The TEAM* approach to palliative care
How oncologists can integrate palliative care into their practice

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MEDICINE

*Time, Education, Assessment, Management

Disclosure – Tom Smith

- Received $5100 in travel expenses to teach at a course sponsored by the makers of MC5A Scrambler Therapy Machine, January 2017
  - Business class air fare to Seoul, Korea
  - Hotel and meals
  - $38 vase for spouse
- Up To Date, Editor, Palliative Care, non-pain symptoms (With Eduardo Bruera)
- ABIM Hospice and Palliative Medicine test writing committee so no disclosure of questions or answers

Take Home Messages – Tom Smith

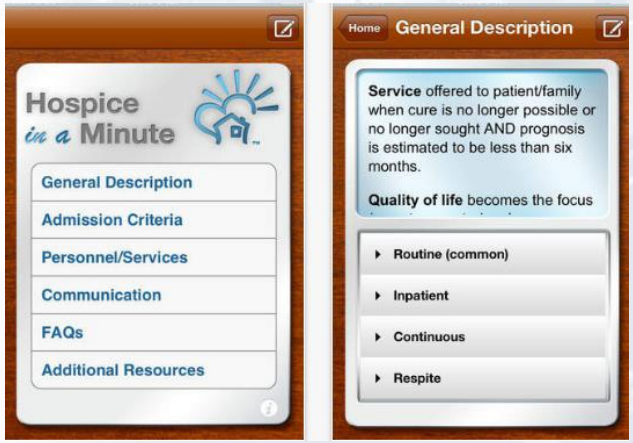
1. Partner with a palliative care team that you trust. Create space in your office for PC help. Unless you can spare an hour a month.

2. Set up a Hospice Information Visit when you think the person has 6-12 months to live, to ensure that "this will be a planned transition, to hospice, if and when you need it."

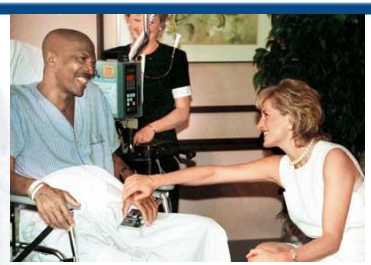
3. At each CT or scan showing progression ask "Would you like to discuss what this means?"
   - Gives them control over the information.
   - You know the situation has changed for them but they don't know the consequences.
   - Don't just go on to "The next chemo will be _____."

Definition of Hospice

- Pioneered in the 1950s by Dame Cicely Saunders.
- **Hospice** is a type and philosophy of care that focuses on the palliation of a terminally ill patient's symptoms.
- When there are no longer curative options, or reasonable options.
- *Hospice reimbursement is set at $160 a day, so all expenses must be covered from this.*



Definition of palliative care



"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**.

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.**"

– Diane Meier, MD, Director, Center to Advance Palliative Care

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Summary of 11 recent studies comparing usual care to UC + PC

Study	Survival	Patient Experience C=caregiver	Cost
Brumley, 2007 (1/3 ca)	=	+++ (↑ satisfaction, home deaths, hospice)	-$7550
Gade, 2008 (1/3 ca)	=	+++ (↓ ICU, ↑hospice)	-$4885
Bakitas 2009 (Cancer)	Longer, 5.5 mon, NS	+++ (better sx, less depression)	=resource use
Temel 2010 (lung ca)	Longer, 2.7 mon, S	+++ (2x less depression)	-$2000
Higginson 2012 (MS)	=	+++++ (5 sxs better) C+	-$2700/12 wks
Zimmermann, 2014 (Cancer)	=	+++, C+	=
Higginson 2014 (dyspnea, most cancer)	Longer, 15/100 at 1000 days = for lung ca	+++	=
Farquhar 2014 (breathlessness)	=	+++ (less distress due to Breathlessness) C+	-$325 for cancer, better QOL Dominates cost-effectiveness
Sidebottom, 2015 (CHF)	=	+++, C+	=
Bakitas 2015 (Ca)	Longer, 6.5 mon, S	=QOL, C+ ↓depression, ↓stress,	= resource use
Ferrell, 2015 (Lung Ca)	Longer 6 mons, NS	QOL+, C+	= resource use
Grudzen, 2016 (ca patients in ED)	Longer, 5 months, NS	=	=
El-Jawahri, 2016 (BMT)	=	↓ depression and anxiety, C+	Not reported

