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Family Practice Oncology Network

Early Integration of Palliative Care

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Early Integration of Palliative Care: Evidence and Practice

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Objectives

- To discuss the difference between policy and practice regarding early palliative care involvement
- To present the current evidence for early palliative care
- To identify barriers to early palliative care
- To discuss models of early palliative care

Contemporary definition of palliative care

- "an approach that improves the quality of life of patients and their families…

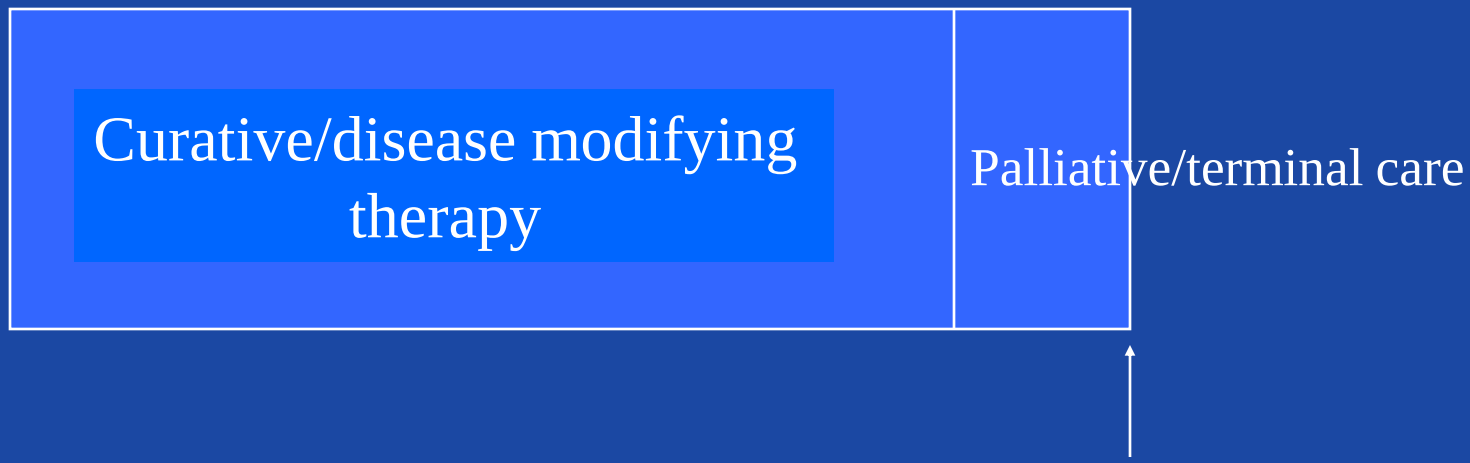
  …through the prevention and relief of suffering

  …by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

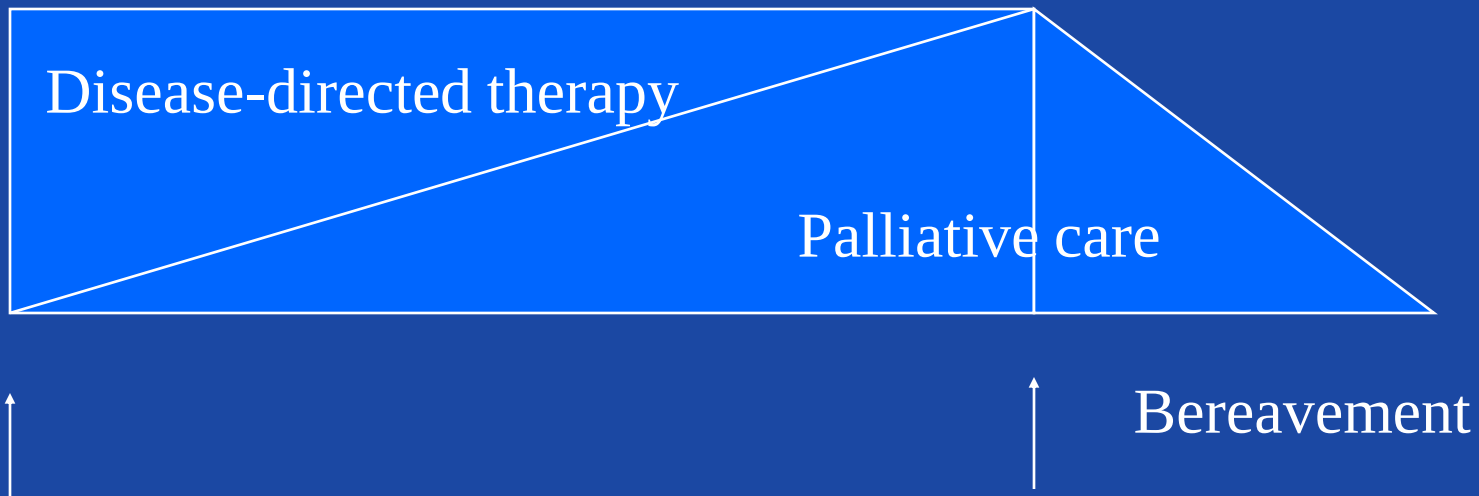
(WHO, 2002)

