Palliative Care: Living As Well as You Can for as Long as You Can

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THE QUEEN’S MEDICAL CENTER
A Physician’s Quest to Transform Care Through the End of Life

The Best Care Possible

IRA BYOCK, MD

author of Dying Well
Objectives

1. Define palliative care
2. Review minimum standards for palliative care
3. Highlight the evidence base for palliative care
Palliative care is specialized medical care for people living with serious illness. It focuses on providing patients with relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family…
Palliative care is provided by a specially-trained team of doctors, nurses, and other specialists who work together with a patient’s other doctors to provide an extra layer of support....
...Palliative care is based on the needs of the patient, not on the prognosis. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.
Palliative care is specialized medical care that treats the symptoms and stress of a serious illness. The goal is to improve quality of life.
• Interdisciplinary team
  – physician, nurse, social worker, chaplain
• At least one prescriber with certification in palliative care
• Comprehensive assessment and management of patient’s symptoms
• Communication on patient and family priorities for care (eg “goals of care” conversations and advance care planning).
• Meaningful and timely 24/7 response to crises
The vast majority of patients referred to hospital-based palliative care programs today leave the hospital alive.

Palliative care complements life-prolonging therapies.

Ideally, palliative care is introduced early during the course of a serious illness.

Based on need, not prognosis.
Data show palliative care:

- Reduces distressing symptoms
- Improves quality of life
- Increases family satisfaction
- May prolong life

Family Experience of Early Palliative Care

- Survey of bereaved family members who received care at a VA medical facility (n=524)
- Overall satisfaction superior among those that received palliative care (P<0.001)
- Early consultations were associated with higher satisfaction (P=0.006)

Timing Matters

- Retrospective analysis of 366 cancer decedents
- Early (> 3 mo) vs late (< 3 mo) palliative care
- Early associated with
  - Fewer ER visits (39% vs 68%, p<0.001)
  - Fewer hospitalizations (48% vs 81%, P<0.003)
  - Fewer hospital deaths (17% vs 31%, P=0.004)

Hui D et al, Cancer, 2014
Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer


151 patients with metastatic lung cancer
Randomized to:

• Standard oncology care
• Standard oncology care plus early palliative care
Early Palliative Care Associated with Improved Quality of Life

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

* Plus–minus values are means ±SD. Quality of life was assessed with the use of three scales: the Functional Assessment of Cancer Therapy–Lung (FACT-L) scale, on which scores range from 0 to 136, with higher scores indicating better quality of life; the lung-cancer subscale (LCS) of the FACT-L scale, on which scores range from 0 to 28, with higher scores indicating fewer symptoms; and the Trial Outcome Index (TOI), which is the sum of the scores on the LCS and the physical well-being and functional well-being subscales of the FACT-L scale (scores range from 0 to 84, with higher scores indicating better quality of life).

† The P value was calculated with the use of two-sided Student’s t-tests for independent samples.
‡ The effect size was determined with the use of Cohen’s d statistic, which is a measure of the difference between two means (in this case, the mean in the group assigned to early palliative care group minus the mean in the group assigned to standard care) divided by a standard deviation for the pooled data. According to the conventional classification, an effect size of 0.20 is small, 0.50 moderate, and 0.80 large.
Early Palliative Care Associated with Improved Mood

Figure 2. Twelve-Week Outcomes of Assessments of Mood.
Median survival

Early palliative care: 11.6 mo
Standard care: 8.9 mo

Figure 3. Kaplan–Meier Estimates of Survival According to Study Group.
Palliative Care Programs in U.S. Hospitals with 50 or more beds, 2000-2016*

Source: CAPC.org
Delivery of Palliative Care

Hospital-Based
Consultation service
Dedicated Unit

Community-Based
Office
Home
Long-term care
Post-acute care
Telehealth
Community Based Palliative Care

- Sharp Healthcare Transitions, 2007-2014
- Propensity matched 368 Transitions patients with cancer, COPD, heart failure, dementia
- Transitions patients had
  - Less hospital use
  - Lower hospital costs
  - Less escalation of cost of care in final 6 months
  - Lower overall healthcare costs

Cassel JB et al, JAGS, 2016
Recent challenges/opportunities for palliative care

- Opioid epidemic
- COVID-19 pandemic
Opioid epidemic

• Universal precautions: Risk assessment and management strategies for patients on opioid therapy
  ✓ Informed consents
  ✓ Use agreements
  ✓ PDMP checks
  ✓ Urine drug screening
  ✓ Rational polypharmacy
  ✓ Pharmacy and Behavioral Health collaboration
  ✓ Naloxone prescribing
COVID-19 Pandemic

- PPE shortages
- Facilities restricting visitors
- Fear, uncertainty, loneliness, guilt
+ Spotlight on advance care planning
+ Rapid adoption of telehealth
Palliative Care

- Focuses on relieving pain and suffering and promoting best possible quality of life
- Can be considered for any serious illness
- Can be used at any time in the course of illness
- Is person-centered and family-inclusive
- Can be combined with curative treatments
- Some studies have shown a survival advantage
- Available to most hospitalized patients
- Available to few community patients
It’s not about prognosis.
It’s about need, it’s about relief
of suffering, and it’s everybody’s job.

-Diane Meier
Mahalo