Oncology and Palliative Medicine: A collaborative approach to the cancer patient

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No disclosures

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- UNR Med alumni
  - MD ‘15, R ‘19, HPM Fellowship ‘23
- Clinical practice
  - Pennington Cancer Institute at Renown, Palliative medicine
- Assistant Dean of Admissions, UNR Med
- UNR Med year 1-2 clinical skills course director

Objectives

- After participating in this session, attendees should be able to
  - Define the roles of hospice and palliative care
  - Describe the ways palliative medicine can be utilized in oncology care.
  - Understand the benefits of early palliative care in care of the cancer patient
  - Illustrate ways palliative care can be integrated into oncology care

Let's have a conversation...

- Please feel free to ask questions throughout the presentation
- You are also welcome to share any experiences you have had working with palliative medicine

What palliative medicine is not…

Common misconceptions:

-palliative care is end-of-life care only

-stigmatization of death and dying

Palliative medicine

- *Palliative care* focuses on improving a patient's quality of life by managing pain and other distressing symptoms of a serious illness. Palliative care should be provided along with other medical treatments. (American Academy of Hospice and Palliative medicine)
- Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice. (National Consensus Project)

Hospice Medicine

- Hospice is palliative care for patients in their last year of life. Hospice care can be provided in patients' homes, hospice centers, hospitals, long-term care facilities, or wherever a patient resides. (AAHPM)
- Hospice is both a philosophy of care and a defined Medicare benefit

Palliative Medicine

Palliative care in oncology

- Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update
- Recommendation: Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer family, friend's, or caregivers of patients with early or advanced cancer to palliative care services.

Ferrell, B. R., Temel, J. S., Temin, S., Alesi, E. R., Balboni, T. A., Basch, E. M., Firn, J. I., Paice, J. A., Peppercorn, J. M., Phillips, T., Stovall, E. L., Zimmermann, C., & Smith, T. J. (2017). Integration of palliative care into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline update. Journal of Clinical Oncology, 35(1), 96–112. https://doi.org/10.1200/jco.2016.70.1474

Essential components of palliative care may include:

- Rapport and relationship building with patients and family caregivers
- Symptom, distress, and functional status management (eg, pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation)
- Exploration of understanding and education about illness and prognosis
- Clarification of treatment goals
- Assessment and support of coping needs
- Assistance with medical decision making
- Coordination with other care providers
- Provision of referrals to other care providers as indicated

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Who is the target population for palliative care in oncology?

Patients with advanced cancer

- Those with distant metastases
- Late-stage disease
- Cancer that is life limiting
- Prognosis of 6-24 months
- High symptom burden treatment regimens

Examples include:

- Pancreatic cancer
- Advanced stage lung cancer
- Glioblastoma
- Head and neck cancer

Palliative is a part of the team

- Care delivered alongside active treatments of their cancer
- Assist with symptom management
- Help facilitate goals of care
- Provide a bridge through different care settings
- Be a guide to hospice when appropriate

