1:30 – 2:30 pm

Initiating Palliative Care in Your Practice

SPEAKER
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Presenter Disclosure Information

The following relationships exist related to this presentation:

- Mary K. Buss, MD, MPH: No financial relationships to disclose.

Off-Label/Investigational Discussion

- In accordance with pmiCME policy, faculty have been asked to disclose discussion of unlabeled or unapproved use(s) of drugs or devices during the course of their presentations.

Initiating Palliative Care in your Practice

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In · i · ti · ate:

– *v*. To cause (a process of action) to begin

Objectives:

1. Describe the impact of palliative care on patient outcomes.
2. Distinguish between palliative care and hospice care.
3. Recognize and triage palliative care needs in patients and families.
4. Identify opportunities and strategies for initiating palliative care in your practice.

What is Palliative Care?

What is Palliative Care?

- Specialized medical care for people with serious illnesses.
- *Focuses on* providing patients with *relief from the symptoms, pain, and stress* of a serious illness—whatever the diagnosis.
- The goal is to improve **quality of life** for both the patient and the family.

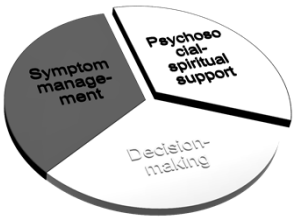
www.getpalliativecare.org

Components of Palliative Care

Symptom Management

- Pain
- Nausea
- Delirium
- Fatigue
- Anorexia
- Anxiety
- Depression

Components of Palliative Care



Psychosocial –Spiritual Support

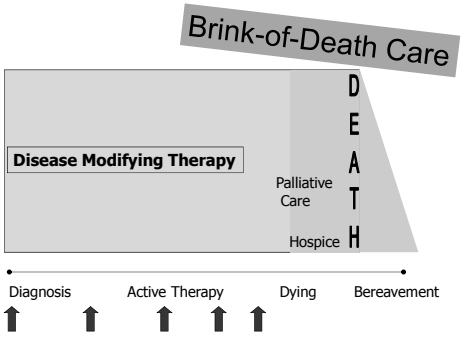
- Counseling
- Social work
- Pastoral care
- Caregiver support
- Bereavement support

Components of Palliative Care

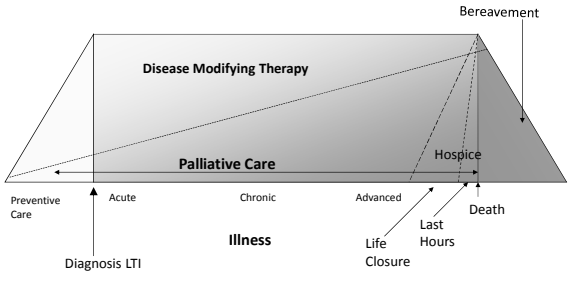
Decision-Making

- Prognostic Awareness
- Personal quality of life
- Values/goals
- Understanding of outcomes
- Advance care planning

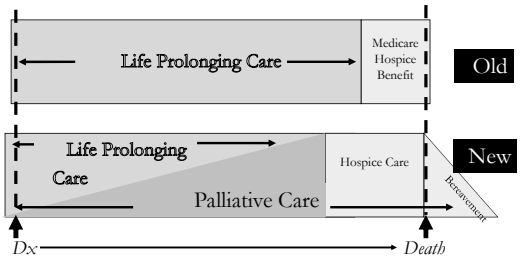
Palliative Care as End-of-Life Care



Palliative Care for Quality of Life



Palliative Care – Models of Integration



Goals of Study:

- Examine effect of early palliative care integrated with standard oncologic care on patient reported outcomes
- QOL at 12 weeks (FACT-L TOI)
- Examine use of health services

Temel, JS et al. N Engl J Med. 2010 363:733-742

Temel Study Design: RCT

IIIb/IV NSCLCA
(8 wks of diagnosis)
ECOG < = 2

Early Palliative Care (n= 77)
-MD/NP visit within 3 wks
- Monthly follow-up

Usual Care (n = 74)
- Palliative Care PRN
(10 PC in first 12 weeks)

Temel: Comments and Questions

- Home Run
- Why did this work?
- Can it be done again?

