Oncology Palliative Care at UNC

Laura C. Hanson, MD, MPH

Director, UNC Palliative Care Program

UNC SCHOOL OF MEDICINE

UNC Palliative Care Program

What is Palliative Care?

"Palliative Care is specialized medical care for people with serious illnesses. It 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 together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment."

Center to Advance Palliative Care

Palliative Care improves value . . .

Palliative Care reduces high-cost care [1,2,3,4]

- ICU transfers
- 30 day readmissions
- Emergency visits
- Cost-savings $1696 per admission to $4855 over 6 months [5]

Early Palliative Care endorsed by ASCO, IOM

. . . while improving patient outcomes

- Cancer patients with Palliative Care experience[6,7,8,9]
  - More advanced care planning communication
  - Reduced ICU admissions
  - Earlier hospice referral
- Cancer patients who receive Palliative Care have less pain and depression, and better quality of life
- Palliative care does not shorten life and may improve survival[6,10,11]

RECENT RESEARCH

Oncology Palliative Care Research at UNC

- Patient-reported outcomes
- Models of palliative care delivery
- Decision-making
- Survivorship
- Parenting effects
- Disparities
- Quality measurement

Oncology Palliative Care Research at UNC

- Uncontrolled symptoms are the primary reason cancer patients present to our ED[12]
- Cancer hospital patients use rapid response (RR) team more than other medical inpatients; 38.5% with RR are then transferred to ICU and 56% die during admission[13]
- Stage IV cancer patients with PC have more comprehensive symptom assessment and goals of care discussions[14]