Bakitas, El−Jawahri, Ferrell, Farguhar, Grudzen, Higginson, Temel, Smith, Zimmermann. JOP in press

ASCO now strongly recommends *concurrent* palliative care


JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update

Betty R. Ferrell, Jennifer S. Temel, Sarah Temin, Erin R. Alesi, Tracy A. Balboni, Ethan M. Basch, Janice I. Firn, Judith A. Paice, Jeffrey M. Peppercorn, Tanyanika Phillips, Ellen L. Stovall,† Camilla Zimmermann, and Thomas J. Smith

Betty R. Ferrell, City of Hope Medical Center, Duarte, CA; Jennifer S. Temel and Jeffrey M. Peppercorn, Massachusetts General Hospital; Tracy A. Balboni,

- *For **every advanced cancer patient**, based on the evidence*
  - *By an interdisciplinary team*
  - *Concurrent with oncology care*
  - *Within 8 weeks of diagnosis*
- *The data are not sufficient to say if Oncologists can do this ourselves*
- *http://ascopubs.org/doi/full/10.1200/JCO.2016.70.1474*
- *http://www.asco.org/sites/new-www.asco.org/files/content-files/practice-and-guidelines/documents/2016-palliative-care-checklist.pdf*

Palliative care has a positive financial impact on the institution – and reduces public health spending

Original Contribution | CARE DELIVERY

Impact of a New Palliative Care Program on Health System Finances: An Analysis of the Palliative Care Program Inpatient Unit and Consultations at Johns Hopkins Medical Institutions

Sarina R. Isenberg, Chunhua Lu, John McQuade, Kelvin K.W. Chan, Natasha Gill, Michael Cardamone, Deirdre Torto, Terry Langbaum, Rab Razzak, and Thomas J. Smith

Johns Hopkins Bloomberg School of Public Health; Johns Hopkins Health System; Johns Hopkins Medical Institutions, Baltimore, MD; Sunnybrook Odette Cancer Centre; University of Toronto; and Canadian Centre for Applied Research in Cancer Control, Toronto, Ontario, Canada

Abstract

Purpose

Palliative care inpatient units (PCUs) can improve symptoms, family perception of care, and lower per-diem costs compared with usual care. In March 2013, Johns Hopkins Medical Institutions (JHMI) added a PCU to the palliative care (PC) program. We studied the financial impact of the PC program on JHMI from March 2013 to March 2014.

The total positive financial impact of the PC program for 2015 was $3,488,863.17.

Isenberg S, et al. J Onc Practice DOI: 10.1200/JOP.2016.014860; published online ahead of print at jop.ascopubs.org on February 28, 2017

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Palliative Care has a good impact on the health system this FY (estimates)

Financial impact	Cases/year projected 2016	Financial Impact per case	Contribution ($/year)	5 year total Contribution
IP PCU Margin (1)			$ 100,000	$ 500,000
IP PCU Cost $1595 savings/transfer (2)	154	$1,595	$ 245,630	$ 1,228,150
PC IP Consult Cost Savings per Case, $2,374 for patients discharged alive (3)	1355	$2,374	$ 3,216,770	$ 16,083,850
PC IP Consult Cost Savings per Case, $6,871 for decedents, 11% died (4)	167	$6,871	$ 1,147,457	$ 5,737,285
JHFAU vetted savings			***$4,709,857***	***$23,549,285***
Early PC OP Consult Cost Savings per case (5) $5198/case	297	$5,198	$ 245,630	$ 34,355,000
Hospice referrals Cost Savings per case, $3400/case (6) Assumes half of the actual savings of $6800	800	$3,400	$ 2,720,000	$ 13,600,000
Professional fees, 50% collection rate (7)			$ 500,000	$ 2,500,000
Improvement in HCAHPS (2% of Medicare reimbursement in 2017).			?	
Increased ICU bed availability leading to revenue			?	
Reduction in 30 day readmissions			?	
Goodwill; impact on disparities			?	
Total impact			$ 8,175,487	$ 74,004,285

