Best Practices in Oncology Palliative Care

February 7, 2019

"Oncology High-Value Best Practices" Webinar Series, Webinar #3

CQC
CALIFORNIA QUALITY COLLABORATIVE
Breakthroughs for Better Health Care

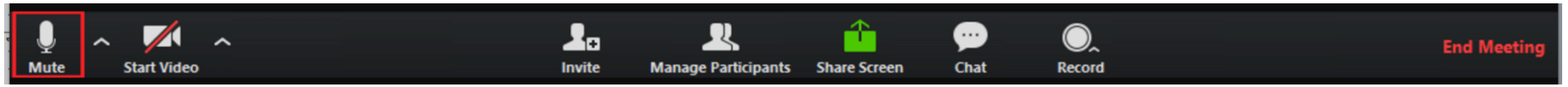
Tech Tips – Zoom Meetings

Attendees are automatically MUTED upon entry

Refrain from using the hold button

Use the chat box, raise your hand, or *unmute yourself and jump in* if you have questions or would like to participate

Direct messages to Jose if you have any technical issues



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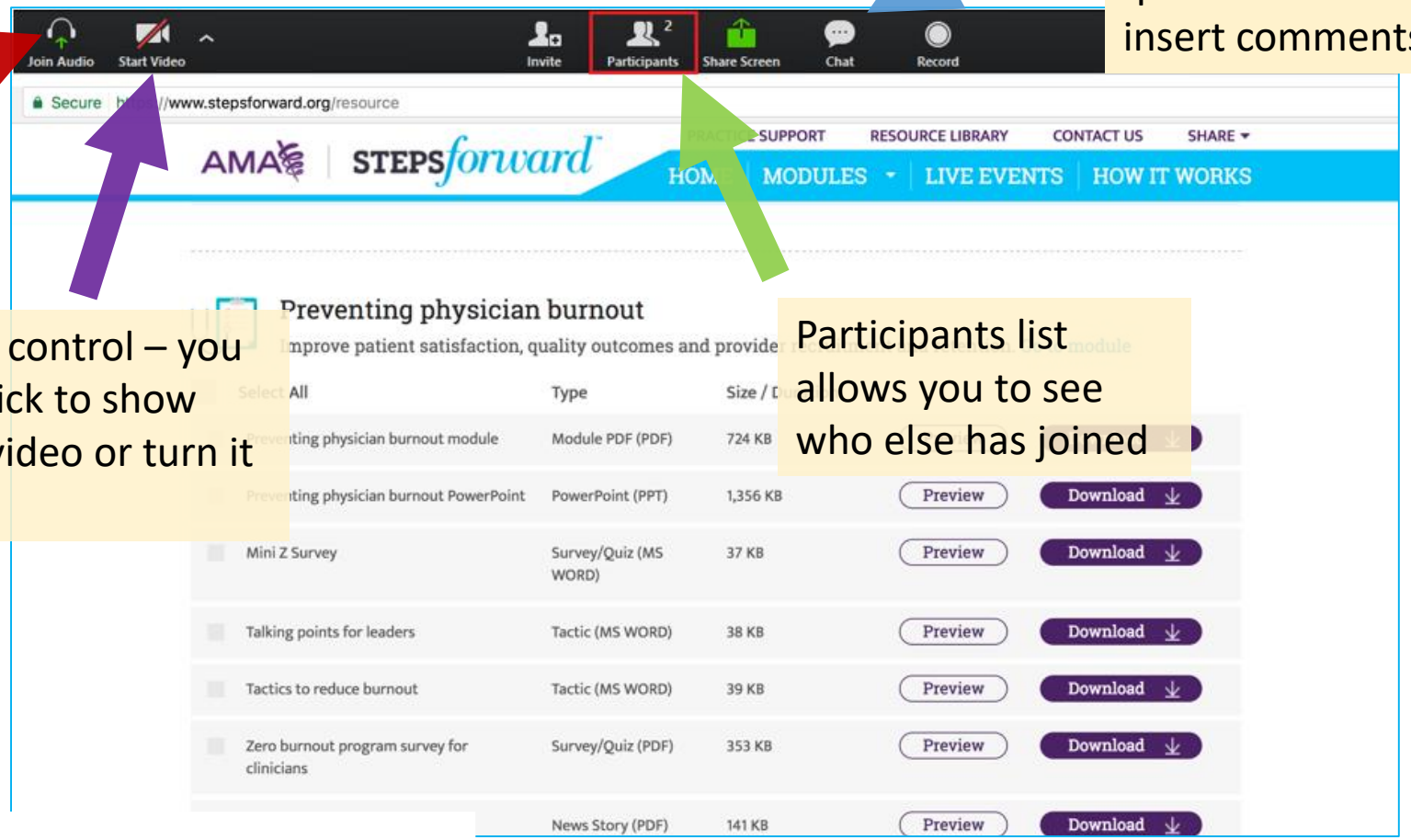
Zoom Tips & Tricks

Chat box so you can ask questions and insert comments

Click here to join audio



Video control – you can click to show your video or turn it off

Participants list allows you to see who else has joined

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Today's Speakers

- Bart Wald, MD
- Medical Director, California Quality Collaborative

- Kavitha Ramchandran, MD
- Clinical Associate Professor of Medicine in the Division of Oncology and
- Stanford Cancer Institute's Medical Director for PathWell

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Who is the California Quality Collaborative (CQC)?

CQC is a health care improvement organization dedicated to advancing the quality and efficiency of the health care delivery system in California. CQC creates scalable, measurable improvement in the care delivery system important to patients, purchasers, providers, and health plans.