Canadian Hospice Palliative Care Association, 2002

Traditional view



New model



Where is the evidence?

Systematic review of palliative care effectiveness

- 22 studies, 19 including patients with cancer
- Most evidence for family satisfaction with care
- 4/13 studies assessing QOL had significant results
- All had methodological or operational difficulties
- None specifically assessed early palliative care in patients with cancer

Zimmermann et al. JAMA. 2008; 299(14):1698-1709

Studies of early palliative care

Bakitas et al, 2009, JAMA 302;7:741-749

- early PC: telephone problem-solving intervention by APNs
- 322 pts, newly-diagnosed advanced GI, GU, lung, breast cancer
- prognosis of one year
- outcomes FACIT-Pal, ESAS, CES-D (every 3 months)
- **Results: improved QOL, mood, but not symptom intensity or reduced days in hospital, ICU, emergency department**

Temel et al, 2010, NEJM 363;8:733-742

- early PC: palliative care team (MD and APN)
- 151 pts, newly-diagnosed advanced non-small cell lung cancer
- ECOG 0, 1, 2
- outcomes FACT-Lung, HADS, PHQ-9 at 12 weeks
- **Results: improved QOL, mood; longer survival (11.6 vs. 8.9 months), despite less aggressive treatment**

THE LANCET
2014; 383: 1721–30

Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial

Camilla Zimmermann, Nadia Swami, Monika Krzyzanowska, Breffni Hannon, Natasha Leighl, Amit Oza, Malcolm Moore, Anne Rydall, Gary Rodin, Ian Tannock, Allan Donner, Christopher Lo

- Early PC: integrated care in palliative care clinic
- 461 pts, advanced GI, GU, lung, breast, gyne cancer
- Prognosis (by oncologist) 6 months to 2 years
- ECOG 0, 1, 2 (by oncologist)
- Outcomes: quality of life*, satisfaction with care, symptom control, difficulty with clinician-patient interactions

*primary endpoint: patient quality of life at 3 months
secondary endpoints: QOL at 4 months, all other outcomes at 3 and 4 months

Overview of study design

24 oncology clinics

Cluster randomized 1:1
Stratified by tumour site: Lung, GI, GU, Breast, Gyne

Early palliative care

Seen within 4 weeks by pc team
Follow-up monthly for 4 months

Outcomes (monthly for 4 months)

Standard care

Seen by pc team upon request
Follow-up as required

Outcomes (monthly for 4 months)