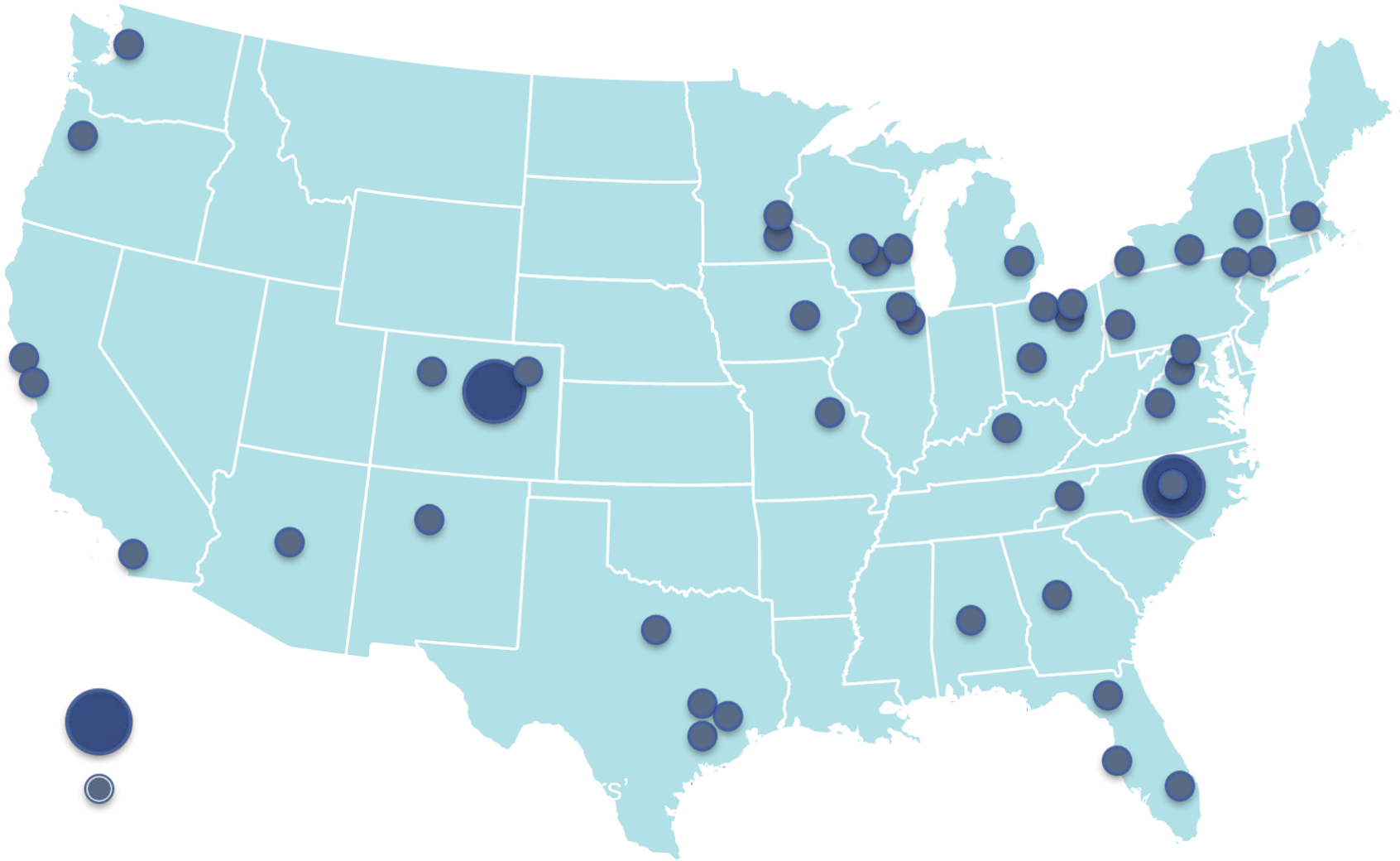
Palliative Care Research Cooperative

- UC4NR012584 award (Jan 2011-Dec 2013)
- U24 NR014637 (Sept 2013-June 2018)
  - Centers: Junior Faculty Development, Project Coordination, Biostatistics
  - Cores: **Measurement (UNC)**, Caregiver Research (City of Hope), Clinical Studies (Duke)
- U2C NR014637 (July 2018-June 2023)
  - Cores: **Measurement (UNC)**, Caregiver Research (City of Hope), Clinical Studies (Duke)

PALLIATIVE CARE RESEARCH COOPERATIVE

UNC INSTITUTE FOR HEALTHCARE QUALITY IMPROVEMENT

Palliative Care Research Cooperative Group (46 US sites)



UNC INSTITUTE FOR HEALTHCARE QUALITY IMPROVEMENT

Integrating Palliative & Oncology Care[15]

Objective: enhance palliative care in advanced cancer

Target Population: Med E patients with Stage IV cancers (+ Med E patients with poor prognosis leukemia)

Interventions:

a) Monthly feedback and training in ACP skills for housestaff
b) Med E census review Stage IV cancer with symptom distress

