The Coleman FOUNDATION

# Greetings & Welcome

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Program Officer
Coleman Palliative Medicine Lead

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The Coleman FOUNDATION

Private foundation established by Dorothy and J.D. Stetson Coleman

The Coleman FOUNDATION

## Main Program Areas

- Entrepreneurship education
- Cancer treatment and care
- Services for individuals with developmental disabilities

# Coleman Cancer Program Area

Palliative Care falls within the cancer program area.

## Cancer Impact Vision

Cancer patients in the Chicago Metro area are fully engaged in their cancer treatment, and achieve the best possible outcome, and quality of life.

# Coleman Supportive Oncology Initiative

Cancer patients are:

- regularly screened for distress, psychosocial support and palliative care needs; and

- receive services identified by screenings from a collaboration of multiple, high quality, community service providers that have core competencies in delivering cancer care.

Supportive Oncology – from diagnosis through survivorship and end-of-life.

# Supportive Oncology Initiative Program Approach

**Design Process Teams**
- Northwestern
- NorthShore

**Process Improvement Sites**
- Rush University Medical Center
- University of Chicago Medical
- University of Illinois Hospital
- Mercy Hospital
- Sinai Hospital
- John H. Stroger Hospital of Cook County

**Patient Safety Organization (PSO)**
Metropolitan Chicago Breast Cancer Task Force

**Core Program Support & Reimbursement Facilitation**
Center for Business Models in Healthcare

# Coleman Supportive Oncology Initiative

## *Process Design Teams:*

*Define processes, stratification factors, measures, tools, education*

**Interact and align at appropriate project points**

| | |
|---|---|
| **North-western Distress and Survivorship** | Define optimal care process / pathways to improve delivery of distress services |
| | Feedback from providers, patients, |
| | Identify validated tools for pilots |
| | Develop process training for Pilots |
| **NorthShore Palliative and Hospice Referral** | Define optimal care process / pathways for delivery of palliative distress services |
| | Feedback from providers, patients |
| | Identify validated tools for pilots |
| | Develop process training for Pilots |
| **Process Team** Pediatric Supportive Oncology | Adjust Project 1-4 design of process / pathways for delivery of pediatric care |
| | Feedback from providers, patients |
| | Identify validated tools for pilots |
| | Develop process training for Pilots |
| **Processes and tools Team –** Pediatric Supportive Oncology | |

## *Supportive Oncology Improvement Sites:*

*Conduct current state assessment of processes, resources, measures, tools, training; identify gaps; implement improvements*

| | |
|---|---|
| **Rush** | **Implement improved supportive oncology care process / pathways** |
| **University of Illinois** | **Implement improved supportive oncology care process / pathways** |
| **University of Chicago** | **Implement improved supportive oncology care process / pathways** |
| **Mercy** | **Implement improved supportive oncology care process / pathways** |
| **Sinai** | **Implement improved supportive oncology care process / pathways** |
| **Stroger** | **Implement improved supportive oncology care process / pathways** |

*Program Critical supporting capabilities / infrastructure "CORE"*

| | |
|---|---|
| **Program facilitation, alignment, common methodology, consortium facilitation** | **Reimbursement** |
| | **Reporting and performance metrics standards** |
| | **Business Process Improvement standards and methods** |
| | **Program / Project Facilitation** |
| **Data collection infrastructure** | **Database of Metrics – Patient Safety Organization (PSO)** |

# Supportive Care

# Distress Screening Tool

# Addresses 35 Care Concerns

## Patient Screening Questions for Supportive Care



All patients are asked to complete this questionnaire as part of their standard of care. Please take a few minutes to answer the following questions to help us better address your needs.

