PALLIATIVE CARE:
What, When, Why, Who, How?

Olumuyiwa Adeboye, MD, FACP
Medical Director, Wolfson Palliative Care Program

“The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians’ failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.”

- Eric Cassell, MD

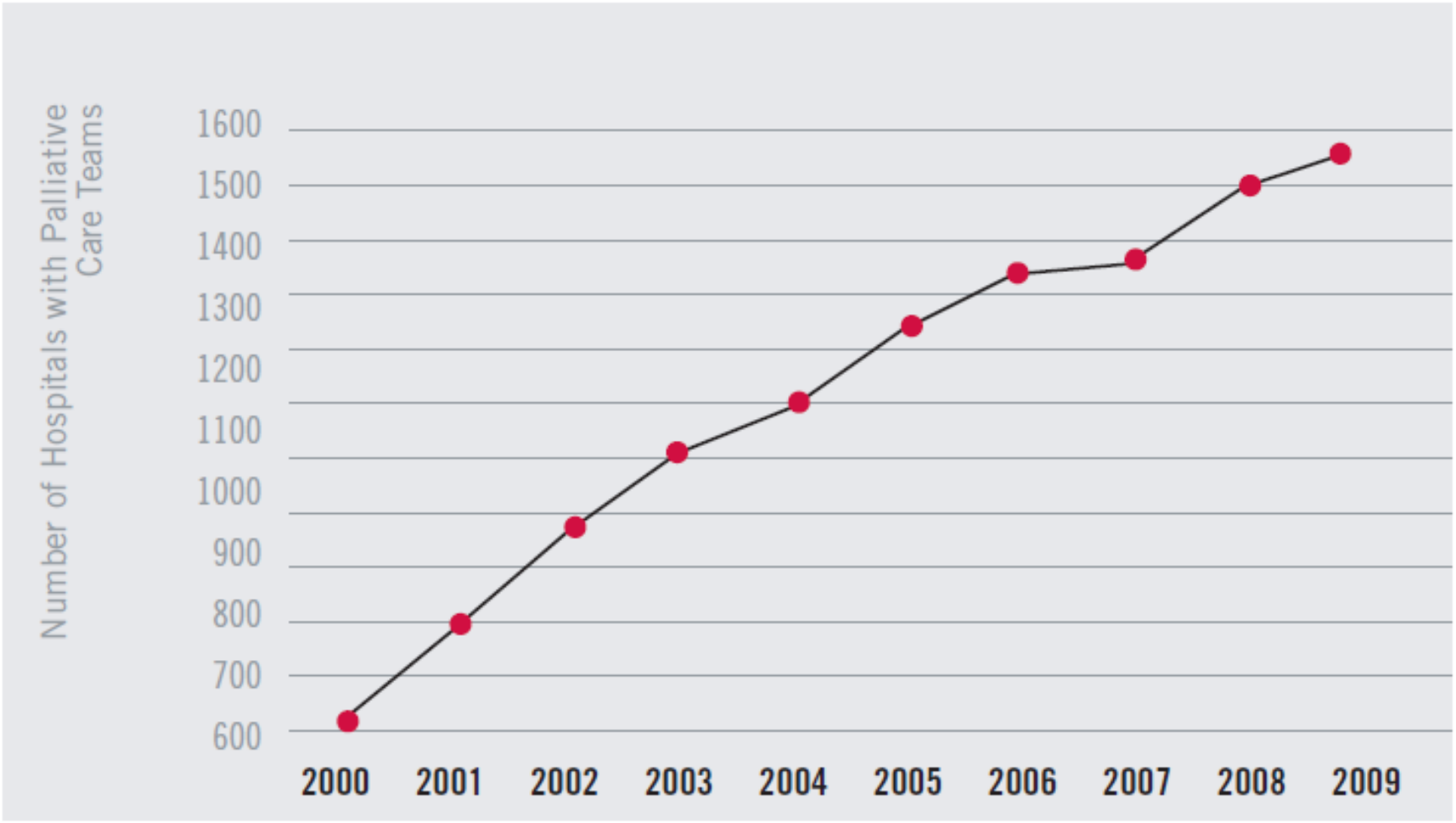
Cases

- GZ
- KB

OBJECTI

- Define **WHAT** Palliative Care is
- Identify **WHEN** Palliative Care is needed
- Discuss **WHY** Palliative Care is important
- Identify **WHO** needs Palliative Care
- Look at **HOW** Palliative Care is provided

Prevalence of U.S. Hospital Palliative Care Teams 2000–2009



Source: Center to Advance Palliative Care, March 2011

A rising trend……

OBJECTIVES

- Define **WHAT** Palliative Care is
- Identify WHEN Palliative Care is needed
- Discuss WHY Palliative Care is important
- Identify WHO needs Palliative Care
- Look at HOW Palliative Care is provided

DEFINITION

- 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 serious illness – whatever the diagnosis.
- 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.

