

Evidence-Based
ONCOLOGY™JUNE 2017
VOL. 23 • NO. 7

ALSO IN THIS ISSUE

Doing More for More Patients



A PREVIVOR'S STORY



Amy Byer Shainman has a family history of mutations in the BRCA gene and cancer, and she is BRCA1 positive. In this excerpt from her upcoming book, Shainman, a patient advocate,

emphasizes the importance of genetic counseling and shares her decision to undergo prophylactic surgery to reduce her risk of developing cancer (SP241).

COLLABORATION, THE FOUNDATION OF CARE TRANSITIONS



Care providers from New York Oncology and Hematology describe the implementation of a collaborative care model, which brings together clinical care providers, social workers, and the family to improve patient experience throughout the cancer care continuum (SP248).



CONFERENCE COVERAGE

NCCN

Coverage of the 22nd Annual Conference of the National Comprehensive Cancer Network (NCCN) held in Orlando, Florida, includes NCCN Guideline updates and sessions that discussed disparity and cancer care access barriers (SP251).

COA

At the 2017 Community Oncology Alliance Conference, sessions and presentations steered attendees through the complex world of CMS' Oncology Care Model, adequate use of a learning health system, coping with rising drug prices, and more (SP259).

PROVIDER PERSPECTIVE

Project ECHO: An Effective Means of Increasing Palliative Care Capacity

Sanjeev Arora, MD; Tracy Smith, BS; Jennifer Snead, PhD; Sarah Zalud-Cerrato, MPH; Lisa Marr, MD; Max Watson, MBChB; Sriram Yennu, MD; Amy Bruce, MPP; Chris Piromalli, DO; Stacy Kelley, MPH; Nandini Vallath, MD; Gabriela Píriz, MD; Gabriel Sehabiaga, MD; and Alvaro Méndez, MD

INTRODUCTION

Globally, the need for integrated palliative care has never been greater. Populations are aging, and rates of terminal non-communicable diseases continue to progress. Approximately half of all patients with cancer, for example, will eventually succumb to their disease—nearly one-third of cancer deaths happen within 6 months of diagnosis.¹ Organizations, such as the National Academies of Science, Engineering, and Medicine (formerly Institute of Medicine) and the American Society of Clinical Oncology, recommend full integration of palliative care as a routine component of comprehensive cancer care.² Integrated palliative care—which encompasses coordination of care for multiple severe, complex conditions; behavioral health concerns;

PAYER PERSPECTIVE

The Carrot or the Stick? Integrating Palliative Care Into Oncology Practice

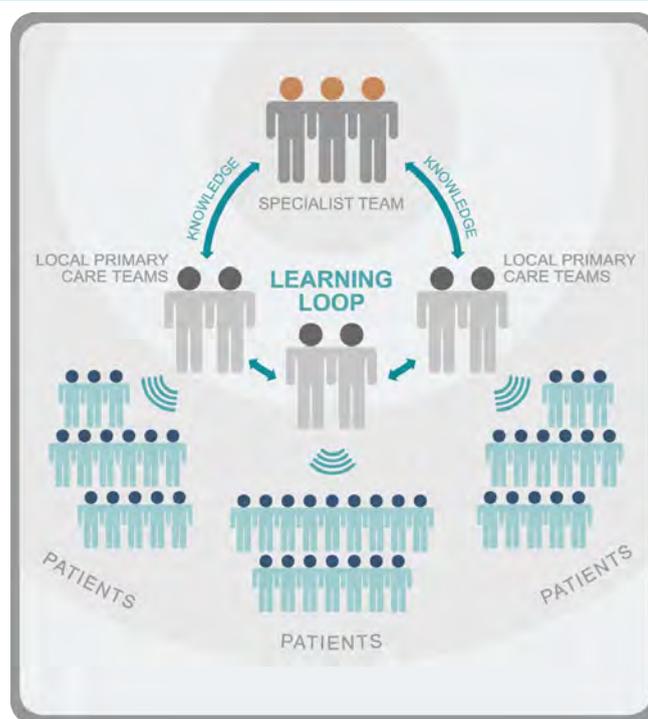
Torrie K. Fields, MPH

IN AN ERA WITH INCREASED EMPHASIS on bending the cost curve while increasing availability of targeted therapies for those with cancer, it can be difficult to strike the right balance between the art and the science of practicing high-quality oncology care. Perhaps just as difficult is the role of a regulating body or healthcare financier in providing the right incentives, policies, and authorization practices that allow clinical judgment while ensuring treatments are of high quality, evidence-based, and align with patient preferences. As cancer interventions become more effective and more complex, it is essential to create guardrails and incentives so that high-quality, patient-centered, cost-effective healthcare continues to be delivered.

