Bridging the Gap: Palliative Care and Oncology in Harmony

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Disclosure

- We are poor federal employees who have no financial or other conflict of interests related to this presentation to disclose.
- Any mention of off-label use of drugs will be clearly mentioned as such.
Objectives

• Discuss the evolution of palliative care and palliative care in oncology
• Discuss the benefits of palliative care in cancer care and the challenges in integrating palliative care in oncology
• Present a collaborative project between palliative care and oncology at the John D Dingell VA Medical Center
HISTORY OF PALLIATIVE CARE

• 1967, Dr. Dame Cicely Saunders creates the first modern hospice in London
• 1974, Florence Wald, Dean of the Yale School of Nursing founded the Connecticut Hospice
• Over the years, there was increasing recognition of the benefits of palliative care and hospice in the care of the terminally ill (Medicare Hospice Benefit, JCAHO hospice accreditation)
• 1991, the VA includes hospice care in the veterans’ benefits package; in 2002, they launched programs to increase access to hospice and palliative care, improve clinician education

National Hospice and Palliative Care Organization, 2014
HISTORY OF PALLIATIVE CARE

• 2006, The American Board of Medical Specialties recognized hospice and palliative medicine as a medical specialty
• Increasing published data on the benefits of palliative care

National Hospice and Palliative Care Organization, 2014
American Society of Clinical Oncology (ASCO)

- Founded in 1964 by a small group of physician members of the American Association of Cancer Research
- A separate society dedicated to issues on clinical oncology.
- Journal of Clinical Oncology, official journal.

American Society of Clinical Oncology, 2014
A search conducted on JCO using key word PC yielded 7 articles, 5 of which were on the palliative use of medications (3 on chemotherapy, 1 on hydromorphone and 1 on hematopoietic colony-stimulating factor).

The 6th article was published in 1991; it was on a survey conducted among 598 randomly selected oncologists who subscribed to the JCO among 598 randomly selected physicians who subscribed to the JCO; found that coping with issues related to palliative or terminal care is the most important causative factor of burnout.

Whippen and Canellos, 1991
The 7th article was on the **challenges of performing an effectiveness research in PC**

Rinck GC, Van den Bos AM, et al
In 1998, ASCO surveyed its members and learned that 90% of the 3,227 medical, surgical, radiation, and pediatric oncologists who responded learned about palliative care through trial and error; 81% said they had inadequate coaching in discussing poor prognosis; 65% said they received inadequate education about controlling symptoms; 33% reported hearing lectures about palliative care issues during oncology fellowship training.

Ferris FD, Bruera E, et al, 2009
• Published “Cancer Care During the Last Phase of Life” and the “Consensus Statement of Recommendations for High-Quality Cancer Care Developed by the American Federation of Clinical Oncologic Societies”; called for efforts to overcome the barriers to the integration of palliative care into cancer care, increase knowledge and skills pertaining to PC, and to improve the experience of patients and families receiving cancer care.

• Recognized that optimal EOL care involves access to state of the art PC rendered by PC clinicians and supported by PC experts when necessary.

ASCO, 1998
2008

• Published “Palliative Cancer Care a Decade Later: Accomplishments, the Need, Next Steps”; identified the current state of PC in cancer care and recommendations to facilitate integration of PC in comprehensive cancer care(4)

Accomplishments:
• Supported the launch of the Education in Palliative and End-of-life Care for Oncology (EPEC-Oncology) Curriculum in collaboration with the National Cancer Institute (NCI)
• Hospice use doubled from 540,000 in 1998 to 1,300,000 in 2006(5)

Ferris FD, Bruera E, et al, 2009
National Hospice & Palliative Care Organization, 2007
American Society of Clinical Oncology

- More PC programs are integrated in cancer care programs
- Incorporation of PC in educational resources and activities
- Inclusion of PC in ASCO’s Annual Meeting and features in JCO

AREAS FOR IMPROVEMENT

- ASCO has not actively pursued steps to increase acceptance that can lead to earlier referral
- Model of care: When the complexity of a patient's suffering exceeds the experience of the primary cancer care team, consultation with palliative cancer care experts may be necessary
VISION FOR 2020

• PC as a **routine** part of comprehensive cancer care, available in all cancer centers
Institute of Medicine

• Independent, nonprofit organization that provide unbiased and authoritative advice to decision makers and the public; many of their studies begin as specific mandates from Congress, others are requested by federal agencies and independent organizations

