The Next Era of Palliative Care

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Outline

• The need for palliative care
• Specialists ≠ solution
• Systems of care
• Measurement and accountability
• Policy change
The need for palliative care
To die in the hospital = “a catastrophe”
A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients

The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)

The SUPPORT Principal Investigators

**Objectives.**—To improve end-of-life decision making and reduce the frequency of a mechanically supported, painful, and prolonged process of dying.

**Design.**—A 2-year prospective observational study (phase I) with 4301 patients.
Growth of specialty palliative care

Prevalence of U.S. Hospital Palliative Care Teams: 2000–2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Hospitals (50+ Beds) with Palliative Care Teams</th>
</tr>
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<tbody>
<tr>
<td>2000</td>
<td>658</td>
</tr>
<tr>
<td>2003</td>
<td>1082</td>
</tr>
<tr>
<td>2006</td>
<td>1357</td>
</tr>
<tr>
<td>2009</td>
<td>1568</td>
</tr>
<tr>
<td>2012</td>
<td>1734</td>
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</table>
View: Palliative care brings comfort

Imagine a pill that allows seriously ill people to live longer, better lives, spend less time in the hospital. Imagine that it even makes it more likely to die at

Early initiation of palliative care for patients with advanced cancer may not only improve their survival, but also reduce

The Challenges of Palliative Care for Children

So much about treating seriously ill children is different from caring for adults

An Extra Layer of Care

The progress of palliative medicine
Specialty Training in Palliative Medicine

- 2008 - Hospice and Palliative Medicine Certification Exam
- 2012 - Board certification requires fellowship training in Hospice and Palliative Medicine
Evidence of palliative care benefit

- 38 RCTs
- Improvements in QOL, physical and psychological symptoms, caregiver burden, healthcare utilization, mortality
Temel Study - 2010

<table>
<thead>
<tr>
<th></th>
<th>Intervention</th>
<th>Control</th>
<th>Available cases analysis*</th>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean observed change from baseline (SD)</td>
<td>n</td>
</tr>
<tr>
<td>FACIT-Sp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 month</td>
<td>154</td>
<td>1·86 (11·99)</td>
<td>168</td>
</tr>
<tr>
<td>2 months</td>
<td>138</td>
<td>0·58 (13·09)</td>
<td>151</td>
</tr>
<tr>
<td>3 months</td>
<td>140</td>
<td>1·60 (14·46)</td>
<td>141</td>
</tr>
<tr>
<td>4 months</td>
<td>122</td>
<td>2·46 (15·47)</td>
<td>149</td>
</tr>
<tr>
<td>QUAL-E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 month</td>
<td>154</td>
<td>1·09 (6·79)</td>
<td>162</td>
</tr>
<tr>
<td>2 months</td>
<td>137</td>
<td>1·38 (7·49)</td>
<td>151</td>
</tr>
<tr>
<td>3 months</td>
<td>139</td>
<td>2·33 (8·27)</td>
<td>139</td>
</tr>
<tr>
<td>4 months</td>
<td>121</td>
<td>3·04 (8·33)</td>
<td>148</td>
</tr>
</tbody>
</table>

New Guidelines

“combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden.”

- ASCO Provisional Clinical Opinion, JCO, 2012
Why specialists ≠ solution
Trends in EOL Care

• 2000-to-2009  **Lower** proportion of Medicare beneficiaries dying in acute care hospitals; ICU use and health care transitions in last month of life increasing.

  -Teno et al. *JAMA* 2013

• 2000-to-2013  In a national survey, bereaved family members rate **lower** overall quality of EOL care.