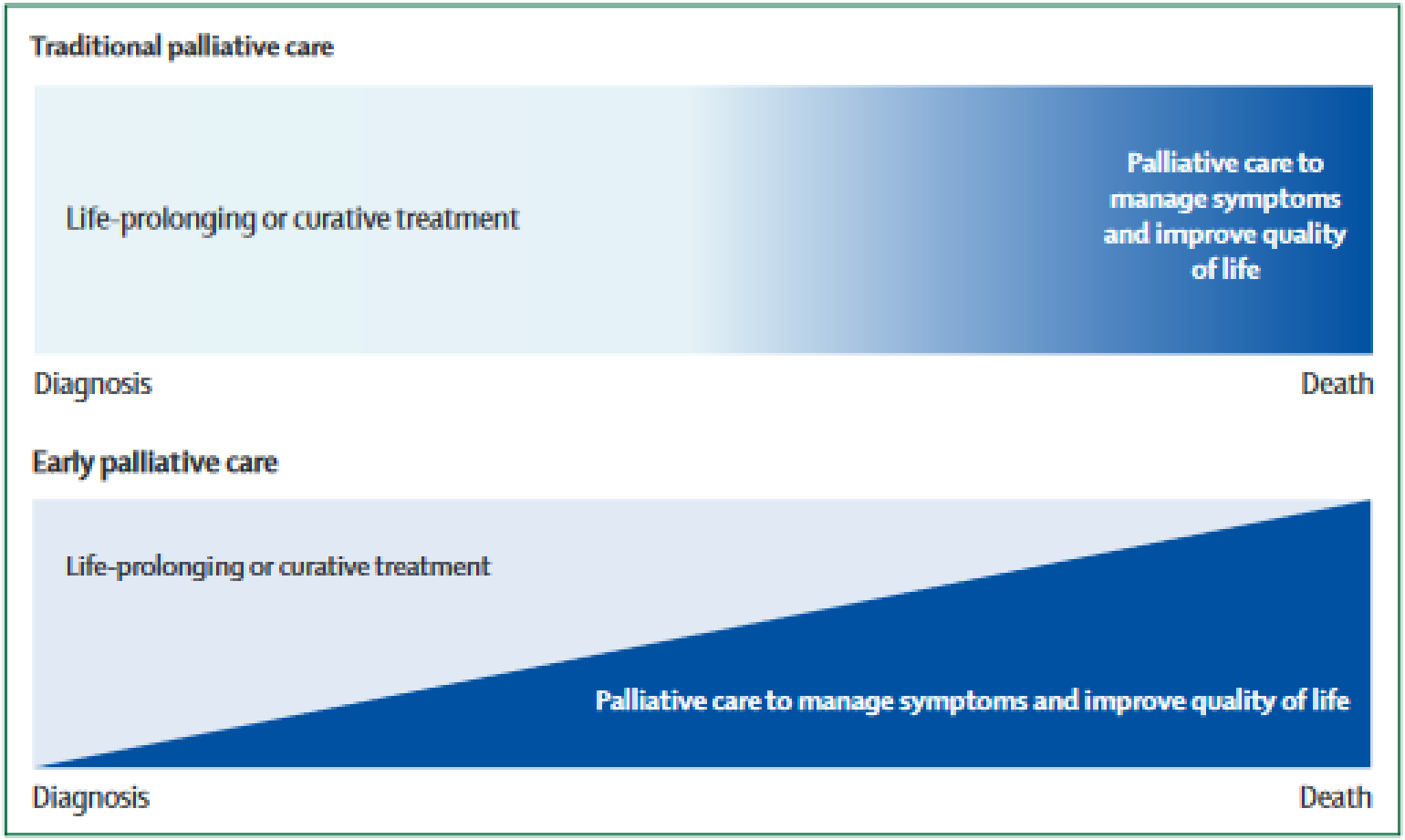

Figure 1: **Traditional versus early palliative care**

Kassa, S., Loge, J., Aapro, M. et al. Integration of oncology and palliative care: a Lancet Oncology Commission. 2018. *The Lancet*. Vol 19 e588-e653. http://dx.doi.org/10.1016/S1470-2045(18)30415-7