Integrating palliative care into a treatment plan, preferably at the point of diagnosis, is crucial to delivering high-quality cancer care. Palliative care—which focuses on relieving the pain, symptoms, and stresses of a serious illness—has the ability to change the delivery and experience of healthcare for patients and caregivers. Many prospective studies have shown

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FIGURE 1. Project ECHO-Model: The ECHO Model Moves Knowledge, Not Patients



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PHARMACIST'S ROLE

Transitions of Care in Patients With Cancer

Brandon R. Shank, PharmD, MPH, BCOP; Phuoc Anh (Anne) Nguyen, PharmD, MS, BCPS; and Emily C. Pherson, PharmD, BCPS

Introduction

While on the one hand healthcare is constantly evolving with new technology, medical advances, policy changes, and reimbursement strategies, on the other hand, the cost of avoidable readmissions or preventable adverse events (AEs) are burdening the healthcare system. Jencks and colleagues concluded that about 20% of Medicare patients were readmitted within 30 days, with about 50% of the 20% who were readmitted having no follow-up post discharge.¹

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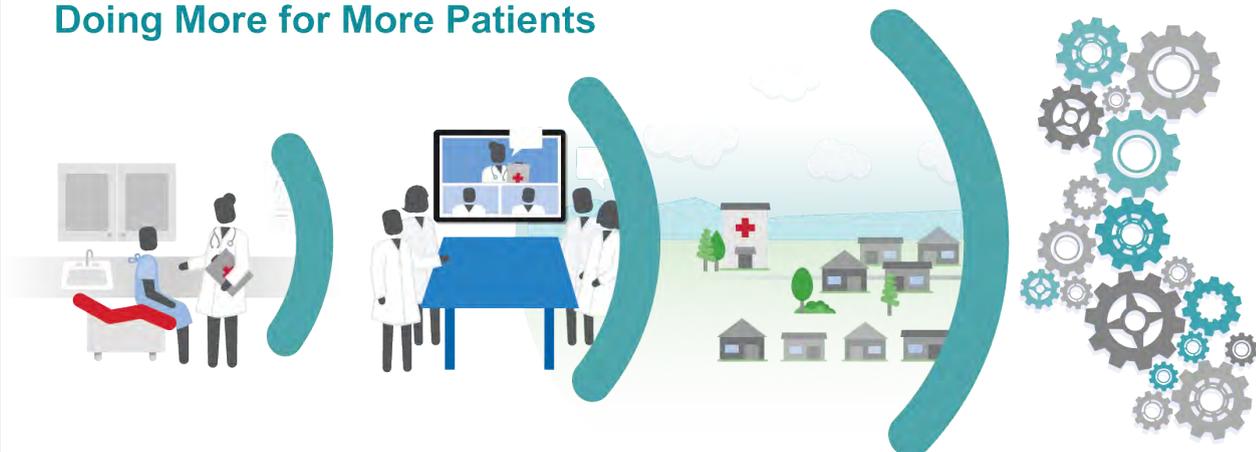
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SPECIAL ISSUE / TRANSITIONS OF CARE

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Doing More for More Patients



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- Right Place
- Right Time

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- Treat More Patients
- Build Community of Practice

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- Retain Providers
- Keep Patients Local

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FROM THE CHAIRMAN

Ensuring Adequate Cancer Care, From Diagnosis to Survivorship



MIKE HENNESSY, SR

PATIENT CARE IS A TEAM EFFORT and is filled with challenges at every step. Often more challenging than the actual care are the communication gaps among providers, which can lead to undesirable outcomes.