Over the **last 14 days,** how often have you been bothered by the following problems? [2]

| *Please mark one box per row* | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious or on edge | ❑ | ❑ | ❑ | ❑ |
| Not being able to stop or control worrying | ❑ | ❑ | ❑ | ❑ |
| Little interest or pleasure in doing things | ❑ | ❑ | ❑ | ❑ |
| Feeling down, depressed, or hopeless | ❑ | ❑ | ❑ | ❑ |

Indicate if any of the following has been a concern for you in the **past 7 days,** please check Yes or No for each.

| YES | NO | **Practical Concerns** |
|---|---|---|
| ❑ | ❑ | Child care issues |
| ❑ | ❑ | Issues paying for food or housing |
| ❑ | ❑ | Issues with transportation to/from treatment |
| ❑ | ❑ | Work / school issues |
| ❑ | ❑ | Insurance coverage issues or no health insurance |
| ❑ | ❑ | Paying for medication or medical care |

| YES | NO | **Family/Caregiver Concerns** |
|---|---|---|
| ❑ | ❑ | Concerns about my children |
| ❑ | ❑ | Concerns about my partner |
| ❑ | ❑ | Concerns about caregivers |
| ❑ | ❑ | Ability to have children |
| ❑ | ❑ | Concerns about other family members |

| YES | NO | **Nutrition Concerns** |
|---|---|---|
| ❑ | ❑ | Weight loss or lack of appetite |
| ❑ | ❑ | Weight gain |
| ❑ | ❑ | Issues with taste |
| ❑ | ❑ | Concerns about nutrition and food |

| YES | NO | **Treatment or Care Concerns** |
|---|---|---|
| ❑ | ❑ | I want to better understand my cancer diagnosis or stage |
| ❑ | ❑ | I want to better understand my prognosis or long term outcome |
| ❑ | ❑ | I have questions about my treatment options, medication, or my plan of care |
| ❑ | ❑ | I want help communicating my wishes for treatment |

| YES | NO | **Physical Concerns** |
|---|---|---|
| ❑ | ❑ | Breathing |
| ❑ | ❑ | Constipation |
| ❑ | ❑ | Diarrhea |
| ❑ | ❑ | Fevers |
| ❑ | ❑ | Nausea or vomiting |
| ❑ | ❑ | Sleep |
| ❑ | ❑ | Changes in urination |
| ❑ | ❑ | Difficulty chewing or swallowing |
| ❑ | ❑ | Mouth sores |
| ❑ | ❑ | Dry mouth |
| ❑ | ❑ | Swollen arms or legs |
| ❑ | ❑ | Feeling full quickly or swollen abdomen |
| ❑ | ❑ | Sexual intimacy or function |
| ❑ | ❑ | Skin dry/itchy, blister/pain |
| ❑ | ❑ | Tingling in hands/feet |
| ❑ | ❑ | Appearance |
| ❑ | ❑ | Use of alcohol/drugs |

| YES | NO | **Spiritual / Faith / Religious Concerns** |
|---|---|---|
| ❑ | ❑ | I have a sense of purpose or meaning |
| ❑ | ❑ | I feel peaceful |
| ❑ | ❑ | I find strength in my faith and beliefs |

*See reverse side to complete*

## Please answer these questions to help us address what you need. - continued



YES ❑ NO ❑ **In the past 7 days, have you been in Pain?** [1,4,5]

If you have No Pain, skip this section and go to "Fatigue/Low Energy"

If YES, you have been in Pain, *please mark one box per row below*

| | No pain | Mild | Moderate | Severe | Very Severe |
|---|---|---|---|---|---|
| In the past 7 days how intense was your pain at its worst? | ❑ | ❑ | ❑ | ❑ | ❑ |
| In the past 7 days how intense was your average pain? | ❑ | ❑ | ❑ | ❑ | ❑ |
| What is your level of pain right now? | ❑ | ❑ | ❑ | ❑ | ❑ |

