead to Emergency Department visits. The program involved nanny led telephone calls to manage symptoms, coordinate care, and grease advance care planning to determine values and pretensions for unborn care. Of the actors, half completed the program, a quarter enrolled in lodge or passed down, 19 were lost to follow up, and 9 withdrew from the program, pullout was more common among cases with smaller symptoms and those who were white. Nearly all cases (83) engaged in some form of advance care planning, and 80 of cases entered lodge care before their death.

Keywords: Advance care; Palliative care; Oncology; Nurse; Quality of life; Telephonic care; Telerehabilitation; Cancer

Introduction

Individualities with advanced cancer experience a high symptom burden, low quality of life, and significant emotional and spiritual requirements compared to those with early stage cancer [1]. Traditional oncology conventions may not give sufficient support for the symptom and cerebral requirements of this population. Symptoms similar as fatigue, pain, dyspnea, anorexia, constipation, depression, and anxiety bear further than the standard 15 nanosecond clinical hassle to address effectively [2,3]. As a result, cases may visit Emergency Departments for symptom operation related to cancer and its treatment. Cases with advanced cancer frequently bear further frequent follow up and care collaboration. still, deaths of palliative care providers, particularly croakers and advanced practice providers, limit the vacuity of specialty palliative care in confluence with traditional cancer care [4,5]. Being palliative care delivery models can be supplemented by nurses to enhance traditional specialist palliative care. For illustration, oncology nurses staffing support lines have demonstrated advancements in symptom inflexibility, but not in healthcare application, when responding to calls regarding concerning symptoms, changes in clinical status, and drug operation [6,7]. Pre-scheduled, nanny initiated calls for cases entering chemotherapy have also shown positive results in symptom operation [8]. Other interventions use lay shipmen to give primary palliative care with a focus on caregivers, while some involve nurses during in person oncology infusion visits [9-14]. Current interventions under disquisition include nurses responding to cases' portal reported dispatches and nanny led telephonic interventions, either alone or combined with in person multidisciplinary sessions [15]. These interventions are frequently psychoeducational, where nurses educate problem working and address the eight palliative care disciplines [16]. While engagement in colorful models has been reported away, predictors of engagement haven't been well studied. Many models have examined the impact on lodge use. This study aims to assess the characteristics of cases who withdrew from the program, determine the proportion of completed advance care planning(ACP) processes, and identify the socio demographic and clinical factors associated with lodge use among the study population.

Method

Study design

This study is a secondary analysis of data from a single intervention

arm of individualities with advanced cancer who were enrolled in Emergency Medicine Palliative Care Access (EMPAllA). EMPAllA is a relative effectiveness trial that tested two forms of palliative care delivery for individualities living with serious illness following ED discharge nanny led telephonic care versus specialty inpatient palliative care [17]. This analysis only includes cases with advanced cancer who were randomized to the nanny led telephonic arm of the study between April 2018 and June 2022. Data comparing the two interventions on primary (quality of life) and secondary issues (healthcare use, loneliness, and survival) will be available in the future. Registered nurses (RNs) certified in lodge and palliative nursing, grounded at New York University Grossman School of Medicine (NYUGSOM), delivered telephonic palliative care across 18 spots under the supervision of a lodge and palliative drug croaker for the nanny led telephonic care arm. The telephonic intervention arm protocol and processes have been reported away [18]. To share in this study, individualities demanded to meet specific criteria, including having a opinion of metastatic solid excrescence before an indicator ED visit at one of the spots during the study period, planning for ED discharge or observation, being aged 50 times or aged, speaking English or Spanish, and having health insurance [17]. Rejections included having two or further inpatient palliative care visits in the former 6 months, lodge use, a history of madness, abiding in a professed nursing or supported living installation, not having a working telephone, or abiding outside predefined geographic area. Cases with end stage organ failure and those randomized to admit specialty inpatient palliative care as part of EMPAllA weren't included in this analysis.