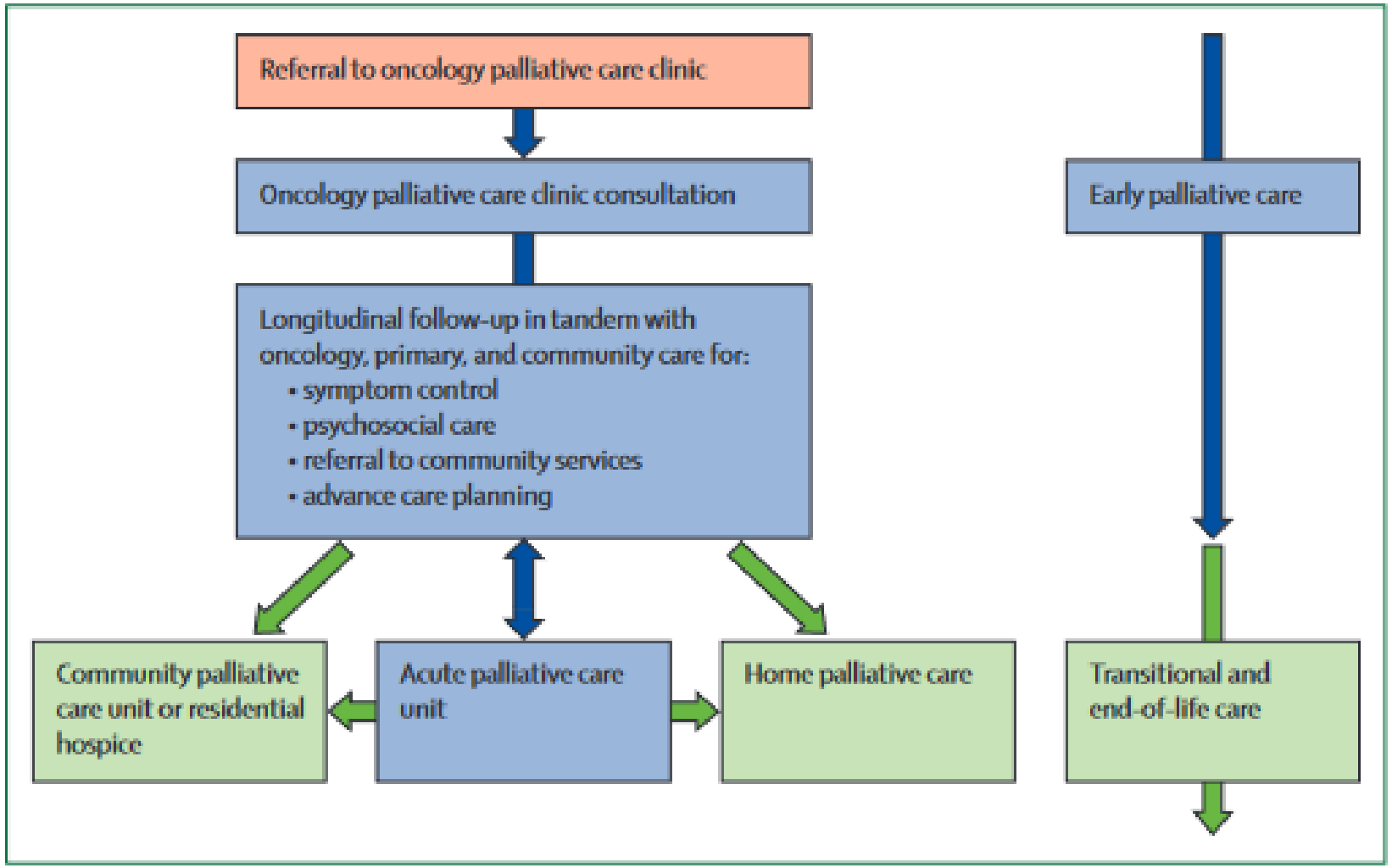

Figure 6: **Tertiary palliative care on the basis of referral to a palliative care clinic**
Referrals are made by the patient's oncologist. Care is integrated and collaborative across acute and community care settings. Ultimately, care is transferred to home, hospice, or a palliative care unit. Figure adapted from Hannon and colleagues.[472]

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What might palliative care look like for patients?

- Once a diagnosis of advanced cancer is made patient is referred to palliative care
- Collaboration with oncologist to anticipate palliative care needs related to treatment protocol
- Establish goals of care (disposition flows from goals of care)
- Follow patient across health care settings as needs dictate
- Interaction with multidisciplinary team
- Transition to hospice when appropriate, again with collaboration of oncologist
- Assist with discontinuation of pain medications
- Remain a support to patient and their family

Benefits of early palliative care consultation

- Reduction in the number of hospitalizations at the end of life
- In many studies palliative care can reduce the total cost of care, often substantially. The VA observed a 38% direct cost savings for patients receiving palliative care.
  - Inpatient vs outpatient
- Better satisfaction in care
  - Improved symptom burden
  - Increase life expectancy?

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Limitations to the research

- The field of palliative care research began relatively recently
- Research funding has been limited
- Majority of research has been in patients with solid tumors
- Research in health disparities in palliative care are lacking
- Often studies are done at single sites, which can limit generalizability

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Clinical examples

Patient #1: Seen in the ER for abdominal pain, imaging findings show concern for pancreatic cancer, biopsy performed, work up with metastatic disease, patient referred to medical oncology along with palliative care.

Patient #2: Referred to radiation and medical oncologist for treatment of head and neck cancer, started on concurrent chemo and radiation, follows typical course and by week 5 of treatment has significant symptom burden, frequently calling office for help.

