Specialty Programs in Palliative Care: Heart Failure and Oncology

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The Coleman Palliative Medicine TRAINING PROGRAM

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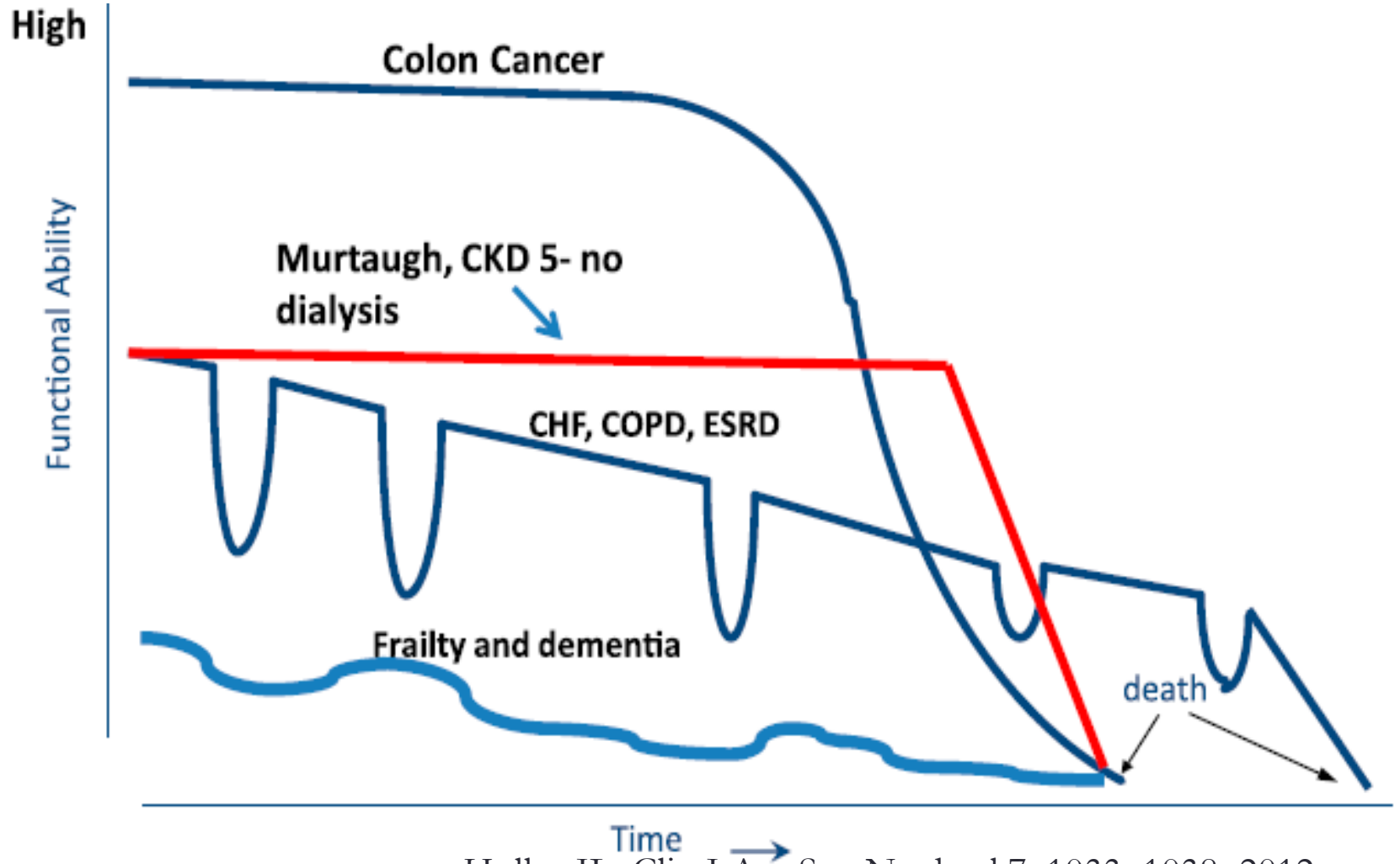
- This presenter has no conflict of interest to disclose.

Lecture objectives

- Discuss approaches for integrating outpatient palliative care in oncology and cardiology
- Identify fundamental similarities and differences in the outpatient palliative care encounter between oncology and cardiology

Illness Trajectories



Holley JL. Clin J Am Soc Nephrol 7: 1033–1038, 2012.

