Early Involvement of Palliative Care

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Why is this important?

- Palliative care is frequently misconstrued as synonymous with end-of-life care
- Palliative care is important throughout the course of a patient's illness
- Approximately 75% of deaths in first world countries are caused by progressive advanced chronic conditions
- Many patients are enrolled in hospice less than 3 weeks before their death
- Does late involvement limit the benefit patients may gain from early palliative services?

Early involvement of palliative care

Chronic conditions that may benefit from palliative care (an incomplete list):

- Cancer
- Emphysema / COPD
- Congestive Heart Failure
- End-stage renal disease
- Cirrhosis or End Stage Liver Disease
- Neurodegenerative Diseases
- Alzheimer’s Disease and Dementia

Few studies investigating early involvement of palliative care

Evidence base is just being developed because less than 1% of all National Institutes of Health funding is devoted to palliative care

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

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Early involvement of palliative care

Goal of the study was to examine the effect of early palliative care integrated with standard oncologic care on patient reported outcomes, the use of health services, and the quality of end-of-life care among patients with metastatic non–small-cell lung cancer

Table 2. Bivariate Analyses of Quality-of-Life Outcomes at 12 Weeks.*

Variable	Standard Care (N=47)	Early Palliative Care (N=60)	Difference between Early Care and Standard Care (95% CI)	P Value†	Effect Size‡
FACT-L score	91.5±15.8	98.0±15.1	6.5 (0.5–12.4)	0.03	0.42
LCS score	19.3±4.2	21.0±3.9	1.7 (0.1–3.2)	0.04	0.41
TOI score	53.0±11.5	59.0±11.6	6.0 (1.5–10.4)	0.009	0.52

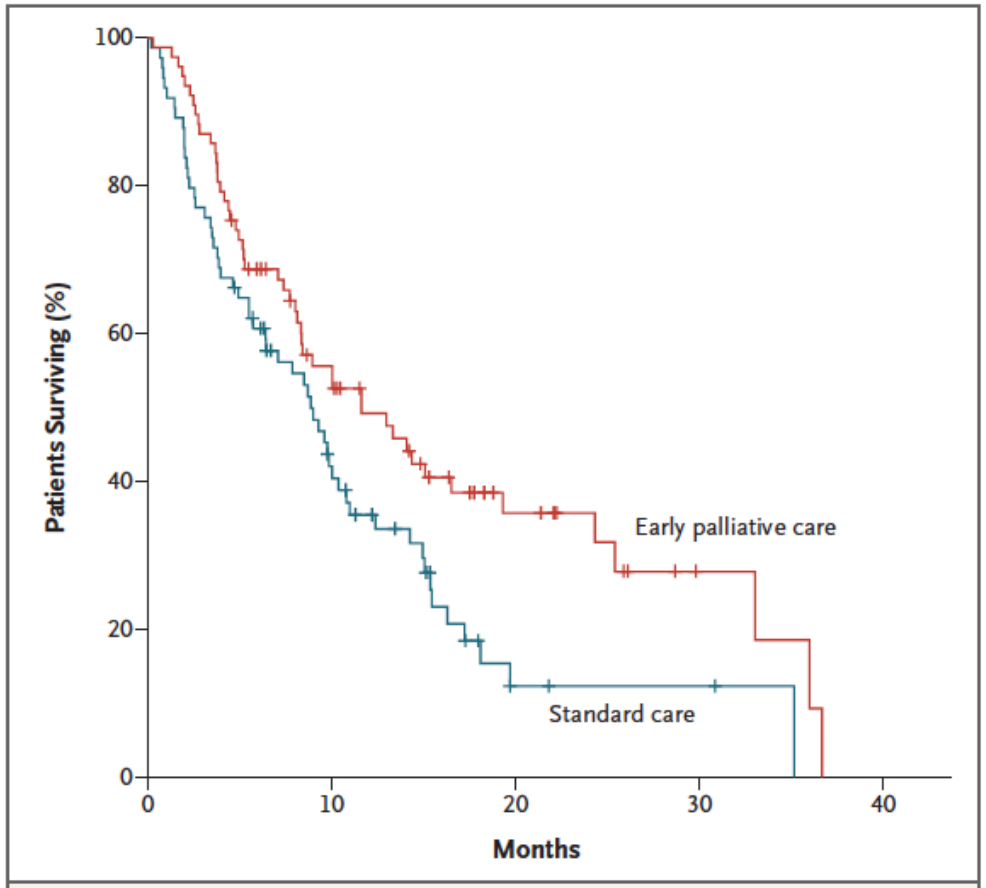

Figure 3. Kaplan–Meier Estimates of Survival According to Study Group. Survival was calculated from the time of enrollment to the time of death, if it occurred during the study period, or to the time of censoring of data on December 1, 2009. Median estimates of survival were as follows: 9.8 months (95% confidence interval [CI], 7.9 to 11.7) in the entire sample (151 patients), 11.6 months (95% CI, 6.4 to 16.9) in the group assigned to early palliative care (77 patients), and 8.9 months (95% CI, 6.3 to 11.4) in the standard care group (74 patients) (P=0.02 with the use of the log-rank test). After adjustment for age, sex, and baseline Eastern Cooperative Oncology Group performance status, the group assignment remained a significant predictor of survival (hazard ratio for death in the standard care group, 1.70; 95% CI, 1.14 to 2.54; P=0.01). Tick marks indicate censoring of data.