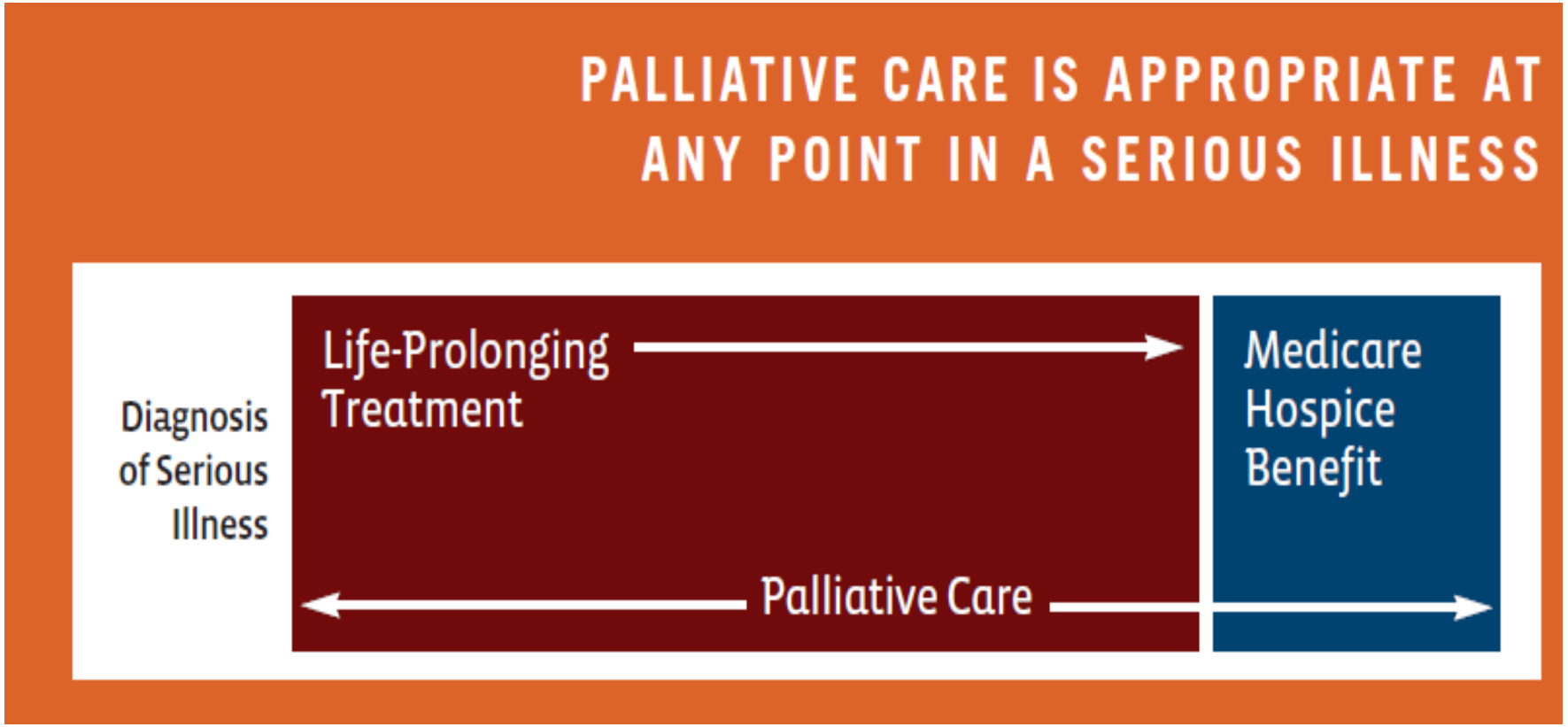
Key Words/Phrases

- 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 serious illness – whatever the diagnosis.
- 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.

OBJECTIVES

- Define WHAT Palliative Care is
- Identify **WHEN** Palliative Care is needed
- Discuss WHY Palliative Care is important
- Identify WHO needs Palliative Care
- Look at HOW Palliative Care is provided

Conceptual Shift for Palliative Care



How Does Palliative Care Differ From Hospice?

- **Non-hospice palliative care** is appropriate at any point in a serious illness. It is provided at the same time as life-prolonging treatment. No prognostic requirement, no need to choose between treatment approaches.
- **Hospice is a form of palliative care** that provides care for those in the last weeks/few months of life. Patients must have a 2 MD-certified prognosis of <6 months + give up insurance coverage for curative/life prolonging treatment in order to be eligible.

Practical Reasons to Call Palliative Care Specialists

- **Assistance with complex symptom management**
  - Managing escalating or refractory symptoms (e.g., pain, dyspnea & nausea)
  - Complex pharmacologic management in patients facing a life-limiting illness (e.g., opioid infusions, opioid rotations, patient-controlled analgesia, methadone initiation, and ketamine initiation)
  - Addressing complex depression, anxiety, grief & existential, spiritual, or psychosocial distress
  - Respite and/or palliative sedation for intractable symptoms

Strand et al. Top 10 Things Palliative Care Clinicians Wished Everyone Knew About Palliative Care. Mayo Clin Proc. 2013;88(8):859-865.

Practical Reasons to Call Palliative Care Specialists

- **Care of complex, severely ill patients over time**
  - New diagnosis with metastatic cancer and/or malignancy with high symptom burden
  - Frequent hospital admissions for the same diagnosis of a serious illness
  - ICU admission with metastatic cancer
  - ICU admission with poor prognosis
  - Prolonged ICU stay

Strand et al. Top 10 Things Palliative Care Clinicians Wished Everyone Knew About Palliative Care. Mayo Clin Proc. 2013;88(8):859-865.

Practical Reasons to Call Palliative Care Specialists

- **Assistance with medical decision making & determining GOC**
  - Discussing transitions in care
  - Complex and/or evolving goals of care discussions
  - Assistance with conflict resolution regarding goals or methods of treatment
  - Redefining hope, in the setting of complex illness
  - Complex code status discussions
  - Assistance with managing patient and/or family conflict or complex social issues
  - Ethical dilemmas

Strand et al. Top 10 Things Palliative Care Clinicians Wished Everyone Knew About Palliative Care. Mayo Clin Proc. 2013;88(8):859-865.