Isenberg SA, et al. J Oncol Pract. 2017 Feb 28:JOP2016014860

JOHNS HOPKINS MEDICINE

Palliative care meets cost-effectiveness criteria and could spend up to $716 a day more

Original Contribution | CARE DELIVERY

Economic Evaluation of a Hospital-Based Palliative Care Program

Sarina R. Isenberg, Chunhua Lu, John McQuade, Rab Razzak, Brian W. Weir, Natasha Gill, Thomas J. Smith, and David R. Holtgrave

Johns Hopkins Bloomberg School of Public Health; Johns Hopkins Health System; and Sidney Kimmel Comprehensive Cancer Center of Johns Hopkins Medical Institutions, Baltimore, MD

Abstract

Purpose

Establish costs of an inpatient palliative care unit (PCU) and conduct a threshold analysis to estimate the maximum possible costs for the PCU to be considered cost effective.

Isenberg S, et al. J Onc Practice 2017
DOI: https://doi.org/10.1200/JOP. 2016.018036;

Cost minimization savings $452 per patient per day

PC inpatient program could generate 3.11 quality-adjusted life years (QALYs) from patients (0.05 QALY) and caregivers (3.06 QALYs).

Could spend up to $716 per patient per day and still meet cost effectiveness criteria.

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Palliative Care fastest growing specialty getpalliativecare.org

90% of >300 bed hospitals

2006: ABMS

2012: fellowship required

www.CAPC.org

There are major workforce shortages

- Should see ~8% of adult discharges
- About 3.4% of adult discharge are seen by palliative care
- 1-1.8 MILLION patients are not seen by palliative care
  - www.capc.org

- 1 hour of PC per month for each of 600,920 cancer deaths would equal 6000 Full Time Equivalents in PC
- 120 fellowship slots a year
- Always referring to PC risks “deskilling oncologists”

- We have to learn to do this ourselves
  - Schenker Y, Arnold R. Toward Palliative Care for All Patients With Advanced Cancer. JAMA Oncol. 2017 May 18. doi: 10.1001/jamaoncol.2017.1059.

Am I doing Palliative Care?

Score 6 or more = good palliative care.

Do I …	Example	Points
ALWAYS ask -	What is your understanding of your disease? How do you like to get medical information? What is important to you? What are you hoping for?	1 1 1 1
Multidimensional symptom assessment	ESAS, MDASI, MSAS, CAPC tool	1
Assessment for depression	Are you depressed?	1
Screening for delirium	Single question or instruments?	1
Documented goals of care discussion	What is your understanding of your disease, now that we have reviewed it?	1
Spiritual assessment	Is religion or spirituality important to you?	1
Have I asked about advance directives	In at least 90% of my seriously patients	1
Do I have a “code status” discussion documented	In at least 50% of my seriously ill patients	1

Program data: GBM patients

Kuchinad K, et al. J Neurooncol. 2017 May 20. doi: 10.1007/s11060-017-2487-8

Table 2: some NQF/QOPI measures

	n	%
Advanced Directive	17	17%
Code Status	40	40%
Hospice Referral	76	76%
Use of Chemotherapy in last 4 weeks of life	17	17%
Hospitalization during last four weeks of life	37	37%
Average length of stay per hospitalization	8.75	--

TEAM Concept in Palliative Care

Time:

- at least an extra hour a month. Every month. Not once.
- Does not have to be the doctor. Advance practice nurses are as good. Oncologists cannot do with a 12 minute visit concentrating on chemo doses.
- Can be in person (Temel, Zimmerman, Ferrell, Higginson, others)
- Or by phone/telemedicine (Bakitas ENABLE II and III).
- But structured, an hour a month.

