

Palliative Care & Oncology Integration:

An Evolving Paradigm

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November 6, 2017



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Main Objective



To show that Palliative Care is a key component in comprehensive cancer care

Objectives

- Review and understand definition of Palliative Care
- Review misconceptions about Palliative Care.
- Discuss barriers and validation for PC
- See how Palliative Care can impact cancer care
- Look at Progress and Goals for Palliative Care Integration with Cancer Care

PC patient

- G.S. 74 y.o. man with colon ca. stage IV
- DX in summer 2013
- RX with surgery and chemotherapy
- Did well until fall 2014, progression
- Chose to resume a new chemo regimen
 - 5FU, leucovorin and Irinotecan x 2 courses
 - Hospitalized briefly with mucositis

PC patient

- Outpatient palliative care consult requested
- Reviewed Advanced Directives:
 - Full code
 - Full treatment
 - Trial of artificial nutrition
- Goals: quality of life, fight the cancer, improve energy, spend less time in bed

PC patient

- PC evaluation continued:
 - Pain score: 4-7/10
 - Depression/anxiety: 0/10
 - Appetite and nausea: 6/10
 - Dyspnea: 0/10
 - Completed 5 wishes
 - Reviewed overall plan of care
 - Plan to continue chemotherapy

PC patient

- Patient entered skilled care for therapy
 - Patient followed by PC RN
 - PC advocated for symptom control
 - Pain meds, anti-emetics before exercise

PC patient

- One month later the patient is declining:
 - Weaker,
 - Confused,
 - Jaundiced,
 - Anorectic
 - Low performance status
- PC RN reviews goals with patient and his wife

PC patient

- New goals
 - Change to DNR
 - No more chemotherapy
 - Hope to get strong enough to go to hospice
 - Continue to assess pain, depression, dyspnea, appetite
- Hospice referral made, transfer to Kavanaugh

Palliative care is:

- Specialized medical care for people with serious illnesses
- Focused on providing patients with relief from symptoms of pain, and the stress of a serious illness
- No regard to the diagnosis or prognosis
- Ultimate goal to improve Quality of Life for patient and their family

Palliative Care is:

- Appropriate at any age or stage of illness
- It can be provided concomitant with active disease treatment
- It is an adjunct to improving quality of life (QOL)

Palliative Care does:

- Give patients a voice in the care they choose
- Identifies decision makers
- Respect patient autonomy
- Try to assist patients in getting the care they want and while respecting their goals and needs

Misconceptions

- Palliative care is hospice
- Cancer patient's symptoms are always addressed and managed
- Cancer patients don't want to hear about prognosis and treatment options
- Cancer patients want to die in the hospital or ICU

Palliative Care does

- Help provide patient/family education
- Answer questions
- Focus on symptoms
- Recognizes caregiver stresses
- Review or create an ACP
- This lead to a goals of care conversation and plan for all to be aware of

