Complex Illness Support
Alongside Standard Oncology
Care for Patients with Incurable Cancer

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Objectives

- Discuss Complex Illness Support
- Review rationale for early Palliative Care
- Summarize Outpatient Experience
- Determine lessons learned

Trajectories of Function and Well-Being over Time in Eventually Fatal Chronic Illnesses

Disease Trajectory

Outpatient Consultation Service
Justification: most patients spend most of their time outside of hospitals

- Opportunity
  - Improved quality patient care
  - Potentially decreased acute care stays and mortality
  - Increased efficiency in health care systems and accountable care organizations

Background
Early, Integrated Palliative Care in Patients with Metastatic Lung Cancer

150 patients with newly diagnosed metastatic NSCLC

- Early palliative care integrated with standard oncology care
- Standard oncology care

Palliative Care Model

- Palliative care provided by physicians and nurse practitioners
- Visits occurred in the Cancer Center (medical oncology, radiation oncology or chemotherapy visits).
- Oncology and palliative care visits were done in tandem or simultaneously.
- Visits were not scripted or prescribed.
- If patients were admitted to the hospital, they were followed by the palliative care team

Temel et al., N.Engl. 2010, 363
Results

Newly diagnosed metastatic NSCLC patients enrolled between 2006-2009

- Reported better QOL and less depression
- Chose less aggressive care at EOL
- “Survival prolonged by 2 months” (11.6 versus 8.9 months)
- “Clinically meaningful improvements in quality of life and mood”

Temel et al., NEJM (2010), 363.

Literature Review: Early Palliative Care

- Incorporation of palliative care ALONGSIDE standard oncological care for NSCLC patients
  - Longer Median survival
  - Increased Quality of life
  - Improved accuracy of illness perception
  - Less aggressive treatments at end of life
  - Fewer depressive symptoms

Project Summary:

October 31, 2016 through March 16, 2017

13 referring physicians:
1 PCP and 12 Oncologists

Referral Guidelines

- Incurable cancer
- Significant symptom burden related to cancer or treatment
- Poor performance status (PPS 50 or less)
- Psychosocial situation interfering with receipt of treatment
- Multiple admissions / ER visits
- Help with complex decision making / advance care planning / goals
- Conflicting goals between patient and family
- Existential distress may benefit from support
- Patient or family request support and consultation
- Seen by inpatient palliative care and needing follow up
- Concerns about caregivers / support systems
- Assistance with complex illness management
- Discussion and referral for hospice care

How Should we Design Interventions to Improve The Delivery of Cancer Care?

1. Focus on patients in the ambulatory care setting
2. Allow patients to have cancer care and Palliative Care
3. Provide early and continued relief from physical and psychological symptoms
4. Enhance communication between patients and clinicians AND patients and their families to improve decision-making
5. Provide the most appropriate care at end of life
**ACCESS**

Embedded Clinic Model

- Collaborative relationship between a host clinic and palliative care staff
- All costs of the clinic operations are born by the host clinic
- Patients referred predominately from the host clinic
- Defined clinical pathways or protocols may exist defining patient flow between the host and palliative care staff

**Complex Illness Support**

- Realistic patient and family-centered care goals:
  - Re-evaluate throughout the duration of illness
  - Empower patients and families about healthcare choices
  - Facilitate referrals to appropriate community programs
  - Encourage Advanced care planning
- Expert symptom and comfort management:
  - Whether pursuing aggressive life prolonging care or comfort measures only
  - Independent of prognosis
- Focus on patients with progressive life limiting illness with prognosis of one year or less

**Actual Referral Diagnosis**

- Metastatic Breast
- Metastatic Pancreatic
- Stage I NSCLC (Poor PS)
- Metastatic pleural Mesothelioma
- Metastatic pelvic adenocarcinoma, unknown primary
- Myelodysplastic syndrome
- Synchronous Stage Lung cancer and metastatic melanoma
- Metastatic lung cancer
- Stage Ib Lung cancer, new epiglottic mass probably cancer
- Stage IIIA lung cancer; difficult surgery decision
- Stage IV endometrial cancer
- Stage IIIB cervical cancer
- Dementia, prostate cancer
- Acute Myelogenous Leukemia, history of Breast and Colon Cancer