TEAM Concept in Palliative Care

Jacobsen J. **Components of early outpatient palliative care consultation in patients with metastatic nonsmall cell lung cancer.** J Palliat Med. 2011 Apr;14(4):459-64. doi: 10.1089/jpm.2010.0382.

TABLE 3. MEDIAN TIME FOR COMPONENTS OF INITIAL OUTPATIENT PALLIATIVE CARE CLINIC VISIT ($N = 62$)

PC consultation	*Median time (range) minutes*
Total time	55.00 (20–120)
Illness understanding	10.00 (0–35)
Symptom management	20.00 (0–75)
Decision making	0.00 (0–20)
Coping	15.00 (0–78)
Planning and referrals	0.00 (0–20)

"Coping" notes were absent from the Oncologists written record
55 minutes

Jorgenson A, Sidebottom AC, Richards H, Kirven J. A Description of Inpatient Palliative Care Actions for Patients With Acute Heart Failure. Am J Hosp Palliat Care. 2016 Nov;33(9):863-870.

- Median 55 minutes
- Orders written for 24%, mostly for pain meds
- Recs to change care made for 40%
- Some element of ACP in 99%
- 79% just one PC visit; 21% two or more
- PC SW 10%, PC Chaplain 5%
- PC introduced Advance Care Planning (ACP; 41.6%)

- **All 5 major symptoms got better (pain, dyspnea, sleep, etc.)**
- **Quality of Life got better**

TEAM Concept in Palliative Care

Education:

- **We don't educate very well. 2/3s of people think they can be cured with palliative treatments.**
  - **Weeks JC, Patients' expectations about effects of chemotherapy for advanced cancer. N Engl J Med. 2012 Oct 25;367(17):1616-25.**
  - **Chen AB, Expectations about the effectiveness of radiation therapy among patients with incurable lung cancer. J Clin Oncol. 2013 Jul 20;31(21):2730-5.**
  - **Kim Y, Pawlik TM. Patient perceptions regarding the likelihood of cure after surgical resection of lung and colorectal cancer. Cancer. 2015 Oct 15;121(20):3564-73. doi: 10.1002/cncr.29530. Epub 2015 Jun 19.**

- **"Prognostic awareness" (being able to admit potential life ending illness) requires direct communication by the health care provider.**
- **In Temel's lung cancer trial, chance of IV chemo in the last month was 9% in the PC group that had good prognostic awareness, versus 55% in usual care group.**
  - **Jackson VA, Jacobsen J, Greer JA, Pirl WF, Temel JS, Back AL. The cultivation of prognostic awareness through the provision of early palliative care in the ambulatory setting: a communication guide. J Palliat Med. 2013 Aug;16(8):894-900. doi: 10.1089/jpm.2012.0547. PMID: 23786425**

TEAM Concept in Palliative Care

Education:

- **Symptom management**
- **Communication with the health care team**
- **Offering only REALISTIC options for treatment**
- **Advance care planning. Recent data suggests DPMA does not make any difference – has to be Living Will or Advance Directive.**
- **"I am worried about you, and what might happen in the future. I would like to talk about where we are with the cancer (or heart disease, or dementia)."**

TEAM Concept in Palliative Care

Assessment: Formal assessments for

- Symptoms (ESAS, MSAS-C, CAPC rounding tool);
- Spirituality (FICA, or “Are you a religious or spiritual person?”);
- Psychosocial (Distress Thermometer, others)
- Goal Setting

- The tools are all available in a checklist format: *http://www.asco.org/sites/new-www.asco.org/files/content-files/practice-and-guidelines/documents/2016-palliative-care-checklist.pdf*

TEAM - Assessments

Alberta Health Services | Covenant Health

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						
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5						
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5						
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5						
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5						

Patient's Name _____

Date _____ Time _____

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

BODY DIAGRAM ON REVERSE SIDE

MSAS-C: Enter: 0=none, 1=a little bit, 2=somewhat, 3=quite a lot, 4=very much, 7=refused