Results: Quality of Life

	Intervention		Control		Available cases analysis*			
	n	Mean observed change from baseline (SD)	n	Mean observed change from baseline (SD)	Adjusted difference between change scores (95% CI)	p value	Effect size†	ICC
FACIT-Sp								
1 month	154	1·86 (11·99)	168	−1·34 (10·12)	..	..	..	..
2 months	138	0·58 (13·09)	151	−2·71 (12·92)	..	..	..	..
3 months	140	1·60 (14·46)	141	−2·00 (13·56)	3·56 (−0·27 to 7·40)	0·07	0·26	0·035
4 months	122	2·46 (15·47)	149	−3·95 (14·21)	6·44 (2·13 to 10·76)	0·006	0·44	0·024
QUAL-E								
1 month	154	1·09 (6·79)	162	−1·19 (7·22)	..	..	..	..
2 months	137	1·38 (7·49)	151	−0·61 (8·13)	..	..	..	..
3 months	139	2·33 (8·27)	139	0·06 (8·29)	2·25 (0·01 to 4·49)	0·05	0·28	0·036
4 months	121	3·04 (8·33)	148	−0·51 (7·62)	3·51 (1·33 to 5·68)	0·003	0·45	0·015
ESAS								
1 month	180	−0·72 (13·01)	172	1·13 (10·79)	..	..	..	..
2 months	158	0·89 (14·83)	160	1·45 (14·08)	..	..	..	..
3 months	151	0·14 (16·93)	149	2·12 (13·88)	−1·70 (−5·26 to 1·87)	0·33	−0·13	0·067
4 months	131	−1·34 (15·98)	155	3·23 (13·93)	−4·41 (−8·76 to −0·06)	0·05	−0·31	0·034

Results: Symptom Control

	Intervention		Control		Available cases analysis*			
	n	Mean observed change from baseline (SD)	n	Mean observed change from baseline (SD)	Adjusted difference between change scores (95% CI)	p value	Effect size†	ICC
FACIT-Sp								
1 month	154	1·86 (11·99)	168	−1·34 (10·12)	..	..	..	..
2 months	138	0·58 (13·09)	151	−2·71 (12·92)	..	..	..	..
3 months	140	1·60 (14·46)	141	−2·00 (13·56)	3·56 (−0·27 to 7·40)	0·07	0·26	0·035
4 months	122	2·46 (15·47)	149	−3·95 (14·21)	6·44 (2·13 to 10·76)	0·006	0·44	0·024
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2 months	158	0·89 (14·83)	160	1·45 (14·08)	..	..	..	..
3 months	151	0·14 (16·93)	149	2·12 (13·88)	−1·70 (−5·26 to 1·87)	0·33	−0·13	0·067
4 months	131	−1·34 (15·98)	155	3·23 (13·93)	−4·41 (−8·76 to −0·06)	0·05	−0·31	0·034

Results: Satisfaction with Care & Medical Interactions

	Intervention		Control		Available cases analysis*			
	n	Mean observed change from baseline (SD)	n	Mean observed change from baseline (SD)	Adjusted difference between change scores (95% CI)	p value	Effect size†	ICC
FAMCARE-P16								
1 month	160	1·77 (8·14)	169	−2·64 (7·96)	..	..	..	..
2 months	140	1·95 (9·12)	157	−2·26 (7·36)	..	..	..	..
3 months	142	2·33 (9·10)	145	−1·75 (8·21)	3·79 (1·74 to 5·85)	0·0003	0·47	<−0·0001
4 months	121	3·70 (8·58)	153	−2·42 (8·33)	6·00 (3·94 to 8·05)	<0·0001	0·73	−0·018
CARES-MIS								
1 month	157	−0·45 (4·33)	170	0·88 (3·32)	..	..	..	..
2 months	144	−0·28 (4·57)	156	0·86 (3·73)	..	..	..	..
3 months	139	−0·16 (5·50)	147	0·85 (4·06)	−0·66 (−2·25 to 0·94)	0·40	−0·21	0·018
4 months	123	−0·35 (4·38)	154	0·61 (3·60)	−0·84 (−1·91 to 0·22)	0·11	−0·24	0·023

Early palliative care for patients with advanced cancer

- Improves quality of life
- Increases satisfaction with care
- Improves mood
- May increase survival

Referral barriers: systematic review

Factors influencing palliative care referral

- Access to palliative care services
- Physicians' understanding and knowledge of the services available
- Perception of loss of control over patient's care
- Perceived reluctance of patients to be referred
- Reluctance to disclose/discuss terminal status

Ahmed N, Bestall JC, Ahmedzai SH, Payne SA, Clark D, Noble B. Systematic review of the problems and issues of accessing specialist palliative care by patients, carers and health and social care professionals. *Palliat Med* 2004;18(6):525-42.