**Number of patients seen: 18**

- Number of patient visits: 22 (13 new and 9 follow up)
  - Race: 16 Caucasian / 2 Hispanic
  - Gender: 2 Male / 16 Female
  - Average age: 71.7 years old
- Treatment status:
  - Receiving cancer treatment: 14
  - Stopped or refused treatment: 3
  - Had not yet started treatment: 1
- Enrolled to hospice: 10
  - One remained alive
  - One patient refused hospice, expired
- Mortality: 10 of 18 expired: 56%

**Interventions Provided by Complex Illness Support**
Emergency department use and disposition: 2 patients
- Weakness and pain – discharged home
- Cough, hallucinations, vomiting: was on hospice, returned to hospice

Hospitalizations and length of stay: 8 patients
- Cholecystectomy – outpatient surgery: 1 day
- Syncope – observation patient: 3 days
- Pulmonary Emboli: 3 days
- Fatigue, nausea: 9 days
- New atrial fibrillation, Cardizem drip: 3 days
- Malignant pleural effusion, tapped: 10 days
- Weakness: 11 days; discharged to Skilled nursing facility
- Anemia, dyspnea: 10 days; discharged to home hospice
- Sepsis: 13 days; discharged to hospice house

ICU use: 1 patient
- Sepsis, intubated. Patient had been seen inpatient and outpatient prior, very resistant to discussions on code status, advance directives, and goals of care.

Average Number of Days from last chemo: 43.6 days
Average Number of Days from last chemo or Radiation: 47.16 days
Average Hospice days: 20.2 days
- One patient refused hospice = no hospice days

Patient satisfaction with Complex Illness Support
- All surveyed strongly agreed:
  - The CIS team was respectful and professional
  - I was able to talk about my goals and preferences for future care
  - The team helped me to feel more comfortable (Emotionally and with symptom management)
  - The CIS team helped to coordinate my care
  - I am satisfied with the CIS team

Comparison to benchmarks

<table>
<thead>
<tr>
<th></th>
<th>CIS</th>
<th>Literature</th>
</tr>
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<tbody>
<tr>
<td>Chemo last 14 days</td>
<td>6%</td>
<td>5.6-20%</td>
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<tr>
<td>Chemo last 30 days</td>
<td>12%</td>
<td>9 - 50%</td>
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<tr>
<td>ED visit</td>
<td>11%</td>
<td>4.57 -47.8%</td>
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<tr>
<td>Hospitalization</td>
<td>44%</td>
<td>4 - 92%</td>
</tr>
<tr>
<td>ICU use</td>
<td>6%</td>
<td>5.86-15.4%</td>
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<tr>
<td>Hospice admission</td>
<td>94%</td>
<td>47- 59.9%</td>
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<tr>
<td>Hospice days</td>
<td>20.2</td>
<td>4 -19.7</td>
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<tr>
<td>Acute care death</td>
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<td>28.6%</td>
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</tbody>
</table>

Treatment at end-of-life

- Average Number of Days from last chemo: 43.6 days
- Average Number of Days from last chemo or Radiation: 47.16 days
- Average Hospice days: 20.2 days
- One patient refused hospice = no hospice days
Reflections

- ‘No show’ patients are reflective of misperceptions about palliative care, how complexly ill patients are, and late referrals.

- Patients and providers are accepting of and asking for outpatient Complex Illness Support.

- In this five month project, 56% of patients referred to Complex Illness support died. This affirms the rationale and need for early supportive care intervention.

- Expanding services would enhance patient care and satisfaction, as well as provide benefit to patients, families, and the healthcare system.

References:


