

## *When to Introduce Palliative Care to Cancer Patients*

Presented by:

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## **New Public Opinion Research on Palliative Care**

- Conducted by B.McInturff and E.Harrington of the national polling firm Public Opinion Strategies.
- Research was commissioned by the Center to Advance Palliative Care (CAPC) with support from the American Cancer Society (ACS) and the American Cancer Society Cancer Action Network (ACS CAN).
- Findings provide a roadmap for communicating with consumers and policymakers on the benefits and future direction of palliative care.



## Key Finding

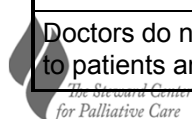
- Although consumers may be content with the quality of health care they receive, they have concerns about the level of care patients with serious illness receive.
- The biggest concerns relate to information sharing between doctor and patient and other doctors, patient control and choice over treatment options, patient understanding about their illness and treatment, and the quality of time doctors spend with patients.



## Biggest Concerns for Patients with Serious Illness

%Biggest/One of Biggest Concerns

Doctors might not provide all of the treatment options or choices available	58%
Doctors might not talk and share information with each other	55%
Doctors might not choose the best treatment options for a seriously ill patient's medical condition	54%
Patients with serious illness and their families leave a doctor's office or hospital feeling unsure about what they are supposed to do when they get home	51%
Patients with serious illness and their families do not have enough control over their treatment options	51%
Doctors do not spend enough time talking with and listening to patients and their families	50%



## Key Finding:

- Physicians are a much more difficult audience than consumers.
  - Physicians tend to either equate palliative care with “hospice” or “end of life” care, and they are very resistant to believing otherwise.
  - This is an important context to have because it demonstrates a problem among referring physicians that will need to be addressed.



## Key finding:

### **Language makes a difference.**

- Palliative care is about improving quality of life, providing an extra layer of support, and having a team focus to patient care.
- Palliative care is about helping both the family as well as the patient with serious illness.
- This research indicates palliative care must be differentiated from hospice or end of life care. Focus group respondents became confused about the meaning of palliative care when the terms hospice or end of life were introduced into the definition of palliative care. *It is important to avoid defining palliative care by what it is NOT.*



## Serious Illness vs. Advanced Illness

Palliative care should be positioned as care for patients with serious illness not advanced illness. Advanced illness is perceived to be more closely aligned with terminal illness.



## Definitions of Palliative Care

How you define palliative care has a big impact on how people feel about palliative care.



## New Language:

- Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis.



## New Language:

- The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.



This revised definition, based on qualitative research, had a significant positive impact.

- Palliative care is a relatively unknown among consumers.
- Once informed, consumers say they would be very likely to consider using palliative care if they or a loved one had a serious illness.
- 95% of respondents agree that it is important that patients with serious illness and their families be educated about palliative care.
- 92% of respondents say it is important that palliative care services be made available at all hospitals for patients with serious illness and their families.



### **Key Finding:**

After hearing the definition of palliative care, consumers strongly agree that:

- Patients with serious illness and their families be educated about palliative care.
- Palliative care is appropriate at any age and any stage in serious illness.
- Palliative care treatment options should be covered by health insurance and Medicare.



## Barriers include:

- The lack of awareness among potential consumers and patients with serious illness that palliative care services exist.
- The term palliative care having little or no meaning to consumers. Many inside the industry framing it as end of life care.
- Physician's attitudes about palliative care.



Palliative care should be an option for any patient with cancer at any stage of their disease.