Nowhere is this team-based care model more evident than in oncology, where not just the care providers, but the patient and family caregivers are increasingly part of

the decision-making process. However, these care delivery models can fall apart unless there's constant, and consistent, communication and information sharing among the multiple

CARE DELIVERY MODELS CAN FALL APART UNLESS THERE'S CONSTANT, AND CONSISTENT, COMMUNICATION AND INFORMATION SHARING AMONG THE MULTIPLE STAKEHOLDERS.

stakeholders. And as the authors from New York Oncology and Hematology highlight in this issue, the roles played by nonclinical interdisciplinary teams is equally important, as it can impact a patient's care plan, care experience, and overall well-being.

A "navigation team,"

the authors write, can help provide continuity of care over the course of a patient's treatment and ensure that important details are addressed as a patient transitions through the healthcare continuum.

Pharmacists, particularly health-system pharmacists, play a critical role in enhancing transitions of care for patients undergoing cancer treatment via medication reconciliation, education, and postdischarge follow-up. A nurse or a pharmacist can be a helpful "transition coach" for older patients and can help prevent readmissions.

With the integration of palliative care into mainstream medicine, but the dearth of specialists who can provide this kind of care especially in rural areas, healthcare organizations are leveraging technology solutions to ensure patients and care providers can take advantage of the select few experts. Project ECHO, or Extension for Community Health Outcomes, is one such global project. Initiated at the University of New Mexico, Project ECHO now has 110 partners across 20 countries. Through teleECHO clinics, which are videoconference-enabled sessions, specialists share their expertise and community providers share their experience with individual patients via case-based learning and telementoring.

Payers, too, have recognized the value of care collaboration and integrating early palliative care into oncology practice, and are providing incentives through reimbursement models to boost the practice.

We hope you enjoy this summer issue of *Evidence-Based Oncology*™. As always, thank you for your readership, and please visit www.ajmc.com for the latest updates in health-care news and research. ♦

Sincerely,

Mike Hennessy, Sr

CHAIRMAN AND CEO

The Transition to Integrate Palliation in Cancer Care

Joseph Alvarnas, MD



JOSEPH ALVARNAS, MD

THE NATURE OF A CANCER

diagnosis and subsequent treatment is that patients are not only faced with the challenges of undergoing complex, often intensive, treatments, but also with the many changes in their care setting, providers, ancillary services, and goals of care that may occur over the course of their cancer journey. Unlike diseases like community-acquired pneumonia, in which care is limited to a discreet episode, the longitudinal nature of care needs for patients with cancer requires a different, more comprehensive system of care delivery. This, by necessity, requires that our system deliver care throughout the numerous transitions that our patients experience. High-quality cancer care can only occur when these “transitions in care” are delivered in a prospectively planning, systematic, patient-centered way. There are diverse arrays of transitions of care that mark the cancer care experience: inpatient to outpatient care, pediatric to adult care, therapy with curative intent evolving toward therapy directed towards palliation.

Throughout these transitions of care the stakes for the patient are very high; we have both an opportunity to contribute substantively to the patient-centeredness of care or to undermine the delivery of effective care. In this issue of *Evidence-Based Oncology™ (EBO™)*, we attempt to illustrate some of these episodes of care and highlight the opportunities for improving the effectiveness of care through these transitions.

One example of an immensely important transition of care for patients is that of ensuring the early integration of palliative/supportive care into post-cancer diagnosis treatment planning. However, the early use of palliative care is often a missed opportunity. There is a common misperception that palliative care solutions are only germane to patients at the end-of-life, thus initiation of these services are often delayed until patients are referred for hospice or comfort care services.¹ Cancer patients have an extraordinary number of care needs that are frequently under recognized and therefore unaddressed within our current care delivery system.

The World Health Organization defines palliative care as:

An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.²

Given the breadth of clinical skills that palliative care physicians can bring to the patient, this set of care services has the ability to complement the skills of the medical oncologist/hematologist in serving unmet patient care needs through treatment and survivorship.