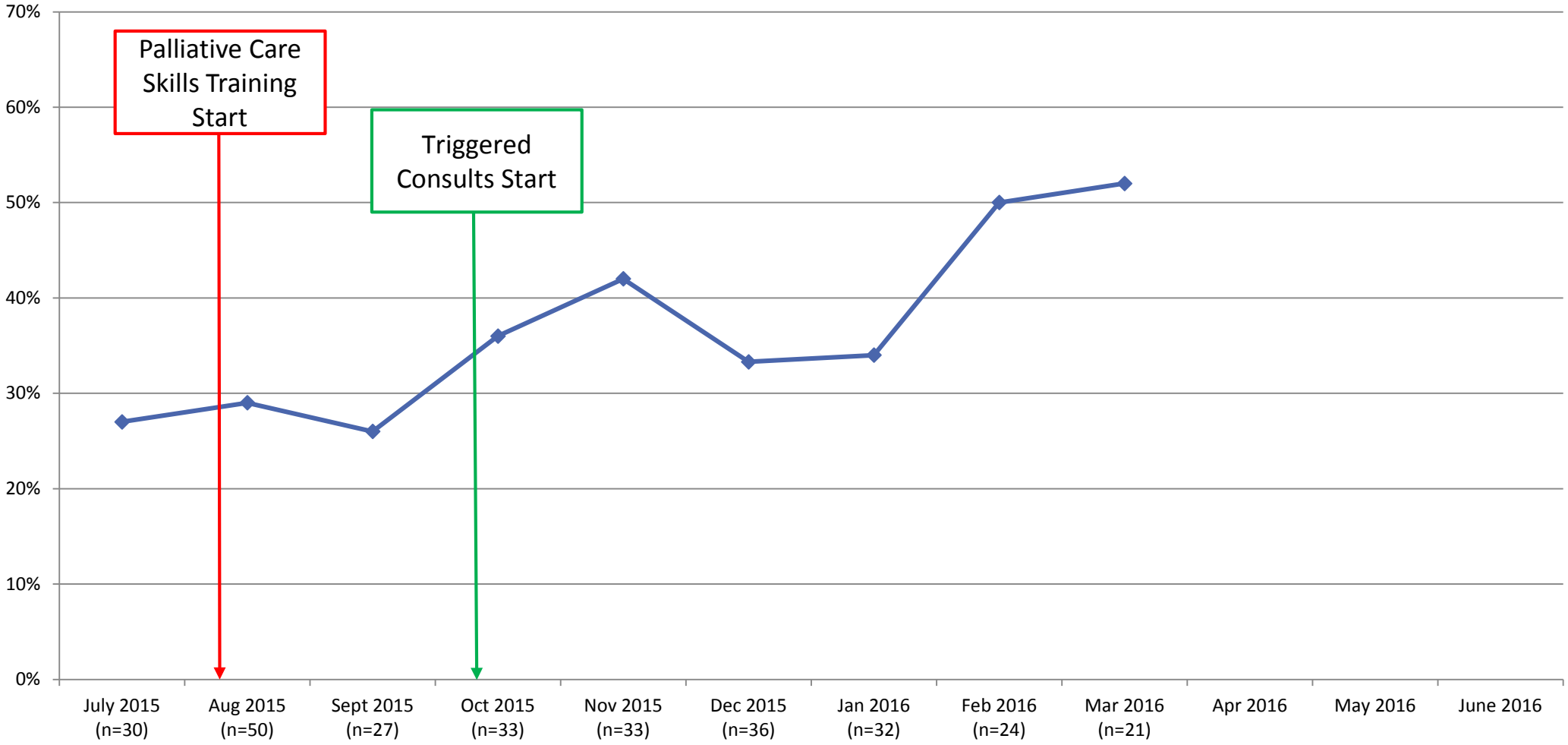
Outcome measures:

- PRIMARY Documented GOC discussions
- SECONDARY PC referral, 30-day readmission, hospice referral, symptom screening and treatment