## New CMS Definition (Does Not Mention Prognosis)

**Palliative care** means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

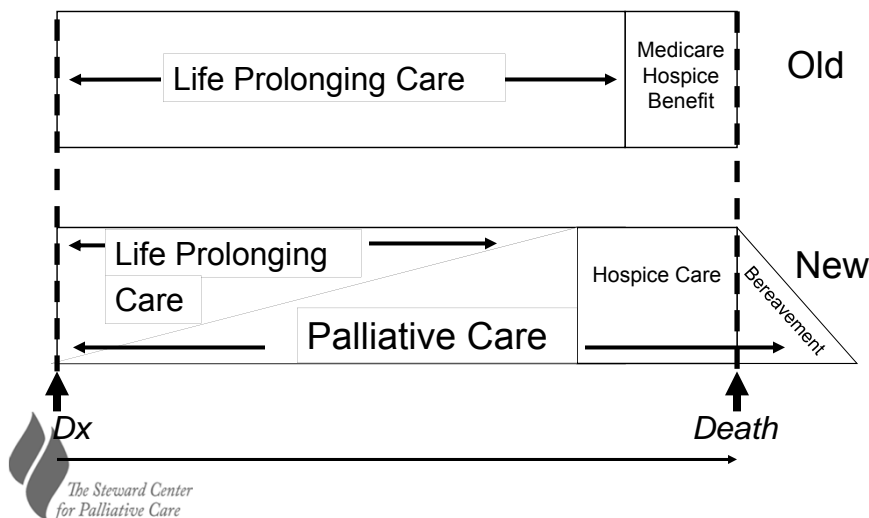
73 FR 32204, June 5, 2008

Medicare Hospice Conditions of Participation – Final Rule



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## Conceptual Shift for Palliative Care





## What Patients with Serious Illness Want

- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones



Singer et al. *JAMA* 1999;281(2):163-168.

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## Conversations about Goals

Demonstrably improve quality, reduce costs

In a prospective multicenter study of 332 seriously ill cancer patients, recall of occurrence of a prognostic/goals conversation was associated with:

- Lower costs of care
- Less ‘aggressive’ care
- Better quality of dying and death
- Lower risk of complicated grief + bereavement

Zhang et al. *Arch Int Med* 2009;169:480-8.  
Wright et al. *JAMA* 2008;300:1665-73.

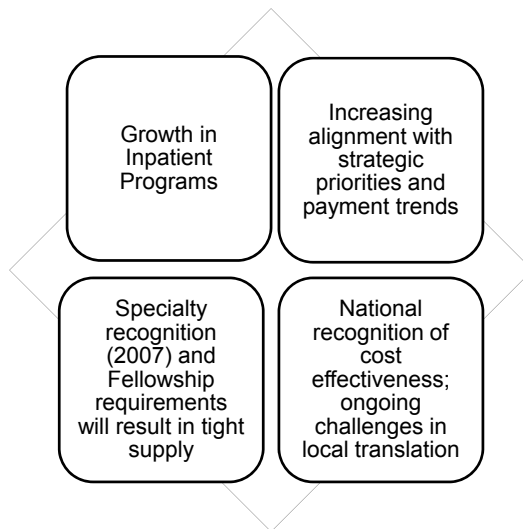


## How Does Palliative Care Differ from Hospice?

- Hospice care provides palliative care for those in the last weeks-months of life under a Federal Medicare Benefit.
- Non-hospice palliative care is appropriate at any point in a serious illness. It can be provided at the same time as life-prolonging treatment.
- Palliative Care does not require enrollment or benefit choice.



## National Context and Trends



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## American Board of Medical Specialties (ABMS) – 2007 Recognition of Hospice and Palliative Medicine (HPM)

### Sponsoring ABMS Boards:

American Board of

- Anesthesiology
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Pediatrics
- Physical Medicine and Rehabilitation
- Psychiatry and Neurology
- Radiology
- Surgery



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## Growth across Sectors, Variation by Locale

- Highly variable access to palliative care
- 33% of all hospitals
- 50% of hospitals with > 50 beds
- 80% of hospitals > 300 beds

(+)predictors: >50 beds, teaching, cancer program, higher educational level

(-)predictors: <50 beds, south, public or sole community provider, for profit hospitals

Goldsmith B et al. J Palliat Med 2008



## Palliative Care Roles

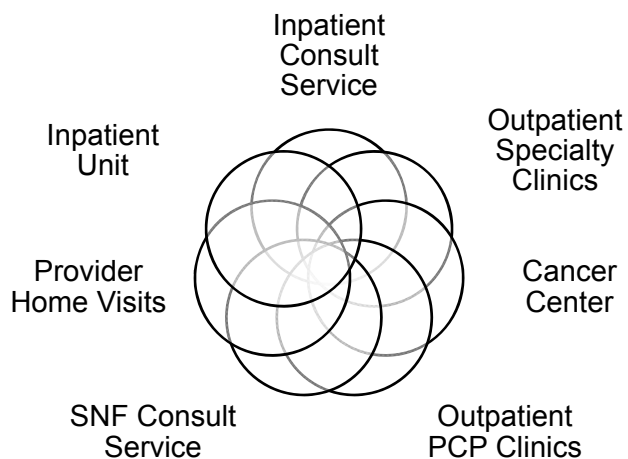
- Expert symptom management – pain, dyspnea, constipation, nausea
- Address issues of emotional distress and suffering
- Expert at family meetings and establishing consensus re goals of care
- Improve patient-professional communication and decision-making
- Coordinate continuity of care across settings