The unique expertise of palliative care physicians can, in fact, help us bring increasingly more patient-centeredness to our care delivery sys-

tem. In a study comparing the impact of an early versus delayed model of palliative care referral for patients with non-small-cell lung cancer, there was no difference in the total number of chemotherapeutic regimens used per patient in either group, but there was a significant improvement for the early consultation group in the use of chemotherapy in the last 60 days of life, a longer interval between the last chemotherapy regimen and death, and a higher proportion of patients who survived for more than 1 week under hospice care.³

Palliative care represents only one of the many opportunities for mindful, value-added care transitions that can enhance the lives of our patients. The idea of carefully aligning expertise and clinical skills, delivered through carefully orchestrated transitions of care, represent a major advance in cancer care. In this issue of *EBO™*, we explore a number of these key opportunities to improve the experience of patients affected by cancer. Sanjeev Arora, MD, and colleagues review the ECHO model of palliative care that brings together primary care physicians and expert specialists for transition-of-care mentoring and communication of best practices. Brandon R. Shank, Phuoc Anh Nguyen, and Emily C. Pherson provide an overview of the role that pharmacists may serve in enhancing the effectiveness of transitions of care for cancer patients in ways that improve medication safety. Amy Byer Shainman shares her experience as a cancer “previvor” in navigating transitions in care for patients who are at high-risk of eventually developing cancer. Finally, Rufus Collea, MD, and colleagues provide their perspective on innovative strategies that can be used to improve palliative care, patient navigation, and interdisciplinary patient-family communication.

How can we ensure that more patients can benefit from effective, early palliative care? Perhaps this involves the breadth of stakeholders who participate in the care of these patients to overcome their prejudices over the word “palliative.” Palliation involves an acknowledgement that a patient’s cancer care needs extend well beyond the need for surgery, chemotherapy, and radiation therapy. In embracing the full range of needs of our patients, including the need to manage the distress associated with a cancer diagnosis, we can continue to bring increasingly effective, patient-centered care to those in need. A partnership between the oncologist and the palliative care physician provides an increasingly robust response to the needs of our patients and their families. ♦

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PROVIDER PERSPECTIVE

Project ECHO: An Effective Means of Increasing Palliative Care Capacity

Sanjeev Arora, MD; Tracy Smith, BS; Jennifer Snead, PhD; Sarah Zalud-Cerrato, MPH; Lisa Marr, MD; Max Watson, MBChB; Sriram Yennu, MD; Amy Bruce, MPP; Chris Piromalli, DO; Stacy Kelley, MPH; Nandini Vallath, MD; Gabriela Píriz, MD; Gabriel Sehabiaga, MD; and Alvaro Méndez, MD

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and end-of-life care—can provide symptom control, psychosocial support, and coordinated transitions of care for patients and their families.³⁻⁵

Yet, as Atul Gawande, MD, MPH, documented in his 2010 book, *Being Mortal*, best practices and innovations in creating or maintaining quality of life (QOL) for individuals nearing the end of their lives, or faced with life-threatening conditions, are not readily accessible to those who need them most.⁶

Despite ongoing efforts to incorporate palliative care concepts and training in medical and nursing education,⁷ barriers to access persist, and palliative care remains an insufficiently researched topic.⁸ The World Health Organization estimates that 19 million adults across the world are in need of palliative care, the majority in low- and middle-income countries, but that in many areas, the level of palliative care provision and access to services remain extremely limited and clinicians often lack the capacity to provide care to all in need.⁹

In the United States, large regional disparities in access to palliative care exist, especially in rural areas and among medically underserved populations.¹⁰ The number of palliative care specialists falls far short of demand, exacerbating geographic, racial, and economic disparities in access.^{11,12} Culture- and country-specific assumptions, perceptions, and laws about palliation, pain relief, and drug prescription/use are also significant impediments to effective palliative treatments.¹³

To overcome the gap between the growing need and the limited resources for palliative care around the globe, a transformative educational intervention is necessary. Such an innovation must effectively disseminate the principles, best practices, and applications of palliative care concepts for the frontline healthcare practitioners who serve communities most in need of that care. For the past 14 years, Project ECHO (Extension for Community Health Outcomes) has leveraged its innovative technology-enabled model for healthcare education to address global disparities in healthcare access for complex chronic conditions such as hepatitis C, HIV, tuberculosis (TB), and opioid use disorder. The ECHO model, which fosters and sustains communities of practice that bring together primary care clinicians with interdisciplinary specialist teams for ongoing case-based learning, mentoring, and sharing of best practices, also has the potential to tip the scales of the world's integrated palliative care crisis. This article describes the work of 7 of Project ECHO's replicating partners from around the world who are implementing the ECHO model to address the knowledge gap that underlies this crisis.

