Update in Palliative Care 2016

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YES INDEED, I'D WANT A NATURAL DEATH... JUST A FEW LIGHT SHOCKS, SOME GENTLE CHEST COMPRESSIONS, A TRACHEAL TUBE TO BREATHE, SEVERAL ROUNDS OF EPINEPHRINE, AND IF IT'S NOT WORKING, WELL THEN JUST LET ME GO PEACEFULLY.
Objectives

- Review recently published peer-reviewed literature from various sources that have an impact on the practice of palliative medicine.
- Discuss basic palliative care principles that support literature outcomes, and how these apply to clinical practice.
- Use the information presented to help better incorporate palliative medicine essentials into the practice of primary care.
Financial Disclosures

- None
Symptomatic Management
Safety and Benefit of Discontinuing Statin Therapy in the Setting of Advanced, Life-Limiting Illness: A Randomized Clinical Trial


- Multicenter, parallel-group, unblinded trial.

- Eligibility: Estimated life expectancy of between 1 month and 1 year 2) statin therapy for 3 months or more for primary or secondary prevention of cardiovascular disease 3) recent deterioration in functional status 4) no recent active cardiovascular disease.

- Randomized to either discontinue (n=189) or continue (n=192) statin therapy and were monitored monthly for up to 1 year.
Safety and Benefit of Discontinuing Statin Therapy in the Setting of Advanced, Life-Limiting Illness: A Randomized Clinical Trial

**Outcomes:**

- No significant difference in death within 60 days.
- Total QOL was better for the group discontinuing statin therapy ($P=0.04$).
- Mean cost savings were $3.37 per day and $716 per patient.
Olanzapine for the Prevention of Chemotherapy-Induced Nausea and Vomiting

  - Randomized, double-blind, phase 3 trial.
  - Compared olanzapine with placebo in combination with other standard chemotherapy antiemetics.
  - Patients with no previous chemotherapy who were receiving high-dose cisplatin or cyclophosphamide-doxorubicin.
  - Received either 10 mg of olanzapine orally (n=192) or matching placebo (n=188) daily on days 1 through 4.
Olanzapine for the Prevention of Chemotherapy-Induced Nausea and Vomiting

Outcomes:

- Proportion of patients with no chemotherapy-induced nausea was significantly greater with olanzapine than with placebo in the first 24 hours after chemotherapy (74% vs. 45%, \( P = 0.002 \)), the period from 25 to 120 hours after chemotherapy (42% vs. 25%, \( P = 0.002 \)), and the overall 120-hour period (37% vs. 22%, \( P = 0.002 \)).

- Some patients receiving olanzapine had increased sedation (severe in 5%) on day 2.
78 PEOPLE
DIE EACH DAY
OVERDOSING ON PAINKILLERS
SOURCE: CDC

Comparing Symptom Burden in Patients with Metastatic and Nonmetastatic Cancer


Compared the symptom burden of outpatients with cancer, either metastatic or localized disease, seen in a palliative care comanagement clinic.

Retrospective, cross-sectional study assessing patient symptoms with multiple patient surveys (re: symptom management, spiritual well-being, QOL).

One hundred and twenty-seven patients (62%) had metastatic cancer and 78 (38%) had nonmetastatic cancer.

Characteristics of the two study groups were similar with regard to age, sex, ethnicity, language, religion, partnership status, and insurance status.
Comparing Symptom Burden in Patients with Metastatic and Nonmetastatic Cancer

**Outcomes:**

- Patients with metastatic disease and localized disease had similar mean symptom burden and mean individual symptom intensity for all symptoms evaluated except for nausea.
- Nausea was worse in patients with metastatic disease and in younger patients.
ASCO Policy Statement on Opioid Therapy: Protecting Access to Treatment for Cancer-Related Pain

- American Society of Clinical Oncology May 2016.
- ASCO Principles for Balancing Opioid Access With the Need to Curb Misuse and Abuse.
ASCO Policy Statement on Opioid Therapy: Protecting Access to Treatment for Cancer-Related Pain

- ASCO Principles for Balancing Opioid Access With the Need to Curb Misuse and Abuse:
  - Cancer patients represent a special population that should be largely exempt from regulations intended to restrict access or limit doses.
  - Consider post-cancer or treatment pain syndromes.
  - After initial screening and assessment of cancer patients, the timing and form of subsequent assessments should be left to the judgment of the treating physician, based on clinical and patient-specific circumstances.
ASCO Policy Statement on Opioid Therapy: Protecting Access to Treatment for Cancer-Related Pain