Med E Patients with Stage IV Cancer

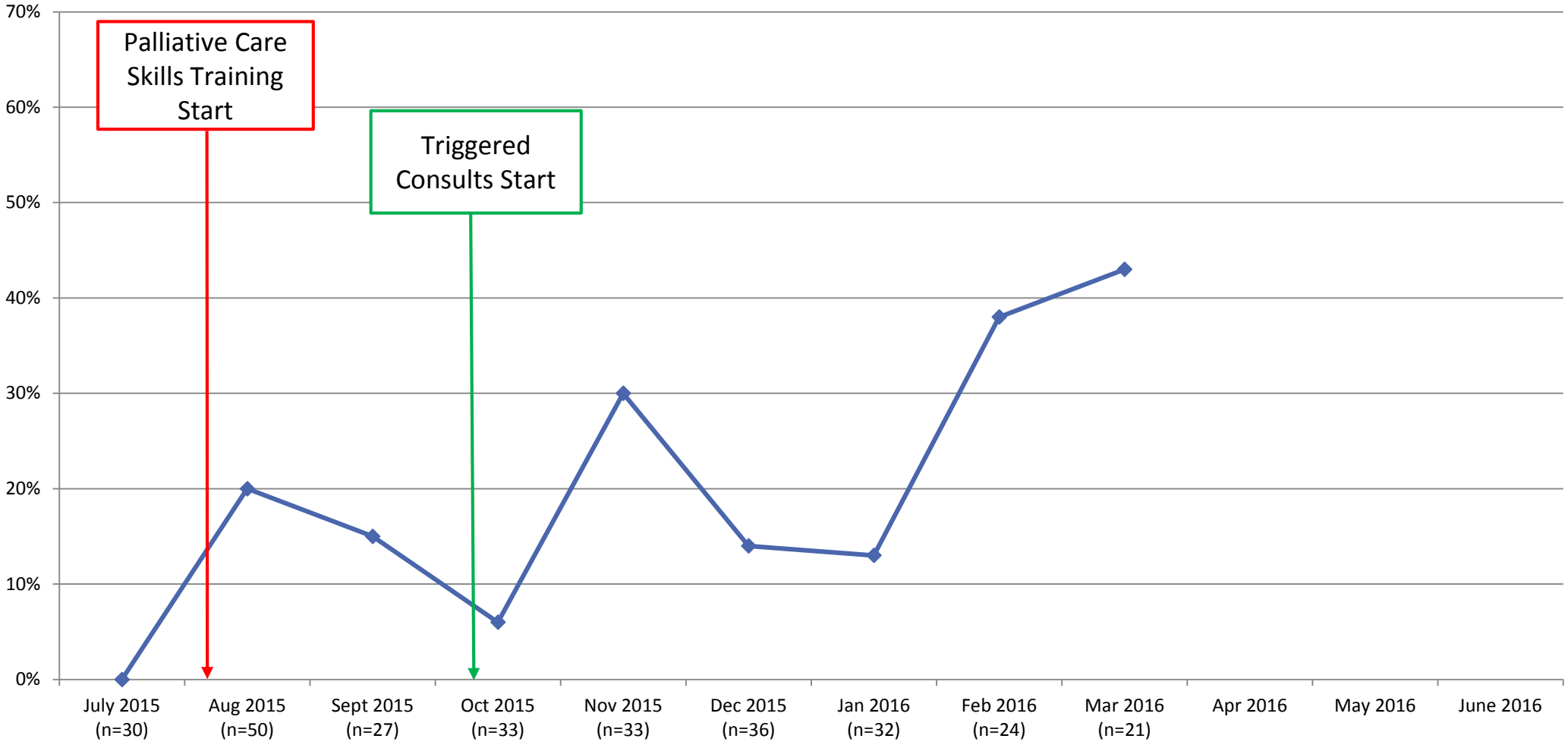
Characteristic	Stage IV Patients (n=330)
Age	61 years (20-91)
Gender female	46%
Race	
White	68%
African American	24%
Primary cancer	
Lung	23%
GI	18%
Breast	16%
GU	14%
Uncontrolled symptoms	
Pain	19%
Dyspnea	33%
Nausea	38%