Project ECHO

Project ECHO improves healthcare workforce capacity and increases access to specialty care for the world's rural and underserved populations. A low-cost, high-impact intervention, Project ECHO links expert multidisciplinary specialist teams with frontline community healthcare providers via ongoing videoconference-enabled sessions. In these teleECHO clinics, specialists share their expertise and community providers share their experience with individual patients via case-based learning and telementoring. Overall knowledge is enhanced as cutting-edge research, treatments, and

best practices from academic and research centers are tested and refined through ongoing discussion and application within community- and culturally-specific contexts on the ground. Participating community providers do not need any additional equipment to participate other than a laptop enabled with internet and a video-camera. The ECHO model builds and strengthens communities of practice through latitudinal learning and the free exchange of knowledge: all participants teach, and all participants learn from one another. Community providers develop the capacity to care for patients with complex conditions where they live.

Project ECHO benefits not only patients in need of care, but also the providers who care for them. The communities of practice built through regular teleECHO clinics reduce professional isolation for providers located in rural areas, building networks and new opportunities for collaboration.¹⁴⁻¹⁷ These additional resources and opportunities support clinic staff retention and increase professional satisfaction.¹⁸⁻²¹ The peer support and mentorship that teleECHO clinics provide enable critical incident stress debriefing and self-care strategies, reducing provider burnout.

Project ECHO moves knowledge, not patients (**Figure 1**). It provides increased access to high-quality healthcare and reduces travel to, and wait times at, centers of medical expertise. The ECHO model, originally designed and implemented in 2003, addressed the lack of hepatitis C care across rural New Mexico. Within 18 months of establishing the first teleECHO clinic sessions, which connected primary care providers and community health workers around the state with a multidisciplinary specialist team at the University of New Mexico (UNM), wait times at the UNM hepatitis C clinic had dropped from 8 months to 2 weeks. Rural providers reported a greater sense of self-efficacy and confidence in treating hepatitis C patients in their own communities. Subsequent research demonstrated that the cure rate of those providers was the same as that in the UNM hepatitis C specialty clinic.¹⁴

Fourteen years later, Project ECHO has grown from 1 program serving rural New Mexico to over 110 partners in over 20 countries addressing over 55 conditions. The ECHO model has proved effective for hepatitis C treatment in the US Department of Veterans Affairs,¹⁵ for training primary care providers in the provision of buprenorphine for treatment of patients with opiate use disorder,¹⁶ and improvements in clinician geriatric mental healthcare knowledge/treatment and decreases in emergency room costs for their patients with mental health diagnoses.¹⁷ Providers participating in teleECHO clinics regularly report increased professional satisfaction and a reduced sense of isolation, along with improved self-efficacy and capacity to care for their patients.¹⁹⁻²¹ Globally, the ECHO model is being deployed in Europe, Asia, Africa, and India to expand frontline health workers' capacity to care for underserved populations across complex chronic conditions »



ARORA

Sanjeev Arora, MD, is director of the ECHO Institute and distinguished professor, University of New Mexico.

SPECIALISTS IN TELE-ECHO CLINICS SHARE THEIR EXPERIENCE WITH INDIVIDUAL PATIENTS VIA CASE-BASED LEARNING AND TELEMENTORING.