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JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Referral Practices of Oncologists to Specialized Palliative Care

Kirsten Wentlandt, Monika K. Krzyzanowska, Nadia Swami, Gary M. Rodin, Lisa W. Le, and Camilla Zimmermann

Listen to the podcast by Dr Bruera at www.jco.org/podcasts

Surveyed Canadian Medical, Radiation and Surgical Oncologists (response rate >70%)

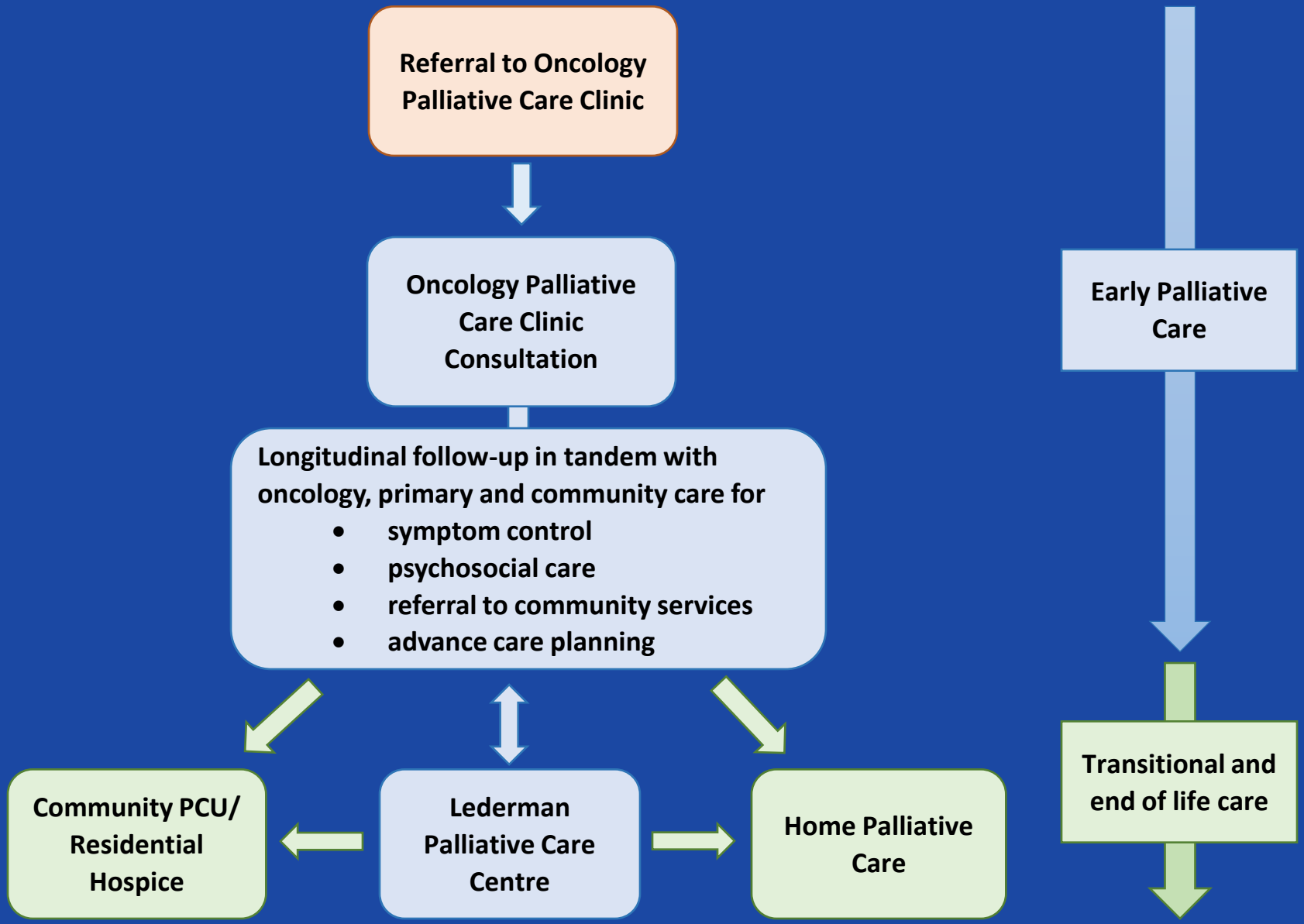
Factors influencing referral (vs not):