Reported by:	x	Patient		Caregiver	RN	MD
Able to respond:	x	Yes		No:	Delirious:	Yes xx No

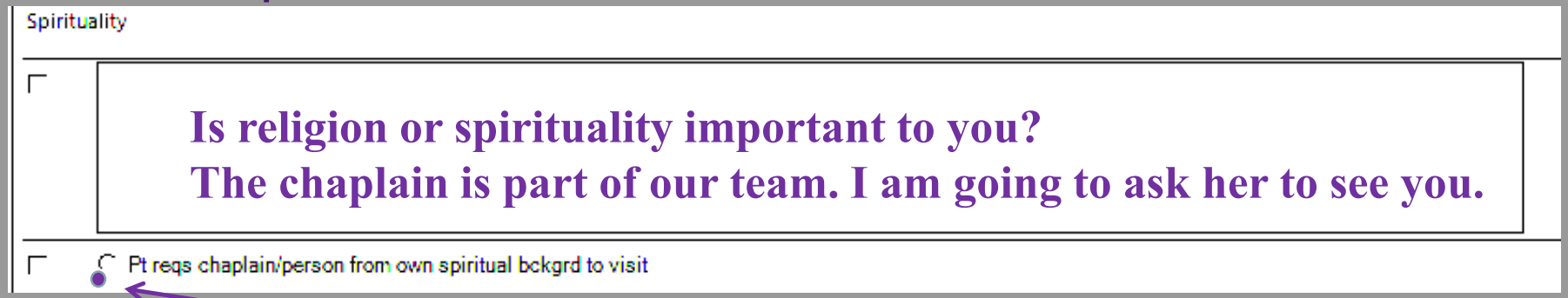
	Pain	Tiredness	Nausea	Depression	Anxiety	Drowsiness	Anorexia	Constipation	Dyspnea	Secretions
0		X years	x	x	x	x	xx	x	x	
1										
2										
3										
4	x									
7										

Does not matter which one you use

But use one!

"Are you bothered by ____?"

Always do a religious/spiritual assessment – and get some help.

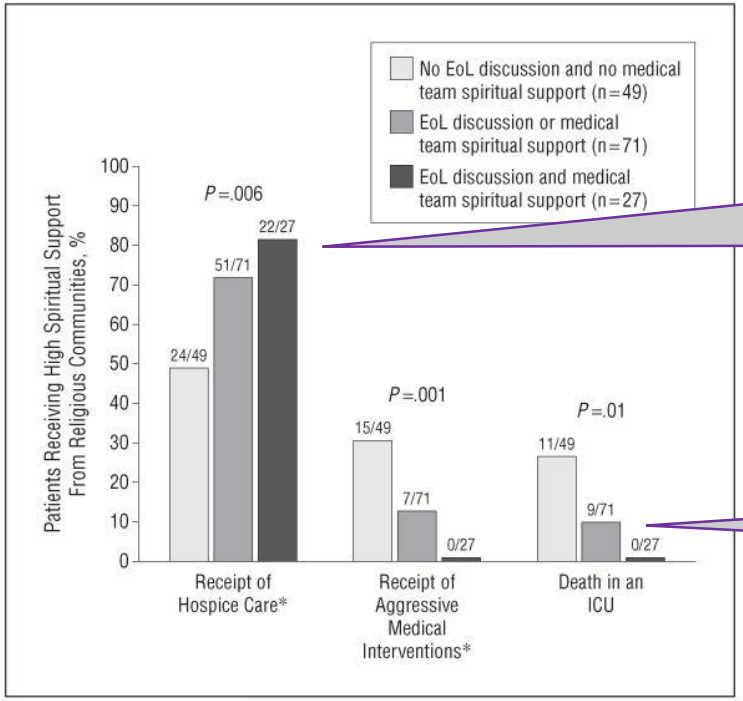


Generates referral to Pastoral Care

- 87% of patients want us to know their spiritual needs; 6% of us ask. Balboni M, et al. J Clin Oncol. 2013 Feb 1;31(4):461-7