- ASCO Principles for Balancing Opioid Access With the Need to Curb Misuse and Abuse:
  - Tailored patient education programs.
  - Non-abuse deterrent formulations should remain available to patients with clinical or other factors where they would be an appropriate option.
  - Compliance tools such as treatment agreements and urine testing subsequent to an initial prescription should NOT be made mandatory for all patients receiving opioid therapy.
Nutrition at the End of Life
Tube Feeding in US Nursing Home Residents With Advanced Dementia, 2000-2014

  - Susan L. Mitchell, MD, MPH et. al.
  - Data were derived from federally mandated Minimum Data Set (MDS) assessments completed quarterly, as required, on all residents in US nursing homes between January 1, 2000, and October 31, 2015.
  - 71,251 residents with advanced dementia and recent dependence for eating were identified.
Outcomes:

- Proportion of residents receiving feeding tubes over the next 12 months declined from 11.7% in 2000 to 5.7% in 2014 (ARR, 0.41 [95% CI, 0.38-0.45]).

- Black residents were more likely to get tube fed in 2000 (ARR, 4.4 [95%CI, 4.0-4.7]) and 2014 (ARR, 5.6 [95%CI, 5.0-6.2]) than white residents.
Feeding tube insertion declining in people with advanced dementia
(nursing home residents with AD and recent onset of dependence for eating)
Mitchell, JAMA, 2016

Data from pallimed.org

4%  5%  6%  7%  8%  9%  10%  11%  12%  13%
"But first, let me give you the good news..."

The Expansion of Palliative Medicine
The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization


- Retrospective analysis to quantify cost savings associated with a home-based palliative care (HBPC) program in a Medicare Shared Savings Program Accountable Care Organization.

- 651 decedents; 82 enrolled in a HBPC program compared to 569 receiving usual care in three New York counties who died between October 1, 2014, and March 31, 2016.
The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization

**Outcomes:**

- Cost per patient during the final three months of life was $12,000 lower with HBPC than with usual care ($20,420 vs $32,420; p = 0.0002).

- Hospital admissions were reduced by 34% in the final month of life for patients enrolled in HBPC.

- HBPC resulted in a 35% increased hospice enrollment rate (p = 0.0005) and a 240% increased median hospice length of stay compared to usual care (34 days vs 10 days; p< 0.0001).
Integrating palliative care across settings: A retrospective cohort study of a hospice home care programme for cancer patients


- Retrospective study cohort comprised patients who were diagnosed with cancer, had an expected prognosis of 1 year or less, and were referred to a home hospice.

- Intervention group (n=321): deceased patients enrolled in the integrated hospice home care programme between September 2012 and June 2014. Historical comparison group (n=593): deceased patients who were referred to other home hospices between January 2007 and January 2011.
Integrating palliative care across settings: A retrospective cohort study of a hospice home care programme for cancer patients

- **Outcomes:**
  - Share of hospital deaths was significantly lower for programme participants (12.1% versus 42.7%).
  - Intervention group had statistically significantly lower emergency department visits and hospitalizations at 30 days, 60 days, and 90 days prior to death.
A cost-effectiveness study of person-centered integrated heart failure and palliative home care: Based on a randomized controlled trial

*Palliative Medicine* 2016, Vol. 30(3) 296-302

- Randomized controlled trial was conducted from January 2011 to 2013 at a county council hospital in Sweden.

- Patients with chronic and severe heart failure and life expectancy < 1 year were randomly assigned to an intervention (n = 36) or control (n = 36) group.

- The intervention group: received the Palliative Advanced Home Care and Heart Failure Care intervention over 6 months. The control group: received usual care.
A cost-effectiveness study of person-centered integrated heart failure and palliative home care: Based on a randomized controlled trial

- **Outcomes:**
  - EuroQol five dimensions questionnaire (EQ-5D) indicated that the intervention resulted in a gain of 0.25 quality-adjusted life years.
  - Significant cost reduction with the intervention.
  - Costs for staffing are higher than usual care but more than made up for by the reduced need for hospital-based care.
  - The intervention made it possible for the county council to use €50,000 for other needs.
5% of Medicare beneficiaries account for fully half of Medicare spending.