Goals of Care Discussed



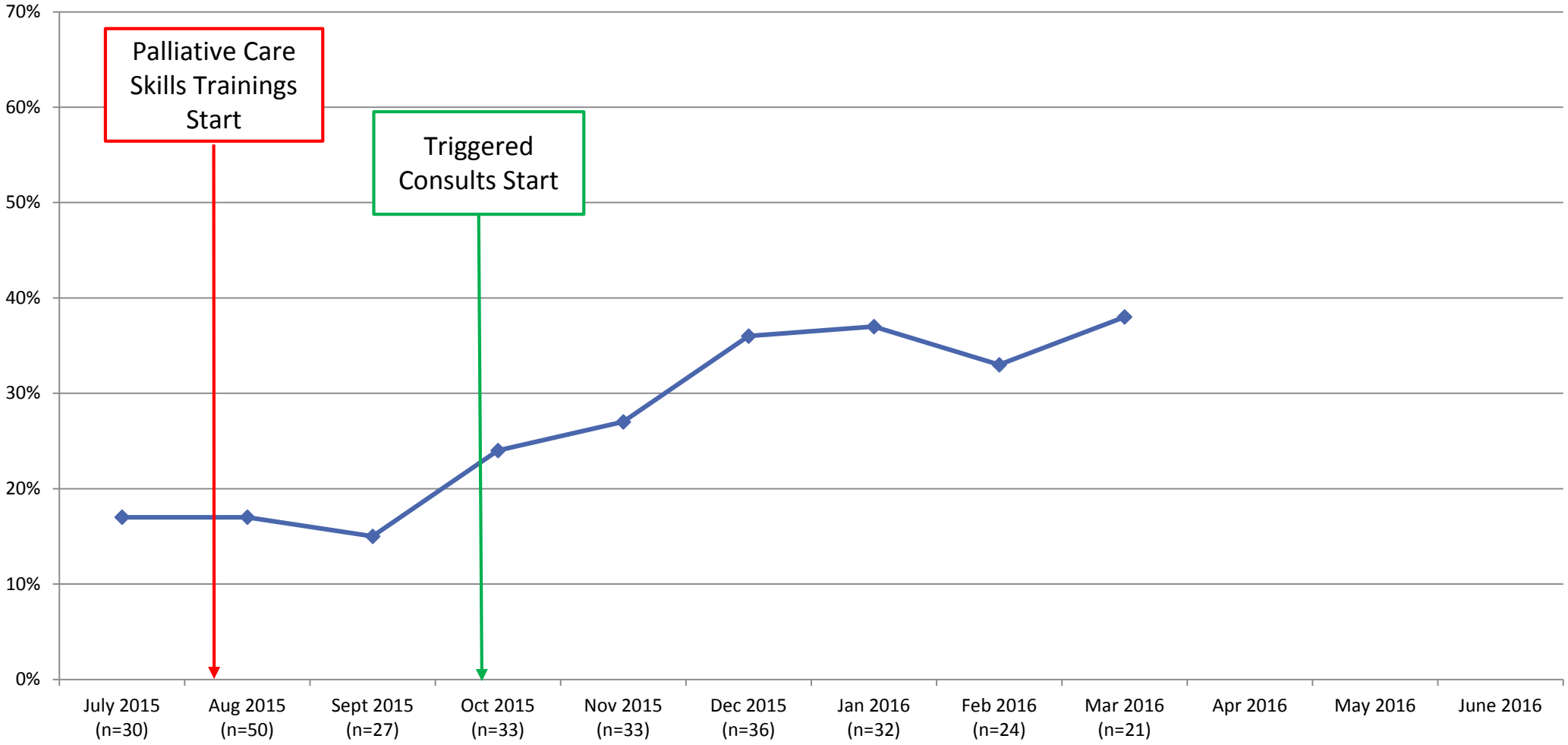
UNC INSTITUTE FOR HEALTHCARE QUALITY IMPROVEMENT

Advanced Care Planning Notes



UNC INSTITUTE FOR HEALTHCARE QUALITY IMPROVEMENT

Palliative Care Consult



UNC INSTITUTE FOR HEALTHCARE QUALITY IMPROVEMENT

Stage IV patients with vs without PC

	Pts with PC consult (n=92)	Pts without PC consult (n=238)
Age*	58.5 yr	62.0 yr
Charlson Score mean[range]	6.83 (6-16)	6.76 (6-11)
GOC discussion*	**84 (92%)**	**39 (15%)**
ACP note*	**44 (48%)**	**16 (7%)**
HCPOA / surrogate *	**63 (69%)**	**74 (31%)**
Pain screen / assess*	**83 (91%)**	**193 (81%)**
ICU transfer (after PC)	5 (5%)	6 (3%)
DNR/DNI*	**57 (63%)**	**68 (28%)**
Spiritual Needs*	**44 (48%)**	**23 (10%)**
Hospice*	**36 (40%)**	**22 (9%)**
30 Day readmission*	72 eligible **9 readmit (12%)**	212 eligible **50 readmits (24%)**