### Fatigue/Low Energy

| *Please mark one box per row* [6] | Not at all | A little bit | Somewhat | Quite a bit | Very much |
|---|---|---|---|---|---|
| During the past 7 days I feel fatigued (low energy) | ❑ | ❑ | ❑ | ❑ | ❑ |
| During the past 7 days I have trouble starting things because I am tired | ❑ | ❑ | ❑ | ❑ | ❑ |
| In the past 7 days how run-down did you feel on average? | ❑ | ❑ | ❑ | ❑ | ❑ |
| In the past 7 days how fatigued were you on average? | ❑ | ❑ | ❑ | ❑ | ❑ |

### Physical Activity

| *Please mark one box per row* [7] | Without any difficulty | With a little difficulty | With some difficulty | With much difficulty | Unable to do |
|---|---|---|---|---|---|
| Are you able to do chores such as vacuuming or yard work? | ❑ | ❑ | ❑ | ❑ | ❑ |
| Are you able to go up and down stairs at a normal pace? | ❑ | ❑ | ❑ | ❑ | ❑ |
| Are you able to run errands and shop? | ❑ | ❑ | ❑ | ❑ | ❑ |
| Are you able to be out of bed most of the day? | ❑ | ❑ | ❑ | ❑ | ❑ |
| Are you able to take care of your personal needs (dress, comb hair, toilet, eat, bathe)? | ❑ | ❑ | ❑ | ❑ | ❑ |

**Other problems or concerns** [1]: _____

_____

***This tool is adapted from:** (1) The National Comprehensive Cancer Network, NCCN Guidelines version 2.2014 Distress Management; (2) the PHQ-4 developed by Drs. Robert L. Spitzer, Janet B.W. Wiliams, Kurt Kroenke and colleagues; (3) Kaiser, M.J., et al., Validation of the Mini Nutritional Assessment short-form (MNA-SF): a practical tool for identification of nutritional status. J Nutr Health Aging, 2009. 13(9): p. 782-8.; (5) PROMIS Item Bank v1.0 Pain Intensity Short Form 3a; (6) PROMIS Item Bank v1.0 Fatigue Short Form 4a; (7) PROMIS Item Bank v1.0 Physical Function Short Form 4a; and PROMIS item bank(8) Living Well Cancer Resource Center Distress Tool.

The development of this tool was supported by The Coleman Foundation

# Nutrition Concerns – "YES" to *Issues with taste*



**Start With** asking patient the below questions

Are you maintaining your weight?

**If YES**

**Options/Recourse**
- Use plastic utensils for metallic taste
- Eat what tastes best
- Eat foods that are rich in calories and nutrients when possible
- Eat flavorful food or add different/additional seasonings to your foods
- Try oral nutrition supplements
- Encourage patient to explore different types of foods to find foods that may work
- Discuss good oral care

**Next Step**: Refer to D if available, if not, refer to D at outside cancer center if possible

D/N - Have discussion/share relative options with patient

May try zinc oxide, 25mg, 4 times a day (QID)

Refer to M - Share Patient Links and Handouts as appropriate

**Timing**: Discuss same day

**If NO**

**Options/Recourse**
- See above Options/Recourse
- Weight loss, see page _____

Do you have any mouth sores or thrush?

**If YES**

For Mouth sores, see page ____

**Options/Recourse**
- Discuss good oral care, usage of biotene/dry mouth rinses even if mouth not necessarily dry
- Treat thrush with oral nystatin if mild, diflucan if significant

**Next Step**: Refer to C

C- Have discussion/share relative options with patient

Refer to M - Share Patient Links and Handouts as appropriate

**Timing**: Routine - within 1 week

**KEY**
C = Physician/APN
D = Registered Dietitian
N = Nurse
M = Materials/Handout
PS = psychosocial
SW = Social Worker

## Notes

**Stages I-III:** Nutrition recommendations are based on individual labs, comorbidities, tolerances and preferences of the patient, not necessarily based on stage. Suggest cooking with additional spices or herbs, flavoring water with lemon, lime or cucumber, using plastic utensils verses metal, sucking on Lemon Heads to rid mouth of metal taste. Discussion on healthy diet consisting of real food verses processed, fruits and vegetables, nuts, beans whole grains and unprocessed meats.