The Symptom Burden of Serious Illness

	Cancer	Other Illnesses
Pain	84%	67%
Trouble breathing	47%	49%
Nausea and vomiting	51%	27%
Sleeplessness	51%	36%
Confusion	33%	38%
Depression	38%	36%
Loss of appetite	71%	38%
Constipation	47%	32%
Bedsores	28%	14%
Incontinence	37%	33%

Seale and Cartwright, 1994

Comparison of Symptoms Between Terminal Illnesses

Symptom	Cancer	AIDS	Heart Disease	COPD
Pain	35-96%	63-80%	41-77%	34-77%
Depression	3-77%	10-82%	9-36%	37-71%
Fatigue	32-90%	54-85%	69-82%	68-80%
Dyspnea	10-70%	11-62%	60-88%	90-95%
Anorexia	30-92%	57%	21-41%	35-67%

Solano et al., J Pain Symptom Management, 2006, 31(1): 58

Clinic Models

Embedded	Co-located	Stand-alone
• Within existing clinic • Focused patient population • Cost supported by host clinic	• Shared space • Independence to determine patients population • Shared cost with host clinic	• Unique clinic • Independence to determine patient population • Full responsibility for costs

Palliative Care in Oncology

Reasons for Delayed Palliative Care in Cancer Care

- Prognostic uncertainty
- Curative potential of anticancer therapies
- Difficulty predicting which patients will need subspecialty palliative care
- Need to respect patient and family coping mechanisms
- Patient, family and clinician fear of engaging in sensitive end-of-life conversations
    - Gomes B, JCO 2015

IOM Report:
Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis

Goal #1: The cancer care team should provide patients with understandable information on:

Cancer prognosis

Treatment benefits and harms

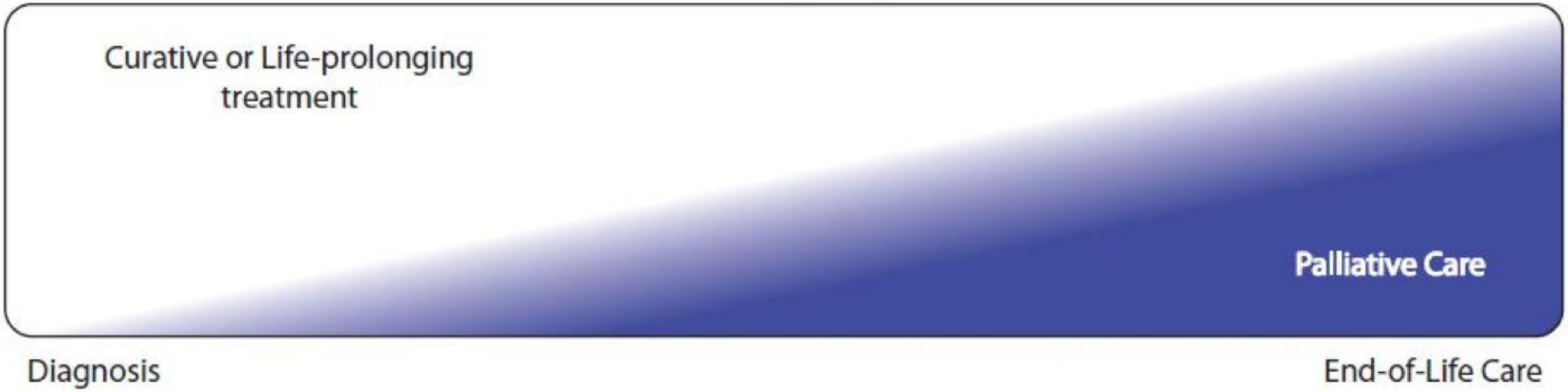
Palliative care

Psychosocial support

Estimates of total out of pocket costs

IOM

- Incorporate palliative care throughout the cancer care continuum



ASCO Provisional Clinical Opinion: The integration of Palliative Care into Standard Oncology Care- Issued March 2012

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

National Comprehensive Cancer Network

- Institutions should develop processes for integrating palliative care into cancer care
- All cancer patients should be screened for palliative care needs at their initial visit, at appropriate intervals and as clinically indicated
- Patients and families should be informed that palliative care is an integral part of their cancer care

The Palliative Care Clinic Visit

- Meeting outside time of crisis
- Explain the role of palliative care
- Comprehensive assessment
  - physical, psychological, emotional, spiritual
- Symptom management
- Clarify understanding of goals of treatment and prognosis
- Advance care planning
- Assistance in transitioning from cancer directed to supportive and comfort focused treatments, including referral to hospice when appropriate