High risk leukemia PC access[16]

Hematologic Malignancy Patients
October 1st through March 31st, 2016

	N=50 patients
Age	Mean=59, Range (20-80)
Cancer Type	
AML +65	18(36%)
AML relapse	13(26%)
ALL relapse	11(22%)
ALL +65	8(16%)
Charlson Index Score	Mean=3.26, Range (2-7)
Palliative Care consult	8(16%)
DNR/DNI order	12(32%)
Documented GOC discussion	18(36%)
ACP note	10(20%)
Hospice Referral	4(11%)
ICU transfer	13(26%)
In-hospital mortality	9 (18%)

- Consider expansion to poor prognosis heme malignancy patients
- Challenges adapting PC to heme malignancy needs
- Low rates of ACP

Oncology Care Team Perspective

- *"I think one thing that we probably could do is once someone is diagnosed as stage 4, consider them for a palliative care consult rather than waiting until they're really symptomatic, because maybe -- I know they've done studies that if you start palliative care earlier, people do better."*

- *"I think that all of the patients that palliative care has taken from us have been very appropriate patients, and they've always given us really good feedback that they always have great recommendations that we're not already doing."*

- *"I think it's a good relationship. It's a strong relationship, and palliative care is also very positive and encouraging of the patients, and like I said, they always have good relationships or good recommendations."*

NEW RESEARCH PROTOCOLS

Collaborative Care Model

Collaborative Care model:

- Primary and specialty care providers work efficiently and flexibly to meet needs of high-risk patients
- Evidence to improve care and outcomes for
  - ✓Outpatient depression (4 clinical trials in cancer care)
  - ✓Alzheimer disease
  - ✓Chronic disease self-management
  - ✓Chronic pain self-management

Palliative Oncology Collaborative Care

Objective: preliminary evidence for CCM in advanced cancer
Target Population: Stage IV cancers (Lung, Breast, GU focus)

Control Phase: usual care
Intervention Phase:

a) Communication skills training for Medical Oncology
b) Systematic tracking of Stage IV cancer Med E admissions
c) PC needs assessment
d) PC Care Coordination – inpatient, outpatient

Outcome measures (60 days):

- PRIMARY - Documented GOC discussions
- SECONDARY – ACP note, referral to PC / Hospice, ER and hospital use

Palliative Oncology Palliative Care

PRIMARY OUTCOME:

Goals of Care discussion during index hospitalization and follow-up outpatient care (60 days)

- cancer diagnosis & stage or overall prognosis
- shared decision-making on goals or major treatment options

(led by Medical Oncology, Primary Care, or Palliative Care)

Palliative Oncology Collaborative Care

Control Phase – early findings (n=223 Stage IV patients)

- 33% with uncontrolled symptoms
- 31% die within 60 days of admission
- 8% referred to hospice (21% decedents)
- 85% Full code (64% at discharge)
- 26% 30-day readmission rate
- 45% have GOC discussion (usually inpatient)
  - half led by Oncology, one-third by PC
  - 27% ACP Note

REACH PC – RCT Early Palliative Care

PI Jennifer Temel (MGH)

N=1250 patients with Stage IV lung CA, ECOG 0-3

RCT monthly PC via telehealth vs in-person

Primary outcome: QOL (FACT-L)

Secondary outcomes:

- Communication of treatment preferences
- LOS hospice
- Patient / caregiver satisfaction

UNC Palliative Care Program

https://www.med.unc.edu/pcare

Adult Palliative Care:

- Katherine Aragon, MD
- Christine Kistler, MD
- Laura Hanson, MD
- Kyle Lavin, MD
- Jen McEntee, MD
- Gary Winzelberg, MD
- Kyle Terrell, NP
- Heather Boykin, NP
- June Dixon, MSW
- Heidi Gessner, Chaplain