  -Teno et al. *JPM* 2015
High symptom burdens

Aggressive, non-beneficial EOL care

Aggressive, non-beneficial EOL care

- 65% of Medicare patients with poor-prognosis cancers are hospitalized and 25% use the ICU in the last month of life
- High intensity EOL care has not shown to improve survival and is associated with worse QOL

Inadequate discussion of patient goals

• > 2/3 of hospitalized older adults face major treatment decisions

• Communication and documentation of patient preferences remains inadequate
  
  o 30% agreement between EOL preferences of elderly hospitalized patients at high risk of dying and documentation in the medical record

-Torke et al. *JAMA Intern Med* 2014
-Heyland et al. *JAMA Intern Med* 2013
Surrogate distress

Who needs palliative care?

• Approximately 3/4 of all deaths
  - Murtagh et al. *Palliative Medicine* 2014

• Hospital, outpatient, long-term care and community settings
Workforce shortages

- 2010 study - 6000-18,000 additional physicians needed to meet current U.S. demand in the inpatient setting alone

--Lupu et al. JPSM 2010
Variable access

• Hospital >> other settings
• Large hospitals > small hospitals
• Public and non-profit hospitals > for-profit hospitals
• New England > other regions of the United States

-CAPC, State-by-State Report Card on Access to Palliative Care 2015
I think you should know that oncologists are territorial and they tend to view this [indicating clinic area] as their complete domain and that they’re responsible for the care of their patient from day one to last day. And they tend not to be very . . . receptive to [having] other physicians interfere with their care.

Some people, even for end-of-life discussions, some people will send patients to palliative care. I don’t. I feel like I shouldn’t dump that on somebody else. If I’ve been following that person, it’s my obligation to have that discussion.

-Schenker et al. *JOP* 2014
-LeBlanc et al. *JOP* 2015
Patient Barriers

- Practical concerns (travel, co-pays, time in “sick role”)
- Equate palliative care with death/dying
- Unlikely to request services unless recommended by oncologist

-Maciasz et al. Supp Care Cancer 2013
-Schenker et al. JPM 2014
Palliative Care = Good Medical Care
Systems of care
Systems Approach

• Focus on a problem, identify related and modifiable processes, develop new protocols
• Reducing hospital-acquired infections, increasing use of immunizations, improving patient safety

- Stone et al. *Annals* 2002; Shortell et al. *JAMA* 2008;
  Bernacki et al. *BMJ Open* 2015
The CONNECT Study

Care Management by Oncology Nurses To Address Palliative Care Needs: A Pilot Trial To Assess Feasibility, Acceptability, and Perceived Effectiveness of the CONNECT Intervention

Yael Schenker, MD, MAS,1,2 Douglas White, MD, MAS,3 Margaret Rosenzweig, PhD, CRNP-C, AOCN,2,4 Edward Chu, MD,5 Charity Moore, PhD,1 Peter Ellis, MD,6 Peggy Nikolajski, CRNP, MSN, AOCNP,6 Colleen Ford, RN, OCN,6 Greer Tiver, MPH,1 Lauren McCarthy,1 and Robert Arnold, MD1
Measurement and Accountability
Measurement and Accountability

- Measuring outcomes that matter to patients and families
- Providing feedback to individual clinicians
### GIM Quality Improvement Criteria FY '16

