The Role of Palliative Care in Cancer

by

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For the Michigan Cancer Consortium

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Definition of Palliative Care:

Palliative care, and the medical sub-specialty of palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a team of palliative care doctors, nurses, social workers and others who work together with a patient’s other doctors to provide an extra layer of support. *It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.*

Center to Advance Palliative Care
ABMS approved creation of Hospice and Palliative Medicine as one of 10 subspecialties in 2006, and HPNA offers National Certification exams for nurses, social workers, aides and Advanced Practice nurses.

Center for the Advancement of Palliative Care; Capc.org

The Joint Commission (TJC) Advanced Certification for Palliative Care Programs

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How Can Palliative Care Help?

• Elements of palliative care consultation
  – Communication with healthcare team
  – Symptom assessment
    • Dyspnea
    • Pain
    • Nausea
    • Constipation
    • Delirium
    • Anxiety/depression
  – Assessment of patient/family’s understanding of illness, options for care
How Can Palliative Care Help?

– Establish goals of care, assist with decision-making
– Conduct family meetings
– Establish or confirm prognosis
– Advance Directives
– Psychosocial/spiritual assessment and support
– Support healthcare team
Palliative Care Improves QOL and Reduces Symptom Burden, Improves Patient Satisfaction

**FIGURE 4:** Meta-Analysis Highlights Improvements in Quality of Life and Reduced Symptom Burden through Palliative Care
## Palliative Care Reduces Costs Across the Continuum

<table>
<thead>
<tr>
<th>Setting</th>
<th>Results</th>
<th>Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>$1,696 costs saved per admission for live discharges; $4,908 for death</td>
<td>Morrison, 2008</td>
</tr>
<tr>
<td></td>
<td>43% fewer ICU admissions</td>
<td>Gade, 2008</td>
</tr>
<tr>
<td></td>
<td>1.1 day length of stay reduction (oncology)</td>
<td>May, 2017</td>
</tr>
<tr>
<td></td>
<td>Automatic palliative care consultation reduced re-admissions by 48%</td>
<td>Adelson, 2017</td>
</tr>
<tr>
<td>Outpatient</td>
<td>In Primary Care: 20% fewer hospital admissions</td>
<td>RTI International, 2006</td>
</tr>
<tr>
<td></td>
<td>In Cancer Center: 50% reduction in hospitalization, with 35% reduction in ED visits</td>
<td>Scibetta, 2015</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>43% reduction in care transitions (to ED or hospital)</td>
<td>Miller, 2016</td>
</tr>
<tr>
<td>Home-Based</td>
<td>36% lower costs ($12,000 saved per patient)</td>
<td>Lustbader, 2016</td>
</tr>
<tr>
<td></td>
<td>48% to 56% reduction in</td>
<td>Cassel, 2016</td>
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</table>
Conceptual Shift for Palliative Care

All hospice is palliative care, but not all palliative care is hospice.
• Americans are sick to death of dying
• The majority of Americans die in the hospital or nursing home
• The experience of dying has changed...especially within the past fifty years...serious, chronic illness is an invention of the late twentieth century
• Staving off death impacts contemporary individual and communal life in ways we have yet to understand
• Because so many treatments now work, many people survive longer with one, or several previously lethal conditions...people are sicker before they die today than ever before

• Striking medical advanced in prolonging or replacing organ functions have not been matched by proficiency in preserving comfort and quality of life for people who are ill or their families
Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life

What are the challenges and barriers to high-quality care near the end of life?

• Barriers in access to care
• A mismatch between the services patients and families need and the services they can obtain
• Inadequate number of PC specialists
  – Too little palliative care knowledge among other clinicians who care for individuals with serious advanced illness
• A fragmented care delivery system spurred by perverse financial incentives that contributes to lack of service coordination across programs and unsustainable growth in costs
Opportunities for improvement

• Improving knowledge within medical communities on engaging patients and families in advanced care planning, shared decision making
• New technology for communication
• Healthcare system reforms
Palliative Care in Michigan
Does your state make the grade?*
# Hospital-Based Palliative Care in Your State*

The availability of palliative care services in U.S. hospitals varies widely by state and region. Most large hospitals now offer palliative care services.

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Programs/Hospitals</th>
<th>By Hospital Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&lt;50 beds</td>
</tr>
<tr>
<td>Michigan</td>
<td>69% (76/111)</td>
<td>48% (20/42)</td>
</tr>
<tr>
<td>East North Central Region</td>
<td>67% (407/609)</td>
<td>41% (95/229)</td>
</tr>
<tr>
<td>National</td>
<td>59% (2,295/3,888)</td>
<td>38% (509/1,508)</td>
</tr>
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</table>

East North Central = OH, IN, IL, MI, and WI

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Percentage of Hospitals with a Palliative Care Program by Community Type

Hospital-based palliative care is less common in rural communities. Nationally, 34% of rural hospitals provide palliative care compared to 72% of urban hospitals.

*Data on hospitals with palliative care were obtained from the American Hospital Association (AHA) Survey Database™ and the National Palliative Care Registry™. For both, the most recent and complete data available are for 2015.*
Staffing per 10,000 Hospital Admissions

Hospital-based palliative care teams are composed of physicians, nurses, social workers, chaplains, and other disciplines. Staffing full-time equivalent (FTE) per 10,000 admissions allows for staffing level comparisons across hospitals of different sizes by standardizing admissions.