HPM Fellows:

Josh Dowd, MD
Sophia Paraschos, MD
Susanna Thach, MD

Pediatric Palliative Care:

- Elisabeth Dellon, MD
- Nicole Stone, NP
- Mary Beth Grimley, PhD

Outpatient Oncology Palliative Care:

- Gary Winzelberg, MD
- Anna Kate Owens, NP
- Meredith Keisler, PharmD

REACH Home Palliative Care:

- Christine Kistler, MD
- Kyle Lavin, MD
- Robin Motley, RN

Works Cited

1. Enguidanos S, Vesper E, Lorenz K. 30-day readmissions among seriously ill older adults. J Palliat Med 2012; 15:1356-1361.
2. Henson LA, Gao W, Higginson IJ, Smith M, Davies JM, Ellis-Smith C, Daveson BA. Emergency department attendance by patients with cancer in their last month of life: a systematic review and meta-analysis. J Clin Oncol 2014; Dec 22. pii: JCO.2014.57.3568. [Epub ahead of print]
3. Obermeyer Z, Makar M, Abujaber S, Dominici F, Block S, Cutler DM. Association between the Medicare hospice benefit and health care utilization and costs for patients with poor-prognosis cancer. JAMA 2014; 312:1888-1896.
4. Khandelwal N, Kross EK, Engelberg R, Coe NB, Long AC, Curtis, JR. Estimating the effect of palliative care interventions and advance care planning on ICU utilization: a systematic review. Crit Care Med 2015; DOI: 10.1097/CCM.0000000000000085. [E-pub ahead of print]
5. Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. Arch Intern Med 2008;168:1783-1790
6. Temel JS, Greer JA, Muzikansky A et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med 2010; 363:733-742.
7. Parikh RB, Kirch RA, Smith TJ, Temel JS. Early specialty palliative care-- translating data in oncology into practice. N Engl J Med 2013; 369:2347-2351.
8. Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized controlled trial. J Palliat Med 2008;11:180-190
9. Zimmermann C, Swami N, Krzyzanowska M, Hannon B, Leighl N, Oza A, Moore M, Rydall A, Rodin G, Tannock I, Donner A, Lo C. Early palliative care for patients with advanced cancer: a cluster randomized controlled trial. Lancet 2014; 383:1721-1730.
10. Bakaitas M, Lyons KD, Hegel MT, Balan S, Brokaw FC, Seville J, Hull JG, Li Z, Tosteson TD, Byock IR, Ahles TA. Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial. JAMA 2009; 302:741-749.
11. Connor SR, Pyenson B, Fitch K, Spence C, Iwasaki K. Comparing hospice and nonhospice patient survival among patients who die within a 3-year window. J Pain Symptom Manage 2007; 33:238-246.
12. Mayer DK, Travers D, Wyss A, Leak A, Waller A. Why do patients with cancer visit emergency departments? Results of a 2008 population study in North Carolina. J Clin Oncol 2011; 29:2683-2688.
13. Austin CA, Hanzaker C, Stafford R, Mayer C, Culp L, Lin FC, Chang L. Utilization of rapid response resources and outcomes in a comprehensive cancer center. Crit Care Med 2014; 42:905-909.
14. Hanson LC, Rowe C, Wessell K, Caprio AJ, Winzelberg G, Beyea A, Bernard SA. Measuring palliative care quality for seriously ill hospitalized patients. J Pall Med 2012; 15:798-804
15. Hanson LC, Collichio F, Bernard SA, Wood WA, Milowsky M, Burgess E, Creedle CJ, Cheek S, Chang L, Chera B, Fox A, Lin FC. Integrating palliative and oncology care for patients with advanced cancer: a quality improvement intervention. J Palliat Med 2017; 20:1366-1371.
16. Freeman AT, Wood WA, Fox A, Hanson LC. Access to palliative care consultation and advance care planning for adults with high-risk leukemia. J Palliat Med 2018; 21:225-228.