<table>
<thead>
<tr>
<th></th>
<th>Dr. Schenker</th>
<th>GIM Actual Rates*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18 Month End Sept' 15</td>
<td>18 Month End Dec' 15</td>
</tr>
<tr>
<td>DM: HbA1c checked past 12 months</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>DM: HbA1c &lt; 8.0</td>
<td>0.80</td>
<td>0.70</td>
</tr>
<tr>
<td>DM: HbA1c &lt; 9.0</td>
<td>0.80</td>
<td>0.83</td>
</tr>
<tr>
<td>DM: DM Pts &gt;=40/On Statin</td>
<td>1.00</td>
<td>0.81</td>
</tr>
<tr>
<td>DM: DM Pts w/ HTN on ACE/ARB</td>
<td>1.00</td>
<td>0.89</td>
</tr>
<tr>
<td>DM: Nephropathy check past 12 mo</td>
<td>1.00</td>
<td>0.94</td>
</tr>
<tr>
<td>DM: Eye Exam done past 12 months</td>
<td>0.80</td>
<td>0.75</td>
</tr>
<tr>
<td>DM: Foot Exam done past 12 months</td>
<td>1.00</td>
<td>0.80</td>
</tr>
<tr>
<td>DM: DM Pts w BP &lt; 140/90, 18-75 yo</td>
<td>0.80</td>
<td>0.74</td>
</tr>
<tr>
<td>Diabetes Score</td>
<td>0.91</td>
<td>0.00</td>
</tr>
<tr>
<td>1°P: Flu Shot past 12 mo if &gt; 65 yo</td>
<td>(0.56)</td>
<td>0.56</td>
</tr>
<tr>
<td>1°P: Pneumococcal Vaccine anytime if 65-79 yo</td>
<td>0.92</td>
<td>0.61</td>
</tr>
<tr>
<td>1°P: Mammogram past 2 yr if 50-74 yo</td>
<td>0.77</td>
<td>0.92</td>
</tr>
<tr>
<td>1°P: Pap Smear 21-64 yo, q 3 or 5 yr as per recs</td>
<td>0.89</td>
<td>0.79</td>
</tr>
<tr>
<td>1°P: Cholesterol past 5 yr if 50-79 yo</td>
<td>0.94</td>
<td>0.83</td>
</tr>
<tr>
<td>1°P: Colo-rectal Ca screen if 50-75 yo as per recs</td>
<td>0.52</td>
<td>0.97</td>
</tr>
<tr>
<td>Primary Prevention Score</td>
<td>0.77</td>
<td>0.00</td>
</tr>
<tr>
<td>2°P: CAD Pts on Statins</td>
<td>1.00</td>
<td>0.92</td>
</tr>
<tr>
<td>2°P: Pts w AFib w CHADS 2+ on Anti-coag</td>
<td>0.77</td>
<td>0.78</td>
</tr>
<tr>
<td>2°P: HTN Pts w BP &lt; 140/90,18-75 yo</td>
<td>0.84</td>
<td>0.71</td>
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<tr>
<td>2°P: All Pts w BP &lt; 140/90,18-75 yo</td>
<td>0.94</td>
<td>0.85</td>
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<tr>
<td>2°P: All Pts Non-Smokers</td>
<td>0.90</td>
<td>0.89</td>
</tr>
<tr>
<td>Secondary Prevention Score</td>
<td>0.92</td>
<td>0.00</td>
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<tr>
<td>Overall Score</td>
<td>0.87</td>
<td>0.00</td>
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<tr>
<td>FYI: Flu Shot past 12 mo if 50-64yo</td>
<td>0.51</td>
<td>0.48</td>
</tr>
</tbody>
</table>
Quality Measures Relevant to Palliative Care

- Pain control
- Documentation of advance directives
- Chemotherapy in last 2 weeks of life (lower = better)
- Hospice use

-ASCO Quality Oncology Practice Initiative Measures, 2013
Policy Change

Nixon Signs $1.6 Billion Cancer Bill, Names Man to Head Fight

WASHINGTON (UPI)—President Nixon today signed into law a $1.6 billion program to find a cure for cancer. This law is a milestone in the long and difficult effort to end the cancer scourge.
Total health-service and social-services expenditures for Organization for Economic Co-operation and Development (OECD) countries, 2005.
Ratio of social to health service expenditures for Organization for Economic Co-operation and Development (OECD) countries, 2005.
Serious illness care takes place at home
Key Points

- Palliative care needs >> palliative care specialists
- Palliative care = good medical care
- Need for:
  - Clinician behavior change, system change, quality improvement
  - Programs that measure and improve quality of palliative care for every patient
  - Funding aligned with goal of improving the experience of seriously ill patients and families
The Future
NEXT EXIT