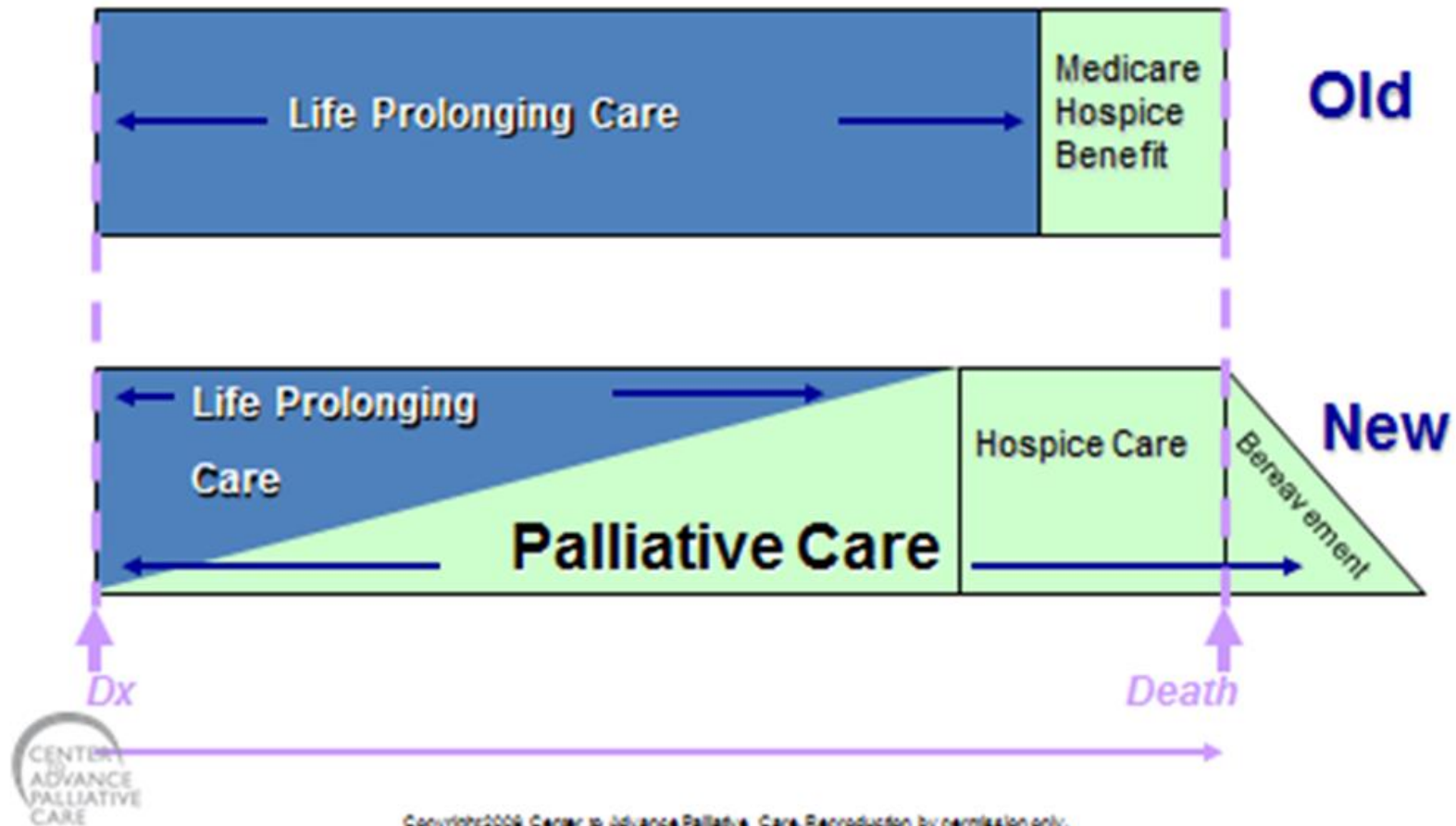
Misconceptions

- Patients are only appropriate for Palliative Care when all treatment options have been exhausted.....
- “I guess we can now get “palliative” involved
- Palliative care conversation will take away hope

There is a significant and increasing body of evidence that supports routinely adding the palliative care model for cancer patients in order to achieve optimal comprehensive care.



Conceptual Shift for Palliative Care



Hospice defined

- Hospice care is end of life care for patients with a terminal illness or diagnosis
- If they follow a normal course they are estimated to have survival of 6 months or less
- The focus of care is on comfort, quality and not cure
- 6 month prognosis is key factor



Palliative care may include consideration of any or all aggressive or curative treatments if they are consistent with the patient and family goals of care and their condition.

Barriers to Palliative Care

- Worry about the right timing for a consult or conversation
- Patients, doctors, and some health systems do not understand Palliative Care
- Palliative Care takes away hope
- Palliative care is equated with hospice
- Palliative care programs not available everywhere

Cancer patients often being palliated

- Realize that many new cancer diagnoses are already at a stage that is not curable
- Their treatment is thus “palliative”
- Why not get the PC team involved at time of their diagnosis?
- If embedded in comprehensive care of cancer patient, no need to worry about timing

Palliative care teams

- Palliative help is needed from all who touch the patient in their cancer treatment
- Primary palliative care by PMD, oncologist
- Nursing staff
- SW, nutritionist, physical therapists
- Care Navigators
- Palliative care specialists

Barriers continued...

- Competition with oncology and palliative care is viewed as trying to talk patients out of treatment



Barriers

- It may feel like the discussion of end of life when the referral is very late
- Patients are really hospice appropriate
- No more treatment options
- Hospice is not a curse word! It is the best care model for end of life care
- Twice as good as anything else

Barriers continued...