Palliative Care

- Early Palliative Care for Patients with Metastatic Non-small Cell Lung Cancer
  - Improved Quality of Life
  - Improved Mood
  - Less Aggressive Care at the End of Life
  - Longer Survival

    - Temel, J, NEJM 2011

Palliative Care

- Effects of Early Palliative Care on Chemotherapy Use and End-of-Life Care in Patients with Metastatic NSCLC
  - No difference in number of chemotherapy regimens
  - Early PC, 50% less likely to have chemotherapy within 60 days of death
  - Early PC, More likely to enroll in hospice > 1 week
    - Greer JCO 2012

Palliative Care

- Early Versus Delayed Initiation of Concurrent Palliative Oncology Care: Patient Outcomes in the ENABLE III RCT
  - No difference in patient reported outcomes for QOL, symptom impact, mood and resource use
  - Improved 1 year survival

    - Bakitas M JCO 2015

Palliative Care in Heart Failure

Congestive Heart Failure (CHF)

- Most simply, it is the inability of the heart to meet the metabolic and physiological demands of the body
- Clinical syndrome that results from a structural or functional cardiac disorder that impedes the ability of the ventricle to fill with or eject blood
- In most patients, HF results as a sequelae of coronary artery disease, myocardial infarction, valvular disease, or longstanding hypertension
- As CHF progresses, causes a cascade of effects impacting every organ system manifesting as the typical physical symptoms

CHF - Epidemiology

- After the age of 40, the estimated risk of developing heart failure is about 1 in 5. This risk is doubled in the setting of uncontrolled hypertension
- After age 65, the incidence of heart failure approaches 1 in 1,000
- Approximately 500,000 new diagnosed cases per year
- Approximately 5 million Americans with the diagnosis of CHF (circa 2010, present numbers higher)
- In 2010, direct and indirect costs of heart failure were estimated at nearly $40 billion and rising.
- Leading cause of hospital admissions and readmissions (within 30 days) in people older than 65

Comparison of Incidence and Deaths Due to Heart Failure to Other Common Causes of Death in the United States

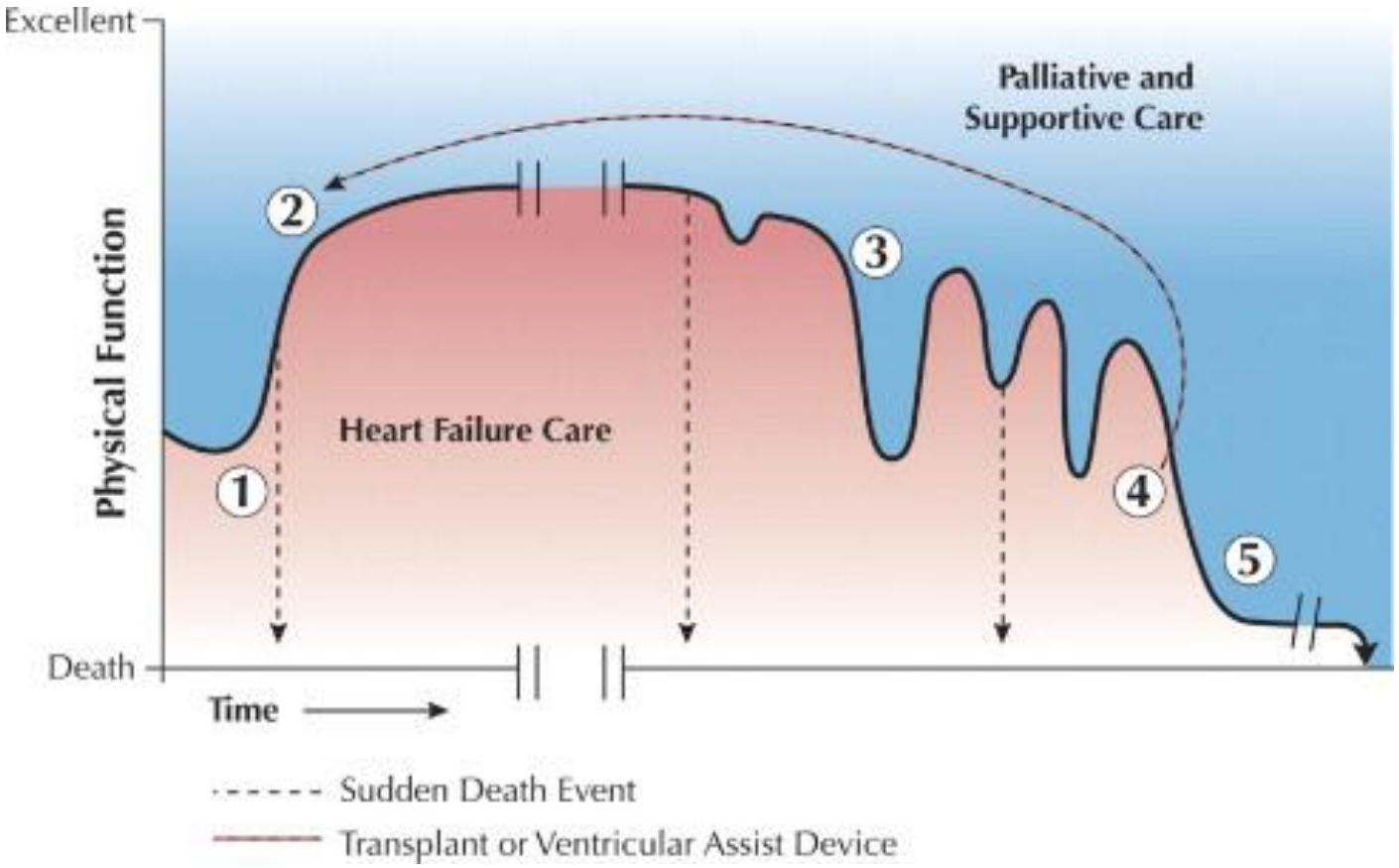
Cause of Death	Incidence	Deaths
Heart Failure	~500,000	284,365
Lung cancer	196,252	158,006
Breast cancer	188,587	41,316
Prostate cancer	189,075	29,002
HIV/AIDS	37,726	16,395