Zimmermann et al.

Study Design

metastatic CA
PS 0-2
n = 461

RANDOMIZE

Palliative Care Consultation and Followup

Routine Oncology Followup

Outcomes at baseline, 1 mon, q3mon
1. Quality of life (FACIT-SP)
2. Symptom intensity (ESAS)
3. Mood (CES-D)
4. Resource use

Zimmermann et al. *Lancet* 2014

Zimmermann et al.

Results

	Palliative Care Δ 3 months	Oncologic care Δ 3 months	P-value	Palliative Care Δ 4 months	Oncologic care Δ 4 months	P-value
FACIT-Sp	1.6±14.5	-2.0±13.6	0.07	2.5±15.5	-4.0±14.2	0.008
QUAL-E	2.3±8.3	0.06±8.3	0.05	3.0±8.3	-0.5±7.6	0.003
ESAS	0.1±16.9	2.1±13.9	0.33	-1.3±16.0	3.2±13.9	0.05
FAMCARE-P16	2.3±9.1	-1.8±8.2	0.001	3.7±8.6	-2.4±8.3	<0.001
CARES-MIS	-0.2 (5.5)	0.9 (4.1)	0.40	-0.4 (4.4)	0.6 (3.6)	0.11

Zimmermann et al. *Lancet* 2014

Quality of EOL Care

Timing of Palliative Care Referral

Within last 30 days of life	Early >3 m N=120 (%)	Late ≤3 m N=246 (%)	P-value
Any emergency room visit	47 (39)	168 (68)	<0.001
2 or more emergency room visits	12 (10)	57 (23)	0.003
Any hospital admission	58 (48)	200 (81)	<0.001
2 or more hospital admissions	12 (10)	52 (21)	0.01
More than 14 days of hospitalization	14 (12)	40 (16)	0.28
Hospital death	20 (17)	77 (31)	0.004
Any ICU admission	7 (6)	28 (11)	0.13
ICU death	3 (3)	10 (4)	0.56
Chemotherapy and targeted agent use	29 (24)	67 (27)	0.61

Hui et al. *Cancer* 2014

Quality of EOL Care

Outpatient vs. Inpatient Palliative Care

Within last 30 days of life	Outpatient Referral N=169 (%)	Inpatient Referral N=199 (%)	P-value
Any emergency room visit	80 (48)	135 (68)	<0.001
2 or more emergency room visits	18 (11)	51 (26)	<0.001
Any hospital admission	87 (52)	171 (86)	<0.001
2 or more hospital admissions	17 (10)	47 (24)	0.001
More than 14 days of hospitalization	14 (8)	40 (20)	0.002
Hospital death	30 (18)	67 (34)	0.001
Any ICU admission	7 (4)	28 (14)	0.001
ICU death	3 (2)	10 (5)	0.15
Chemotherapy and targeted agent use	41 (25)	55 (28)	0.55

Hui et al. *Cancer* 2014

Value of Palliative Care

- Improves patient **quality of life**
  - 5 RCTs show benefit
- Enhances patient/caregiver **satisfaction**
  - 7 RCTs show improvement
- Reduces **symptom burden**
  - 2 RCTs show benefit
- Reduces health care utilization (aka **cost**)
  - 9 RCT studies show lower costs