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## Services / Design Options



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## Interdisciplinary Team Design

- Usually MD or Advanced Practice Nurse
- MD + APN or RN or combo
- Social Worker
- Chaplain
- Administrator, Data Analyst
- Also, possible Pharmacist, Complimentary Therapies, Volunteer Coordinator, PT, and other roles



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## Benefits (beyond patient & family)

- Service offer to physicians / helps them
- Builds relationships to community, to regional referral sources
- Provides triage support for inpatient admissions and outpatient care
- Reduces distress and improves self care for staff
- New skills enhance IDT of other programs



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# Palliative Care Consult Services reduce Direct Costs & ICU use

## Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group

(REPRINTED) ARCH INTERN MED/VOL 168 (NO. 16), SEP 8, 2008 WWW.ARCHINTERNMED.COM  
1783

Downloaded from www.archinternmed.com at Mt Sinai School Of Medicine, on September 9, 2008  
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**Additional article that uses the Cost Study data and expands concept for strategic planning:**

Albert L. Siu, Lynn H. Spragens, Sharon K. Inouye, R. Sean Morrison and Bruce Leff, "The Ironic Business Case for Chronic Care in the Acute Care Setting" *Health Affairs*, January/February 2009 113-125.



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## Savings Dilemma

- Inpatient cost avoidance accrues to hospital or payer
- Outpatient resource cost will exceed direct revenue from FFS services
- Big picture savings + positive Quality & Service
  - Implication = Need for thoughtful design, collaboration, and funding



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## Practical Considerations

- Palliative Care Services will not cover costs through billing. Other benefits include:
  - Effective use of specialists & PCP time;
  - Can provide continuity of relationship during extended course of care, at transitions points, and across continuum (particularly in hospital)
  - Cost savings to hospital
- Shortage of certified physicians and IDT give incentive to support education to expand “primary palliative care” skills across the board



The following research supports the need for all cancer patients to have access to palliative care.



Early Palliative Care for Patients with  
Metastatic Non-Small-Cell Lung  
Cancer

Temel JS, Greer JA, Muzikansky A,  
Gallagher ER, Admane S, Jackson VA,  
Dahlin CM, Blinderman CD, Jacobsen  
J, Pirl WF, Billings JA, Lynch TJ.  
N Engl J Med. 2010;363 (8):733-42.



Methods

Design: Non-blinded RCT of early outpatient  
palliative care integrated with standard oncologic  
care compared with standard oncologic care alone.  
All participants received standard oncologic care.

Inclusion Criteria: Pathologically confirmed  
metastatic NSCLC diagnosis within last 8 weeks,  
ECOG 0-2, able to read and respond in English  
Exclusion Criteria: If already receiving palliative care  
not eligible, could receive after enrollment

Funding: ASCO Career Development Award,  
Joanne Monahan Cancer Fund, Golf Fights Cancer





### Palliative Care Intervention

- Patients met with a member of the palliative care team in outpatient setting within 3 weeks after enrollment and at least monthly until death.
- Additional visits were scheduled at the discretion of the patient, oncologist, or PC provider.
- Guidelines for visit were adapted from National Consensus Project for Quality Palliative Care
- Template in EMR to document care provided.
- Attention paid to physical / psychological symptoms, goals of care, decision making regarding treatment, and coordinating care.



### Outcomes

- Patient Reported Measures
  - Trials Outcome Index (TOI):
  - Physical well-being, function, and symptoms
  - Mood
    - Depression p (HADS-D and PHQ-9) and Anxiety (HADS-A)
- Health Care Use
  - Chemotherapy, hospice, hospitalizations, ED
  - Aggressive care = chemo within 14 days, no hospice, <3 days in hospice
  - Resuscitation preferences documented in EMR
- Survival



## Analysis

- Baseline questionnaire before randomization
- Follow up assessments at 12 weeks – either completed during outpatient visit or mailed
- Evaluated change in QOL and mood over 12 weeks; Kaplan Meier for survival with Cox proportional-hazards adjusting for demographics and baseline ECOG.