- 40% have persistent high spending year after year because of one or more life-limiting illnesses, often accompanied by chronic debilitating conditions.
- Only 11% of “the costliest 5%” are in their last year of life.
  - Many are not predictably dying or eligible for hospice.
  - Is there a need for something else? **New levels of care?**
The Practice of Palliative Care
The Growth of Palliative Care in U.S. Hospitals: A Status Report


Data obtained from multiple sources including the National Palliative Care Registry, American Hospital Association (AHA) Annual Surveys, and the Dartmouth Atlas of Healthcare.

Multivariable logistic regression was used to examine predictors of hospital palliative care programs.
Outcomes:

- Ninety percent of hospitals with 300 beds or more were found to have palliative care programs as compared to 56% of hospitals with fewer than 300 beds.

- Not-for-profit hospitals and public hospitals were, respectively, 4.8 times and 7.1 times more likely to have a palliative care program as compared to for-profit hospitals.

- Palliative care penetration was highest in the New England (88% of hospitals), Pacific (77% of hospitals), and mid-Atlantic (77% of hospitals) states and lowest in the west south central (43% of hospitals) and east south central (42% of hospitals) states.
Access to palliative care in the U.S.

This graph shows the total percentage of palliative care offered in each state, both by nonprofit and for-profit hospitals, as well as the grade each state received for its performance.

Graphic by Kelvin Suddason
Quality of End-of-Life Care Provided to Patients With Different Serious Illnesses


- Retrospective cross-sectional study conducted in all 146 inpatient facilities within the Veteran Affairs health system among patients who died in inpatient facilities between October 1, 2009, and September 30, 2012.

- Clinical diagnoses categorized as end-stage renal disease (ESRD), cancer, cardiopulmonary failure (congestive heart failure or chronic obstructive pulmonary disease), dementia, frailty, or other conditions.
Quality of End-of-Life Care Provided to Patients With Different Serious Illnesses

- **Outcomes:**
  - Family-reported quality of end-of-life care was significantly better for patients with cancer and those with dementia than for patients with ESRD, cardiopulmonary failure, or frailty.
  - The quality advantage was mediated by palliative care consultation, setting of death, and a code status of do-not-resuscitate.
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>No. (%)</th>
<th>P Value&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cancer</td>
<td>Dementia</td>
</tr>
<tr>
<td>All veteran decedents (n = 57,728)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>23,523 (40.8)</td>
<td>3675 (6.4)</td>
</tr>
<tr>
<td>Measures of care at the end of life</td>
<td></td>
<td></td>
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<tr>
<td>Palliative care consultation</td>
<td>73.5</td>
<td>61.4</td>
</tr>
<tr>
<td>Do-not-resuscitate order</td>
<td>95.3</td>
<td>93.5</td>
</tr>
<tr>
<td>Died in inpatient hospice</td>
<td>42.9</td>
<td>32.3</td>
</tr>
<tr>
<td>Died in the intensive care unit</td>
<td>13.4</td>
<td>8.9</td>
</tr>
<tr>
<td>Bereaved Family Survey participants (n = 34,005)&lt;sup&gt;d,e&lt;/sup&gt;</td>
<td>40.3</td>
<td>6.6</td>
</tr>
<tr>
<td>Overall rating of patient’s care was excellent</td>
<td>59.2</td>
<td>59.3</td>
</tr>
<tr>
<td>Health care professionals always listened to concerns</td>
<td>73.8</td>
<td>75.7</td>
</tr>
<tr>
<td>Health care professionals always provided the medical treatment</td>
<td>79.1</td>
<td>80.4</td>
</tr>
<tr>
<td>Health care professionals always kept family informed about patient’s</td>
<td>68.2</td>
<td>71.1&lt;sup&gt;f&lt;/sup&gt;</td>
</tr>
<tr>
<td>Health care professionals always gave enough emotional support</td>
<td>64.6</td>
<td>67.5&lt;sup&gt;f&lt;/sup&gt;</td>
</tr>
<tr>
<td>Patient had frequent uncontrolled pain&lt;sup&gt;j&lt;/sup&gt;</td>
<td>55.0</td>
<td>49.4&lt;sup&gt;g&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Abbreviation: ESRD, end-stage renal disease.
<sup>a</sup> Analyses adjusted for age, race, sex, next-of-kin relationship, and comorbidity, and clustered by facility.
<sup>b</sup> P value for the overall association of diagnosis with each outcome.
<sup>c</sup> Table excludes 25 decedents from Table 1 who were missing covariate data.
<sup>d</sup> P < .003 for the comparison of each diagnosis vs cancer for all outcomes regarding measures of care at the end of life.
<sup>e</sup> Analyses weighted for survey nonresponse. Table excludes 10 Bereaved Family Survey participants for whom no survey weight could be calculated because of missing covariate data.
<sup>f</sup> Among the 34,005 Bereaved Family Survey participants for whom survey weight could be calculated. Sample size varies to reflect percentage of missing data for individual survey items: overall rating (1,4), health care professionals always listened to concerns (2.6), provision of desired medical treatment (3.5), health care professionals informed family (1.9), health care professionals gave enough emotional support (3.0), and patient had frequent uncontrolled pain (13.7).
<sup>g</sup> P < .05 for the comparison of each diagnosis vs cancer.
<sup>h</sup> P < .001 for the comparison of each diagnosis vs cancer.
<sup>i</sup> P < .01 for the comparison of each diagnosis vs cancer.
<sup>j</sup> Includes only the 81.7% of patients who, per family report, experienced pain.
Differences in palliative care quality between patients with cancer, patients with organ failure and frail patients: A study based on measurements with the Consumer Quality Index Palliative Care for bereaved relatives