- Started in 2007
- Multi-stakeholder governance
  - Core funding from health plans sharing a delivery system
  - Administered by the Pacific Business Group on Health
- **Purpose:** Identify and spread best practices across outpatient delivery system in California
  - Trains 2,000 individuals from 250 organizations each year

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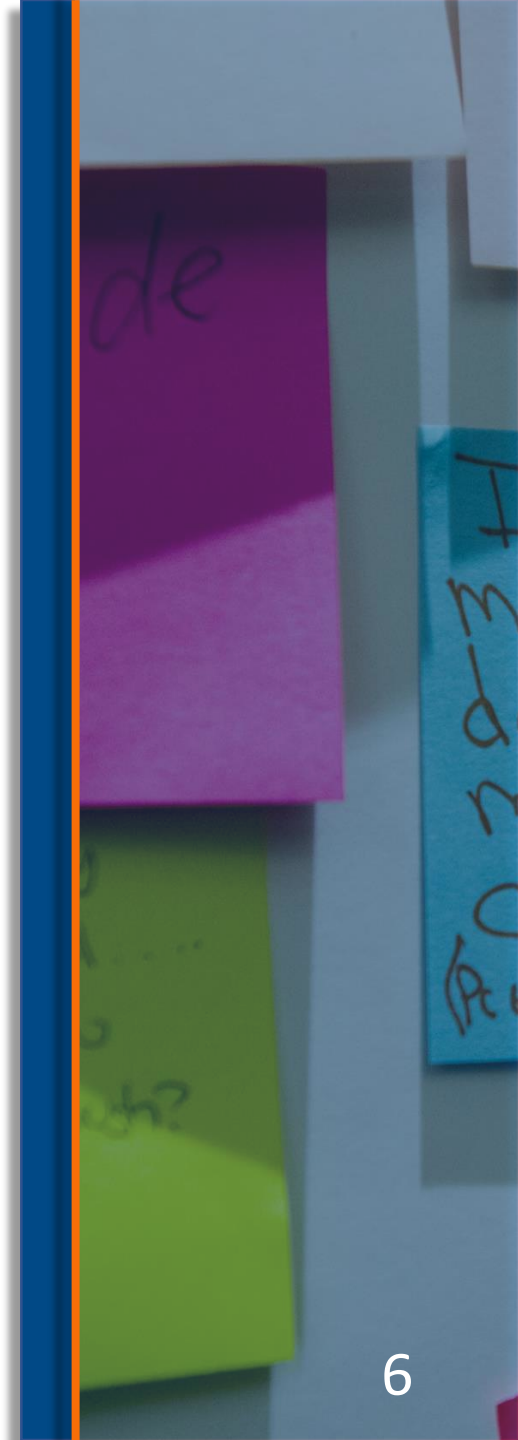

Oncology Series
Webinar Dates

- **Benefits & Limitations of Oncology Guidelines** (Anthony Ciarolla, MD)
- **Personalized Medicine** (Mark Pegram, MD)
- **Palliative Care** (Kavitha Ramchandran, MD)

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Best Practices in Oncology Palliative Care

Kavitha Ramchandran MD
Clinical Associate Professor
Medical Director- PathWell, Stanford Cancer Institute
Thoracic Oncology and Palliative Medicine
Stanford University

For our Patients:
Barriers **and challenges for quality of life**

Identity

"I feel really, really tired and still don't have the energy. I'm a really energetic person, who's very engaged in life and living and doing, and this has been very problematic for me…(to be) afraid that I'm not going to be able to get back to being normal."

Finance and insurance

"Dealing with it on my own, the finances, the insurance issues, the calls, not understanding what they were saying. It would have been very helpful to have some coaching or assistance with that.

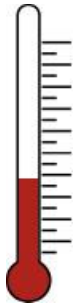
Information

"Because of the chemo brain that hit like a ton of bricks, it was very overwhelming and very challenging."

Barriers **and challenges** *(cont'd)*

Emotional Distress	*"I think it's more mental than physical. Physically, I'm fine. Mental was the hard part because you have all these feelings…you think you're immortal, and then something like that hits, and you're like 'I got to deal with my mortality,' and that's a big thing to deal with."*
Isolation / Lack of Support	*"I went from a small tumor on my chest to stage 4 cancer in 10 years. I consider this my second recurrence. It's not a cake walk. I've been dealing with this pretty much on my own."*
Concern for Caregivers	*"I was thinking of other people that this might effect, other than myself, and the torture that they're going to have to go through."*