## Key Findings: Enrollment

- 283 patients eligible, 151 randomized (59 refused, 60 not offered)

	Standard Care (N=74)	Early PC (N=77)
Age	65	65
Female	49%	55%
White	95%	100%

- All patients randomized to PC (except 1) received at least one PC visit, mean 4 (0-8)
- Ten patients randomized to standard care received palliative care.



### Key Findings – QOL and Mood

- PC patients had 2.3 point increase in mean QOL (TOI score) compared to 2.3 decrease in QOL (TOI score) ( $p=.04$ )
- PC group had lower rates of depression and anxiety

	Standard Care	Early PC	p
HADS-D	38%	16%	.01
PHQ-9	17%	4%	.04
HADS-A	30%	25%	.66



### Key Findings – End-of-Life Care

- At time of analysis, 70% of patients had died
- Standard care patients more likely to receive aggressive care (54% vs. 33%,  $p=.05$ ) and less likely to have resuscitation preferences documented in EMR (28% vs. 53%,  $p=.05$ )
- PC patients had longer LOS in hospice, less ED visits and less hospitalizations (none statistically significant)
- PC patients had longer survival (11.6 vs. 8.9 months,  $p=.02$ )



## Key Issues

Is the question important?

- The RCT for which we've been waiting
- The benefit of palliative care has always been known to HPM audience, but continue to need to prove the added benefit (and lack of harm) to clinicians and community



## Key Issues

What are the results?

- Early palliative care provided at the same time as life-sustaining treatments for patients with metastatic NSC lung cancer improves QOL and mood  
□ □
- Palliative care is associated with improved mood and QOL, less use of aggressive therapies, longer hospice stays, and improved survival (in spite of less use of aggressive care)
- Results don't explain why



## Key Issues

Are the results valid?

- High quality trial of a palliative care intervention in patients with advanced disease
- Issue of power to detect difference in some outcomes
- Intervention not well characterized



## Key Issues

Can I apply the results to my patients?

- Proves benefit of palliative care, helps dispel concerns about shortening life
  - Be careful not to over-generalize
- Predominantly white population
- Trial in a single academic medical center with very mature palliative care program



## Clinical Bottom Line

Early palliative care integrated with standard oncologic care for patients with metastatic NSCLC is associated with improved QOL, mood, less use of aggressive therapies at the end-of-life, and longer survival.



## Majority of Georgia hospitals lack palliative care programs

- Investigators exploring how many hospitals provide palliative care services reported in the *Journal of Palliative Medicine* that 82% of Georgia hospitals continue to lack such programs.
- Knowledge of palliative care by staff members was limited.
- Anne P. Glass, PhD, and Molly Burgess, B.M.T. at the Institute of Gerontology in the College of Public Health at the University of Georgia in Athens, surveyed Georgia hospitals listed on Medicare.gov and inquired about palliative care services.
- At more than half of the 128 hospitals included in the study, 55%, representatives of the facility, including directors of nursing and social work, said they did not know what palliative care was.
- Another 27% knew what it was but said the hospital did not have a program.
- Only 18% indicated they offered palliative care.



## **The Joint Commission Releases Standards for Advanced Certification Program in Palliative Care**

- The Joint Commission (TJC) accredited hospitals now have the option of seeking Advanced Certification in Palliative Care. The new certification program launches September 1, 2011.



## **To be eligible for Palliative Care Certification, a hospital must:**

- Have a formal, defined inpatient palliative care program.
- Provide services following palliative care guidelines or evidence-based practice.
- Use data actively for performance improvement.



## Joint Commission Certification

- The standards for palliative care certification are built on the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care and the National Quality Forum's National Framework and Preferred Practices for Palliative and Hospice Care Quality.
- They were developed under the guidance of The Joint Commission Health Care Services Task force, which is composed of experts in palliative care and key stakeholders.



## Joint Commission Certification

This is an important step forward because certification:

- Sends a strong signal of importance and legitimacy to hospital administration, payers, policymakers and organized medicine.
- Spurs palliative care program leaders to adhere to quality guidelines.
- Serves as a stepping-stone to the presence of a quality palliative care program in all U.S. hospitals.





## Take Home Message

Understand what palliative care is!

Use the new definition.

It is not hospice care.



## Take Home Message

Palliative care should be an available option  
for all cancer patients at any stage of  
disease.



***Thank You!***



*The Steward Center  
for Palliative Care*