  - Data collected through the Consumer Quality Index Palliative Care questionnaire for bereaved relatives.
  - Data were analyzed of 456 relatives of deceased patients with cancer, patients with organ failure and frail patients from various care settings in the Netherlands.
Differences in palliative care quality between patients with cancer, patients with organ failure and frail patients: A study based on measurements with the Consumer Quality Index Palliative Care for bereaved relatives

**Outcome:**
- Compared with the bereaved relatives of patients with cancer, bereaved relatives of patients with organ failure or frailty were more likely to negatively assess the palliative care provided to both the patient and themselves.
- Statistically significant for both to patient and relatives.
Illness Trajectory and Prognostication...

Source: J Am Geriatr Soc © 2011 Blackwell Publishing
Future of the Palliative Care Workforce: Preview to an Impending Crisis


- In Press Accepted Manuscript; Published online: September 26, 2016.

- Conducted an electronic survey of members of the American Academy of Hospice and Palliative Medicine [the largest physician membership society for palliative care] with a 36% response rate.
Future of the Palliative Care Workforce: Preview to an Impending Crisis

**Outcomes:**

- Participants future plans: 19% expressing a 50% or higher chance of leaving the field in 5 years, 47% intending to leave in 10 years, and 66% leaving in 15 years.

- Multivariable logistic regression analysis demonstrated that physicians <age 50, those with burnout, and those with >75% clinical effort were at the greatest risk to leave the field early.
Education, implementation, and policy barriers to greater integration of palliative care: A literature review

- *Palliative Medicine* 2016, Vol. 30(3) 224-239

- Literature review using PubMed from 2005 to March 2015 augmented by primary data collected from 405 hospitals included in the Center to Advance Palliative Care’s National Palliative Care Registry for years 2012 and 2013.

- World Health Organization’s Public Health Strategy for Palliative Care as a framework for analyzing barriers to palliative care integration.
Education, implementation, and policy barriers to greater integration of palliative care: A literature review

- **Education-related barriers:**
  - Lack of adequate education and training for medical residents.
  - Perception of palliative care as end-of-life care by healthcare providers and the public.

- **Implementation-related barriers:**
  - Inadequate size of palliative medicine-trained workforce.
  - Challenge of identifying patients appropriate for palliative care referral.
  - Need for culture change regarding palliative care across settings.
Education, implementation, and policy barriers to greater integration of palliative care: A literature review

- **Policy-related barriers:**
  - Fragmented structure of the US healthcare system.
  - Need for greater funding for palliative care research.
  - Lack of adequate reimbursement and incentives for palliative care for complex patients.
  - Regulatory barriers to greater palliative care integration in the nursing home setting.

- **Bottom line:** We have a long way to go...
That’s it!!
Questions??

“He’s our new Palliative Specialist!”