Integrating Palliative and Oncology care for patients with advanced cancer

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IHQI
One patient’s experience

49 y/o Asian woman diagnosed with stomach cancer 6 years ago. She is married and has 2 sons in college and a daughter in high school.

• Presents to hospital with bony metastases, intractable pain and dyspnea. Mental status altered due to symptoms.

• Day of admission she speaks with her outpatient oncologist, who recommends hospice.

• Due to pain and mental status changes, patient reluctant to participate in goals of care discussion.
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 reduces costs . . .

- Palliative Care reduces $^{1,2,3,4}$
  - ICU transfers
  - 30 day readmissions
  - Emergency visits

- Cost-savings range from $1696 per admission to $4855 over 6 months $^5$
... while improving patient outcomes

- Cancer patients with Palliative Care experience\textsuperscript{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\textsuperscript{6,10,11}
Our baseline practices

At UNC Hospitals

- Uncontrolled symptoms are the primary reason cancer patients present to our ED\textsuperscript{12}

- Cancer hospital patients use rapid response team more than other medical inpatients; 38.5\% are then transferred to ICU and 56\% die during admission\textsuperscript{13}

- With PC -- Stage IV cancer patients receive more comprehensive symptom assessment and goals of care discussions\textsuperscript{14}
QI Project Summary

Objective: Enhance palliative care for hospitalized patients with advanced cancer

Target Population: Med E patients with Stage IV cancers

Intervention:

a) Structured data from chart reviews
b) Monthly feedback and training in ACP skills for housestaff
c) Daily Med E census review for potential PC consults
d) Review of ICU transfers

Outcome measures:

- PRIMARY Documented GOC / ACP discussions (goal 48% by July 2016)
- SECONDARY ICU transfer (days), 30-day readmission, hospice referral, symptom screening and treatment
Monthly Meetings

Issues and Questions:
- The relationship among inpatient and outpatient oncology, in regards to GOC
- Chemotherapy vs hospice referrals
- What influence does a particular attending have on our numbers?
- How does information spread among residents?
- Why are some patients successfully referred to palliative or supportive care while others are not?

Problems addressed:
- Revising house staff trainings
- Adding triggered consults
- Enhancing data collection
- Assessing how often patients are referred to supportive care
Goals of Care Discussed

- Palliative Care Skills Training Start
- Triggered Consults Start

Advanced Care Planning Note

Palliative Care Skills Training Start

Triggered Consults Start

- July 2015 (n=30)
- Aug 2015 (n=50)
- Sept 2015 (n=27)
- Oct 2015 (n=33)
- Nov 2015 (n=33)
- Dec 2015 (n=36)
- Jan 2016 (n=32)
- Feb 2016 (n=24)
- Mar 2016 (n=21)
- Apr 2016
- May 2016
- June 2016
## Stage IV patients with vs without PC

<table>
<thead>
<tr>
<th></th>
<th>Pts with PC consult (n=78)</th>
<th>Pts without PC consult (n=208)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Charlson Score</strong> mean[range]</td>
<td>6.83 (6-16)</td>
<td>6.76 (6-11)</td>
</tr>
<tr>
<td><strong>GOC discussion</strong></td>
<td>70 (90%)</td>
<td>32 (15%)</td>
</tr>
<tr>
<td><strong>ACP note</strong></td>
<td>40 (51%)</td>
<td>14 (7%)</td>
</tr>
<tr>
<td><strong>MD reports ADs</strong></td>
<td>53 (68%)</td>
<td>24 (12%)</td>
</tr>
<tr>
<td><strong>MD reports HCPOA / surrogate</strong></td>
<td>54 (69%)</td>
<td>69 (33%)</td>
</tr>
<tr>
<td><strong>ICU transfer (after PC)</strong></td>
<td>3 (4%)</td>
<td>6 (3%)</td>
</tr>
<tr>
<td><strong>DNR/DNI</strong></td>
<td>49 (63%)</td>
<td>55 (26%)</td>
</tr>
<tr>
<td><strong>Spiritual Needs</strong></td>
<td>35 (45%)</td>
<td>19 (9%)</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>13 (17%)</td>
<td>16 (8%)</td>
</tr>
<tr>
<td><strong>30 Day readmission</strong></td>
<td>63 eligible 4 readmit (6%)</td>
<td>187 eligible 43 readmits (23%)</td>
</tr>
<tr>
<td><strong>Median LOS</strong></td>
<td>7 days (1-44)</td>
<td>3 days (1-30)</td>
</tr>
</tbody>
</table>
Successes

- In March, 52% of patients have a documented care discussion—this exceeds our primary outcome goal of 48%.

- Percentages of patients with PC consults and ACP notes have also increased.

- As number of PC consults increase, fewer need to be triggered.
Opportunities

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

<table>
<thead>
<tr>
<th>N=38 patients</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Mean=58, Range (20-80)</td>
</tr>
<tr>
<td><strong>Cancer Type</strong></td>
<td></td>
</tr>
<tr>
<td>AML +65</td>
<td>13 (34%)</td>
</tr>
<tr>
<td>AML relapse</td>
<td>10 (26%)</td>
</tr>
<tr>
<td>ALL relapse</td>
<td>9 (24%)</td>
</tr>
<tr>
<td>ALL +65</td>
<td>6 (16%)</td>
</tr>
<tr>
<td><strong>Charlson Index Score</strong></td>
<td>Mean=3.26, Range (2-7)</td>
</tr>
<tr>
<td><strong>Palliative Care consult</strong></td>
<td>5 (13%)</td>
</tr>
<tr>
<td><strong>MD reports Advanced Directives</strong></td>
<td>7 (18%)</td>
</tr>
<tr>
<td><strong>DNR/DNI order</strong></td>
<td>12 (32%)</td>
</tr>
<tr>
<td><strong>Documented GOC discussion</strong></td>
<td>14 (37%)</td>
</tr>
<tr>
<td><strong>ACP note</strong></td>
<td>6 (16%)</td>
</tr>
<tr>
<td><strong>Spiritual Needs Assessed</strong></td>
<td>21 (55%)</td>
</tr>
<tr>
<td><strong>Hospice Referral</strong></td>
<td>4 (11%)</td>
</tr>
<tr>
<td><strong>ICU transfer</strong></td>
<td>7 (18%)</td>
</tr>
<tr>
<td><strong>In-hospital mortality</strong></td>
<td>5 (13%)</td>
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- Consider expansion of project to poor prognosis heme malignancy patients
- Embedding ACP training for house staff
- Connecting to outpatient oncologist and supportive care team
Case Example Follow-up

Woman with Stage IV stomach cancer in pain, unable to participate in GOC discussion on day of admission

- PC consulted on day 2 for symptom management and to assist GOC discussion

- As patient’s pain stabilized, she increasingly engaged in GOC discussions

- She elected DNR on day 3. Discharged with hospice on day 6.
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.”

- “So, I mean, on one hand I've been hearing talk, at least on the conferences of this automated referral type of thing that’s supposed to be happening where palliative care is supposed to be getting involved kind of pretty automatically.”
Sustainability and Spread Plans

- Tracking system and mechanism for continued triggered consults

- Publications / presentations
  - Main analysis
  - Malignant hematology descriptive analysis
  - Root cause analyses of rapid responses and ICU transfers

- Expand to outpatient oncology
Team members
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Works Cited