Patient feedback surveys

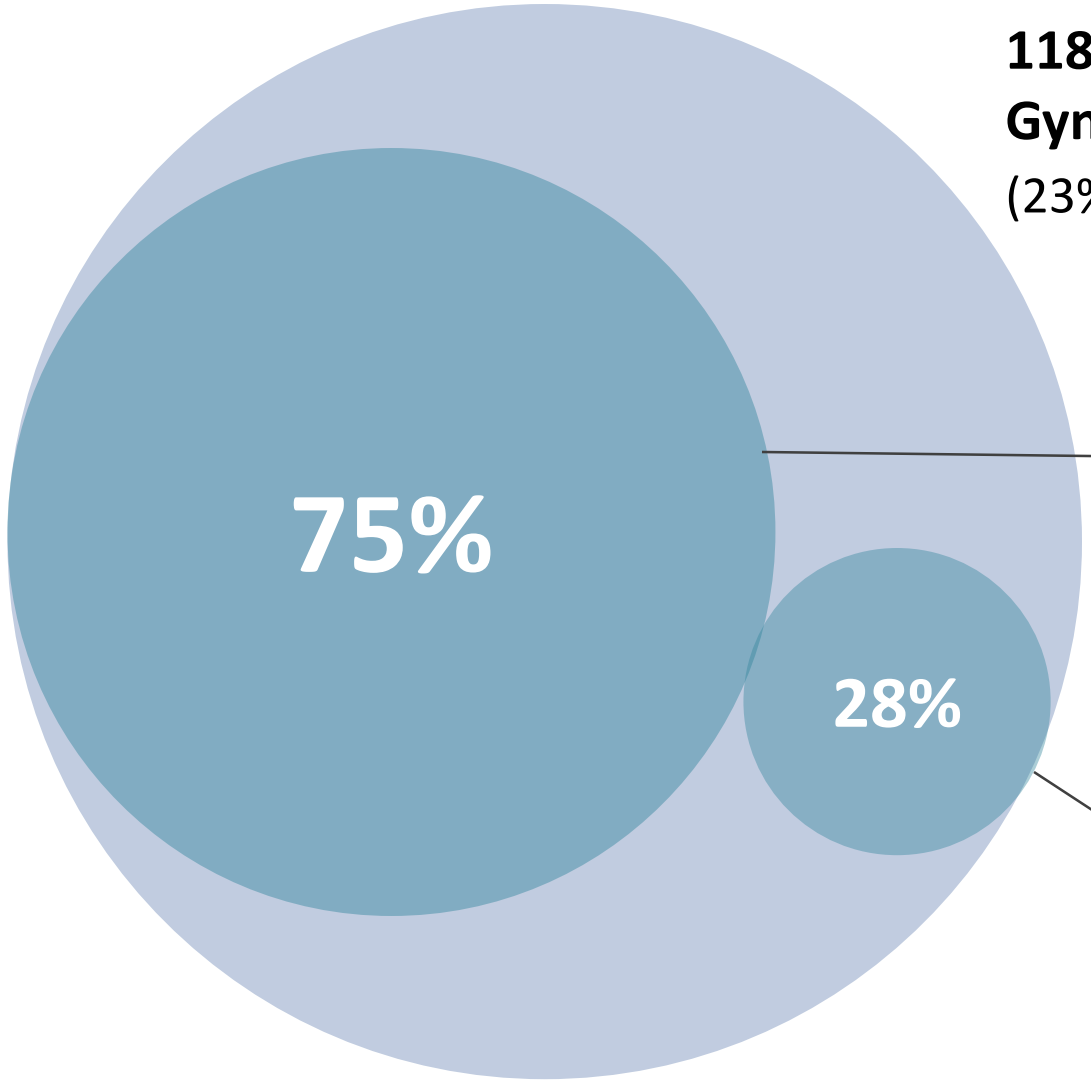


39% of patients report that care teams **ask about physical, emotional and social goals.**

43% report providers explain how cancer and treatment could **affect normal daily activities.**

57% of patients report care teams make them feel as though they **care for the whole person.**

Observation of Oncology Clinics



118 clinic visits in Hematology and Gynecologic Oncology

(23% new patient)

Included discussion of physical symptoms

Included discussion of social, emotional or spiritual concerns

At a system level: a crisis

- Cost- 125 billion in 2010→ projected to be 160 billion in 2020
- Acute care in cancer→ accounts for 48% of health care costs
- Lack of Goal Concordant Care

Mariotto AB, Yabroff KR, Shao Y, et al: Projections of the cost of cancer care in the United States: 2010-2020. J Natl Cancer Inst 103:117-128, 2011 Crossref, Medline, Google Scholar
Fisher ES, Wennberg DE, Stukel TA, et al: The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. Ann Intern Med 138:273-287, 2003 Crossref, Medline, Google Scholar