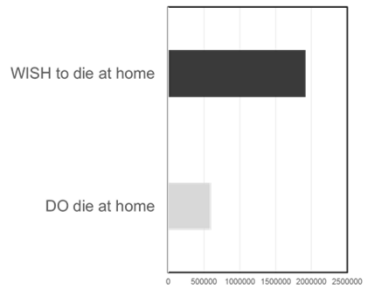
RCT: Randomized Controlled Trial

Al-Jawahri, J Supp Onc 2011

Palliative Care and Hospice

Similarities and Differences

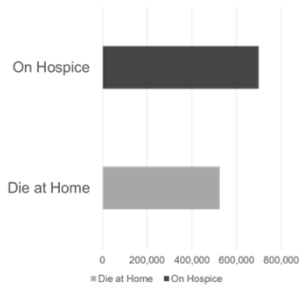
Where Americans Die



- 80% wish to die at home
- < 25% die at home.

- National Hospice Palliative Care Organization 2004

Dying with Hospice



- 700,000 die with hospice
- 75% at home

- National Hospice Palliative Care Organization 2004

What Is Hospice?

- Managed care benefit for terminally ill patients
- Focus of care is ***palliative***, not ***curative***
  - Pain and symptom management
  - Avoidance of hospital
- Promotes "living until you die" philosophy
- 13 months of bereavement care

Where Is Hospice?

- Usually home-based care
  - Hospice Nurse on-call 24/7
  - NOT in home care 24 hrs/day
- Some free-standing hospice residences
  - Usually there is a 'lodging' fee associated.
- Barriers in a Skilled Nursing Facility (SNF)
  - Due to fiscal restraints of hospice benefit
  - Hospice evolving to accommodate this need

Who Is Hospice?

- Team oriented
- Medical Director, nursing, social work, chaplain, home health aides, volunteers.
- **Primary Care physician** is central to plan of care, though the locus of control shifts to patient and family, hospice team, designing a model of care reflective of patient/family autonomy

Myths of Hospice

~~Hospice = dying sooner~~

- 4,493 patients with malignancy or CHF who died within 3 years of identifying event
- Compared Hospice v. non-hospice cohorts
- On average, those who received hospice lived 29 days *longer!*
  - *J Pain Symptom Manage.* March 2007

Myths of Hospice

~~Hospice = *DNR*~~

- DNR NOT required
- DNR is consistent with overall philosophy and goals of hospice care

Limitations of Hospice

Patients must have prognosis of < 6 months

- **BUT** hospice will provide care for longer if patient has continued poor prognosis
- **BUT** physicians notoriously over-estimate prognosis
- **BUT** evolving, more flexible criteria for dementia

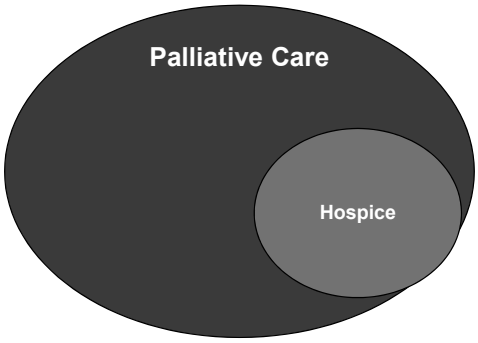
Limitations of Hospice (2)

Patients must forego any disease-modifying therapy (e.g. chemotherapy)

- **BUT** 'open access' hospices allow sophisticated (aka expensive) treatment if consistent with patient goals
  - Palliative chemotherapy
  - Transfusions
  - TPN

Palliative Care ≠ Hospice

	Palliative Care	Hospice
Philosophy /Goals	Quality of life	Comfort
Life Expectancy	Serious illness; no prognostic limits	< 6 months
Delivery	Consultation; co-management	Home-based nursing
	WITH treatment for underlying disease	EXCLUDES disease-directed treatment*



Why Not More?

Who needs palliative care?