Summary of results

Early integration of palliative care with standard oncologic care in patients with metastatic non–small-cell lung cancer resulted in:

- Survival that was prolonged by approximately 2 months
- Improvement in quality of life and mood
- Greater documentation resuscitation preferences
- Less aggressive care at the end of life

Early involvement of palliative care

American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care

Thomas J. Smith, Sarah Temin, Erin R. Alesi, Amy P. Abernethy, Tracy A. Balboni, Ethan M. Basch, Betty R. Ferrell, Matt Loscalzo, Diane E. Meier, Judith A. Paice, Jeffrey M. Peppercorn, Mark Somerfield, Ellen Stovall, and Jamie H. Von Roenn

Table 1. Randomized Trials of Palliative Care: Population, Sample Size, and Intervention

Reference	Sample Size		Study Population	Intervention
	Usual Care	Palliative Care		
Bakitas et al, 2009[11]	161	161	Advanced-stage cancer patients enrolled in rural NCI comprehensive center	A multicomponent psychoeducational intervention conducted by APNs: four weekly educational sessions, then monthly follow-up; medical visits with palliative care clinicians.
Brumley et al, 2007[12]	152	145	Homebound terminally ill patients (life expectancy < 1 year) who had one or more visits to the ER or hospitalization in the last year; 47% had cancer	Interdisciplinary home-based care health care program designed to enhance comfort and improve QOL (hospice model). Team of MD, RN, and social worker.
Gade et al, 2008[14]	237	275	Patients hospitalized with life-limiting illnesses (27% in palliative care arm had cancer)	Interdisciplinary palliative care team (palliative care MD and nurse, hospital social worker, and chaplain) that provides consultative service; home service continued with local resources.
Meyers et al, 2011[15]	128	348	Cancer patients and caregiver dyads enrolled in phase I, II, or III clinical trials at comprehensive cancer centers (City of Hope, University of California at Davis, The Johns Hopkins University)	Simultaneous Care Educational Intervention: Linking Palliation and Clinical Trials. Educational sessions by trained educators with the patient and caregiver that included the COPE problem-solving model.
Pantilat et al, 2010[16]	53	54	Chronically ill, hospitalized elderly patients (22% had cancer)	Palliative medicine consultation with MD visits daily and recommendations made to primary attending MD.
Rabow et al, 2004[17]	40	50	Patients in outpatient clinics with diagnosis of advanced CHF, COPD, or cancer (33%)	Comprehensive care team of interdisciplinary palliative care experts (social worker, nurse, chaplain, pharmacist, psychologist, art therapist, volunteer coordinator, and three MDs). Seven-component interventions (including assessment, social work, caregiver training, medication review, spiritual/psychological support, home visits, phone calls).
Temel et al, 2010[6]	74	77	Patients with newly diagnosed metastatic NSCLC enrolled within 8 weeks of diagnosis	Met with outpatient palliative care team (six MDs, one APN) within 3 weeks, then at least monthly. EMR documentation of care provided.

Abbreviations: APN, advanced practice nurse; CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; COPE, Creativity, Optimism, Planning, and Expert Information; EMR, electronic medical record ER, emergency room; MD, doctor of medicine; NCI, National Cancer Institute; NSCLC, non-small-cell lung cancer; QOL, quality of life; RN, registered nurse.

Table 3. Randomized Trials of Palliative Care: Outcomes Improved With Palliative Care