Palliative Care: A Definition

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

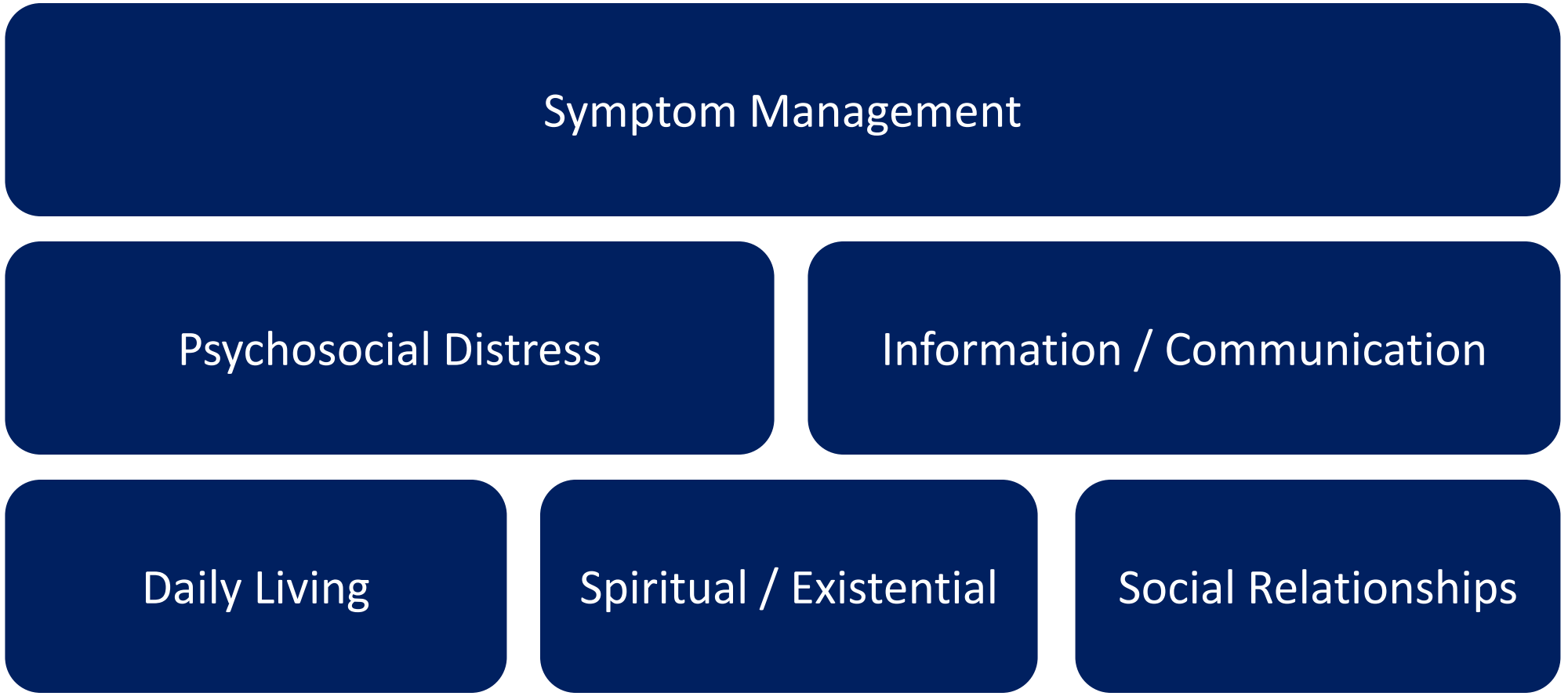
The evidence

Study	Patient Population	Intervention	Outcomes	Conclusion
Temel et al, 2010	151 Advanced NSCLC patients	Usual care vs. Palliative care- q month intervals	Improved - Survival (p=.02) - QOL (p=.03) - Less aggressive EOL care (p=.05) - Psycho-social health (p=.01)	Integrated palliative care with oncologic care improves QOL and survival
Bakitas et al, 2009	312 patients, advanced solid tumor, prognosis < 1year	Usual care vs usual care + 4 weekly sessions followed by telephone intervention (based on chronic disease management model)	Improved - QOL (p=.02) - Psycho-social health (p=.02) - Symptom intensity (p=.06)	Chronic disease management model is effective in advanced cancer as a low resource palliative care model
Zimmerman et al, 2014	461 patients, Advanced cancer, prognosis of 6-24 months	Usual care vs. Usual care + palliative care visit monthly	Improved - QOL (p=.003) - Satisfaction (p=.001) - Symptom intensity (p=.05)	Integrated palliative care into oncologic care in advanced disease improves QOL, satisfaction and symptom intensity

The recommendation:

ASCO	Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services.
NCCN	Palliative care should be initiated by the primary oncology team (including physicians, nurses, social workers, mental health professionals, chaplains, physician assistants, pharmacists, and dietitians) and then augmented via collaboration with an interdisciplinary team of palliative care experts to address intractable symptoms and/or complex psychosocial issues.
IOM	The committee finds that a palliative approach typically affords patients and families the highest quality of life for the most time possible. For the purposes of the report, the committee defines palliative care as that which provides relief from pain and other symptoms, supports quality of life, and is focused on patients with serious advanced illness and their families. Palliative care may begin early in the course of treatment for a serious condition.

Primary Palliative Care: Core Skills



Capurro et al. Effectiveness of eHealth Interventions and Information Needs in Palliative Care: A Systematic Review. J Med Internet Res 2014;16(3):e72.
Schenker et al. Do Patients with Advanced Cancer and Unmet Palliative Care Needs Have an Interest in Receiving Palliative Care Services? J Palliat Med 2014;17(6).

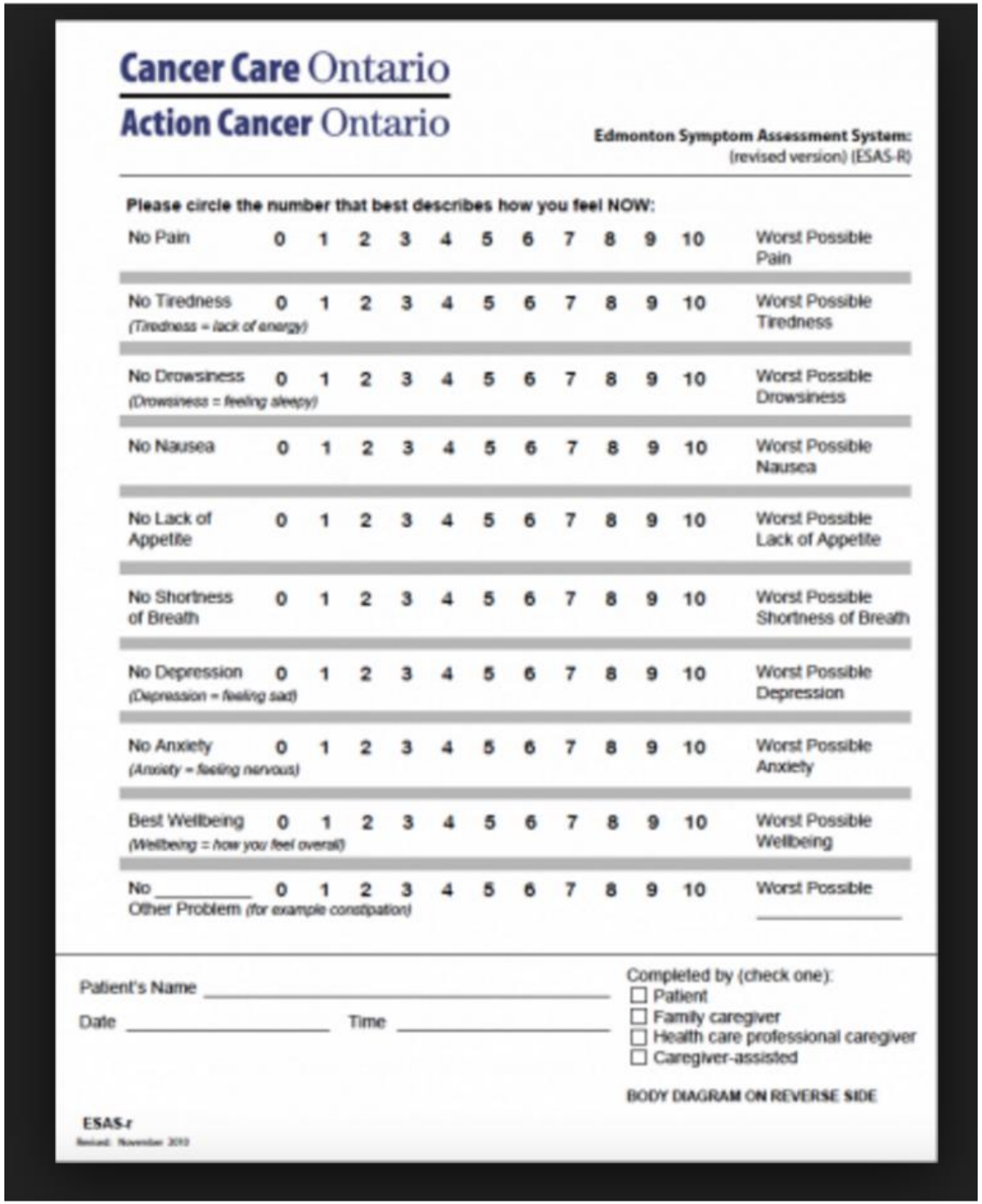
Primary Palliative Care: Team and Structure