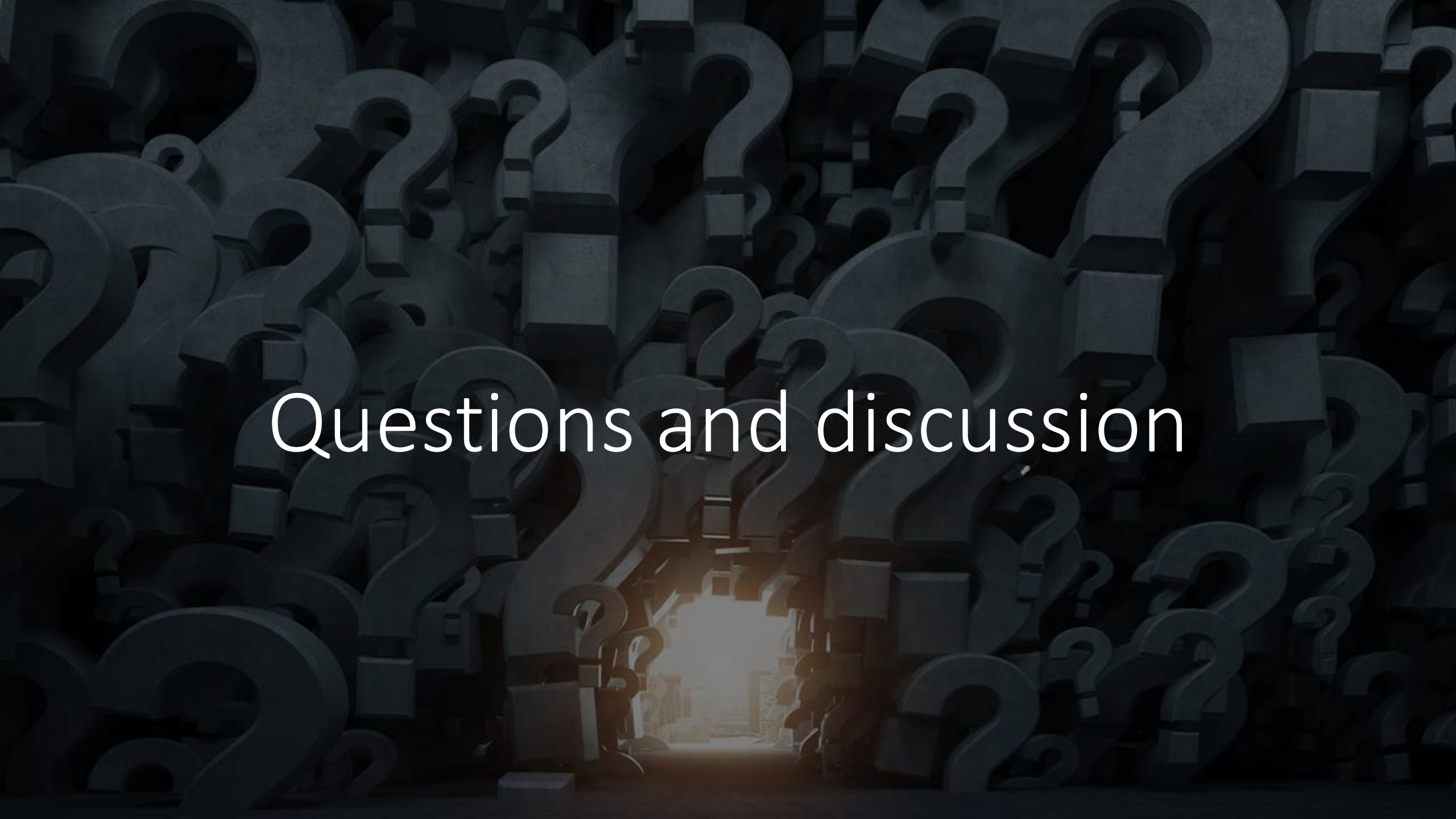
Patient #3: Patient long established with oncologist for treatment of lymphoma, has completed treatment, was managed with high doses of opioids and with use of benzodiazepines, time to wean off high risk medications.

Patient #4: Presented to the ER for neck and abdominal pain, subsequent work up and hospitalization for new diagnosis of colon cancer, started on methadone by inpatient palliative team, needs management of pain medications upon discharge.

Obstacles uncovered

- Line between chronic pain management and palliative pain management
- Who is the captain of the ship?
- Prescribing challenges due to inventory and prior authorizations
- Coverage when out of the office
- How to measure productivity or impact on patient care

What does the future hold for palliative care?


Questions and discussion