• 2001, “Improving Palliative Care for Cancer”; identified barriers of palliative care integration to cancer care: attitudinal, behavioral, economic, educational, legal, focus of research on cure and not palliative care

*Institute of Medicine of the National Academies, 2001*
Institute of Medicine

Recommendations:
- The National Cancer Institute (NCI) should require research in palliative care and symptom control for recognition as a “Comprehensive Cancer Center”
- Private insurers should provide adequate compensation for end of life care
- Organizations that provide information about cancer treatment (NCI, American Cancer Society, etc.) should **include information on palliative care throughout the course of disease** on their patient materials
Institute of Medicine

- Published “Delivering High-Quality Cancer Care: Charting A New Course For A System in Crisis” in 2013

Findings:

- Many patients do not receive adequate information on goals of treatment, palliative care for symptom management and, side effect of treatments; due to lack of knowledge on how to provide the care or does not see PC as an important component of quality cancer care
The Institute of Medicine has published "Dying in America" in 2014. They have pushed for advance care planning earlier and during multiple occasions in life based on a 2013 survey that showed 90% of Americans agreed to the benefit of end of life discussions with their families but only <30% have done it, and majority were >65 y/o with 1 or more chronic condition(s).

American healthcare is poorly equipped to provide end of life care due to: shortage of palliative care experts, reluctance among providers to discuss end of life issues and, inadequate financial and organizational support for the needs of dying patients.

Calls for improved end of life training in medical schools.
Oncology

OFFCOLOGY

Reynolds
Barriers to PC Integration in Cancer Care

Views of Palliative Care

• Viewing of Palliative Care as alternative approach and philosophy to cancer care

• Association between palliative care and hospice care

Barriers to PC Integration in Cancer Care

Self-Defined Professional Roles

• Palliative Care as an integral role in the care they provide to the patients

• Referral to Palliative Care as neglecting responsibilities and patient abandonment

Barriers to PC Integration in Cancer Care

- Oncologists unaware of the availability of services and eligibility for referral to PC

- Limited outpatient PC clinics; 2010 study showed that only 59% of NCI cancer centers had PC outpatient clinics, and 22% for non-NCI centers

- Only 1/3 of PC program leaders identified their professional background as palliative care; board certification was not a requirement for physicians or nurses in a majority of programs

- While inpatient care services are more widely available for NCI cancer centers, only 56% of non-NCI centers reported having an inpatient consultation team.

Hui, Elsayem, Maxine et al, 2010
Barriers to PC Integration in Cancer Care

Limited effectiveness research in comprehensive palliative cancer care

- Course of disseminated cancer is diverse
- Physical and cognitive deterioration may hamper the completion of the study
- Quality of life and satisfaction scores are sometimes complicated and difficult to interpret
- Effective symptom management is typically subjective and may be influenced by personal characteristics

Rinck GC, van den Bos, et al, 1997
Benefits to PC Integration in Cancer Care

- Patients with advanced cancer who receive palliative care consultations early in the course of their disease report better symptom control, quality of life, lower rates of depression and improved survival rates than those not receiving consultations.

- Initiating palliative care upon diagnosis of advanced cancer also improves patients’ understanding of their prognosis.

  Bakitas M, Lyons KD, Hegel MT, et al, 2009
Benefits to PC Integration in Cancer Care

- Early involvement of palliative care may also lead to lower total spending on inpatient health care by decreasing lengths of stay, admissions to the intensive care unit, and pharmacy and laboratory expenses

Meier DE., 2011
Ciemins EL, Blum L, et al, 2007
Benefits to PC Integration in Cancer Care

- Early outpatient palliative care decreases the need for acute care services, leading to fewer hospital admissions and emergency department visits.

- Patients receiving Palliative Care services are more likely to forgo costly inpatient care at the end of life than are other patients.