	Outcomes						
Reference	Symptoms	Quality of Life	Mood	Satisfaction	Resource Use	Advance Care Planning	Survival
Rabitiss et al, 2009[10]	Improved ($P = .06$)	Improved ($P = .02$)	Improved ($P = .02$)	Not measured	No difference	No difference	No difference
Brumley et al, 2007[13]	Not measured	Not measured	Not measured	Improved ($P < .05$)	Cost $12,670 v $20,222 ($P = .03$); home death more likely (OR, 2.30; $P < .001$). Hospital days reduced by 4.36 ($P < .001$). ED visits reduced by 0.35 ($P = .03$)	Not measured	No difference
Gade et al, 2008[14]	No difference	No difference	No difference	IPCS patients reported greater satisfaction with their care experience ($P = .04$) and providers' communication ($P < .001$)	Total mean health costs $6,766 lower (IPCS: $14,690; UC: $21,252; $P < .001$). Net cost savings of $4,855 (staffing costs) per patient ($P < .001$). Longer median hospice stays (24 days v 12 days; $P = .04$).	IPCS patients had more ADs at discharge than UC patients (91.1% v 77.9%; $P < .001$)	No difference
Meyers et al, 2011[15]	Not measured	Patients: no difference. Caregivers: declined at less than half the rate of controls ($P = .02$)	No difference	Not measured	Not measured	Not measured	Not measured
Pantilat et al, 2010[16]	No difference*	Not measured	Depression not reported; anxiety no difference	Not measured	Not measured	No difference	Not measured
Rabow et al, 2004[17]	Less dyspnea ($P = .01$); no change in pain†	No difference	Less anxiety ($P = .05$); no change in depression ($P = .26$)	No difference	No difference	55% v 29% ($P = .12$)	Not measured
Temel et al, 2010[6]	Improved ($P = .04$)	Improved ($P = .02$)	Less depression ($P = .01$)	Not measured	Less aggressive care ($P = .05$)	More ADs documented in PC group ($P = .05$)	11.6 v 8.9 months ($P = .02$)

Abbreviations: AD, advance directive; ED, emergency department; IPCS, interdisciplinary palliative care service; OR, odds ratio; PC, palliative care; UC, usual care.
*The consultant team did not track whether the primary inpatient team followed the recommendations. In a concurrent study done at the same institution,[16] the primary team followed recommendations only 8% to 17% of the time. This may partly explain the lack of effect IS. Pantilat, personal communication, May 2011).
†The primary care provider followed recommendations for opioid prescription in 8% of cases and for antidepressant prescription in only 17% of cases.

Summary

- Palliative care, when combined with standard, leads to better patient and caregiver outcomes including:
  - Improvement in symptoms
  - Quality of life
  - Patient satisfaction
  - Reduced caregiver burden

- More appropriate referral to and use of hospice
- Reduced use of futile intensive care

Palliative care in the ICU

- **Greater than half of hospital deaths in the United States occur in the intensive care unit (ICU)**
- **Approximately 20% of Americans receive ICU care near the end of life**

Integrating palliative care with intensive care for critically ill patients with lung cancer

Elizabeth B Gay[1], Stefanie P Weiss[2] and Judith E Nelson[2*]

- 1,500 patients with stage IV lung cancer reported discussing hospice with a care provider, yet more than 70% of those patients died within 6 months (the time period for hospice eligibility)
- Majority of more than 4,000 physicians did not initiate discussions of prognosis, resuscitation status, hospice, and preferred site of death even if death were expected within 6 months
- Providers would postpone discussions until the patient became symptomatic, failed disease-directed treatment, or even might never conduct these discussions unless initiated by the patient or family

Table 1. Quality measures for palliative and end-of-life care by domain (27)

Patient and family-centered decision making
1. Assessment of the patient's decisional capacity[a]
2. Documentation of a surrogate decision maker within 24 hrs of admission[a]
3. Documentation of the presence and, if present, contents of advance directives[a]
4. Documentation of the goals of care[a]

Communication within the team and with patients and family
5. Documentation of timely physician communication with the family[a]
6. Documentation of a timely interdisciplinary clinician–family conference[a]

Continuity of care
7. Transmission of key information with transfer of the patient out of the ICU[a]
8. Policy for continuity of nursing services[b]

Emotional and practical support for patients and family
9. Open visitation policy for family members[b]
10. Documentation that psychosocial support has been offered[a]

Symptom management and comfort care
11. Documentation of pain assessment[a]
12. Documentation of pain management[a]
13. Documentation of respiratory distress assessment[a]
14. Documentation of respiratory distress management[a]
15. Protocol for analgesia/sedation in terminal withdrawal of mechanical ventilation[b]
16. Appropriate medications available during withdrawal of mechanical ventilation[a]

Spiritual support for patients and family
17. Documentation that spiritual support was offered[a]

Emotional and organizational support for clinicians
18. Opportunity to review experience of caring for dying patients by ICU clinicians[b]

Early involvement of palliative care: Summary

- Communication, symptom management, and family support
- Improve the quality of life for patients and families
- One study showed enhanced survivorship over standard care alone
- Facilitate goals of care discussion
- Reduce suffering from physical, psychosocial, and spiritual aspects of serious illness and injury
- Can be offered concurrent with appropriate life prolonging treatments
- Not simply an alternative to “aggressive” or life prolonging care

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