Adler ED et al., Circulation 2009; 120:2597

ACC/AHA & NYHA comparison

Medscape® www.medscape.com

NYHA	ACC/AHA	
	A	Patient is at high risk of developing CHF
1	B	Patient is asymptomatic but has developed structural heart disease
2-3	C	Patient has symptoms with mild to moderate activities and has structural heart disease
4	D	Patient has symptoms at rest and has advanced structural heart disease



1 – Initial symptoms of HF develop and treatment initiated
2 – Plateau of variable length on medical management (or following mechanical support/transplant)
3 – Functional status declines with variable slope; intermittent exacerbations
4 – Stage D HF with refractory symptoms
5 – End of life

Integration of Palliative Care in Cardiology

- Unlike oncology, there are few guidelines regarding the integration of palliative care in cardiac patients
- Some reason include :
  - Relative novelty of palliative care in the cardiology arena, including physician familiarity and comfort with palliative care
  - Difficulty in prognosticating the disease course, even in advanced heart failure
  - Palliative care physician availability

Integration of Palliative Care in Cardiology

- Suggested situations to introduce palliative care into the patient encounter include :
  - Initiation of home inotropes
  - High symptom burden
  - Lack of further advanced medical treatment options
  - Left Ventricular Assist Device placement (now mandated)

Integration of patient, family, and clinician data regarding end-of-life care

Selman et al. Heart 2007, 93:963

Patients' and carers' experiences

1. High rate of psychological morbidity reported among patients
2. Carers experience anxiety, dread and guilt
3. Lack of communication regarding end-of-life issues between patients, carers and staff