TABLE. Palliative Care ECHO Projects

Organization Name (type)	Funding Streams	Hub Structure (number of individuals, type of professions)	Spokes (number of individuals, type of professions)	Time Period	Curriculum (number of sessions, case presentations by spokes, etc)
University of New Mexico (AMC)	Philanthropic grant	Members of the palliative care consultation service at UNMH, with physicians; social workers; chaplains; advance practice nurses, guest participants in the community; and learners, including medical students, residents, and fellows.	Community participants include physicians, physician assistants, advance practice nurses, nurses, pharmacists, social workers, chaplains, and psychologists.	2011-2014	1.5 hours biweekly; 15-month curriculum in 6 categories: introduction to palliative care, communication techniques, pain assessment and management, non-pain symptom management, psychosocial issues, and special topics
	Legislative allocation		Nonspecialists of all disciplines.	New session, Fall 2017-ongoing	1 hour weekly over lunch; 12-month curriculum focused on primary palliative care knowledge and skills
Northern Ireland Hospice/Health and Social Care Board (hospice/government)	Government of Northern Ireland	Composition varies across multiple ECHOs addressing palliative care issues.	Caregivers, nurses, home healthcare staff, nursing home staff, assisted living staff, pain care teams, and prison healthcare teams.	November 2014-ongoing	Varied; see echonorthernireland.co.uk/
Servicio de Medicina Paliativa, Hospital Maciel/Universidad de la República/ Administración de Servicios de Salud del Estado, Uruguay (AMC)	Government of Uruguay	Members of the palliative care unit of Maciel Hospital, including doctors specializing in palliative care, nurses, social workers, psychologists, and the ECHO technical team.	Professionals from all over the country participate: physicians, family doctors, general practitioners, nurses, social workers, and psychologists.	August 2015-ongoing	1.5 hours biweekly; 2 clinical cases per meeting are discussed
ResolutionCare Institute; 501(c)(3) not for profit	Partnership HealthPlan of California (Medicaid MCO), California Healthcare Foundation, local foundations, and individual donors	Palliative care specialty interdisciplinary team plus national palliative care leaders as guest faculty throughout the pilot.	Primary care teams in Federally Qualified Health Centers and Indian Health Services clinics.	September 2015-June 2016	1.5 hours biweekly
University of Texas MD Anderson Cancer Center (AMC)	Sister Institution Network Fund	Faculty specialists at MD Anderson Cancer Center Department of Palliative Care, Rehabilitation, and Integrative Medicine.	Palliative care clinicians, primary care physicians, mid-level providers, nurses, technicians, and community health workers. Collaborators in South Africa, Zambia, Kenya, Nigeria, Ghana, Brazil, and Mozambique.	May 2016-ongoing	1 hour bimonthly
Alaska Native Tribal Health Consortium; 501(c)(3) not for profit	Alaska Native Tribal Health Consortium institutional support	Led by palliative care specialty interdisciplinary team, including outpatient and inpatient providers as well as rural healthcare providers and interested staff across the Alaska Tribal Health System.	Rural healthcare providers, medical staff, and community members.	Spring 2017-ongoing	Primary palliative care with a goal of establishing regional palliative care resource teams throughout the state to offer primary palliative care support to patients and families facing advanced serious illness.
Trivandrum Institute of Palliative Sciences (AMC)	ECHO India Trust	Members of the multi-disciplinary team at Trivandrum Institute of Palliative Sciences comprising physicians, nurses, medical social workers, psychiatrists, psychologists, and needs-based specialists.	Hospital-based practitioners, nongovernment organization representatives, and private and governmental palliative care providers.	January 2017-ongoing	2.5 hours biweekly, including case discussion and didactic presentations within a 6-month curriculum on the theme "Treat that Pain."

AMC indicates academic medical center; ECHO, Extension for Community Health Outcomes; MCO, managed care organization; UNMH, University of New Mexico Hospital.

like HIV, cancer, hepatitis C, multidrug-resistant TB, and behavioral health.

Project ECHO provides a unique model to address global disparities in access to palliative care. The ECHO model has been replicated by early adopters to expand, support, and disseminate knowledge of primary palliative care to providers working with rural and underserved populations, enabling them to address the complex needs of their patients with advanced serious illness. In its focus on ongoing mentorship and development of multidisciplinary communities of practice, the ECHO model is particularly suited to palliative care, which at its best involves care teams supporting patients and their families in the transition

from medical support for a specific condition to a focus on overall QOL. Each of the brief narratives below recounts the experience of implementing ECHO for palliative care from the perspective of 7 of our replicating partners (also, see **Table**).

