Palliative Care in the Community

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American College of Surgeons Commission on Cancer (CoC) Standard 2.4

"Palliative care services are available to patients either on-site or by referral"

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Statement from ASCO

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 (e.g. QOL, survival, healthcare services utilization, costs) and society, should be an area of intense research.

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Georgia's Comprehensive Cancer Control Plan (2014-2019)

The plan offers a strategic vision to reduce the cancer burden in the state. Access to palliative care is one of the eight priority areas. The Reference Committee supports statewide leadership, including not-for-profit sectors, business, government and academia, to bring together communities and resources to identify best practices for palliative care, reduce variation of care, and promote appropriate legislation and regulatory action as necessary.

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Palliative Care

1. Palliative care can help address the multi-faceted aspects of care for patients facing a serious illness
2. Palliative care is appropriate at any stage of serious illness
3. Early integration of palliative care is becoming the new standard of care for patients with advanced cancer

- Strand, J., Kamdar, M., & Carey, E., (2013). Top 10 Things Palliative Care Clinicians Wished Everyone Knew about Palliative Care. *Mayo Clinic Proceedings*, 88, 859-865.

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4. Moving beyond cancer: Palliative care can be beneficial for many chronic diseases
5. Palliative care teams manage total pain
6. Patients with a serious illness have many symptoms that palliative care can help address
7. Palliative care can help address the emotional impact of serious illness on patients and their families

- Strand, J., Kamdar, M., & Carey, E., (2013). Top 10 Things Palliative Care Clinicians Wished Everyone Knew about Palliative Care. *Mayo Clinic Proceedings*, 88, 859-865.

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What is the difference between Palliative Care and Hospice?

PALLIATIVE CARE	HOSPICE
❖ Supportive care for ***anyone*** with a serious illness	❖ Specialized care for the ***terminally*** ill
❖ Available at ***any*** stage of a serous illness	❖ Available at the END stages of an *incurable* illness
❖ CAN have it along with curative treatments	❖ *NO* longer receiving curative treatments
❖ NOT dependent on prognosis	❖ *Prognosis is usually 6 months or less*

Pina, I. L., *Palliative Care: When to Refer a Patient and How to Have This Important Discussion* Webinar, March, 2014

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Generalist Palliative Care versus Specialist Palliative Care

Generalist Palliative Care Skill Set
(Skills ALL providers in the hospitals are expected to gain comfort with)

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

Specialist Palliative Care Skill Set
(Skills beyond the generalist level that can be offered)

- 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:
  - Between patient & family
  - Within the family
  - Between staff and family
  - Among treatment teams
- \+ Assistance in addressing cases of near futility

Landmark Study: Palliative Care Extends Survival

- 151 patients with metastatic non-small cell lung cancer randomized to usual care or early palliative care
- Palliative care group lived 2.7 months longer despite usual care receiving more aggressive care
- Palliative care patients had improved quality of life and improved mood

- Temel, J, et al. (2011). Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine*, 2010, 363, 733-742.

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Georgia Cancer Control Consortium (GC3)

GC3 RECOMMENDED STANDARDS FOR PROVIDING OUTPATIENT PALLIATIVE CARE

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All items should be provided on-site or by referral to another agency, but the following standards should be considered a recommended standard and be included in the design of palliative care programs. If the Cancer Center refers to another agency for Palliative Care, it is recommended that the Cancer Center retain a copy of a written agreement which includes a program outline.

1. Scope of Services must be in writing: Palliative Care services should be considered at the time of diagnosis and be continually available throughout treatment, surveillance, and when applicable, during bereavement.

2. Core Team includes MD, RN/APRN, Social Worker/Counselor; and Chaplain as indicated. Other team members may include Pharmacist, Mental Health Clinician, and Trained Volunteer. Certification strongly encouraged if applicable.

3. Availability 24/7. This can be collaborative coverage between the cancer center and palliative program.

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4. Collection of data is retained on site, which includes but not limited to, reason for referral, symptom and pain management, etc.

5. Palliative Care Program provides evidence of education to referral sources and patients/families regarding the palliative program and services.

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6. The program links the patients to community resources that are available to meet their healthcare needs.

7. Palliative Team facilitates discussions on goals of care including the disease process and prognosis so that the patient/family are able to make informed decisions about their care.

8. The program utilizes team-based care planning involving patients and families in decisions about their clinical care to include advance care planning. Advance Directives and POLST documents should be made available for patients.

9. The documented palliative plan of care is developed based on the patient's assessed needs, strengths, limitations and goals.

10. The palliative program evaluates and revises the plan of care to meet the patient's ongoing needs and documents the revisions in the patient's medical record. Ensure continuity of care across the range of clinical settings and effective communication between patient, family, team members and providers.

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11. The team assesses and documents the patient's pain, dyspnea, constipation and other symptoms.

12. The program assesses and documents the patient's anxiety, stress, and other psychological symptoms. Psychosocial support is provided to patients and families when needed. Spiritual support is provided as indicated.

13. The patient is monitored for the effectiveness and medical necessity of medications.

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14. Processes should be in place for detecting and managing suspected aberrant drug-related behaviors.

15. Palliative Care team will evaluate all medical conditions and assist in coordinating care across the care continuum.

16. The program conducts regular patient care conferences with the members of the interdisciplinary team.

17. Data collection is timely, accurate, complete and relevant to the program.

18. Hospice is presented as an option to patients and families when the prognosis is six months or less and/or death would not be surprising.

19. Bereavement support is offered to the patient's family and team members who provided care to the patient.

How can we possibly do it?