<table>
<thead>
<tr>
<th>Region</th>
<th>Mean FTE per 10,000</th>
<th>Median FTE per 10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan (n=9)</td>
<td>2.7</td>
<td>2.4</td>
</tr>
<tr>
<td>East North Central (n=60)</td>
<td>3.7</td>
<td>2.6</td>
</tr>
<tr>
<td>National (n=369)</td>
<td>3.3</td>
<td>2.5</td>
</tr>
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</table>

America's Care of Serious Illness

2015 State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals

Beaumont
Palliative Care in Oncology
2019 NCCN Guidelines: Standards of Palliative Care

• Develop processes for integrating palliative care into cancer care, both as part of usual oncology care and for patients with specialty PC needs

• Screen patients for palliative care needs at their initial visit, at appropriate intervals, and as clinically indicated

• Inform patients/families/caregivers that palliative care is an integral part of their comprehensive cancer care

• Provide education to all healthcare professionals and trainees to develop effective palliative care knowledge, skills, and attitudes

• Palliative care specialists and interdisciplinary palliative care teams, including board-certified palliative care physicians, advance practice nurses, physician assistants, social workers, chaplains, and pharmacists, should be readily available to provide consultative or direct care to patients/families/caregivers and/or health care professionals who request or require their expertise

• Monitor palliative care quality by quality improvement programs
NCCN Guidelines for Palliative Care Referral

1. Unmanaged symptoms
2. Moderate to severe distress related to cancer diagnosis and therapy
3. Serious comorbid physical and psychosocial conditions
4. Complex psychosocial needs
5. High distress score
6. Poor prognostic awareness/need for goals of care discussion
7. Potentially life-limiting disease
8. Metastatic solid tumors or refractory hematologic malignancies
9. Patient/and family request for palliative care
10. Patient request for hastened death
Palliative Care in Advanced Lung Cancer: Temel study

- Randomized control trial, non-blinded, outpatient setting, diagnosis non-small cell lung CA made within 8 weeks
- Compared “standard care” vs. “standard care” plus early palliative care
- 151 enrolled, 2006-2009; 27 died by week 12, 86% completed follow-up (n=107)
- Monthly outpatient palliative care follow-up until death
- Assessed physical/psychosocial symptoms, guided decision making, and established goals of care

Temel study conclusions

- Early palliative care patients reported significantly improved quality of life and mood
- Significantly more palliative care patients had resuscitation preferences documented
- Survival advantage for patients receiving palliative care in spite of decreased use of “aggressive care” (by approximately 2 months)
Meta-analysis: Impact of Interdisciplinary Specialty PC on Survival and QOL

- Identified 9 studies
- 5 were high quality
- 3/5 studies had heterogeneous advance cancer diagnoses
- 3 of the 5 looked at long-term survival
  - Patients randomized to OP specialty PC had a 14% absolute increase in 1 year survival
  - Median survival was 4.56 months longer
- QOL was measured in 5 high quality studies
  - OP specialty PC improved QOL relative to controls, including for physical and psychological measures
  - QOL measures included physical (k=2), psychological (k=5) and global (k=5)

Palliative care sees the person beyond the cancer treatment. It gives the patient control. It brings trained specialists together with doctors and nurses in a team-based approach to manage pain and other symptoms, explain treatment options, and improve quality of life during serious illness. Palliative care is all about treating the patient as well as the disease. It's a big shift in focus for health care delivery—and it works.

Specialty Palliative Care in Oncology: a distinct role

Subhead content
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
Palliative care and Oncology care: complementary roles


- Qualitative observational analysis, based on 2010 Temel RCT

- Analyzed 68 audio-recorded clinic visits (34 each)

- Examined themes of clinician communication, comparing content and frequency of discussions between oncologists and PC clinicians
Study Conclusions

• PC clinicians play distinct, complementary role to oncologists

• PC clinicians tend to assess and elaborate on patient understanding of prognosis and treatment and emphasize effective coping, caregiver needs, and ACP

• Overall, PC clinicians supplemented oncology care
Oncology and Palliative Care: Communication Differences

![Graph showing communication differences between oncologists and palliative care clinicians.](image)

**FIG. 2.** Frequency of six major topics by clinician type.

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Diane Meier on Communication

- https://www.youtube.com/watch?v=7kQ3PUyhmPQ
Barriers to early palliative care in Oncology
Barriers and patterns of PC referrals

• Lack of availability of OP and Community based palliative care

• Lack of consensus in the literature guiding on which patients should be referred in the ambulatory setting\(^1,2\)

• Referrals to PC tend to occur late in the disease course for patients with uncontrolled symptoms\(^2\)

• Patient characteristics influence referrals: early referrals were younger, more likely to have head and neck cancer, and tended to be referred for treatment-related side effects\(^3\)

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Conclusion

• As cancer treatments become more effective, cancer has become a chronic illness

• Access to palliative care varies based on setting, the preponderance being in the inpatient setting

• Early palliative care has been shown to improve quality of life, symptom management, patient and family satisfaction, and in some cases, extended life expectancy

• Oncology and palliative care key stakeholders have an opportunity to collaborate to improve patient care
Questions?