**Stage IV:** Nutrition recommendations are based on individual labs, comorbidities, tolerances and preferences of the patient, not necessarily based on stage. Similar to recommendations on weight loss, may be natural part of dying process. If patient closer to dying, discuss lowered appetite/nutritional needs. Encourage eating for pleasure and comfort. Review cultural implication of eating/drinking less.

## Patient Links and Handouts:

- American Cancer Society, Information on Taste and Smell Changes
- Cancer.Net, Information on Taste Changes
- AICR, Heal Well, A Cancer Nutrition Guide

Journey Connections

## References:

- NIH, PDQ®, Nutrition in Cancer Care, Nutrition Therapy, Alterations of taste and smell





**Sample Follow Up Reference Document**

**52 distress**
**47 survivorship**

# Inpatient Oncology or ICU Reasons to Refer

## Inpatient Reasons for Referral to Palliative Specialist

1. Needs someone to support or lead a challenging advance care planning or goals of care discussion[1]
2. Has progressive disease where uncontrolled symptoms interfere with quality of life or performance status[1]
3. Has a cancer diagnosis and has failure to thrive or frailty[1]
4. Patient or family requests a palliative care consult[1]
5. Patient with life limiting cancer and poor functional status (ECOG of 3) and patient or health care agent has declined a hospice referral
6. Patient with chemotherapy-refractory advanced cancer with a good functional status who is not yet being referred for hospice[1]
7. Patient with any stage cancer diagnosis whose quality of life and/or survival is limited by debility, has frequent hospitalizations and/or other concurrent chronic medical issues such that prognosis is less than one year[1]
8. Patient has a life limiting oncologic illness and prolonged hospital stay (greater than seven days) without evidence of clinical improvement[1]
9. Stage IV malignancy or refractory hematologic malignancy in the setting of poor functional status[1]
10. Current or past enrollee of hospice program[1]

## ICU - Reasons for Referral to Palliative Specialist

1. ICU stay longer than seven days without evidence of improvement[1]
2. Cardiac arrest (either in or out of hospital)[1]
3. Multi-system organ failure (three or more)[1]
4. Stage IV malignancy or refractory hematologic malignancy[1]
5. Poor neurologic prognosis with low chance of meaningful recovery[1]
6. Inability to wean a patient from the ventilator[1]
7. Team/family discussing tracheostomy, feeding tube or long term care placement[1]
8. Current of past enrollee of hospice program[1]
9. Family disagreement with the medical team, with the patient's advance directive, or with each other[1]
10. Patient or family request[1]





# Outpatient Oncology Reasons to Refer

## Outpatient Reasons for Referral to Palliative Specialist

1. Needs someone to support or lead a challenging advance care planning or goals of care discussion[1]
2. Has progressive disease where uncontrolled symptoms interfere with quality of life or performance status[1]
3. Has a cancer diagnosis and has failure to thrive or frailty[1]
4. Requests a palliative care consult[1]
5. Patient with life limiting cancer and poor functional status (ECOG of 3) and patient or health care agent has declined a hospice referral
6. Patient with chemotherapy-refractory advanced cancer with a good functional status who is not yet being referred for hospice[1]
7. Patient with any stage cancer diagnosis whose quality of life and/or survival is limited by debility, has frequent hospitalizations and/or other concurrent chronic medical issues such that prognosis is less than one year[1]

## Reasons for Referral to Hospice Care

1. The patient is no longer able to come into the oncology clinic for visits due to debility, symptoms etc.[2]
2. Patient with chemotherapy-refractory metastatic solid tumor malignancy or refractory hematologic malignancy
3. Life expectancy less than six months and goals of care focused on comfort[4]
4. Poor performance status (ECOG 2 or more) inhibits use of chemotherapy
5. Patient with a cancer diagnosis, other serious chronic comorbidities, debility and/or frequent hospitalizations and a life expectancy less than six months[2, 4]

[1] Weissman DE, Meier DE. Identifying patients in need of a palliative care assessment in the hospital setting: A consensus report from the Center to Advance Palliative Care. J Palliat Med. 2011;14:17–23.