- Care planning with patient/family
- Pain and symptom management
- Effective communication
- Continuity of care
- Attention to spiritual comfort
- Psychosocial support
- Bereavement support
- Hospice as option when appropriate

Determine the Clinic Practice Model

- Cancer Center provides palliative services
- Co-manage palliative clinic with existing Palliative Program
- Partnership with Hospice
- Refer out to Palliative Program

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Inpatient Hospitalization of Oncology Patients: Are We Missing an Opportunity for End-of-Life Care?

Gabrielle B. Rocque et al. JOP 2013;9:51-54

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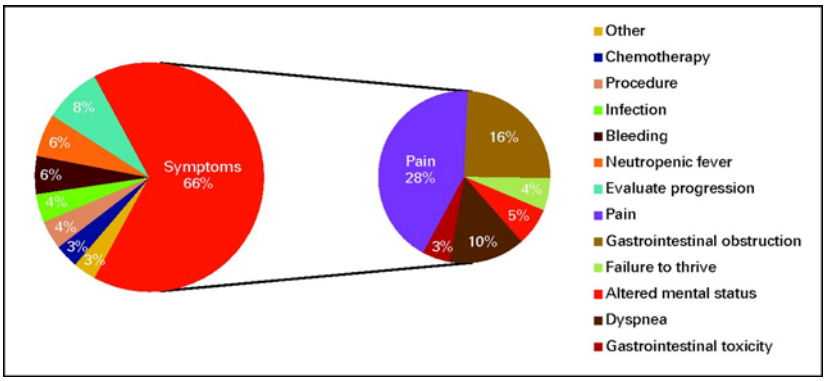
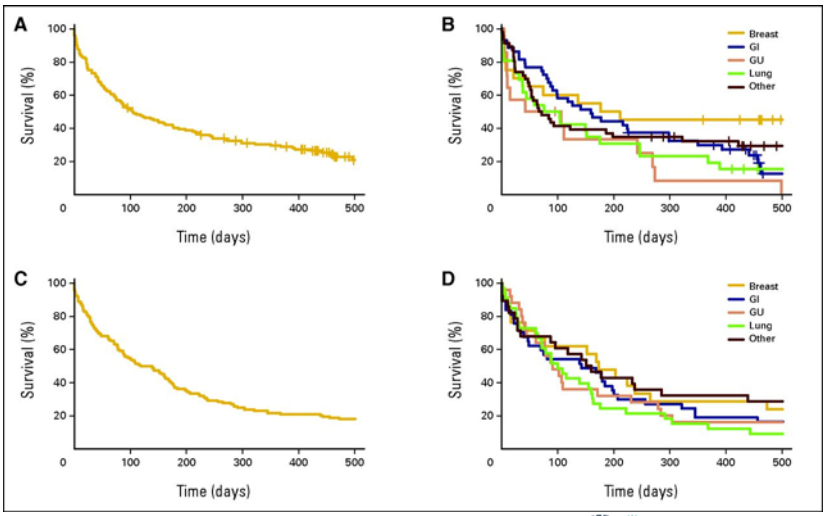
Chief reasons for admission to the inpatient oncology service.



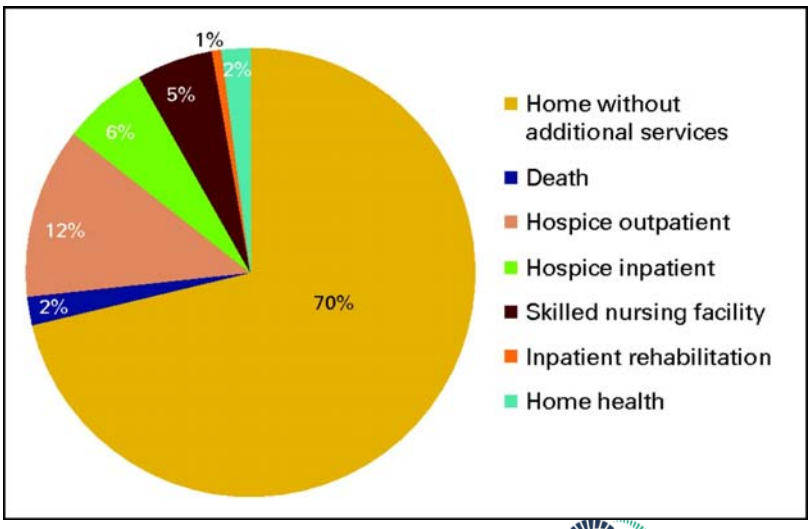
Gabrielle B. Rocque et al. JOP 2013;9:51-54

(A) Overall survival and (B) survival by disease type of patients in 2010 survey.



Gabrielle B. Rocque et al. JOP 2013;9:51-54

Percentages of patients who received supportive services at discharge.



Gabrielle B. Rocque et al. JOP 2013;9:51-54

- *"The terminally ill fear the unknown more than the known, the professional disinterest more than ineptitude, and the process of dying more than death itself."*

- Doyle and Denton: Pain and Symptom Control in Terminal Care. 1986

What Concerns Patients the Most?

St. Columba's Hospice, Edinburgh, England

Stevenson, L. W., *Disease Management and Palliative Care* Lecture, Sept. 2015

Resources

- Gabrielle B. Rocque et al. JOP 2013;9:51-54
- Temel, J, et al. (2011). Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine*, 2010, 363, 733-742.
- Strand, J., Kamdar, M., & Carey, E., (2013). Top 10 Things Palliative Care Clinicians Wished Everyone Knew about Palliative Care. *Mayo Clinic Proceedings*, 88, 859-865.
- www.asco.org/pco/palliativecare
- www.capc.org
- www.aahpm.org
- www.ghpco.org

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