The predictor variables in this study included sociodemographic characteristics similar as age, coitus, race, race, income, and educational

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position, as well as quality of life, symptom burden, and loneliness. Quality of life was measured using the Functional assessment of cancer therapy general, which is a 27 item five point Likert type instrument scored from 0 to 108 [19]. Advanced scores indicate better quality of life. Symptom burden was measured using the revised Edmonton Symptom Assessment Scale [20], which is a 10 item numerical standing scale scored from 0 to 100. A score of 31 or advanced indicates clinically significant symptom burden. For this study, symptom burden was measured as a double variable high (score of 31 or advanced) or low [21,22]. Loneliness was measured using the three item loneliness scale (Cronbach nascence=0.72) [23], which is a three point Likert type scale scored from three to nine. A score of 7 or advanced represents "veritably lonely" [24]. For this study, loneliness was measured as a double variable veritably lonely or not. Engagement in the 6 month program was measured as the time to pullout, with laundering due to loss to follow-up, death, or the end of the 6 month period, whichever came first. nurserers communicated cases daily to yearly grounded on their requirements, and nanny interventionists collected ACP process data. The rudiments of ACP included having exchanges about pretensions of care, naming, informing, or establishing a healthcare deputy in the electronic health record (EHR), completing an advance directive (announcement), participating the announcement with a provider or healthcare deputy, establishing the announcement in the EHR, and agitating lodge. It's unclear whether the nanny completed a healthcare deputy or announcement form from scrape or streamlined a preliminarily completed document, as this was outside the compass of this analysis. also, it's unknown whether the cases' wishes represented a change from those preliminarily proved.

Analysis

This study describes the birth sociodemographic and clinical characteristics of the nanny led palliative care intervention group with advanced cancer using means and standard diversions for nonstop variables, and frequentness and probabilities for categorical variables. To assess predictors associated with time to pullout from the telephonic program, a mixed goods Cox commensurable hazards model was estimated, conforming for age, coitus, presence of a caregiver, income, race, race, functional status, religion, education, quality of life, symptom burden at trial registration, and whether the case was enrolled before or during the COVID-19 epidemic (Table 1). The COVID-19 epidemic

Table 1: Characteristics of study participants, showing the distribution among those that withdrew and didn't withdraw from the program (N=218).

Predictor	Hazard Ratio
Age	1.03 (95% CI: 0.99, 1.07)
Sex	
Male	1.86 (0.85, 4.09)
Female	Reference category
Have caregiver	
No	1.78 (0.59, 5.35)
Yes	Reference category
Income	
<25k yearly income	1.16 (0.38, 3.54)
25k+ yearly income	Reference category
Recruited pre-COVID-19	
Yes	1.53 (0.48, 4.86)
No	Reference category
Symptom burden (ESAS-r) at baseline	
Low symptom burden	1.90 (1.02, 3.53)
High symptom burden	

status was defined as "present" if the indicator ED visit was on or after February 1, 2020. The model included a point-specific arbitrary effect to regard for possible clustering by position or sanitarium point. All covariates were determined a priori. Also, the need to include an RN-specific arbitrary effect to regard for implicit clustering at the RN position was estimated, but its addition didn't impact the overall estimates and was barred from the final model. Logistic retrogression modeling was used to assess the effect of patient characteristics associated with dying in lodge compliances with missing data at birth were barred from the analyses. All analyses were conducted using R, Version4.1.0 (R Foundation for Statistical Computing), including the survival and lme4 packages [25].

Results

The study actors had a mean age of 66 (SD 10) times, and 107 were manly. Nearly three diggings of the sample were white, one quarter were black, and nearly all were English speaking fresh characteristics of the study actors can be set up in Table 1. The mean birth FACT-G score was 68 (IQR 55 to 83) out of a possible score of 108. Of the actors, 88 had low symptom scores, and 33 reported feeling veritably lonely. An aggregate of 211 cases were included in the pullout analysis, as seven cases had missing covariate information at birth. Of these 211 subjects, 105 were engaged for the full 6 months and graduated from the program, while 54 failed or were enrolled in lodge during the intervention period. Forty stopped answering or returning calls and were considered lost to follow-up, and 19 laboriously withdrew from the program, indicating they no longer wished to be communicated by the nanny.

Among the 19 subjects who withdrew from the study, six completed the original assessment and were engaged for 2 to 4 months, while 13 withdrew during the original RN phone call. Of those 19 subjects, 11 were no longer interested in the program; four had scheduling conflicts due to work or other croaker movables. Two individuals were unable to communicate via phone, and two others decided to withdraw after speaking with their oncologist.

According to the Cox commensurable hazards model, white subjects were more likely to withdraw thanon whites and those with low birth symptom burden were more likely to withdraw than those with high symptom burden. Other characteristics, similar as age, coitus, having a caregiver, income, race, education position, functional status, reclamationpre COVID-19, and quality of life as measured by the FACT-G didn't appear to be related to the decision to withdraw.