- Satisfaction with availability of SPC service
- Comprehensiveness of services available to them
- Acceptance by PC service of patients on chemotherapy

Factors influencing early referral (at diagnosis or during chemo):

- Satisfaction with availability of PC service
- Acceptance by PC service of patients on chemotherapy
- Completing a rotation in palliative care
- 1/3 agreed they would refer earlier if palliative care was renamed supportive care

Pathway of palliative care upon referral to the Princess Margaret Oncology Palliative Care Clinic



Typical referrals made from the OPCC

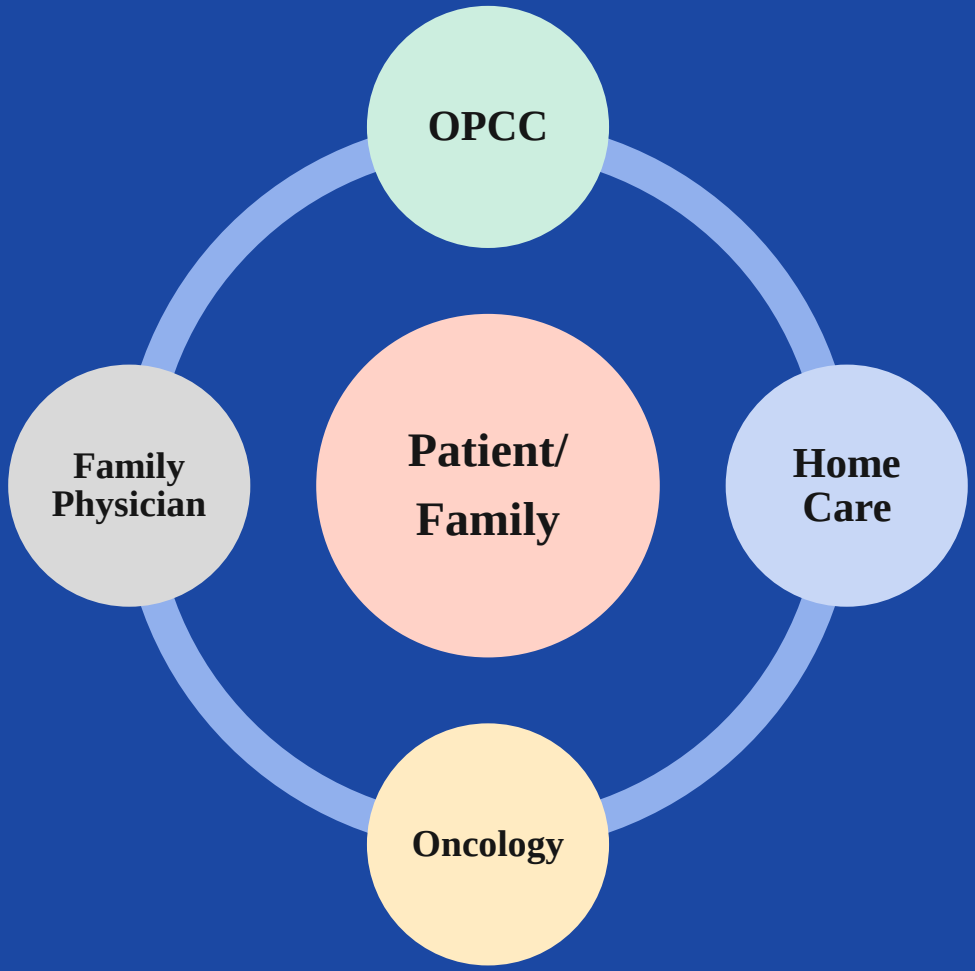
[1]Community Care Access Centre services include nursing, personal support, physical therapy, occupational therapy, and equipment such as hospital bed, walker, wheelchair.