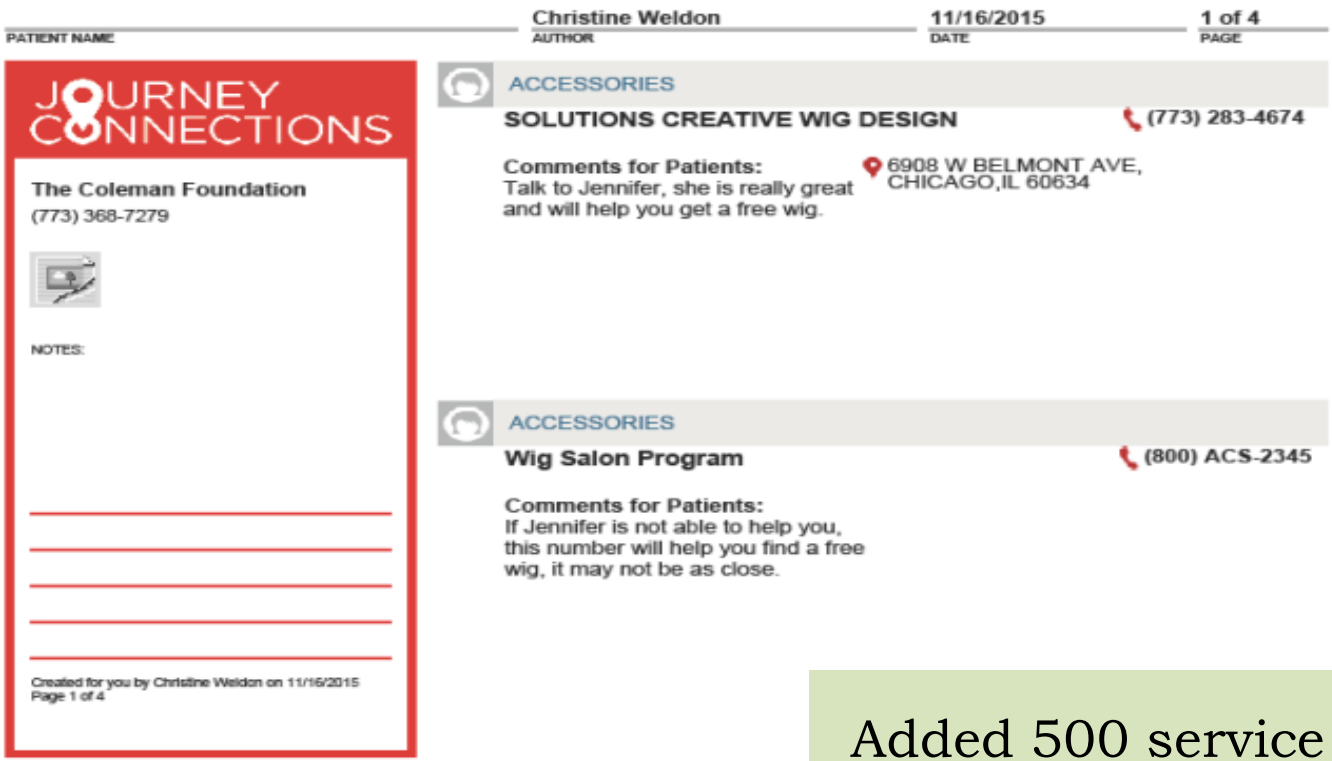
[2] National Hospice and Palliative Care Organization. http://www.nhpco.org/sites/default/files/public/NHHP_Palliative_Care_Pocket-Card.pdf. Accessed January 22, 2016.