- People who get spiritual care from chaplains use hospice more, ICU less. (TS- Better care at EOL, at a cost we can afford.) Balboni TM, et al. JAMA Intern Med. 2013 Jun 24;173(12):1109-17

Do the spiritual assessment, call the chaplain, and have a Goals of Care/EOL discussion if appropriate – *it changes care at the end of life.*



82% chance of Hospice with End of Life discussion and chaplain

And no one died in the ICU

- People who have EOL discussion and get spiritual care from chaplains use hospice more, ICU less. Balboni TM, et al. JAMA Intern Med. 2013 Jun 24;173(12):1109-17

TEAM Concept in Palliative Care

Assessment: Start with Communication Prompts

1. How do you like to get medical information?
2. What is your understanding of your situation?
3. What is important to you?
4. What are you hoping for?
5. Have you thought about a time when you could be sicker…Living Will or advance directive?

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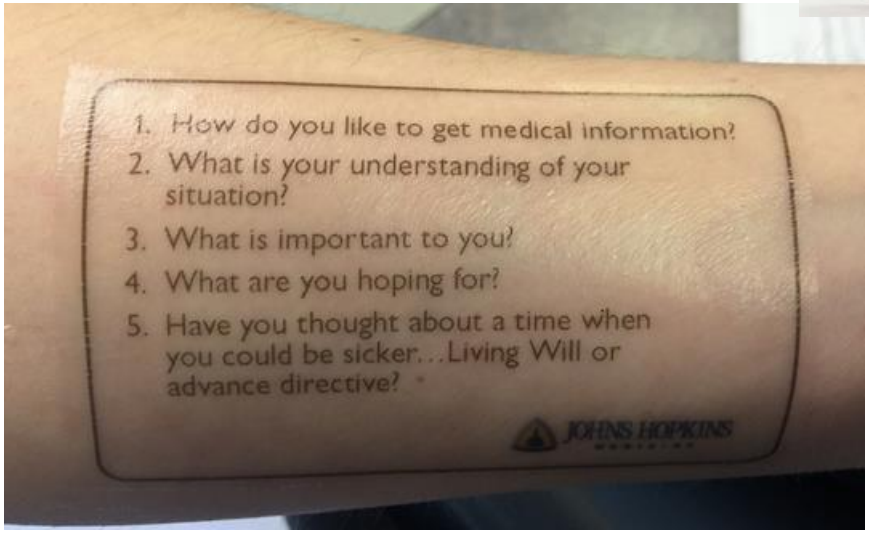


Inspired by Morris DA, Johnson KS, Ammarell N, Arnold RM, Tulsky JA, Steinhauser KE. What is your understanding of your illness? A communication tool to explore patients' perspectives of living with advanced illness. J Gen Intern Med. 2012 Nov;27(11):1460-6. doi: 10.1007/s11606-012-2109-2. Epub 2012 May 26.

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

Goals of Care embedded in the EMR

- ✓ INFO
- ✓ Understanding
- ✓ Goals
- ✓ AMDs
- ✓ CODE status

✓ SOME STRUCTURED SYMPTOM ASSESSMENT (ESAS, MSAS-C, CAPC tool)

✓ Spiritual assessment

- Opioids 101
- Adjuvants 101
- CPR discussion and documentation*
- Goals of Care discussions “What do you think will happen to you?”

Quill TE, Abernethy AP. **Generalist plus specialist palliative care--creating a more sustainable model** N Engl J Med. 2013 Mar 28;368(13):1173-5. doi: 10.1056/NEJMp1215620. Epub 2013 Mar 6.