The UNM Experience

The UNM Hospital started the first palliative care teleECHO clinic in 2011. Pre- and post-surveys of participants have demonstrated improved self-efficacy ($P = .0073$) and greater knowledge of pain and non-pain symptom management with participation ($P = .0156$).²² In the fall of 2017, a new session of the UNM Palliative Care ECHO will begin, this time with a focus on primary pal-

FIGURE 2. Doing More For More Patients: Project ECHO Improves Access to Care

liative care for non-specialists of all disciplines. In preparation for this next phase, members of the teleECHO clinic specialist team are traveling around the state to conduct needs assessments and discuss potential benefits of this clinic with nonspecialists.

Northern Ireland Hospice

Northern Ireland Hospice first implemented ECHO for palliative care in 2014 under the leadership of medical director Max Watson, MD. Community hospice nurses (CHNs) who were employed reported that ECHO created a safe space for those working in isolation to talk about and learn from failures and successes in their own work, and to support each other. The original 6-month pilot was evaluated using a mixed-methods prospective longitudinal cohort study involving 28 CHNs. Mean knowledge scores improved significantly, as did overall self-efficacy scores. Seventy percent of CHNs reported that the technology used in ECHO had given them access to education that would have been hard to access due to geography. The study provided evidence for Project ECHO-connected networks of CHNs as an affordable solution to the United Kingdom's growing need for hospice and palliative care. The Northern Ireland Hospice has become an ECHO superhub, and in partnership with the Health and Social Care Board of Northern Ireland, has launched 19 different teleECHO clinics, many of which address integrated palliative care.

ResolutionCare

Northern California-based ResolutionCare launched a palliative-care-to-primary-care teleECHO pilot program in September 2015. Working with Partnership HealthPlan of California, a non-profit healthcare organization contracted with the State of California to administer Medi-Cal benefits, ResolutionCare implemented the ECHO model to provide hospice and palliative medicine training to primary care teams at 10 federally qualified health centers throughout Northern California.²³ In addition to using ECHO for developing palliative care curricula and networking community partners with physicians and other healthcare professionals, ResolutionCare's pilot explores value-based systems of pay-

ment. After April 2017, when California Senate Bill 1004 on Palliative Care goes into effect, standardizing value-based systems statewide, the ResolutionCare's pilot program will become an ongoing initiative to address California's exploding demand for palliative care.²⁴

Uruguay

The palliative care service of Montevideo's Hospital Maciel in partnership with Universidad de la República, started a palliative care teleECHO clinic in August 2015. Prior to this, the ECHO model had been implemented to train hepatitis C providers in Uruguay. The palliative care teleECHO clinic for adults created an interdisciplinary network of health professionals who assist patients in advanced or terminal stage of their disease throughout the country. Multidisciplinary specialist teams collaborate with providers in comprehensive patient and family assistance, collective decision-making, and a holistic, QOL approach to patient care. Watson, of ECHO Northern Ireland, traveled to Uruguay during the initiative's planning stages to engage local providers, share best practices for utilizing the ECHO model for hospice and palliative care, and learn about how palliative care is practiced in Latin America. Watson's mentorship at the beginning of the teleECHO palliative care clinic in Uruguay further demonstrates the collaborative potential of the global ECHO network.²⁵

MD Anderson Cancer Center

In May of 2016, the Department of Palliative Care, Rehabilitation, and Integrative Medicine at the University of Texas MD Anderson Cancer Center launched its Palliative Care ECHO Telementoring Program (ECHO PACA) in collaboration with clinicians in South Africa, Zambia, Kenya, Nigeria, Ghana, Brazil, and Mozambique. ECHO PACA's goal is to build a network of palliative care experts »

OVER 14 YEARS, PROJECT ECHO HAS GROWN FROM 1 PROGRAM SERVING RURAL NEW MEXICO TO OVER 110 PARTNERS IN OVER 20 COUNTRIES ADDRESSING OVER 55 CONDITIONS.