[3] Prigerson, H., Bao, Y., Shah, M. et al, Chemotherapy use, performance status, and quality of life at the end of life. JAMA Oncol. 2015.

[4] Medicare Guidelines for Hospice eligibility

CFI 2014 Supportive Oncology Initiative Goal: Cancer patients are 1) regularly screened for psychosocial support and palliative care needs; and 2) receive all services as identified by these screenings (from diagnosis through survivorship and end-of-life) from a collaboration of multiple high quality service providers that have core competencies in delivering cancer care.

# Connecting to Community Service Providers
# JourneyConnections
# (Compliments of Lilly Oncology)



PATIENT NAME | Christine Weldon (AUTHOR) | 11/16/2015 (DATE) | 1 of 4 (PAGE)

JOURNEY CONNECTIONS

The Coleman Foundation
(773) 368-7279

NOTES:

Created for you by Christine Weldon on 11/16/2015
Page 1 of 4

ACCESSORIES

**SOLUTIONS CREATIVE WIG DESIGN** (773) 283-4674

**Comments for Patients:**
Talk to Jennifer, she is really great and will help you get a free wig.

6908 W BELMONT AVE,
CHICAGO,IL 60634

ACCESSORIES

**Wig Salon Program** (800) ACS-2345

**Comments for Patients:**
If Jennifer is not able to help you, this number will help you find a free wig, it may not be as close.

Added 500 service providers
Access 180 social workers

# Distress Training Modules

**Live on NCCN Website**

| Module | Objectives | Faculty |
|---|---|---|
| **1. The Importance of Distress Screening in Patient Care.** | 1. Understand the importance of screening for distress and practical and physical concerns in patient care, outcomes and adjustment to cancer.<br>2. Explain the standards and guidelines on distress screening (Commission on Cancer) and understand the importance of distress screening and the role distress screening has on meeting ACOS, COC, QOPI, NAPBC Accreditation Standards.<br>3. Describe three components of distress and supportive oncology screening (psychosocial, practical, physical). | Frank J. Penedo, PhD<br>James Gerhart, PhD |
| **2. How to conduct a Supportive Oncology Screening.** | 1. Explain which guidelines and instruments inform various sections of the supportive oncology screening tool.<br>2. Describe the appropriate timing and frequency of / to utilize / of administration of the supportive oncology screening tool.<br>3. Discuss examples of how different healthcare organizations have used the supportive oncology screening tool. | Jen Obel, MD<br>Christine Weldon, MBA |
| **3. How to handle distress (mild, moderate and severe PHQ-4 results).** | 1. Explain how to score and interpret the PHQ-4 in real time.<br>2. Understand the follow up process for patients scoring with mild, moderate or severe depression and/or anxiety.<br>3. Understand the need for immediate follow up for patients indicating immediate risk of harming self or others. | James Gerhart, PhD<br>Suzanne Armato, MA |
| **4. How to talk to a patient about their practical and family concerns.** | 1. Identify the most common practical and family concerns patients face.<br>2. Understand what interventions and resources are available to share with patients reporting mild, moderate and severe levels of distress with practical and family concerns.<br>3. Documentation needed to communicate your follow up efforts. | Melissa Minkley, MSW, CSW, OSW-C<br>Anne Bowman, CHES<br>Megan McMahon, PhD |
| **5. What is Supportive Oncology?** | 1. Describe the supportive oncology components.<br>2. Explain the appropriate timing of supportive oncology service initiation.<br>3. Differentiate components that may be more needed on early vs. late stage cancer (young adult vs. elderly). | Frank J. Penedo, PhD<br>Nancy Vance, BS<br>Craig A. Pressley, MSW, LCSW, OSW-C<br>Shelly S. Lo, MD |
| **6. What and how to document supportive oncology needs and care/referrals in patient's medical records.** | 1. Explain the key components of supportive oncology that should be tracked in medical records in order to: Support the patient through their care continuum, Communicate across the care team, Demonstrate compliance with the Commission on Cancer standard.<br>2. Contrast how care sites have implemented supportive oncology screening, results and care in EPIC.<br>3. Describe how care sites have implemented supportive oncology screening, results and care in Cerner. | James Gerhart, PhD<br>Cathy Deamant, MD<br>Julia Trosman, MBA |