Practical Reasons to Call Palliative Care Specialists

- **Questions regarding future planning needs**
  - Determining and discussing prognosis, where desired
  - Care and planning in the setting of advanced illness
    - Consider referral when one would answer "yes" to the question, ***"Would I be surprised if my patient died within 12 months?"***
  - Discussing issues pertaining to artificial feeding or hydration
  - Determining present and future care needs
  - Help with determining hospice eligibility and providing hospice education

Strand et al. Top 10 Things Palliative Care Clinicians Wished Everyone Knew About Palliative Care. Mayo Clin Proc. 2013;88(8):859-865.

OBJECTIVES

- Define WHAT Palliative Care is
- Identify WHEN Palliative Care is needed
- Discuss **WHY** Palliative Care is important
- Identify WHO needs Palliative Care
- Look at HOW Palliative Care is provided

WHY?

The sickest

10% of the U.S. population

accounts for

64% of health care

expenditures.

Source: Zuvekas SH, Cohen JW. Prescription drugs and the changing concentration of health care expenditures. *Health Affairs*. 2007 Jan–Feb;26(1):249–57.

WHY?

- **Outcomes of Palliative Care**
  - Reduction in symptom burden
  - Improved patient and family satisfaction
  - Improved QOL
  - Reduced costs

WHY?

CLINICAL INVESTIGATIONS

Do Palliative Consultations Improve Patient Outcomes?

David Casarett, MD, MA,[*] Amy Pickard, BA,[*] F. Amos Bailey, MD,[†] Christine Ritchie, MD, MPH,[†] Christian Furman, MD, MPH,[‡] Ken Rosenfeld, MD,[§] Scott Shreve, MD, MBA,[‖] Zhen Chen, PhD,[#] and Judy A. Shea, PhD[*]

J Am Geriatr Soc 56:593–599, 2008

Table 2. Respondents' Perceptions of Care in the Last Month of Life

Score	β Coefficient (95% Confidence Interval)*	Palliative Consultation Adjusted Score†	Usual Care Adjusted Score†
Overall score	0.13 (0.09–0.17)	65	54
Domain scores			
Information and communication	0.17 (0.09–0.24)	67	56
Emotional and spiritual support	0.17 (0.09–0.25)	69	56
Care around the time of death	0.19 (0.14–0.24)	63	45
Access to benefits and services after the patient's death	0.07 (0.00–0.15)	61	52
Access to home care services	0.09 (0.03–0.16)	72	64
Well-being and dignity	0.14 (0.06–0.22)	65	52
Single-item scores			
Patient received the treatment he or she wanted	1.06 (0.60–1.51)	76	57
Patient never received unwanted treatment	0.77 (0.27–1.26)	82	74
Patient was admitted to the facility of his or her choice	0.66 (0.07–1.24)	87	79
Symptoms			
Pain	0.44 (0.02–0.86)	2.15	1.88
Dyspnea	0.19 (−0.24–0.62)	1.03	0.87
Confusion	0.35 (−0.13–0.83)	0.56	0.16
Symptoms related to posttraumatic stress disorder	1.06 (0.15–1.98)	1.92	0.77

WHY?

ORIGINAL CONTRIBUTION

Effects of a Palliative Care Intervention on Clinical Outcomes in Patients With Advanced Cancer

The Project ENABLE II Randomized Controlled Trial

Bakitas M et al. JAMA 2009;302(7):741-9

Palliative care improves outcomes in hospital

- **Results of systematic reviews**
  - Compared to conventional care, palliative care teams were associated with significant improvements in:
    - Pain
    - Non-pain symptoms
    - Patient/family satisfaction
    - Hospital length of stay
    - Reduces in-hospital deaths

Jordhay et al Lancet 2000; Higginson et al, JPSM, 2003;

Finlay et al, Ann Oncol 2002; Higginson et al, JPSM 2002.