- Oncology and Palliative Care do have different cultures
 - Biomedical model of disease, complex new regimens and targeted therapy
- Contrast with more holistic view of the disease process and all that it affects

Hope

- Hope comes from having goals.
- In advanced cancer or other serious illness we should not rely on the unidimensional concept of hope based only upon “cure” or disease control
- Hope relies on dignity, comfort, closure, being heard, small goals at end of life leading to growth despite shorter lifespan

Hope

- These measures are achieved through:
 - Empathy for patient suffering
 - Acceptance and affirmation of this suffering on the part of physicians and staff

Some caveats for PC team

- Palliative care team must know and understand the evidence base for cancer treatments proposed
- Palliative care treatment must be where the patients are:
 - Physically
 - psychologically
- **QOL** regardless of intent to cure is still paramount
- Need to focus on what **can** be done!
- Make it a **positive**

How do we integrate these disciplines ?



Oncology and Palliative care

- The disciplines are complementary
- Not competing
- Patients and families expect better survival
- They also expect better QOL and symptom control
- Total care approach
 - Reduces symptoms
 - increase QOL
 - lower costs

Complementary

- The two disciplines really do share a common goal.....
- Improved quality of life for the patient and his/her family and caregivers

Some validation studies

- Increasing body of medical literature supports the integration
- ASCO, NCCN, NIH
- Let me show just a few of these

Early referral is beneficial to many

- Facilitates timely treatment of symptoms
- Offers psychosocial support and counsel
- Helps with care transitions when appropriate
- Decreases caregiver distress
- Improves QOL scores

Palliative Care Validation

- Bakitas et al showed that nurse educational sessions empowered patients to discuss palliative and end of life needs resulting in better QOL and mood
- Temel et al in their “big bang/landmark” paper with advanced lung cancer patients showed that patients receiving ambulatory PC had better QOL, improved mood, lower cost of care and in their study lived 2.7 months longer

More Validation studies

- Benowitz in JNCI article recommended screening all cancer patients for
 - Nutritional
 - Psychosocial issues
 - Depression
 - Family understanding
 - Resources at home
- Use as a trigger tool for palliative care evaluation

Validation studies

- 238 homebound terminally ill outpatients who received usual care or usual care plus in home palliative care services
- Physician, nurse, and SW
- Goals of care, course of disease, outcomes expected and success of treatment options

Validation studies

Outcomes Measured Were

- Satisfaction with care
- Use of medical services
- Site of death
- Cost of care

Results

- PC arm had better satisfaction at 30 & 90 days, $p < 0.05$
- ED visits 35% less, $p = .02$
- Fewer hospital days by 4.36, $p < .001$
- PC arm patients were 2.2x as likely to die at home, $p < .001$
- PC cost 12,670 versus 20,222, $p = 0.03$
- Survival was the same in the two groups
- No evidence of harm in any other way

