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Impact of concurrent palliative care in the lung cancer patient

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Impact of concurrent Palliative Care in lung cancer

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Objectives

• “Upstream” or early Palliative care in Lung CA
• Models of delivery
• “Downstream” impacts: business case for early Palliative Care
Early Palliative Care for Patients with Metastatic NSCLC  

*N Engl J Med* 2010; 363:733-742

- 2010, Jennifer Temel et al. published a seminal paper in NEJM on early referral (within 8 wks. of diag) to subspecialty PC at MGH in patients newly diagnosed with advanced non-small-cell lung cancer

- Objective: Does early PC for ambulatory NSCLC pts. improve QoL and other factors (symptoms, mood, health care utilization)?

- Methods: 151 patients RCT simultaneous standard cancer care with palliative care co-management from diagnosis (monthly visits) vs. control of standard cancer care only
Early Palliative Care for Patients with Metastatic NSCLC  
*N Engl J Med* 2010; 363:733-742

- Results at 30 months: 70% of subjects had died
- Improved QOL (FACT-L 98 vs. 91.5, *p*<0.03)
- Reduced depression (HADS 16% vs. 38%, *p*<0.01; PHQ-9 4% vs. 17%, *p*<0.04)
- 53% of subjects in PC arm had documented resuscitation preferences compared to 28% in the usual care arm.
- Reduced ‘aggressiveness’ of care (33% vs. 54%, *p*<0.05) (chemo < 14d before death, no hospice care, or hospice < 3 d before death)
- Fewer hospitalizations and ED visits amongst PC group
- Trend towards greater use of hospice in the PC group (69% vs 60%)
- Median survival in the PC group was 11.6 months from enrollment vs. 8.9 months in the usual care group (*p*<0.02)
“Early outpatient palliative care in addition to usual oncology care for metastatic non-small cell lung cancer improves physical symptoms, depression, sense of well-being, and not only doesn’t shorten life, but it may also prolong life.”
Explaining palliative care to oncology patients

• PC is a specialized area of medicine which provides an added layer to the care of patients with cancer
• Help with symptom management, address psychosocial and spiritual needs, improve quality of life
• Can be provided at any stage and along with curative treatments
• “Pilot” and “co-pilot” analogy
Who will benefit? Conceptual models for integrating palliative care at cancer centers

## Criteria for palliative care referral

<table>
<thead>
<tr>
<th>Delphi criteria</th>
<th>Modified Delphi criteria</th>
<th>Basic criteria</th>
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</thead>
<tbody>
<tr>
<td>• Severe physical symptoms</td>
<td>• Severe physical symptoms</td>
<td>• “surprise question”: If provider would not be surprised if patient were to die within a year</td>
</tr>
<tr>
<td>• Severe emotional symptoms</td>
<td>• Severe emotional symptoms</td>
<td>• Poor functional or performance status</td>
</tr>
<tr>
<td>• Patient request for hastened death</td>
<td>• Spinal cord compression</td>
<td>• Severe emotional or physical symptoms</td>
</tr>
<tr>
<td>• Spiritual or existential crisis</td>
<td>• Brain or leptomeningeal mets</td>
<td></td>
</tr>
<tr>
<td>• Assistance with decision making or advanced care planning</td>
<td>• within 3 months of diagnosis of CA with projected survival of 12 mo or less</td>
<td></td>
</tr>
<tr>
<td>• Spinal cord compression</td>
<td>• Progression after second line therapy</td>
<td></td>
</tr>
<tr>
<td>• Brain or leptomeningeal mets</td>
<td></td>
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<tr>
<td>• Delirium</td>
<td></td>
<td></td>
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<tr>
<td>• At patient request for referral within 3 months of diagnosis of CA with projected survival of 12 mo or less</td>
<td></td>
<td></td>
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<tr>
<td>• Progression after second line therapy</td>
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</table>
Models of care delivery in PC
Case presentation

• 65 yr. old M with metastatic non small cell lung cancer in the setting of advanced COPD for which he is dependent on home O2.

• He was diagnosed in 2/2019 when he was getting a CT scan for chronic MAC infection.

• He was referred to Palliative care 07/2020 for pain management related to his cancer.

• He lived alone, he has completed XRT, has had problems tolerating systemic chemo, pneumonitis related to immunotherapy, and this is on hold, did not have a health care directive.

• He was followed by Palliative care until he passed in 01/2022
Integrated Care Model

• Patients first undergo universal systematic assessments for physical (disease related and chemo related), psychological, and spiritual concerns (MDASI), and communication and decision-making needs by an interprofessional team.

• Comprehensive management plan is developed: patient education, family support, and various pharmacologic and nonpharmacologic interventions tailored to the individual's needs.

• Specialized needs are addressed (e.g., pulmonary medicine for thoracentesis, pain service for nerve blocks, endocrinology for diabetic management).

• Comorbidities also are addressed.
Whole patient care

• Integrative and complementary therapies
• Counseling and support
• Educational resources
• Lifestyle change support: nutrition counseling, exercise and physical activity consultations and tobacco cessation
• Ensures high standard of supportive care addressing complex symptom concerns, minimizes duplication of services by appropriately triaging, and optimizes personalized patient care interventions.
Making the business case for Palliative Care

Palliative care reduces avoidable spending and utilization in all settings:

- **48%** readmissions
- **50%** admissions
- **43%** hospital/ED transfers
- **36%** total costs

Source: Center to Advance Palliative Care

**Settings:**
- Inpatient
- Outpatient
- Skilled Nursing
- Home-Based

Comparison of health care utilization and care quality for 297 patients with cancer who died having received early versus late palliative care.

<table>
<thead>
<tr>
<th>Early palliative care (&gt; 90 days before death)</th>
<th>Late palliative care (&lt; 90 days before death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations</td>
<td></td>
</tr>
<tr>
<td>33%</td>
<td>66% (p &lt; 0.01)</td>
</tr>
<tr>
<td>ICU stay</td>
<td></td>
</tr>
<tr>
<td>5%</td>
<td>20% (p &lt; 0.01)</td>
</tr>
<tr>
<td>ED use last month of life</td>
<td></td>
</tr>
<tr>
<td>34%</td>
<td>54% (p = 0.04)</td>
</tr>
<tr>
<td>Direct costs of inpatient care last 6 mo of life</td>
<td></td>
</tr>
<tr>
<td>$19,067</td>
<td>$25,754 (p &lt; 0.01)</td>
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<tr>
<td>Direct costs of outpatient care</td>
<td></td>
</tr>
<tr>
<td>$13,040</td>
<td>$11,549 (p = 0.85)</td>
</tr>
<tr>
<td>Venue of care</td>
<td></td>
</tr>
<tr>
<td>outpatient 84%</td>
<td>82% inpatient</td>
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</table>
Effect of early palliative care on health care costs in patients with metastatic NSCLC 2012 ASCO Annual Meeting

• 151 patients with newly diagnosed met. NSCLC followed for 18 mos.
• 133 (88.1%) participants had died.
• Early PC group had mean cost savings of $2,282 per patient in total health care expenditures during the final month of life.
• Lower costs for inpatient visits (mean saving per patient=$3,110) and chemotherapy administration (mean saving per patient=$640).
• Outpatient clinic expenses were similar between groups.
• Costs for hospice services were greater for the early palliative care group because of the longer lengths of stay in hospice care (mean cost per patient=$1,125).
Upstream Palliative care for lung cancer...