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

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

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

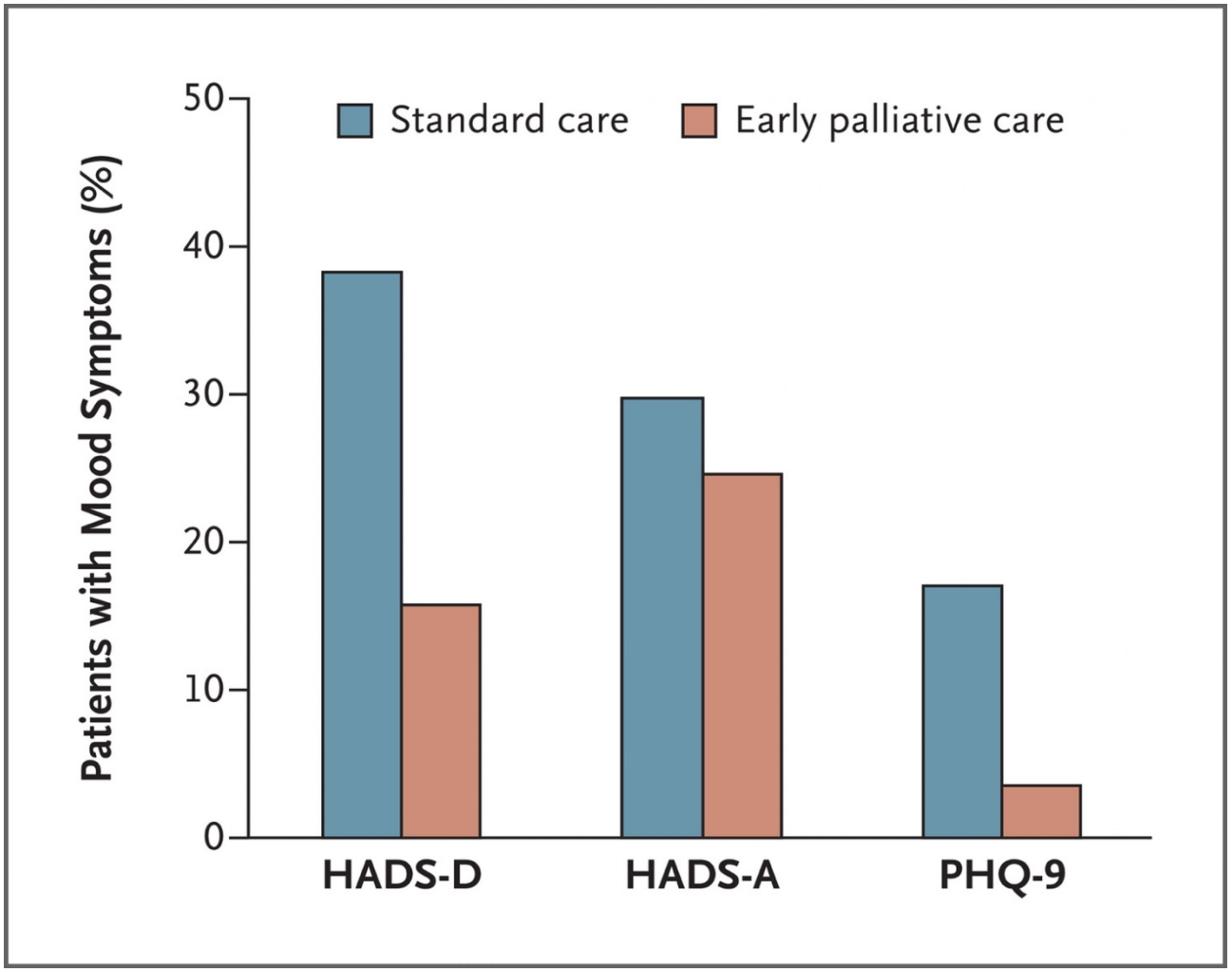
Temel et al. Early palliative care for patients with non-small-cell lung cancer. NEJM 2010;363:733-42.

Palliative Care Improves Quality

- Randomized trial simultaneous standard cancer care with palliative care co-management from diagnosis versus control group receiving standard cancer care only:
  - **Improved quality of life**
  - **Reduced major depression**
  - **Reduced 'aggressiveness'** (less chemo < 14d before death, more likely to get hospice, less likely to be hospitalized in last month)
  - **Improved survival** (11.6 mos. vs. 8.9 mos., $p<0.02$)

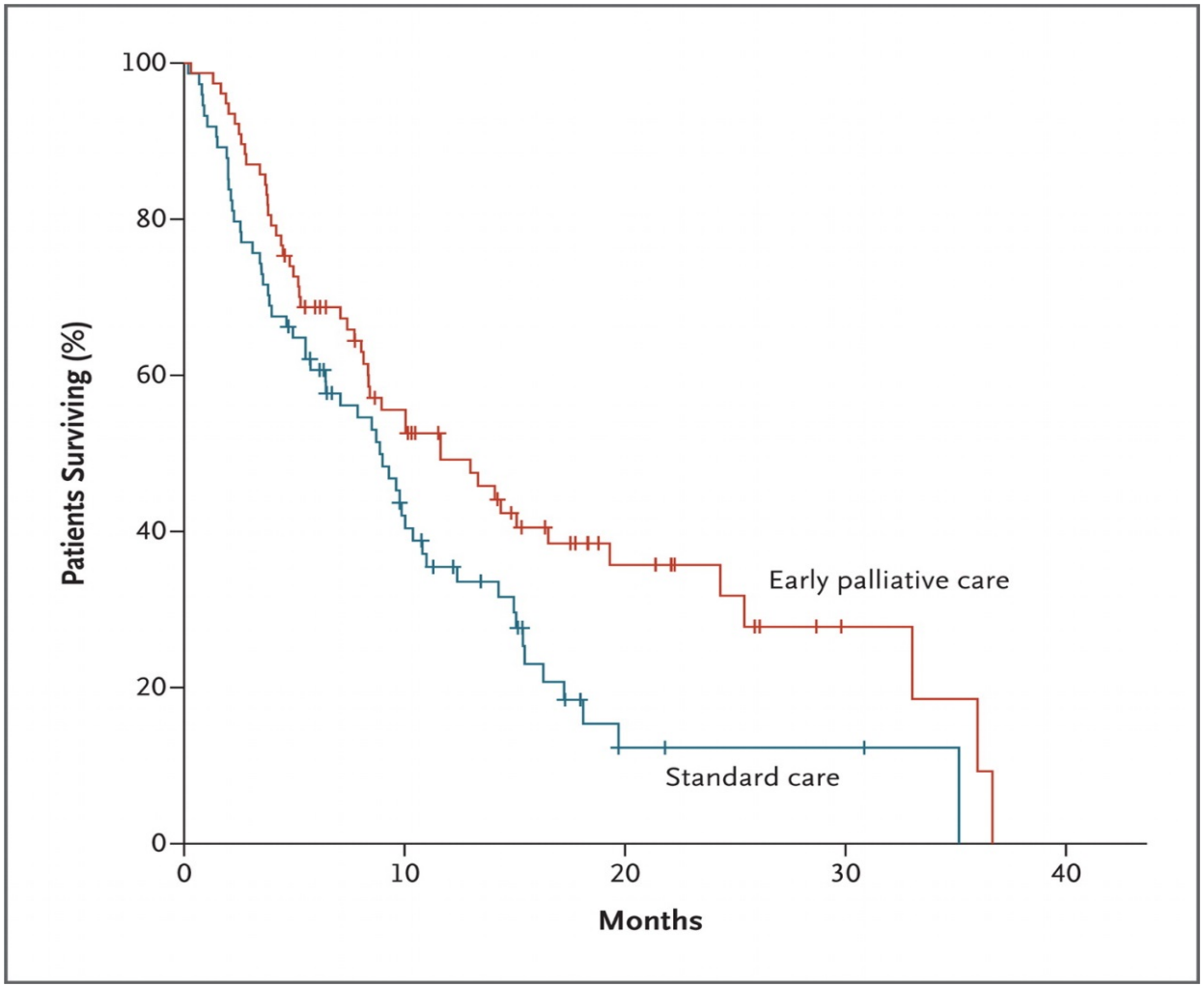
Temel et al. Early palliative care for patients with non-small-cell lung cancer NEJM2010;363:733-42.