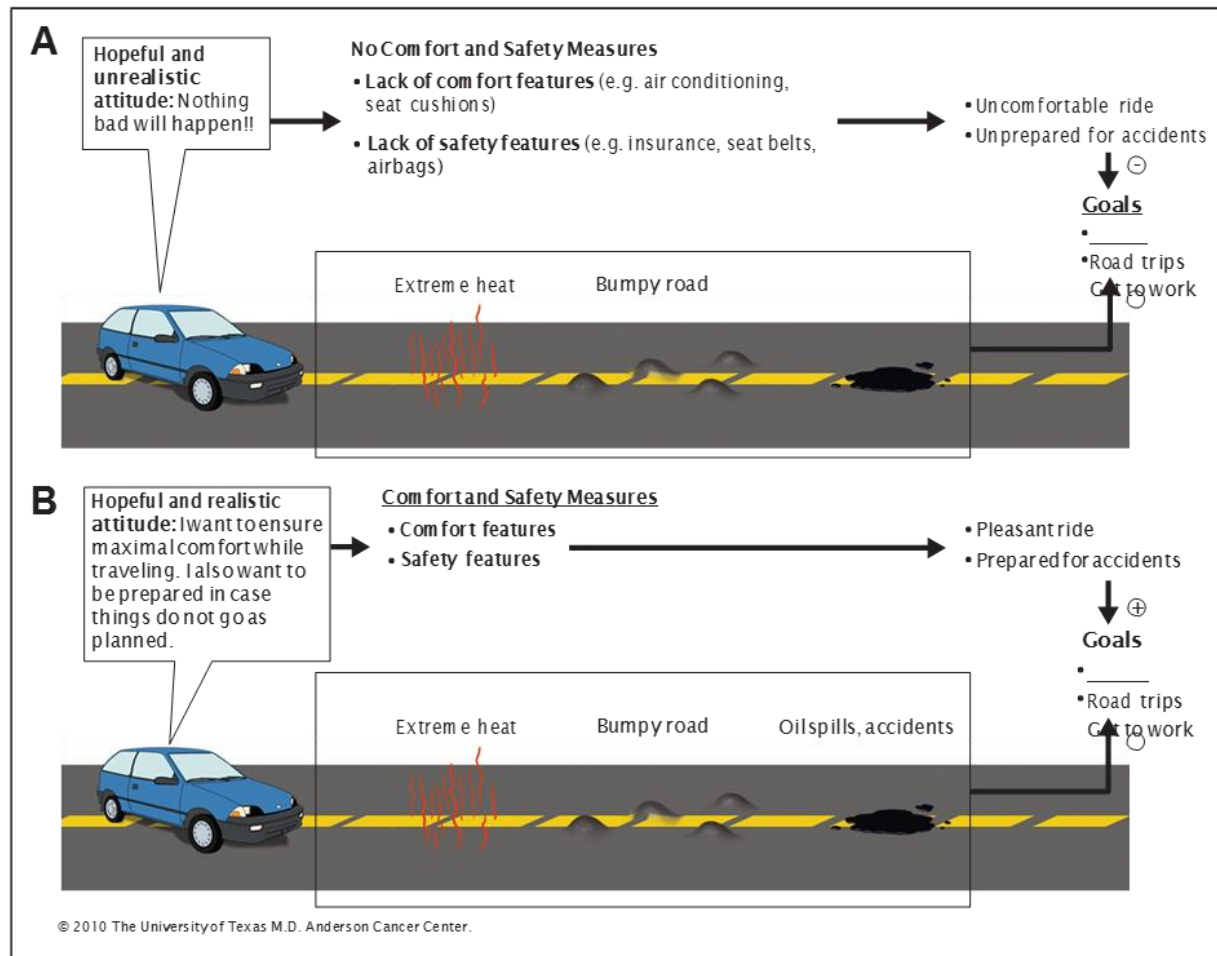


Fig 1. The use of a car is an analogy for setting goals of care. (A) A hopeful and unrealistic driver wishes that nothing bad will happen on the road. This is in contrast to (B) the hopeful and realistic driver, who knows the importance of comfort measures and of being prepared for the trip ahead. Reprinted with permission from The University of Texas M. D. Anderson Cancer Center.