Specialty PC for the hardest cases

- **Opioid rotation**
- **Gabapentin for cough, pruritis**
- **Nebulized lidocaine for cough**
- **Opioids for dyspnea (mimic endogenous opioids)**
- **Nebulized fentanyl for dyspnea**
- **Methadone**
- **Assume opioid prescribing**
- **Checking in CRISP or similar database**
- **Ketamine po and IV**
- **Lidocaine infusions**
- **Neuropathic pain prevention and treatment**
- **Single fraction RADIATION**
- **Blocks, Intrathecal meds, spinal and peripheral nerve stimulation**

- **Help move "stuck" people to do AMDs**
- **Help with legacy work**

Quill TE, Abernethy AP. **Generalist plus specialist palliative care--creating a more sustainable model** N Engl J Med. 2013 Mar 28;368(13):1173-5. doi: 10.1056/NEJMp1215620. Epub 2013 Mar 6.
Cheng MJ, King LM, Alesi ER, Smith TJ.**Doing palliative care in the oncology office.** J Oncol Pract. 2013 Mar;9(2):84-8. doi: 10.1200/JOP.2013.000885.

TEAM Concept in Palliative Care

Management:

- by set protocols AND an interdisciplinary team (APNs, social workers, chaplains, doctors, pharmacists)
- Those who have END OF LIFE discussions (goals of care, understanding of illness) are more likely to be satisfied, die at the place of their choosing, have less distressed relatives, etc.
- But we MUST start the conversations.
  - Stein RA, Sharpe L, Bell ML, Boyle FM, Dunn SM, Clarke SJ. Randomized controlled trial of a structured intervention to facilitate end-of-life decision making in patients with advanced cancer. J Clin Oncol. 2013 Sep 20;31(27):3403-10. doi: 10.1200/JCO.2011.40.8872. Epub 2013 Jul 29.
  - Mack JW, Walling A, Dy S, Antonio AL, Adams, Keating N, Tisnado D. Patient beliefs that chemotherapy may be curative and care received at the end of life among patients with metastatic lung and colorectal cancer. Cancer. 2015 Jun 1;121(11):1891-7. doi: 10.1002/cncr.29250. Epub 2015 Feb 11.
  - Kumar P, Temel JS. End-of-life care discussions in patients with advanced cancer. J Clin Oncol. 2013 Sep 20;31(27):3315-9. doi: 10.1200/JCO.2013.49.6562. Epub 2013 Jul 29.