Twelve-Week Outcomes of Assessments of Mood



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

Kaplan-Meier Estimates of Survival According to Study Group



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

The NEW ENGLAND JOURNAL of MEDICINE

VOLUME 30 · NUMBER 8 · MARCH 10 2012

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care

Thomas J. Smith, Sarah Temin, Erin R. Alesi, Amy P. Abernethy, Tracy A. Balboni, Ethan M. Basch, Betty R. Ferrell, Matt Loscalzo, Diane E. Meier, Judith A. Paice, Jeffrey M. Peppercorn, Mark Somerfield, Ellen Stovall, and Jamie H. Von Roenn

Provisional Clinical Opinion

Based on strong evidence from a phase III RCT, patients with metastatic non–small-cell lung cancer should be offered concurrent palliative care and standard oncologic care at initial diagnosis. While a survival benefit from early involvement of palliative care has not yet been demonstrated in other oncology settings, substantial evidence demonstrates that palliative care—when combined with standard cancer care or as the main focus of care—leads to better patient and caregiver outcomes. These include improvement in symptoms, QOL, and patient satisfaction, with reduced caregiver burden. Earlier involvement of palliative care also leads to more appropriate referral to and use of hospice, and reduced use of futile intensive care. While evidence clarifying optimal delivery of palliative care to improve patient outcomes is evolving, no trials to date have demonstrated harm to patients and caregivers, or excessive costs, from early involvement of palliative care. Therefore, it is the Panel's expert consensus that combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden. Strategies to optimize concurrent palliative care and standard oncology care, with evaluation of its impact on important patient and caregiver outcomes (eg, QOL, survival, health care services utilization, and costs) and on society, should be an area of intense research.

Effect of Palliative Care on Hospital Costs

ORIGINAL INVESTIGATION

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

Background: Hospital palliative care consultation teams have been shown to improve care for adults with serious illness. This study examined the effect of palliative care teams on hospital costs.

Methods: We analyzed administrative data from 8 hospitals with established palliative care programs for the years 2002 through 2004. Patients receiving palliative care were matched by propensity score to patients receiving usual care. Generalized linear models were estimated for costs per admission and per hospital day.

Results: Of the 2966 palliative care patients who were discharged alive, 2630 palliative care patients (89%) were matched to 18 427 usual care patients, and of the 2388 palliative care patients who died, 2278 (95%) were matched to 2124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of $1696 in direct costs per admission ($P=.004$) and $279 in direct costs per day ($P<.001$) including significant reductions in laboratory and intensive care unit costs compared with usual care patients. The palliative care patients who died had an adjusted net savings of $4908 in direct costs per admission ($P=.003$) and $374 in direct costs per day ($P<.001$) including significant reductions in pharmacy, laboratory, and intensive care unit costs compared with usual care patients. Two confirmatory analyses were performed. Including mean costs per day before palliative care and before a comparable reference day for usual care patients in the propensity score models resulted in similar results. Estimating costs for palliative care patients assuming that they did not receive palliative care resulted in projected costs that were not significantly different from usual care costs.

Conclusion: Hospital palliative care consultation teams are associated with significant hospital cost savings.

Arch Intern Med. 2008;168(16):1783-1790

Reducing Hospital Cost

By R. Sean Morrison, Jessica Dietrich, Susan Ladwig, Timothy Quill, Joseph Sacco, John Tangeman, and Diane E. Meier