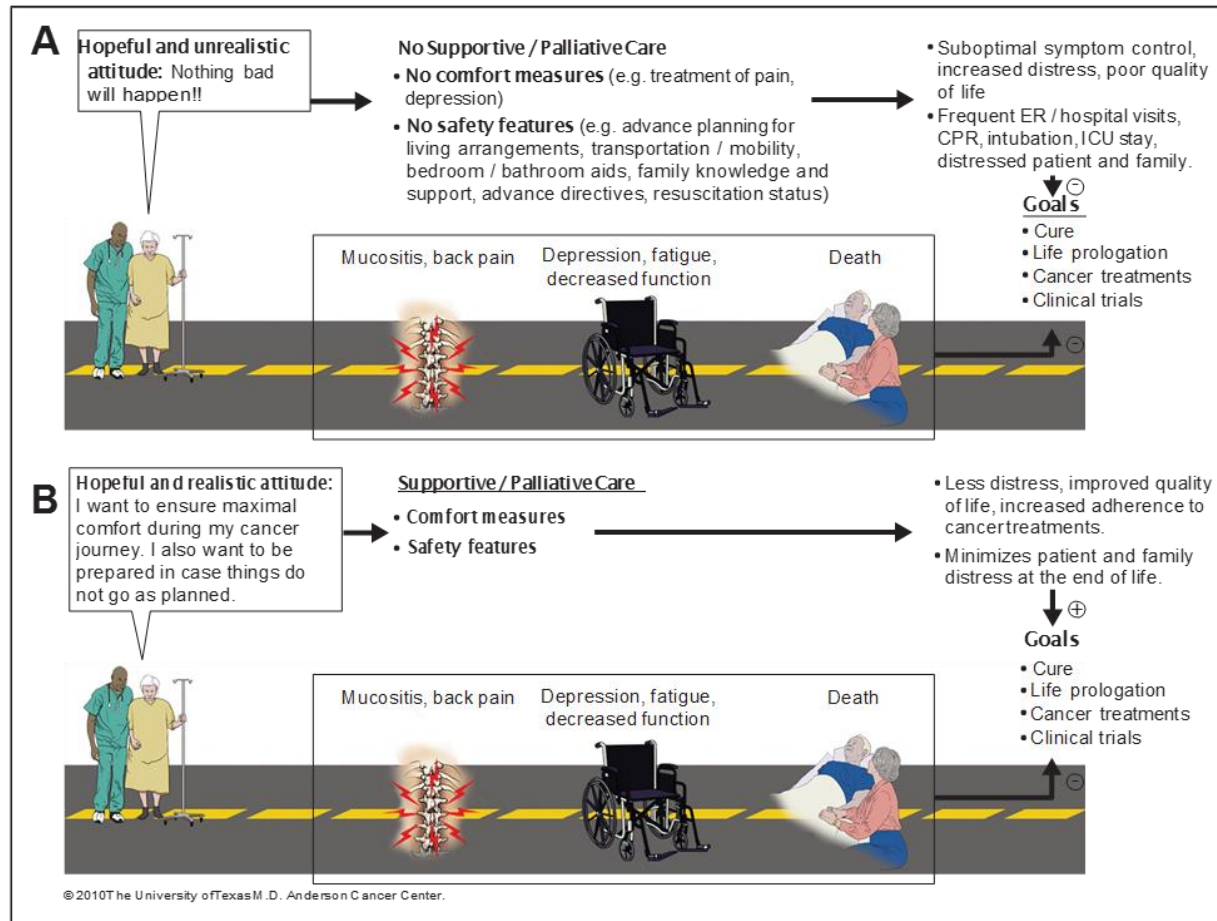


Fig 2. (A) A hopeful and unrealistic patient focuses on cancer cure and life-prolongation measures, without paying attention to her symptoms and advance care needs. This results in unnecessary distress for patients and families. This is in contrast to (B) a hopeful and realistic patient, who has the same goals for cancer control, but is better equipped to manage symptoms and prepared for crisis because of the concurrent use of supportive/palliative care. ER, emergency room, CPR, cardiopulmonary resuscitation, ICU, intensive care unit. Reprinted with permission from The University of Texas M. D. Anderson Cancer Center.

The message is that early palliative care in conjunction with oncologic care can assist in:

- Decision making, symptom management
- Understanding adverse effects of treatment
- Enhance knowledge
- Help patients select treatment consistent with their goals, working with oncologists
- Improve overall quality of care

Models and Tools

- Distress screening tools
- Embedded triggers for consultation
- Electronic entry of data by patients before or between appointments
 - Symptoms
 - Stressors
 - Emotions
 - These can be reviewed by nurse/doctor ahead of time
- Inpatient consultation
- Outpatient consultation
 - home
 - clinic
- Palliative care clinic in cancer center
- Palliative care team members embedded in oncology clinic
- Interdisciplinary teams to review a patient population

Accomplishments and progress locally

- Integration of palliative care representative in the JSCC quality program
- New metrics to encourage improved ACP for patients
- Training of oncology staff in ACP tools
- Participation by PC in the pancreas/biliary tumor board weekly
- Creation of a cancer patient rehabilitation program
- Educational presentations have been made to oncology physicians

Accomplishments

- Increased numbers of overall palliative care consults in hospital
- Opening of a PC outpatient clinic in the JSCC
- Care navigators aware of PC work
- Nutritional support programs for cancer patients
- Distress screening tool and counseling for cancer patients

Nursing roles:

- Oncology nurses are in position to provide generalist palliative care
- They know and understand the trajectory of many cancers
- They can assess symptoms
- They provide emotional support
- Studies have documented value of nurse led programs

Nursing roles continues:

- Oncology nurses develop patient trust
- Are aware of patient vulnerability and need for empathy
- Can provide the empathetic communication needed for the cancer journey
- Can advocate for more specialty care
- In a position to provide upstream care

Summary

- The goals of oncology care and palliative care really are aligned:
 - Help patients with cancer live longer and with better QOL
 - To help relieve distress for patients and families: physical, emotional, spiritual, social
 - To respect and honor the goals of patients and understand what gives them the quality they want

Looking back at the patient presented earlier it appears that these goals were met with collaboration of oncology and palliative medicine

Thank You