[2]Medical/surgical specialists may include neurosurgery, ophthalmology, dentistry, etc.

[3]Other supportive care services at the cancer centre include spiritual care, wound care, dietitian, music therapy, occupational or physical therapy, etc.

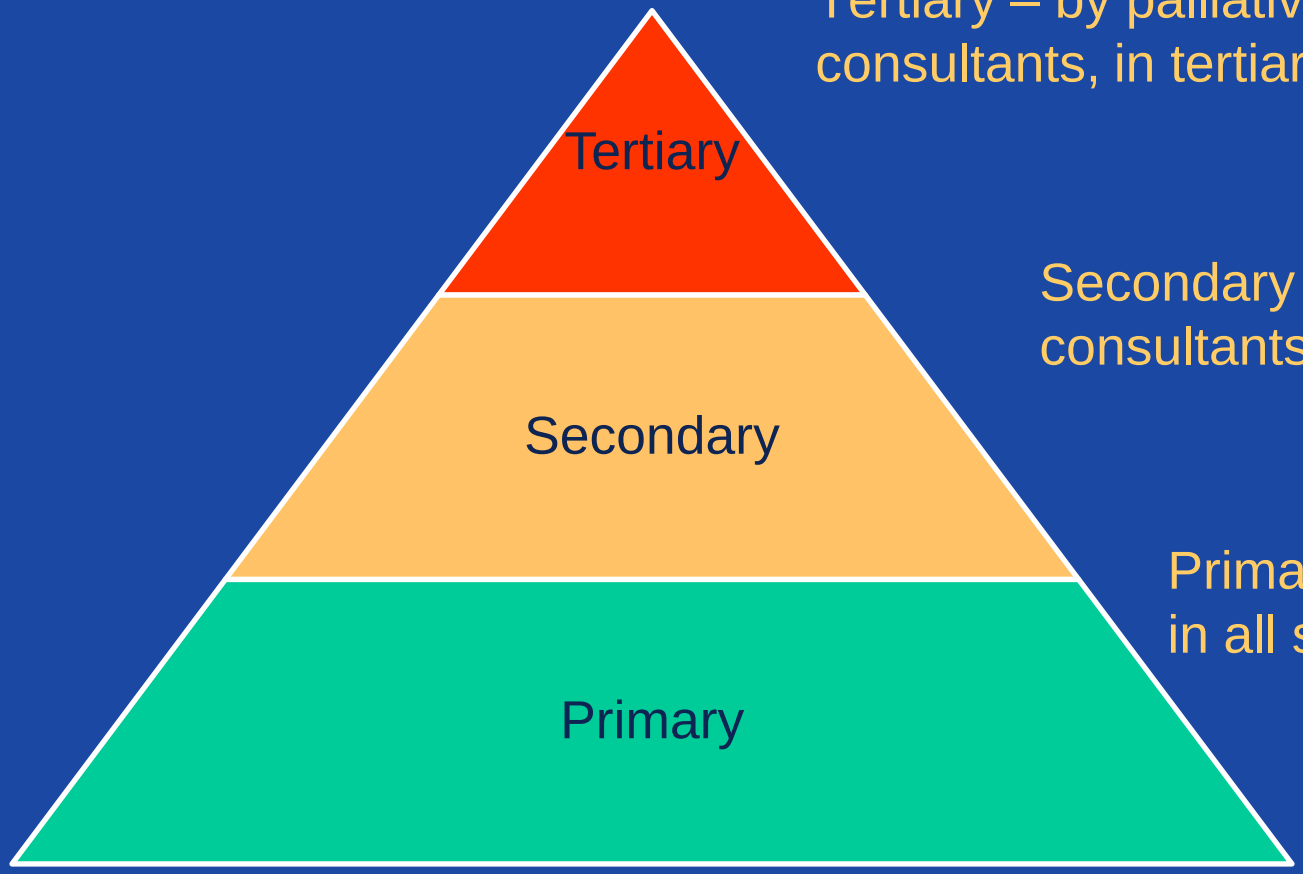
Abbreviations: OPCC, Oncology Palliative Care Clinic; CCAC, Community Care Access Centre.

