Playing Well in the Sandbox: Growing an Outpatient Palliative Care Clinic While Enhancing Collaboration with Interventional Pain Clinicians

Jacob J. Strand, M.D.[1], Kelly Wu, M.D., Kelly J. Christensen P.A.-C[1]
[1]Section of Palliative Medicine, Division of General Internal Medicine
Mayo Clinic, Rochester, MN

Background & Significance

Pain is one of the most commonly experienced and feared symptoms faced by patients facing a serious illness and a common reason for referral to a palliative care service. Palliative care teams are able to control symptoms of pain in most circumstances.

However, a substantial minority of patients will have inadequate analgesia and/or intolerable side effects with systemic therapies . For these patients, minimally-invasive interventional pain therapies can be significantly beneficial.

Despite these benefits, studies demonstrate a lack of collaboration between palliative care and interventional pain providers, resulting in fewer patients receiving potentially beneficial interventions.

We report on intentional processes put in place in our outpatient palliative care clinic since 2012 that have enhanced the collaboration between interventional pain and palliative care teams.

Process & Culture Change

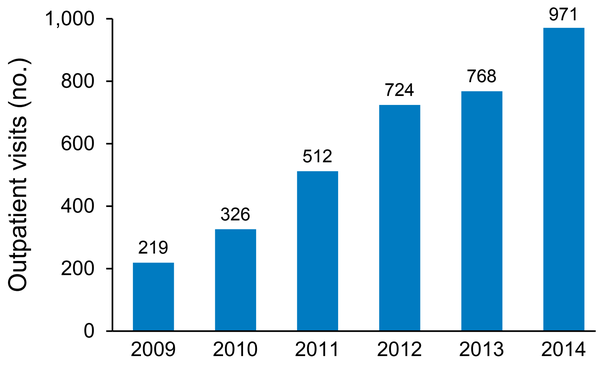
- Weekly "Pain Board"; meeting between interventional pain service and outpatient palliative care clinicians to collaborate on complex cases.
- Educational exchange between interventional pain and palliative care fellowship program.
- Dedicated weekly "referral" clinician to help with triage of requests for interventions on palliative care patients.
- Formation of cross-disciplinary research team
- Monthly leadership meeting between both groups to troubleshoot and plan.

Collaborative Growth

- The outpatient palliative care clinic at Mayo Clinic in Rochester, MN experienced rapid growth over the last six years **(see Figure 1)**.
- Internal referrals from palliative care clinic to interventional pain increased over five fold.
- Celiac plexus neurolytics blocks increased by 90%
- Intrathecal drug delivery system implantation increased by 90%

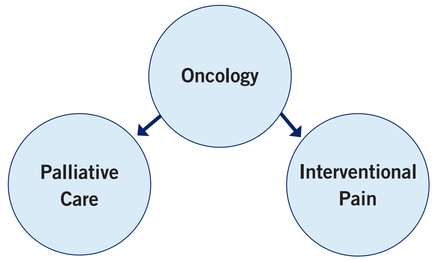
Figure 1

Total outpatient visits



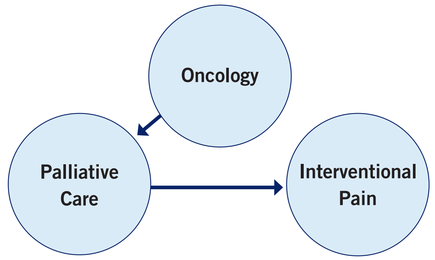
Models of Interaction

Traditional Model



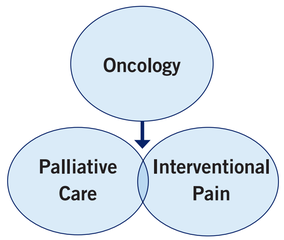
Oncology providers refer to either Palliative Care or Interventional Pain for cancer pain management, with limited interaction between services.

Palliative Care Centered Model



Oncologists refer directly to Palliative Care, who then refer to Interventional Pain if a procedure or other assistance is needed.

Interdisciplinary Model



Oncology providers refer to a interdisciplinary cancer pain center in which both Palliative Care and Interventional Pain collaborate to decide how to best manage a patient's cancer pain.

Benefits of Collaboration

CLINICAL:
This targeted collaborations can lead to increased cross-referral between services, reduction of "turf battles" and more rewarding and collegial relationship of between services.

EDUCATIONAL/RESEARCH:
At our institution, we have instituted cross-training between the two accredited fellowship programs. Palliative medicine fellows spend one month on the inpatient pain service and pain fellow rotate through the outpatient palliative care clinic
Several joint quality improvement projects are in process focusing on patient reported outcomes after interventional procedures and patient/ caregiver experiences transitioning to hospice care after intrathecal pump placement.

FINANCIAL:
Rather than acting as independent silos of pain management, collaboration between palliative care and pain could thus yield a decrease in redundant care and better utilization of the individual expertise of each service.

References

1. Center for the Advancement of Palliative Care (www.capc.org)
2. Daut, R, and Cleeland, C. The prevalence and severity of pain in cancer. Cancer 1982; 50:1913–1918
3. JJ Bonica. Treatment of cancer pain: current status and future need, in: HL Fields, R Dubner, R Cervero (Eds.), Advances in pain research and therapy, vol 9. Raven Press, New York (1985), pp. 617–628.
4. Kay et al. Provision for Advanced Pain Management Techniques in Adult Palliative Care: a National Survey of Anaesthetic Pain Specialists. Palliative Medicine 2007; 21(4):279-284.
5. Linklater et al. Pain Management Services in Palliative Care: A National Survey. Palliative Medicine 2002; 16(5):435-9.
6. Tei et al. Treatment Efficacy of Neural Blockade in Specialized Palliative Care Services in Japan: A Multicenter Audit Survey. Journal of Pain and Symptom Management 2008; 36(5):461-467.
7. Tworney et al. Collaboration in Difficult Pain Control in Palliative Medicine - Its Good to Talk. Journal of Pain and Symptom Management 2006; 31(6):483-484.