ADDITIONAL RESOURCES

OncLive

Hear about the palliative care program offered at the University of Chicago from Stacie Levine, MD: onclive.com/link/1177.

in Africa, connecting experts and providers through the ECHO model to provide increased access and quality palliative care for patients with life-limiting cancer diagnoses.²⁶

Alaska Native Tribal Health Consortium

The Alaska Native Tribal Health Consortium (ANTHC) in Anchorage is America's largest and most comprehensive Native-owned health services organization. It serves over 150,000 Alaska Native people statewide, representing 229 federally recognized tribes. Through the Alaska Native Medical Center, ANTHC began offering oncology-based comprehensive palliative care services in October 2015 and launched a palliative care teleECHO clinic in the spring of 2017, extending palliative care services to inpatient, outpatient, and rural settings across the Alaska Tribal Health System. Project ECHO will enable ANTHC and tribal partners to utilize existing resources to support patients, families, providers, and communities throughout Alaska, providing support and mentorship for the development of community-based palliative care resources. The goal of the ANTHC Palliative Care Project ECHO is to establish regional palliative care resource teams throughout the state to offer primary palliative care support to patients and families facing advanced serious illness.

Trivandrum Institute of Palliative Sciences

In India, the Trivandrum Institute of Palliative Sciences (TIPS) implemented the ECHO model for palliative care in January of 2017. This teleECHO clinic aims to strengthen the palliative care knowledge and capacity of practitioners from India and neighboring countries (including Nepal, Bhutan, and Bangladesh). TIPS conducts its teleECHO clinic with technological support and guidance from the Project ECHO superhub team based in Delhi, further evidence of the capacity of the global ECHO network to provide mentorship and support across regions and conditions.²⁷

The ECHO Institute in Albuquerque, New Mexico, is also leading a Palliative Care ECHO Collaborative, a broader community of practices that connects all ECHO replicating partners working in palliative care to share best practices and strategies for addressing the global palliative care crisis. The collaborative is exploring opportunities to engage in collective research and the development of a palliative care curriculum and certification that can be standardized for primary care clinicians and other healthcare providers around the world. Delivered through the culturally adaptive ECHO model, this curriculum and certification could then be effectively modified by palliative care ECHO teams working in diverse geographic areas to suit the specific needs of participants.

The network of palliative care practitioners, researchers, and interested partners built by the Palliative Care ECHO Collaborative would also shape the development of best practices and serve as a catalyst to raise awareness about global palliative care needs. Such conversations are already well underway: in India, for instance, the ECHO model has become useful for conversations with the oncology community regarding the scope of palliative care across the cancer spectrum. India's National Cancer Grid, which connects 106 cancer centers,²⁸ has included palliative care experts in its ECHO virtual tumor board. The engagement and dialogue among participants opens up possibilities for mutual learning and further collaborations in transforming quality of care provided and perceived.

Conclusion

There is growing national and international interest in palliative care but a recognized inability for specialists to provide such care to the patients and families who need it most. Project ECHO is an effective

solution to the problem of disseminating the skills and expertise of centralized palliative care specialists to the frontline primary care providers working in geographically, culturally, and economically diverse communities.

The ECHO model can assist healthcare providers, medical staff, and community members to acquire new skills, competencies and best practices in palliative care. By working with administrators and community leadership, efforts to improve the QOL and coordination of care for patients with advanced serious illness will also help identify and address local, national, and regional gaps and needs in healthcare resources, services, and support. As the Project ECHO network in palliative care grows, so does the global stock of palliative care knowledge and best practices, as partners continue to teach and learn from one another in ever-widening communities of practice (Figure 2). ♦

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FUNDING SOURCES: Grant: 5R24016510 from the Agency for Healthcare Research Quality "Expansion of Rural Health Care Research Infrastructure through the ECHO Model"; Bristol-Myers Squibb Foundation "Project ECHO for Cancer Care: Reducing Disparities in Cancer Care"; General Electric Foundation "Expanding the ECHO Model to Improve Healthcare Efficiency and Quality in Federally Qualified Healthcare Centers"

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