THE CARE SPAN

Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries

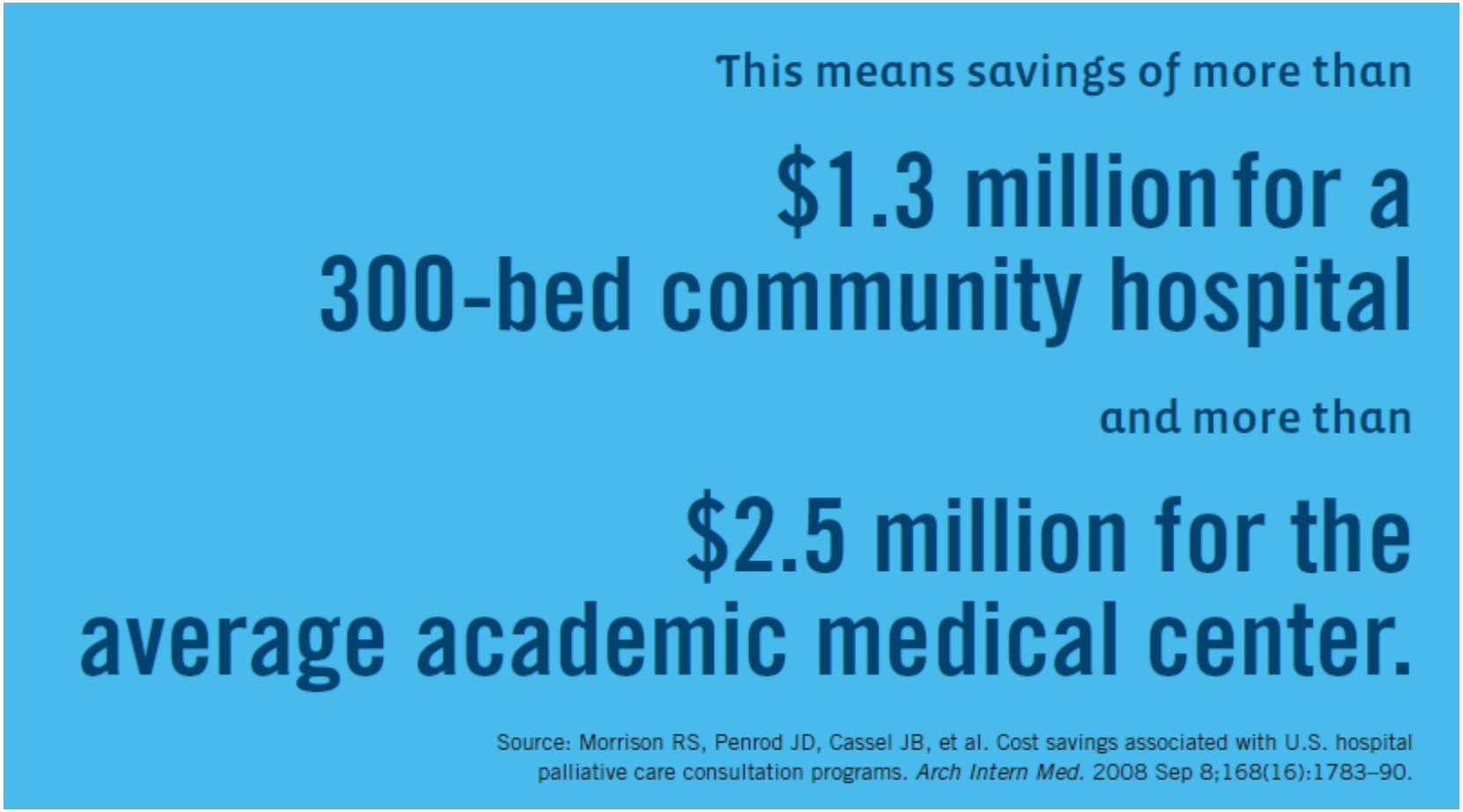
Patients enrolled in Medicaid who received palliative care incurred

$6,900 less

in hospital costs than a matched group receiving usual care.

The patients receiving palliative care spent **less time** and were **less likely to die** in intensive care units, and were more likely to **receive hospice referrals.**[5]

Reducing Hospital Cost



If palliative care teams were fully integrated into the nation's hospitals, total savings could exceed $6 billion per year.

How Palliative Care Reduces Length of Stay and Cost

- **Palliative care:**
  - Clarifies goals of care with patients and families
  - Helps families to select medical treatments and care settings that meet their goals
  - Assists with decisions to leave the hospital, or to withhold or withdraw death-prolonging treatments that don't help to meet their goals

CENTER TO ADVANCE PALLIATIVE CARE

"It is thornlike in appearance, but I need to order a battery of tests."

OBJECTIVES

- Define WHAT Palliative Care is
- Identify WHEN Palliative Care is needed
- Discuss WHY Palliative Care is important
- Identify **WHO** needs Palliative Care
- Look at HOW Palliative Care is provided

JOURNAL OF PALLIATIVE MEDICINE
Volume 14, Number 1, 2011

DOI: 10:1089/jpm.2010.0347

Special Report

Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting

A Consensus Report from the Center to Advance Palliative Care

David E. Weissman, M.D.[1] and Diane E. Meier, M.D.[2]

Patients with…..

- **A potentially life-limiting or life-threatening condition**
  - Any disease/disorder/condition that is known to be life-limiting
    - Dementia
    - COPD
    - Chronic renal failure
    - Metastatic cancer
    - Liver cirrhosis
    - Muscular dystrophy
    - Cystic fibrosis

Weissman et al: Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting. A Consensus Report from CAPC. J. Palliat Med 2011;14, 1-7

Patients with…..

- **A potentially life-limiting or life-threatening condition**
  - Any disease/disorder/condition that has a high chance of leading to death
    - Sepsis
    - Multi-organ failure
    - Major trauma
    - Complex congenital heart disease

Weissman et al: Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting. A Consensus Report from CAPC. J. Palliat Med 2011;14, 1-7

Criteria at the Time of Admission

A potentially life-limiting or life-threatening condition and….

- Primary Criteria
  - Answer Yes to the **“surprise question”:**
    - *Would I be surprised if the patient died within 12 months or before adulthood?*
  - Frequent admissions
    - (e.g., more than one admission for same condition within several months)
  - Admission prompted by difficult-to-control physical or psychological symptoms
    - (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)
  - Complex care requirements
    - (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings)
  - Decline in function, feeding intolerance, or unintended decline in weight
    - (e.g., failure to thrive)

Criteria at the Time of Admission

A potentially life-limiting or life-threatening condition and….

- Secondary Criteria
  - Admission from long-term care facility or medical foster home*
  - Elderly patient, cognitively impaired, with acute hip fracture
  - Metastatic or locally advanced incurable cancer
  - Chronic home oxygen use *
  - Out-of-hospital cardiac arrest
  - Current or past hospice program enrollee *
  - Limited social support (e.g., family stress, chronic mental illness)*
  - No history of completing an advance care planning discussion/ document

*Based on a consensus panel opinion

Criteria during each Hospital Day

A potentially life-limiting or life-threatening condition and ….