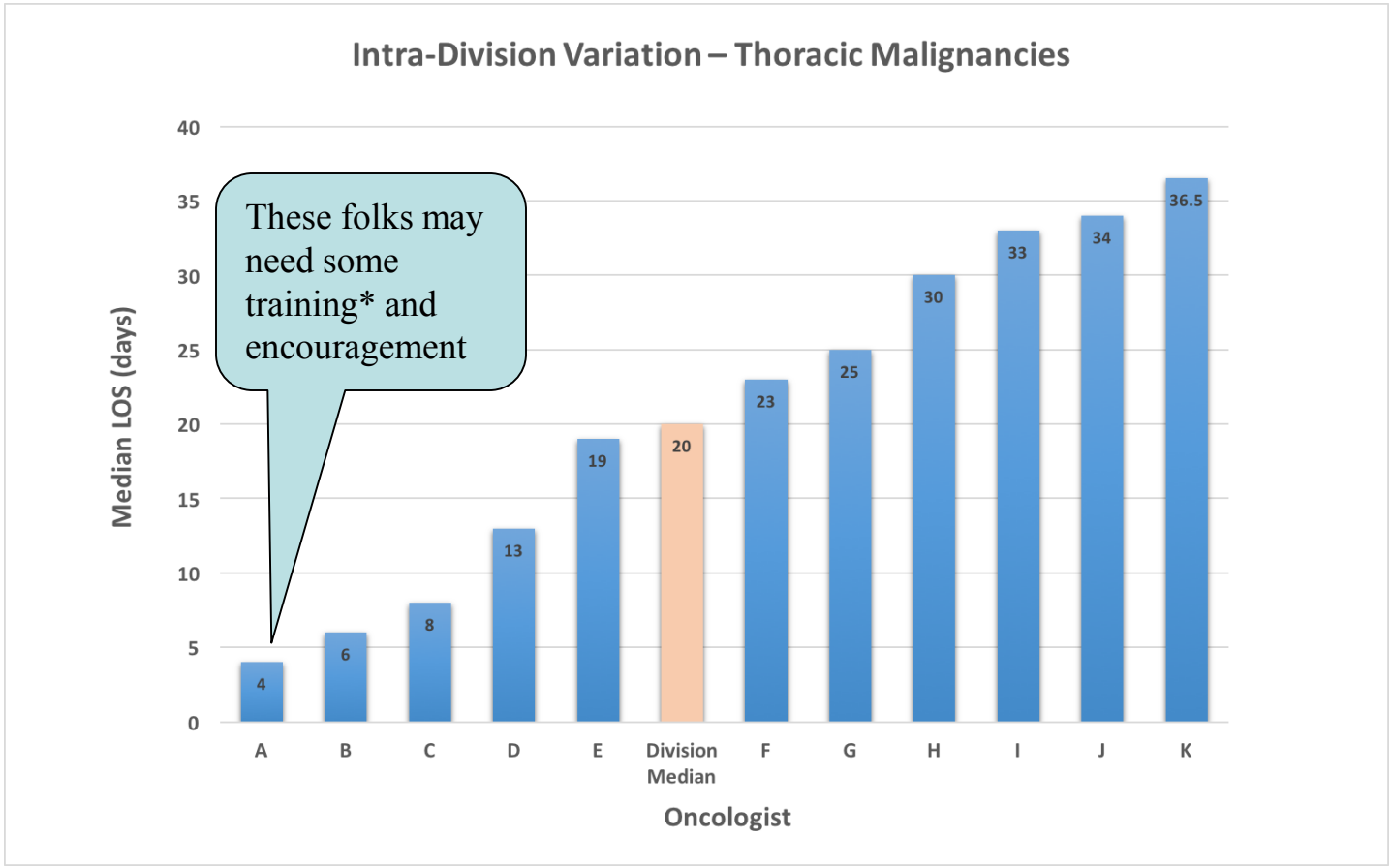
TEAM Concept in Palliative Care

Management:

- **When the patient has progressive disease, or ECOG performance status change, bring up the prognosis again. "Would you like to discuss what this means?"**
- **Prognostic Disclosure discussions decreased patient's over optimistic life expectancy by 17 months.**
  - Enzinger AC, Zhang B, Schrag D, Prigerson HG. Outcomes of Prognostic Disclosure: Associations With Prognostic Understanding, Distress, and Relationship With Physician Among Patients With Advanced Cancer. J Clin Oncol. 2015 Nov 10;33(32):3809-16. doi: 10.1200/JCO.2015.61.9239. Epub 2015 Oct 5.
- ***If palliative care sees the patient as an inpatient, the 30-day readmission rate is cut from 15% to 10%. If during that consultation, we have the "goals of care" discussion the 30-day readmission rate risk is cut to 5%.***
  - O'Connor NR, Moyer ME, Behta M, Casarett DJ. The Impact of Inpatient Palliative Care Consultations on 30-Day Hospital Readmissions J Palliat Med. 2015 Nov;18(11):956-61. doi: 10.1089/jpm.2015.0138. Epub 2015 Aug 13.

Divisional Data

Wang X, et al. J Oncol Pract. 2017 May;13(5):e496-e504. doi: 10.1200/JOP.2016.018093.



* The surprise question: “Would you be surprised if this person died in the next 6 months? If not, set up a ‘Hospice Information Visit’ to introduce a planned transition.”

Conclusions

1. ASCO now recommends concurrent palliative care by an interdisciplinary team within 8 weeks of diagnosis.
2. Oncologists may be able to provide some of this care ourselves.
3. Expect
   - An hour a month per patient
   - Difficult conversations
   - Hospice information visit to ensure smooth transition for “if and when” needed
   - Whenever the scan is worse, ask “Would you like to discuss what this means?”