- Prognosis
- Symptom burden/poor quality of life

Identifying High Risk Patients - Levine Score

Characteristic	Points
70-74	1
>= 75	2
Length of Stay > 5days	1
Discharge to Nursing Home	1
COMORBIDITIES	
CHF	1
PVD	1
Dementia	1
Renal disease	1
Cancer	1
Metastatic cancer	2

Levine Score ≥4

> 46% 1 year mortality

Serious Illness Criteria

- **CHF** class III/IV with an ejection fraction <30% and > 1 CHF hospitalizations in 1 year
- **ESRD** on dialysis with a Charlson Comorbidity Score ≥ 5
- **COPD** with an FEV1 <30% OR FEV1 <50% on home O2, or respiratory failure requiring ICU within the preceding year
- **Cirrhosis** with Child's class C or MELD (Model of End Stage Liver Disease) score >20

Serious Illness Criteria - 2

- a life expectancy less than one year.

http://eprognosis.ucsf.edu/

Identifying High Risk Patients

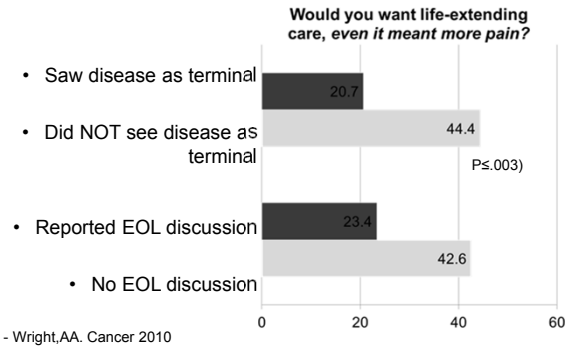
The SURPRISE Question:

Would you be surprised if NAME died in the next year?

Why does prognosis matter?

How can **you** change the care **YOUR** patients receive at the end of life?

Life-Extending *v* Comfort-focused Care



- Wright,AA. Cancer 2010

Prognosis and Palliative Care

- Prognosis difficult to predict
- Patients have inaccurate perceptions about their prognosis
- Understand prognosis → different decisions about medical care.

Who needs palliative care?

- Prognosis
- Symptom burden/poor quality of life

Symptom Burden Screening

- ESAS (Edmonton Symptom Assessment Scale)
- MSAS (Memorial Symptom Assessment Scale)
- Pain Scales
- Distress Scales

How does **Palliative Care** work differ from **Primary Care** work?

Primary Palliative Care	**Specialty Palliative Care**
Basic pain and symptom management	Management of **refractory** pain or other symptoms
Basic management of depression and anxiety	Management of more **complex** depression, anxiety, grief, and existential distress
Basic discussion about: - prognosis - goals of treatment - suffering - code status	Assistance with **conflict** resolution regarding goals or methods of treatment: -Within families - between staff and families -Among treatment teams

- Quill and Abernathy. Generalist plus specialist palliative care – creating a more sustainable model. NEJM. Epub March 6, 2013.

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Initiating Palliative Care:

Find out what matters

- "Given your current health, what's most important to you?"
- "When you think about your future, what worries you?"

Introducing Palliative Care

- **" . . . *provides a layer of support for people with serious illness.*** The team focuses on controlling symptoms and the stress of having a serious illness."
- ". . . helps patients with serious illness ***live as well as possible***. I consider them part of the larger team that can help me take the best possible care of you."

Steps in Advance Care Planning

1. **oPening Lines**
2. **Perception of Illness clarified**
3. **P**roxy Identification
4. **Preferences elicitation**
5. **P**en and Ink (documentation)

"Doc, I want everything."

With palliative care, you will receive **everything** . . .

- To minimize pain
- To maximize comfort
- To honor wishes
- To maintain dignity
- To facilitate informed decisions
- To support patients and families

Take Home Points

1. Evidence shows that palliative care can:
   1. Improve quality of life
   2. lower symptom burden
   3. Reduce health care utilization
2. Palliative care MORE hospice care.
3. Asking "*What's most important?"* can help patients make better choices.

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9. VitalTalk.org

Opportunity is missed by most people because it is dressed in overalls and looks like work.

- *Thomas Edison*