•Primary Criteria

- Answer Yes to the **“surprise question”:**
  - *Would I be surprised if the patient died within 12 months or before adulthood?*
- Difficult-to-control physical or psychological symptoms
  - (e.g., more than one admission for same condition within several months)
- ICU length of stay ≥ 7 days
- Lack of Goals of Care clarity and documentation
- Disagreements or uncertainty among the patient, staff, and/or family concerning
  - major medical treatment decisions
  - resuscitation preferences
  - use of nonoral feeding or hydration

Criteria during each Hospital Day

A potentially life-limiting or life-threatening condition and ….

- Secondary Criteria
  - Awaiting, or deemed ineligible for, solid-organ transplantation
  - Patient/family/surrogate emotional, spiritual, or relational distress
  - Patient/family/surrogate request for palliative care/hospice services
  - Patient is considered a potential candidate, or medical team is considering seeking consultation, for:
    - Feeding tube placement
    - Tracheostomy
    - Initiation of renal replacement therapy
    - Ethics concerns
    - LVAD or AICD placement
    - LTAC hospital or medical foster home disposition
    - Bone marrow transplantation (high-risk patients)

"There's no easy way I can tell you this, so I'm sending you to someone who can."

OBJECTIVES

- Define WHAT Palliative Care is
- Identify WHEN Palliative Care is needed
- Discuss WHY Palliative Care is important
- Identify WHO needs Palliative Care
- Look at **HOW** Palliative Care is provided

HOW?

- Primary palliative care
  - The basic skills and competencies required of all physicians and other health care professionals
- Secondary palliative care
  - Specialist clinicians that provide consultation and specialty care
- Tertiary palliative care
  - Care provided at tertiary medical centers where specialist knowledge for the most complex cases is researched, taught, and practiced

von Gunten CF: Secondary and tertiary palliative care in US hospitals. *JAMA*. 2002;287(7):875-881.

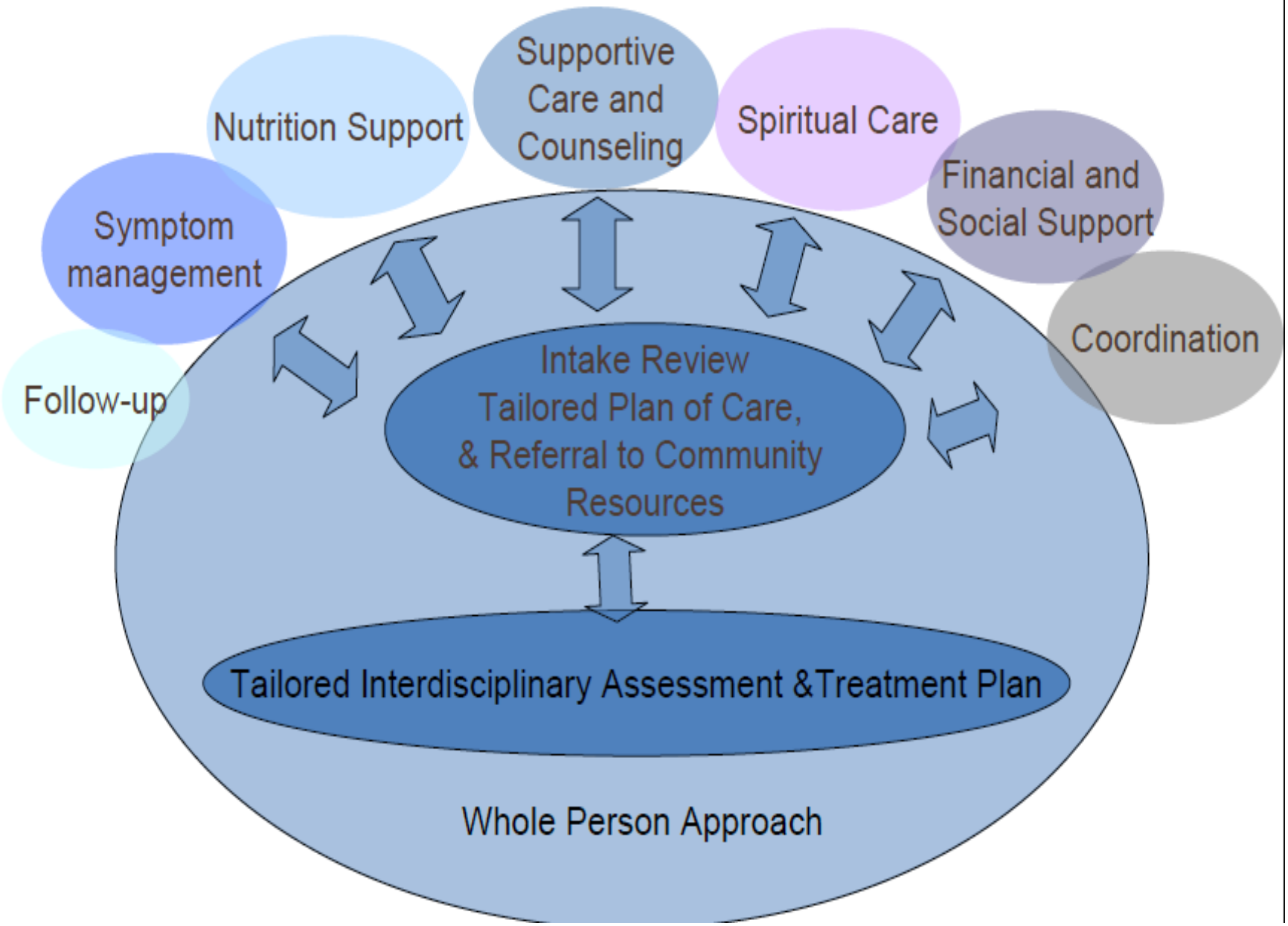
At THOCC

- Consultation model - In Patient for now
- Client = Referring MD/Team
- Interdisciplinary team – MD, APRN, SW's, Hospital Chaplains
- Focus on 3 domains:
  - Relieve physical and emotional suffering
  - Improve patient-physician-family communication and decision-making
  - Strengthen transition management and continuity of care across settings