# Survivorship Training Modules

**Live on NCCN Website**

| Module | Objectives | Faculty |
|---|---|---|
| **1. What is survivorship?** | 1. Define who is a cancer survivor.<br>2. Understand what is survivorship care.<br>3. Discuss trends of the survivorship population. | Frank J. Penedo, PhD Stephanie Merce Boecher, RN, OCN, MSN, BSN,BA<br>Sara M. Goetzman, BA |
| **2. Comprehensive Care for Cancer Survivors.** | 1. Understand what is comprehensive follow-up care for cancer survivors.<br>2. Common models of survivorship care.<br>3. Major challenges of survivorship care. | Sheetal Kircher, MD<br>Javier Macias, BA<br>Frank J. Penedo, PhD |
| **3. Commission on Cancer Requirements for Survivorship Care.** | 1. Identify the minimal data elements required by CoC Program Standard 3.3 to be included in cancer survivorship care plans.<br>2. Identify to which patients CoC-accredited institutions need to provide comprehensive care summaries and follow-up plans under Standard 3.3.<br>3. Summarize the timeline by which CoC-accredited institutions need to provide comprehensive care summaries and follow-up plans to increasing numbers of eligible patients. | Sofia F. Garcia, PhD<br>Sara M. Goetzman, BA |
| **4. Common Late and Long Term Effects.** | 1. Understand the late effects of cancer treatment.<br>2. Understand long term complications of cancer treatment. | Patricia Robinson, MD<br>Sara M. Goetzman, BA |
| **5. Lifestyle and Behavioral Factors.** | 1. Understand why it is important for cancer survivors to achieve and maintain a healthy lifestyle following active treatment for cancer.<br>2. Describe the lifestyle/behavioral domains associated with the NCCN standards for survivorship.<br>3. Describe the benefits/risks of engaging in healthy lifestyle behaviors as part of cancer survivorship. | Teresa A. Lillis, PhD<br>Carol A. Rosenberg, MD |
| **6. Common Psychosocial Challenges of Survivors/Psychosocial Sequela of Cancer.** | 1. Identify common psychosocial experiences and concerns of cancer patients and survivors.<br>2. Understand experiences of depression, emotional distress and fear of cancer recurrence.<br>3. Understand financial concerns and return to work and/or other other roles. | Teresa A. Lillis, PhD<br>Frank J. Penedo, PhD |
| **7. Prevention and Cancer Screening.** | 1. Discuss appropriate cancer screening.<br>2. Identify cancer prevention strategies. | Patricia Robinson, MD<br>Frank J. Penedo, PhD |
| **8. Genetic Testing for Patients, Families and Survivors.** | 1. Identify the reasons to perform genetic testing on a cancer survivor.<br>2. Describe the impact of a BRCA mutation on medical management of a cancer survivor.<br>3. Describe the impact of Lynch Syndrome on medical management of a cancer survivor. | Carol A. Rosenberg, MD Shelly S. Lo, MD |