Discussion

Our study enrolled 218 persons living with advanced cancer from the ED in a telephonic nanny - led palliative care intervention, nearly partial remained engaged throughout the 6 month program, a quarter failed, and the rest were lost to follow up or withdrew. White subjects or those with low symptom burden were most likely to laboriously withdraw; utmost subjects who failed were enrolled in lodge, with a short standard length of stay of 6 days. ACP completion appeared to be high in subjects who failed nurserers had difficulty engaging with oncologists on behalf of cases.

Our study is one of the many to demonstrate high engagement and lodge registration in an advanced cancer population watched for telephonically, roughly three diggings of subjects remained engaged in the program until death, lodge registration, or completion of the six month intervention period, which is a high position of engagement former nanny led telephonic interventions for persons living with

cancer have substantially concentrated on symptom operation in individualities witnessing chemotherapy, with many focused simply on advanced cancer. Some have used interventions touched off by case reported symptoms via smartphone or web-grounded apps. In other populations, a meta-analysis of nanny led telehealth for aged grown-ups and telerehabilitation reported advanced quality of life, tone-care, and habitual complaint pointers. These analyses suggest a need for further exploration to explore which individualities may profit the most as well as the optimal styles for delivery. Also, whether these programs should be time-limited or handed on an ongoing base to those with serious illness is yet to be determined. The telephonic arm of our program had a low rate of active pullout, which is analogous to other programs for persons living with advanced cancer. Engagement was advanced than in the CONNECT trial, where oncology infusion nursers made three in-person or telephonic visits over three months in 56 of subjects and completed at least two visits in 78. Pullout from our program was advanced for those with lower symptom burden. It's possible that subjects without burdensome symptoms didn't feel the program would be helpful. This aligns with substantiation from subjects with low symptom burden enrolled in the enable II trial of telephonic advanced practice nursing care who didn't find the program helpful. This led authors to include cases in after cancer stages and with advanced symptom burden in posterior trials. Widely enrolling persons with high symptom burden in telephonic nanny led programs may ameliorate adherence, engagement, and more efficiently target scarce nanny coffers. Persons who tone identifies as white were also more likely to withdraw, which has not been seen away. One thesis is that the program increased access to those who witness systemic racism and bias within the healthcare systems. Navigation and access handed by the nursers may be more largely valued by this population. Attesting and probing this miracle would bear disquisition in unborn work. Our study set up high situations of ACP completion, which appeared to be high for subjects who ultimately failed. Our nursers had training in motivational canvassing and esteeming choices, which are established ACP engagement programs. Training nursers in multiple tools to deliver ACP telephonically may ameliorate uptake.

Eighty percent of those who failed were enrolled in lodge previous to death, which appears to be high compared to other studies of persons living with advanced cancer. The median length of stay in lodge was 6 days, which is lower than the public standard of 18 days for persons living with cancer. A shorter lodge length of stay is associated with dropped satisfaction among bereft caregivers. Our short lodge length of stay could be attributed to the large chance of New York residents, a state with one of the shortest lengths of stay and smallest lodge application rates in the country. Further exploration is demanded to estimate how telephonic interventions can ameliorate lodge length of stay. Only one telephonic intervention to date has demonstrated reductions in healthcare use and increased use of lodge. One challenge we faced was that nursers were only suitable to engage in two way communication with oncologists lower than one third of the time. Studies have shown that when oncologists understand patient care preferences and prognostic, it can ameliorate communication around thing accordant care and increase before registration in lodge. Working within a single health system enables internal communication practices similar as secure dispatches and inbox dispatches that were unapproachable to the nursers in our program. Rather, the nursers tried to empower cases and their caregivers to initiate exchanges with their oncologists; still, we don't have attestation of whether or not this passed, furnishing multiple styles for communicating prognostic understanding and wishes may ameliorate thing accordant care. Further exploration is

demanded to identify optimal styles of communication to ameliorate oncologist engagement with telephonic nursers, especially when they aren't housed in the same institution.

Conclusion

Our telephonic nanny led palliative care program showed high situations of subject engagement, ACP completion, and lodge use previous to death. Still, whites and those with low symptom burden more constantly withdrew. Farther exploration is demanded to identify why certain individualities are more or less likely to engage in nanny led telephonic care. It would also be precious to probe whether prioritizing individualities with high symptom burden and/ or those near to death is more effective in perfecting care for persons living with advanced cancer.

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Conflict of Interest

Author declares no conflict of interest.

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