Main providers of longitudinal care for ambulatory patients with advanced cancer



Abbreviations: OPCC – Oncology Palliative Care Clinic

Levels of palliative care



Tertiary – by palliative care consultants, in tertiary care settings

Secondary – by palliative care consultants, in all settings

Primary - by all care providers, in all settings

A Model to Guide Hospice Palliative Care, CHPCA, 2002

Who should get early palliative care?

- Eligibility: All patients with a chronic, complex, life-threatening illness

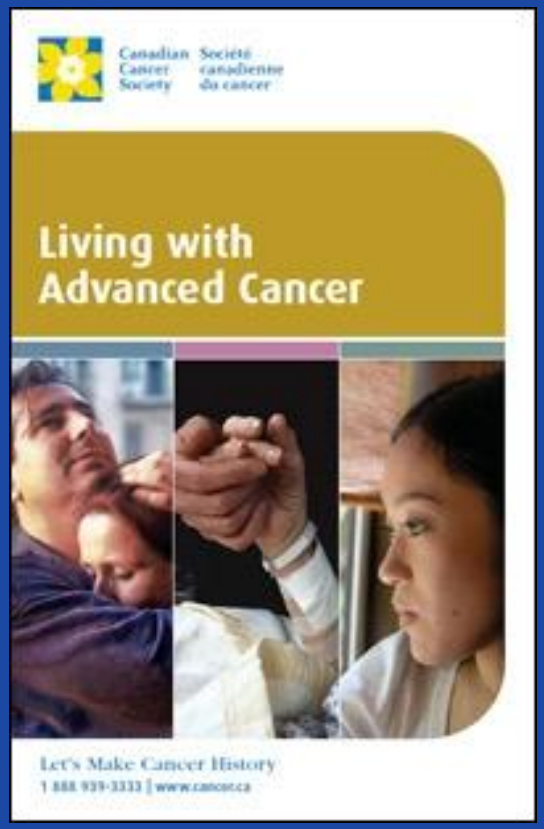
That's a lot of people!!

- There is a need for
  - Referral criteria
  - Symptom screening
  - Training for all physicians and other healthcare providers to provide primary palliative care

Organizations supporting early palliative care

- Canadian Hospice Palliative Care Association: *"Palliative care services are helpful not only when a person is approaching death but also during the earlier stages of an illness. Palliative care may be combined with other treatments aimed at reducing or curing the illness, such as chemotherapy."*
- American Society of Clinical Oncology: "*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."*
- *"* European Society for Medical Oncology: *"the ESMO Designated Centres of Integrated Oncology and Palliative Care accreditation programme… recognises that centres have achieved a high standard of integration of medical oncology and palliative care."*
- Canadian Cancer Society: *"palliative care can and should be provided throughout the cancer journey."*
- College of Family Physicians of Canada: "*As a matter of social justice, all Canadians—regardless of age, disease, stage of disease, and geographical location—should have access to palliative care that meets national standards."*

CCS Booklet –
Living with Advanced Cancer



Canadian Cancer Society, 2010

"Everyone says, 'Oh, how can you do this?' I think most people can do it, it's just they're not faced with it. And when you are faced with it, it depends on how you choose to cope"

(*Jasmin, 53, discusses living with advanced ovarian cancer*)

Conclusion

- Early referral to palliative care improves satisfaction with care, and helps prevent the usual decline in quality of life that occurs with advancing illness
- RCTs are particularly challenging in this population of patients, but can be overcome
- The model of care for this trial can be modified for other settings and populations