- An interdisciplinary team
- Regular screening for symptoms and psycho-social needs
- Care pathways to ensure triaging and care for identified needs
- Education and skills for training and staff

A primary palliative care checklist

Screening for pain							
Screening for non-pain physical symptoms							
Screening for depression							
Screening for anxiety							
Management of pain							
Management of non-pain physical symptoms							
Management of depression							
Management of anxiety							
Screening for psychosocial distress							
Screening for spiritual care needs, spiritual distress							
Functional assessment							
Screening for needs for medical equipment, assistance with ADLs							
Screening for caregiver burnout, needs							
Advance Care Planning (ACP)							
Screening for prior ACP							
Refer patients to health classes/staff for ACP education and support							
Assist/coach patients with completing ACP							
Assist patients with identifying surrogate decisionmaker							
Document patient surrogate and prefer-ences regarding life-sustaining treatments (AHCD/POLST)							

Routine symptom screens



Cancer Care Ontario
Action Cancer Ontario

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name _____

Date _____ Time _____

Completed by (check one):
- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS-r
Revised: November 2010

PROMIS Global

Global Health-
PROMIS Global Health (10) SF

	Please respond to each item by marking one box per row	Excellent	Very good	Good	Fair	Poor
Global 01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 02	In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 09	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Completely	**Mostly**	**Moderately**	**A Little**	**Not At All**
Global 06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	In the past 7 days	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
Global 10	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		None	**Mild**	**Moderate**	**Severe**	**Very Severe**
Global 08	How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global 07	How would you rate your pain on average?	☐ 0 No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst Imaginable Pain				

Scoring:
Re-code Global07. The recoded score ranges from 1 to 5.
(0 No pain **=5**; 1, 2, or 3 **=4**; 4, 5, or 6 **=3**; 7, 8, or 9 **=2**; 10 worst pain imaginable **=1**)

Routine psycho-social screens

- Standardized screening instruments for depression and anxiety PHQ 9 and PHQ 2
- Global screens- PROMIS, Canadian Problem Checklist

PHQ 2

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At all**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Spiritual screen

- **F:** What is your faith or belief?
  Do you consider yourself spiritual or religious?
  What things do you believe in that give meaning to your life?

I: Is it important in your life?
What influence does it have on how you take care of yourself?
How have your beliefs influenced in your behavior during this illness??
What role do your beliefs play in regaining your health?

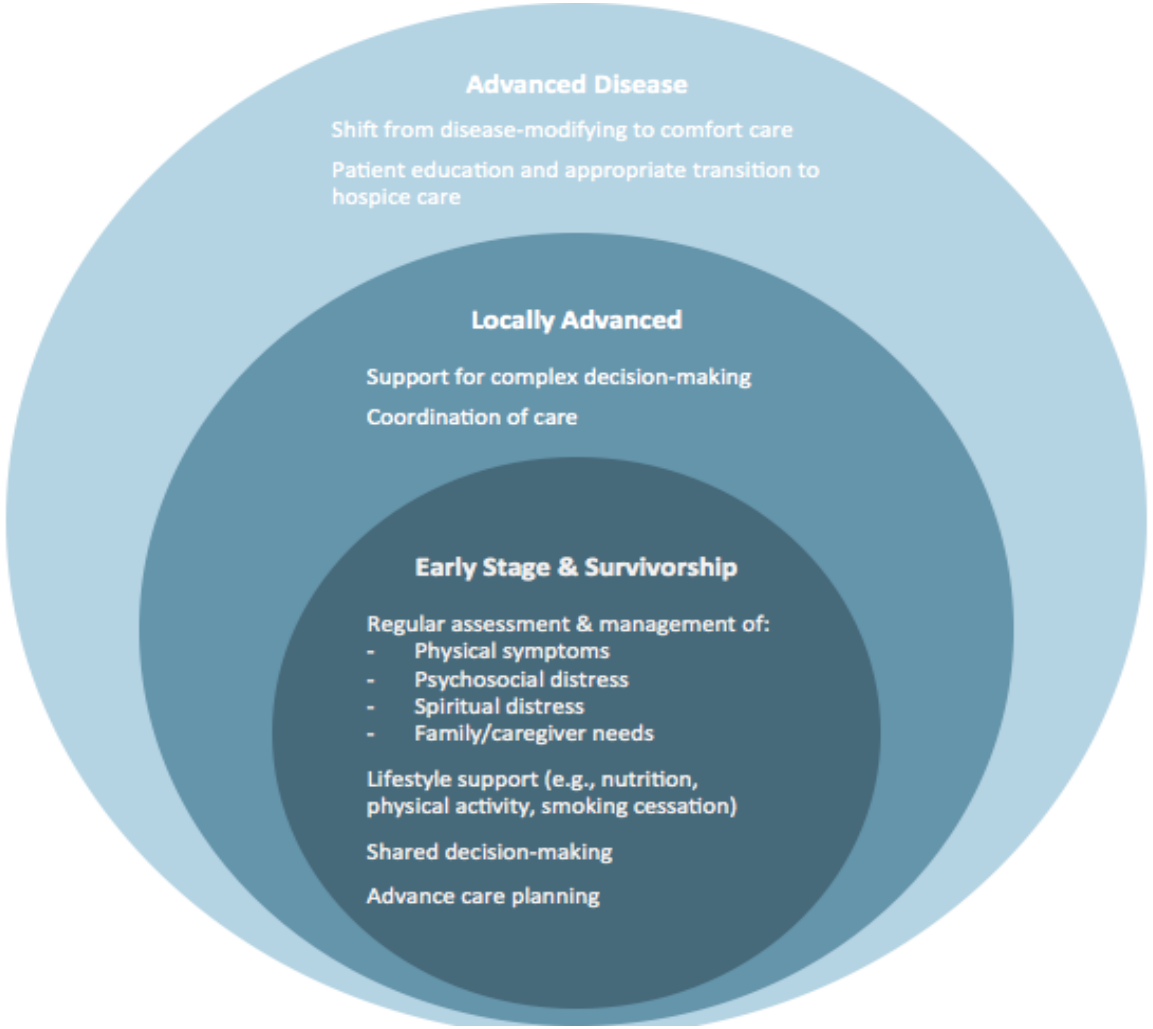
C: Are you part of a spiritual or religious community?
Is this of support to you and how?
Is there a person or group of people you really love or who are really important to you?