  Temel JS, Greer JA, et al, 2010
“I’m afraid it’s cancer... And not the good kind.”
John D Dingell VA Medical Center
John D Dingell VA Medical Center

- 217 in-patient beds (acute, nursing home and psychiatry)
- Average age: 60
- Male, 91%, Female 9%
- 31% of patients below the pension rate ($1054/month for single Veteran)
- 47% of Veterans receive compensation for service related injury/illness. 5% receive non-service related financial benefits.
- 15% of non-compensable Veterans are above the pension rate and have co-pays for medications and/or office visits.
John D Dingell VA Medical Center

- Service available to more than 330,000 veterans living in Wayne, Oakland, Macomb and St. Clair counties

US Department of Veterans Affairs, 2014
JDDVAMC, 2013
Challenges to Integration

- View of palliative care as a non-scientific discipline
- Belief that oncologists are skilled and knowledgeable in symptom management
- Equating PC with hospice care
Integrated Services

- Weekly Tumor Board
- Active palliative care representation in the Cancer Committee
- Regular “huddles” with chemotherapy nurses and other oncology staff
- Accessibility in the oncology and chemotherapy clinics
Purpose: Improve QOL of patients with Stage IV lung cancer by improving the timeliness of Palliative Care involvement and minimizing Urgent Care/ED visits during the course of treatment.

PC involvement has been shown to improve QOL for both the patient and family by focusing on symptom management, psychosocial support and identifying goals of care.

Identified practice: Patients referred to PC if found not to be eligible for palliative chemotherapy or they chose not to pursue disease modifying therapies.

Proposed changes: PC consulted during initial Oncology visit. PC to see the patient within 3 weeks and follows along with Oncology throughout the disease trajectory.

Outcomes/Conclusions

- In 2013, 29% of the referrals came from Acute Care and the rest came from oncology. Shorter palliative care involvement and hospice length of stay in 2013 may have been impacted by the advanced state of illness for a large number of the patients that year. Many of these patients were not qualified for or did not pursue palliative chemotherapy.

- In 2007-09, 56% of the referrals came from acute care and 6% from oncology. This indicates that oncology has been engaged in the collaborative and has taken ownership of the referral process.

- Average Urgent Care visits were impacted by PC involvement, decreasing from 1.8 days to 1 day.

- In 2013, there were about 3-4 patients who served as outliers wherein palliative care involvement was not timely, taking over 100 to 200 days; possible causes identified:
  - New staff oncologist who was not familiar with the collaborative.
  - Increased work volume for palliative care prevented early capture of this delay as evidenced by increasing total volume of consults.

Current Status of The Collaborative

- Continue to work with oncology and other services involved in sustaining the success of this collaboration.

- Expansion of efforts to improve the timeliness of PC involvement in other Stage IV malignancies including esophageal, prostate, pancreatic, and colon cancers.
Overall Results

Days

VETERANS HEALTH ADMINISTRATION
Overall Results

Median values for 2013 showed a slight increase in timeliness but still fell within desired goals.
Origin of Consults

- **Oncology**
- **Acute Care**
- **Other**

Comparison of visits from 2007-09 and 2013:

- **2007-09**:
  - Oncology: 10%
  - Acute Care: 50%
  - Other: 40%

- **2013**:
  - Oncology: 20%
  - Acute Care: 30%
  - Other: 50%

Comparison across years:

- **2007-09**: 1.8 UC visits
- **2011**: 1.6 UC visits
- **2013**: 1.4 UC visits

UC visits indicate a slight decrease in consultations across the years.
Outcomes/Conclusions

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• 93% of the patients referred to Palliative Care had Social Work involvement at time of diagnosis on baseline. Hiring of full time Oncology Social Worker likely impacted the number of referrals from Oncology service.

• Average Urgent Care visits were impacted by PC involvement, decreasing from 1.8 days to 1 day.
Outcomes/Conclusions

• Shorter palliative care involvement and hospice length of stay in 2013 may have been impacted by the advanced state of illness for a large number of the patients that year. Many of these patients were not qualified for or did not pursue palliative chemotherapy.

• Increase in number of consults, nearly 100 more in 2013 as compared to the baseline, may have played a role in the timeliness of palliative care intervention as the size of the palliative care consult team did not change. It also to be noted that there were no palliative care fellows that year.
Outcomes/Conclusions

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Secrets to Success?

• Dedicated oncology/palliative care social worker and nurse practitioner, and the ability to be seen as part of the “team”, accessibility and visibility
• Supportive oncology as an initial approach
• Success in managing symptoms, psychosocial issues that reflects in improved patient and family satisfaction, as well as easing the load off of oncology
Areas for Improvement

Need for Continuing Education

• “Will re-assess PS in 2 weeks” (to see if qualified for chemotherapy)
• Reluctance in discussing poor prognosis
“You’ve got six months, but with aggressive treatment we can help make that seem much longer.”


References


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