# Palliative Training Modules

**Live on NCCN Website**

| Module | Objectives | Faculty |
|---|---|---|
| **1. Pain Assessment: The Basics** | 1. Understand different types of cancer pain.<br>2. Understand how to thoroughly assess pain.<br>3. Understand and treat opioid side effects. | Shelly S. Lo, MD<br>Joanna Martin, MD |
| **2. Pain – Beyond the Basics** | 1. Understand treatment options for pain management including opioids and adjuvant medications.<br>2. Understand opioid pharmacology.<br>3. Understand optimal dosing of opioids.<br>4. Convert from one opioid to another. | Shelly S. Lo, MD<br>Joanna Martin, MD |
| **3. How to Communicate Prognosis** | 1. Understand how we communicate is as important as what we communicate.<br>2. Identify barriers common pitfalls to empathic communication of serious news to patients and families.<br>3. How to communicate a prognosis, responding to patient emotions in an empathic and respectful manner, eliciting a patient's understanding of their illness and what is most important to their future. | Lauren Wiebe, MD<br>Megan McMahon, PhD<br>Betty Roggenkamp, BA |
| **4. Goals of Care** | 1. Understand how we communicate is as important as what we communicate.<br>2. Identify barriers common pitfalls to empathic communication of serious news to patients and families.<br>3. Tailor conversations and recommendations for a plan of care to a patient's individual goals and preferences. | Lauren Wiebe, MD<br>Megan McMahon, PhD<br>Betty Roggenkamp, BA |
| **5. POLST – Physician Orders for Life Sustaining Treatment, Using Illinois POLST as Example** | 1. Distinguish the relationship between an advance directive and the POLST (Practitioner Orders for Life- Sustaining Treatment) Form.<br>2. Identify patients who are appropriate to initiate a discussion about POLST.<br>3. Utilize the IL POLST form to create actionable medical orders for ensuring seriously ill patient's decisions about life-sustaining treatments are respected across settings of care. | Catherine Deamant, MD<br>Amy Scheu, MSH |
| **6. Advance Care Planning Over Time** | 1. Review the components of advance care planning discussion tailored to stages of health.<br>2. Describe the elements of an advance care plan based on a model of behavior change. | Catherine Deamant, MD<br>Amy Scheu, MSH |
| **7. Reasons to refer to Hospice and Palliative Care** | 1. Know basics of what an outpatient palliative care program provides and when a patient would be eligible.<br>2. Know basics of what hospice provides and when a patient is eligible for hospice care.<br>3. Understand how an outpatient palliative care program differs from hospice.<br>4. Know when to make an inpatient or outpatient palliative care or hospice referral. | Joanna Martin, MD<br>Amy Scheu, MSH<br>Jen Obel, MD |
| **8. Nausea** | 1. Identify common etiologies of nausea in oncology patients.<br>2. Access and evaluate etiology of nausea/vomiting.<br>3. Use pharmacologic and non-pharmacologic methods for managing nausea and vomiting. | Kathleen Derov, RN<br>Lauren Wiebe, MD |
| **9. Constipation** | 1. Assess for cause and severity of constipation.<br>2. Treat constipation in cancer patients. | Kathleen Derov, RN<br>Lauren Wiebe, MD |
| **10. Primary Palliative Care verses Specialty Palliative Care** | 1. Define palliative care.<br>2. Identify primary oncology team practices that are considered "primary palliative care".<br>3. Compare palliative care provided by a primary oncology team to palliative specialist care. | Catherine Deamant, MD<br>Christine Weldon, MBA |
| **11. Dyspnea & Shortness of Breath** | 1. Describe the causes of dyspnea.<br>2. Understand how to assess for dyspnea.<br>3. Review pharmacologic and nonphamacologic ways to manage dyspnea.<br>4. Understand how to educate the patient and/or family about dyspnea. | Joanna Martin, MD |

# Coleman Supportive Oncology Initiative

Cycle 2 - begins January l, 2017

- Invited proposals 6 process improvement sites
- 4 new sites

# Coleman Supportive Oncology Initiative for Children with Cancer

Project lead:

Lurie Children's Hospital

Process sites:

- Rush Children's Hospital
- UOC Comer Children's Hospital
- Lurie Children's Hospital

# Thank you for participating in the Primary Palliative Medicine Training Program