A: How would you like me, your healthcare provider to address these issues in your healthcare?

Touch Points in the Cancer Experience

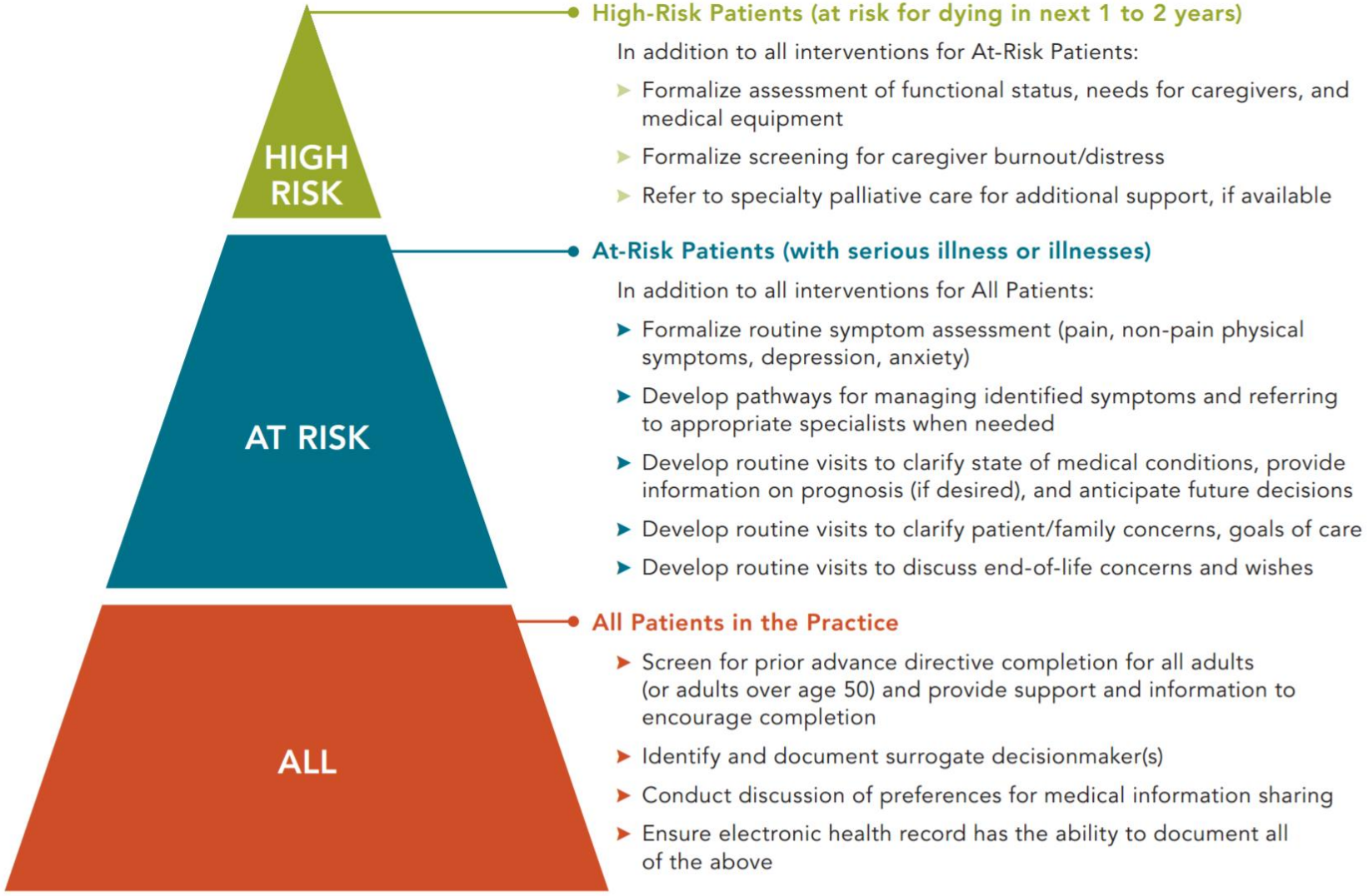
	Pre- and Initial Diagnosis	Ongoing Clinic Appointments	Treatment and Side Effects	Survivorship and/or hospice
Disease Management	• Referral • Diagnostic tests • Discuss medical history • Discuss diagnosis and treatment options	• Discuss current-state, diagnosis and treatment options	Treatment • Surgery • Infusion/Chemotherapy • Radiation Therapy • Stem Cell Transplant • Oral meds/Chemotherapy • Clinical trial Acute Side Effect Management • Emergency Department • Hospital admission	• Remission • Watch and Wait • Slow disease progression • Maintenance therapy • Metastases (e.g., begin new treatment cycle)
Palliative Care And Symptom Support	• Assess (baseline) medical and psychological state • Discuss goals of care	• Assess medical, psychological, social and spiritual state • Ongoing medical , psychological, social and spiritual support ▪ Internal resources ▪ Community resources	• Ongoing medical , psychological, social and spiritual support ▪ Internal resources ▪ Community resources	• Ongoing medical , psychological, social and spiritual support ▪ Internal resources ▪ Community resources • Hospice

