Palliative care provides many benefits for seriously ill patients. These include improved goal-concordant care, improved quality of life, reduced symptom burden, and reduced health care utilization [1]. Palliative care is a relatively new field and models of care delivery are evolving in order to meet the ever-growing demand. Virtual care, or the use of any technology to allow a health care provider to remotely interact with their patients, is an area that is rapidly growing due to its many possible advantages when compared to care provided in the clinic or hospital. Virtual care can be more convenient for patients, improves access to care for those with mobility or transportation difficulties [2], and is well accepted by patients [3, 4].

One of the most prominent areas of change in palliative care is the transition out of the acute care setting and into the community to focus more on virtual care models and patient-reported outcomes (PROs). The recent coronavirus pandemic has accelerated this shift, demonstrating the importance of meeting patients where they are and avoiding unnecessary exposure to health care settings. As this much-needed transition occurs, standardization of palliative care processes and methods is important for ensuring that state-of-the-art palliative care services are provided to this high-need, vulnerable population.

The National Quality Forum outlines quality measures for palliative care that can be broken down into eight domains: physical aspects of care, structure and processes of care, psychiatric and psychological aspects of care, cultural aspects of care, spiritual aspects of care, social aspects of care, care of the imminently dying, and ethical and legal aspects of care. Unfortunately, a systematic review of quality measures for palliative care in cancer patients across all settings demonstrates that most palliative care interventions focus on only two domains: physical aspects of care and care of the imminently dying [5]. Furthermore, within the domain of physical aspects, only pain and dyspnea are regularly measured [5]. Focus on these limited quality measures is even more pronounced in the inpatient setting [6]. Moving palliative care to the ambulatory setting allows clinicians to develop a longitudinal relationship with patients, helping them to understand their prognosis and make decisions about their serious illness care over time and creating an opportunity to systematically track broader quality domains [6].

PROs have been shown to improve patient-clinician communication, clinician awareness of symptoms, symptom management, patient satisfaction, quality of life, and overall survival [7]. There is rapidly growing interest in trying to incorporate PROs into routine clinical care. Although there are barriers to this, ranging from administrative to workflow concerns, community-based palliative care and the use of telemedicine present excellent opportunities for integrating PROs and possibly closing the current gaps in addressing unmet domains of palliative care. Some prac-
tical benefits of PROs include the ability to collect them by internet, automated telephone systems, or downloaded applications; their reflection of how patients feel and what their function is in their own care; and integration into routine serious illness care without significant additional burden to clinicians [7].

Providers have been adopting telemedicine to bring specialty palliative care to the homes of seriously ill patients. In the context of the recent pandemic, this process has been dramatically accelerated [8]. While this has been effective in many ways, as has been described in the United Kingdom, telemedicine services are at risk of being implemented but not evaluated in a standard and systematic way [9].

In summary, palliative care incorporates a large number of quality measures across various settings. While there are helpful general guidelines, a consensus about a core set of measures on which to focus is missing, and further research is needed to develop this consensus. Each program should identify local priorities and develop a key set of measures to track in order to ensure ongoing process evaluation and improvement. As we roll out new virtual care models to meet the needs of our seriously ill populations, one key area of focus should be the use of PROs to engage patients and ensure that we can deliver on all of the broad, holistic domains of palliative care. The current pandemic has accelerated this implementation process, and it is imperative that we continue to adhere to evidence-based quality measures in palliative care to ensure that, as we expand access to care and deliver it in new and creative ways, it continues to be high quality and patient centered. NCMJ

Kyle Lavin, MD, MPH clinical assistant professor, University of North Carolina Palliative Care Program, Chapel Hill, North Carolina

Paul E Zimmerman, MD palliative care fellow, University of North Carolina Palliative Care Program, Chapel Hill, North Carolina

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References

1. Von Roenn JH, Temel J. The integration of palliative care and oncology: the evidence. Oncology (Williston Park). 2011;25(13):1258-1260, 1263, 1264-1265.
2. Calton BA, Rabow MW, Branagan L, et al. Top ten tips palliative care clinicians should know about telepalliative care. J Palliat Med. 2019;22(8):981-985. doi: 10.1089/jpm.2019.0278.
3. Donelan K, Barreto EA, Sossong S, et al. Patient and clinician experiences with telehealth for patient follow-up care. Am J Manag Care. 2019;25(1):40-44.
4. Bonsignore L, Bloom N, Steinhauser K, et al. Evaluating the feasibility and acceptability of a telehealth program in a rural palliative care population: TapCloud for palliative care. J Pain Symptom Manage. 2018;56(1):7-14. doi: 10.1016/j.jpainsymman.2018.03.013.
5. Kamal AH, Gradison M, Maguire JM, Taylor D, Abernethy AP. Quality measures for palliative care in patients with cancer: a systematic review. J Oncol Pract. 2014;10(4):281-287. doi: 10.1200/JOP.2013.001212.
6. Hoerger M, Greer JA, Jackson VA, et al. Defining the elements of early palliative care that are associated with patient-reported outcomes and the delivery of end-of-life care. J Clin Oncol. 2018;36(11):1096-1102. doi: 10.1200/JCO.2017.75.6676.
7. Basch E, Barbera L, Kerrigan CL, Velikova G. Implementation of patient-reported outcomes in routine medical care. Am Soc Clin Oncol Educ Book. 2018;38:122-134. doi: 10.1200/EDBK_200383.
8. Calton B. Telemedicine in the time of coronavirus. J Pain Symptom Manage. https://www.jpmsjournal.com/article/50885-3924(20)30170-6/fulltext. Accessed April 30, 2020.
9. Hancock S, Preston N, Jones H, Gadoud A. Telehealth in palliative care is being described but not evaluated: a systematic review. BMC Palliat Care. 2019;18(1):114. doi: 10.1186/s12904-019-0495-5.

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Address correspondence to Kyle Lavin, CB 7160, Neurosciences Hospital, 2nd Floor, Chapel Hill, NC 27599 (kyle_lavin@med.unc.edu).

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