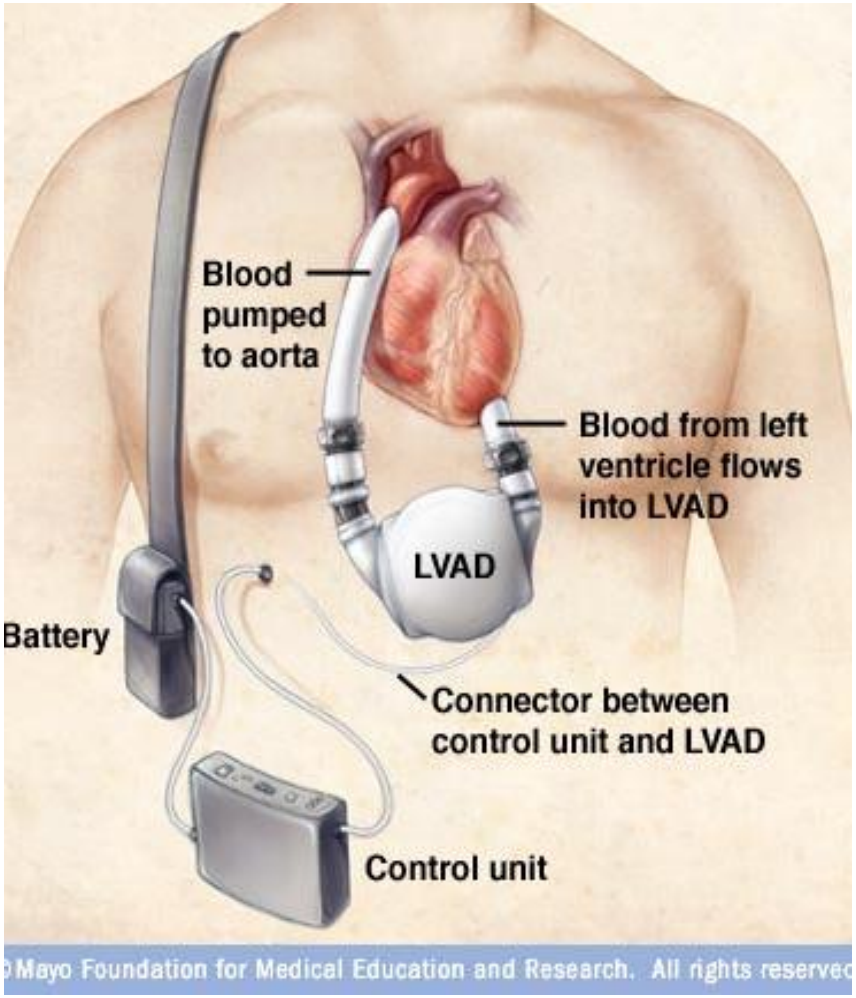
End-of-life preferences

1. Wide range across patient and carer groups
2. Mobility and age main deciding factors for patients; pain, quality of life and cognitive ability for carers
3. No discussion of preferences with staff

Barriers to improving end-of-life care

1. Disease-specific
   - Unpredictable disease trajectory
   - Public perception of CHF as benign in comparison with cancer
2. Staff-specific
   - Cardiac staff need training in palliative care, including communication skills
   - Palliative care staff would benefit from training in CHF symptom management

Left Ventricular Assist Device (LVAD)



- LVADs were originally designed as bridge therapies for heart failure patients awaiting transplants
- Recently approved for use as a “destination therapy” for those ineligible for a transplant
- Improves quality of life for some number of years post implantation. Current data shows good survival for 5+ years in best case scenarios

LVADs and Palliative Care

- CMS recently issued guidelines recommending the addition of a palliative care specialist to the inter-disciplinary team evaluating candidates for LVAD placement
- As of October, 2014, the Joint Commission (JCAHO) has mandated that institutions which perform VAD implantations must have a “palliative care representative on the core interdisciplinary team”
- No consensus yet on the proper timing regarding palliative care involvement nor content of the meeting, however general topics for discussion include:
  - Advance directives, HCPOA
  - Symptom inventory
  - Psychosocial assessment (often done by social worker), evaluation of other types of support (e.g. coping skills, family support)
  - General goals of care
  - Eventual discussion of end-of-life scenarios, including feelings about device deactivation

Pre-implantation: Preparedness Planning

- Several challenges/area for further development were identified in this study:
  - Patient/caregiver misunderstanding on the role of palliative care in the pre-implantation context
  - Inability to consult on all emergent implantations (e.g. INTERMACS 1 patients)
  - Uncertainty regarding the ideal timing to bring up more complex issues such as “worst case scenarios” and LVAD deactivation
- Reports from other centers reveal a wide difference in the acceptance of palliative care by the LVAD team

Peri- and post-implantation period

- Assist with symptom control, including complex post-operative pain
- Continue to assess psychosocial support system
- Continue to build rapport with the patient / caregivers
- As the QOL benefit of the LVAD diminishes, support the patient/caregivers and continue to address evolving goals of care

Summary

- As palliative care evolves and gains greater support as standard of care in life-limiting illnesses, new challenges are arising to identify the best time to involve palliative care as well as how to best deliver that care
- The outpatient encounter is an ideal setting to address symptom burden as well begin to develop rapport for later conversations which include goals for end of life care

THANK YOU!