Recommendations: By Stage in Oncology



Chandrasekar, Divya, Erika Tribett, and Kavitha Ramchandran. "Integrated Palliative Care and Oncologic Care in Non-Small-Cell Lung Cancer." *Current Treatment Options in Oncology* 17.5 (2016): 1-16.

At a practice/ system level



Quality of Life

Physical

Occupational/Physical Therapy
Palliative (physical + other symptoms)
Speech / Swallowing
Lymphedema
Pain Management
Ostomy / Wound Care
Nutrition
AYA
Integrative Medicine
Radiation Oncology (tumor removal)
Survivorship
Supportive Care
Supportive Derm Oncology
Sleep Clinic *
Smoking Cessation

Emotional

Financial Services
Supportive Care
Psycho-oncology
Spiritual Care
Neuro Psychiatry
Nutrition
Speech / Swallowing
AYA
Survivorship
Financial Counseling
Pain Management
Smoking cessation
Social Work

Social

Social Work
Nutrition
Smoking Cessation
AYA
Supportive Care
Spiritual Care
Psych Onc
Survivorship
Financial Counseling
Pain Management

Spiritual / Existential

Spiritual Care
Supportive Care
Social Work
Integrative Medicine

Assessment


I GOT IT! I GOT IT! I GOT IT!!
MOORE 8-26
THUNK!
SUN IN MY EYES? WIND GOT HOLD OF IT? STRUGGLING WITH `PERSONAL ISSUES'?? GOTTA THINK!!
© Steve Moore/Distributed by Universal Uclick via CartoonStock.com
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What does “assessment” mean?

- Follow up question on the quality and intensity of a symptom
- Interference with function
- Asking the question “Are these needs met?”

Intervention

Table 3: Defining Primary and Specialty Palliative Care

Primary vs Specialty-level Palliative Care Skill Set

- Primary palliative care
  - Identification of symptoms/suffering
  - Basic management of pain and symptoms
  - Basic management of depression and anxiety
  - Basic discussions about:
    - Prognosis
    - Goals of treatment
    - Suffering
    - Code status
- Specialty-level palliative care
  - Management of refractory symptoms
  - Management of complex depression, anxiety, grief, and existential distress
  - Assistance with conflict resolution regarding goals or methods of treatment
    - Within families
    - Between staff and families
    - Treatment teams
  - Assistance in addressing cases of near futility

Adapted from: Quill TE, Abernethy AP. *N Engl J Med* 2013;368:1173-1175.

Specialist Palliative Care

- Usually team based
  - Medical/ psycho-social/ spiritual care
- Often available at academic medical centers
- Inpatient/Outpatient/ and Home based
- Practitioner with higher level training in palliative care
  - MD with fellowship training
  - APP with certification in palliative care
  - SW with certification in palliative care

Why it works, a hypothesis

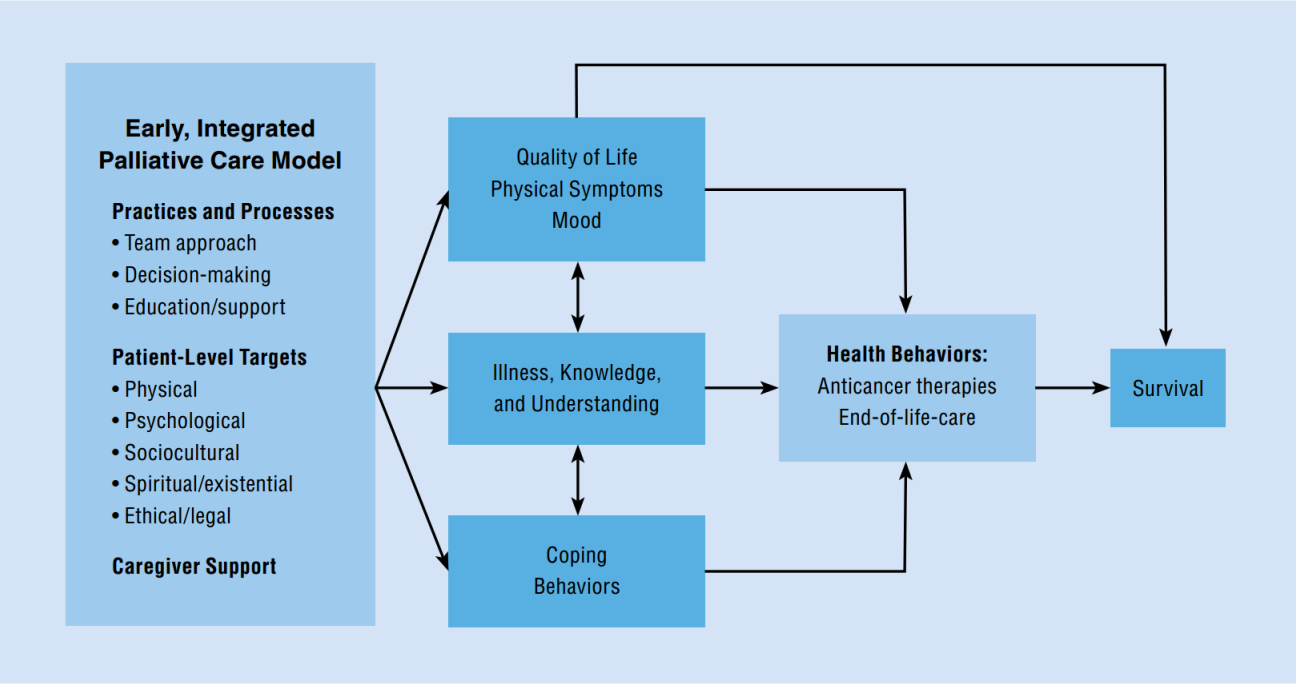

Fig 1. — Hypothesized relationships between early palliative care interventions and clinical outcomes.