Table 1. Roles and Functions of Palliative Care Service Members

Role	Function
Medical care	Provide consultation and/or management of portions or all of a patient's care by a physician, sometimes with a nurse practitioner or physician assistant
Nursing	Provide comprehensive assessment and implementation of treatments; contribute extensive experience and expertise
Psychosocial care	Provide psychosocial assessment and support to patient and family unit; contribute expertise in family systems theory
Spiritual care	Help patient and family find meaning and hope in the transcendent dimension; work with community pastors as indicated
Pharmacy	Provide consultative expertise in drug therapy, drug interactions, and patient/family education
Administration	Ensure smooth functioning of the team and facilitate problem solving
Volunteers	Provide additional care and support to patient and family; contribute time, the most valuable commodity
Therapy (eg, physical, occupational, music, massage)	Provide adjunctive therapies designed to achieve the goals of care; treat both patients and families

von Gunten CF: Secondary and tertiary palliative care in US hospitals. *JAMA*. 2002;287(7):875-881.


Supportive Care and Counseling
Nutrition Support
Spiritual Care
Financial and Social Support
Symptom management
Coordination
Follow-up
Intake Review Tailored Plan of Care, & Referral to Community Resources
Tailored Interdisciplinary Assessment &Treatment Plan
Whole Person Approach

Key Elements of Pall. Care Visits

- Relationship and rapport building
- Addressing symptoms
  - Symptom assessment and review
  - Symptom management
- Addressing coping
  - Ability to cope
  - Spirituality and faith
  - Emotional status
  - Referral to social work, psychiatry, or psychology

Yoong et al. Early Palliative Care in Advanced Lung Cancer: *A Qualitative Study*. *JAMA Intern Med. 2013;173(4):283-290.*

Key Elements of Pall. Care Visits

- Establishing illness understanding
  - Information preference
  - Prognostic awareness
  - Current illness status
- Discussing cancer treatments
  - Effect of cancer treatments
  - Decision making about cancer treatment

Yoong et al. Early Palliative Care in Advanced Lung Cancer: *A Qualitative Study*. *JAMA Intern Med. 2013;173(4):283-290.*

Key Elements of Pall. Care Visits

- End-of-life planning
  - Resuscitation preferences
  - Hospice discussion or referral
  - Practical or personal plans
  - Health care proxy
- Engaging family members

Yoong et al. Early Palliative Care in Advanced Lung Cancer: *A Qualitative Study*. *JAMA Intern Med. 2013;173(4):283-290.*

Representative Skill Sets for Primary and Specialty Palliative Care

Representative Skill Sets for Primary and Specialty Palliative Care.

Primary Palliative Care

- Basic management of pain and symptoms
- Basic management of depression and anxiety
- Basic discussions about
  - Prognosis
  - Goals of treatment
  - Suffering
  - Code status

Specialty Palliative Care

- Management of refractory pain or other symptoms
- Management of more complex depression, anxiety, grief, and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment
  - Within families
  - Between staff and families
  - Among treatment teams
- Assistance in addressing cases of near futility

Quill TE, Abernethy AP - Generalist plus Specialist Palliative Care-Creating a More Sustainable Model. N Engl J Med 2013; 368:1173-1175

Back to Cases……

- GZ

- KB

Top 10 Things We Wished Everyone Knew About Palliative Care

- 1. Can help address the multifaceted aspects of care for patients facing a serious illness
- 2. Is appropriate at any stage of serious illness
- 3. Early integration is becoming the new standard of care for patients with advanced cancer
- 4. Can be beneficial for many chronic diseases (moving beyond Cancer)
- 5. Manage total pain

Strand et al. Top 10 Things Palliative Care Clinicians Wished Everyone Knew About Palliative Care. Mayo Clin Proc. 2013;88(8):859-865.

Top 10 Things We Wished Everyone Knew About Palliative Care

- 6. Can help address many symptoms patients with a serious illness have
- 7. Can help address the emotional impact of serious illness on patients and their families
- 8. Assist in complex communication interactions
- 9. Patients' hopes and values equate to more than a cure: in addressing the barriers to Palliative Care involvement
- 10. Enhances health care value

Strand et al. Top 10 Things Palliative Care Clinicians Wished Everyone Knew About Palliative Care. Mayo Clin Proc. 2013;88(8):859-865.

PALLIATIVE CARE COUNTS

Did You Know?

U.S. News & World Report

includes the presence of palliative care services in its evaluation criteria.

Palliative care is recognized as a core component of quality through The Joint Commission Advanced Certification in Palliative Care.

Family Practice News
digital network
News and Views that Matter to Family Physicians

Practice Trends

Few states meet palliative care benchmark

By: RICHARD FRANKI, Family Practice News Digital Network

08/16/13

Only four states have effective strategies in place to improve access to and knowledge of palliative care services, the American Cancer Society Cancer Action Network reported.

The ACS CAN awarded top scores (5-6 points) to Connecticut, Maryland, Massachusetts, and Rhode Island using a scoring system that combines grades from the Center to Advance Palliative Care's national palliative care report card with actions on model legislation.

State performance on palliative care services and legislation

THANK YOU!!!!!

- QUESTIONS?