From Irwin KE, Greer JA, Khatib J, et al. Early palliative care and metastatic non-small cell lung cancer: potential mechanisms of prolonged survival. *Chron Respir Dis.* 2013;10(1):35-47. Reprinted by permission of SAGE Publications.

How it works, Potential solutions

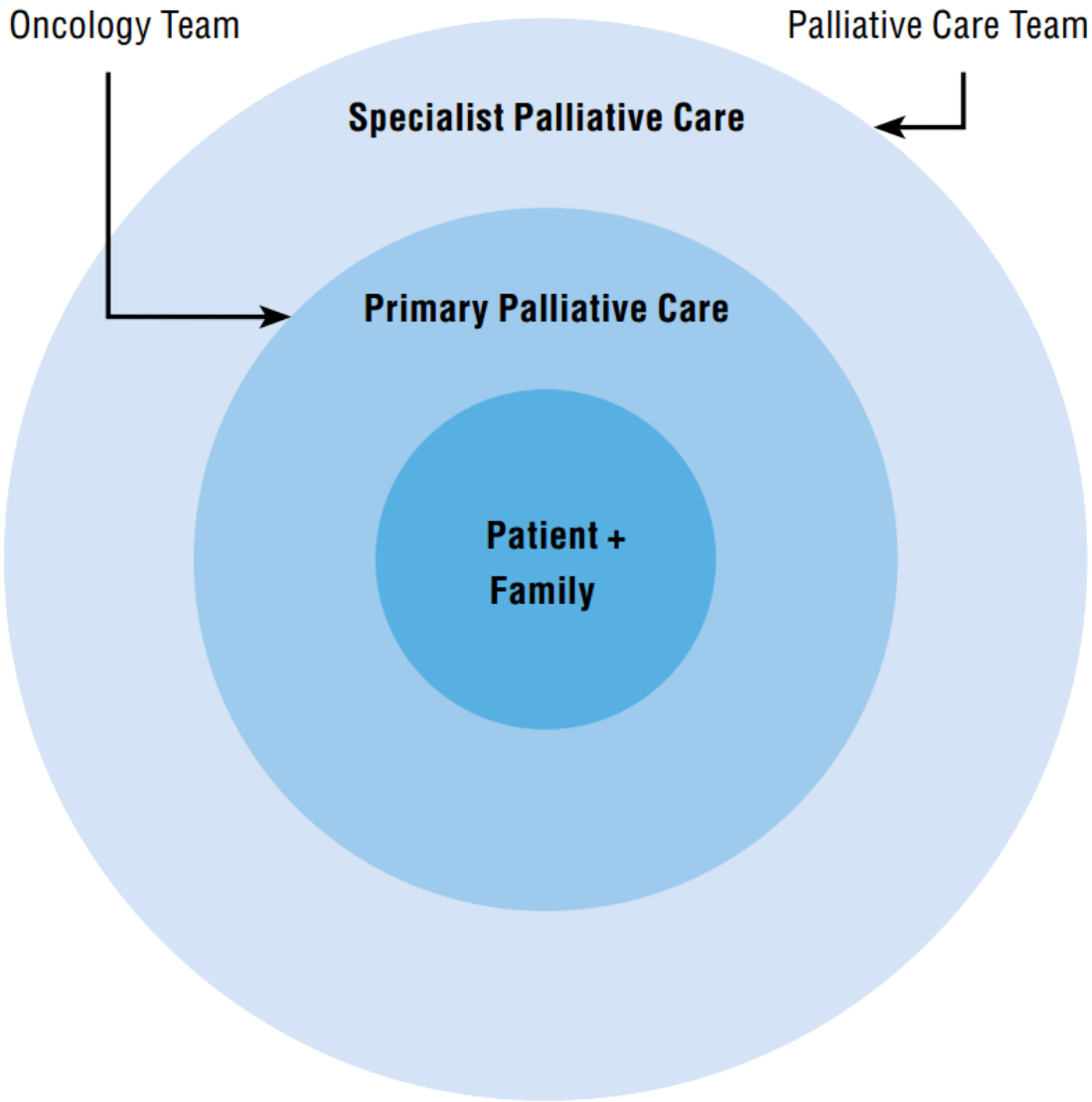

Fig 2. — Patient-centered model of primary and specialist palliative care that leverages oncology and specialist teams.

Ramchandran, Kavitha, et al. "Integrating palliative care into oncology: a way forward." *Cancer Control* 22.4 (2015): 386-395.

How can you learn more?

- Palliative Care Always, Stanford Online - Launch date 3/19 (lagunita.stanford.edu)
- ASCO Palliative Care in Oncology Symposium (9/2019)
- American Association of Hospice and Palliative Medicine
- Center to Advance Palliative Care

A clinical example:

- Mr. Smith has a diagnosis of metastatic prostate cancer. He has a regular oncologist but is seeing him less frequently. He comes to you complaining of pain in right rib cage. He has known bone metastases. He is currently taking no pain medication.

Primary vs. Specialist Palliative Care

What would you do now?

Thank you to our patients, families and colleagues!