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OUTCOMES  
RESEARCH

# Integrating Palliative and Oncology Care in Patients with Advanced Cancer

Jennifer Temel, MD

Massachusetts General Hospital Cancer Center

Director, Cancer Outcomes Research



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# Overview

1. Why should we be thinking of novel care models for patients with advanced cancer and their families?
2. Why is integrated palliative and oncology care an appealing model?
3. What is the data supporting integrated care?
4. What other care models should we be considering?

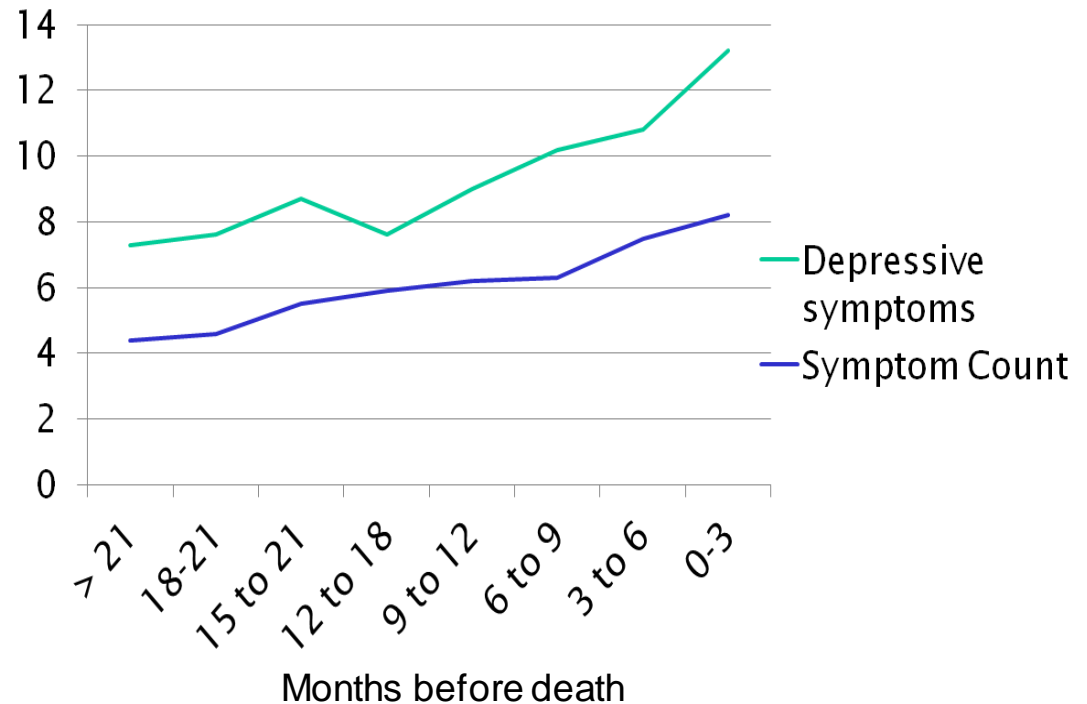


# Why should we be thinking about early palliative care in the first place?

1. Patients are suffering
2. Patients' families are suffering
3. Oncology care is becoming much more complex.
  - Genotype directed therapy.
  - Greater prognostic uncertainty.



# Patients with Advanced Cancer Experience Substantial Physical and Psychological Symptoms



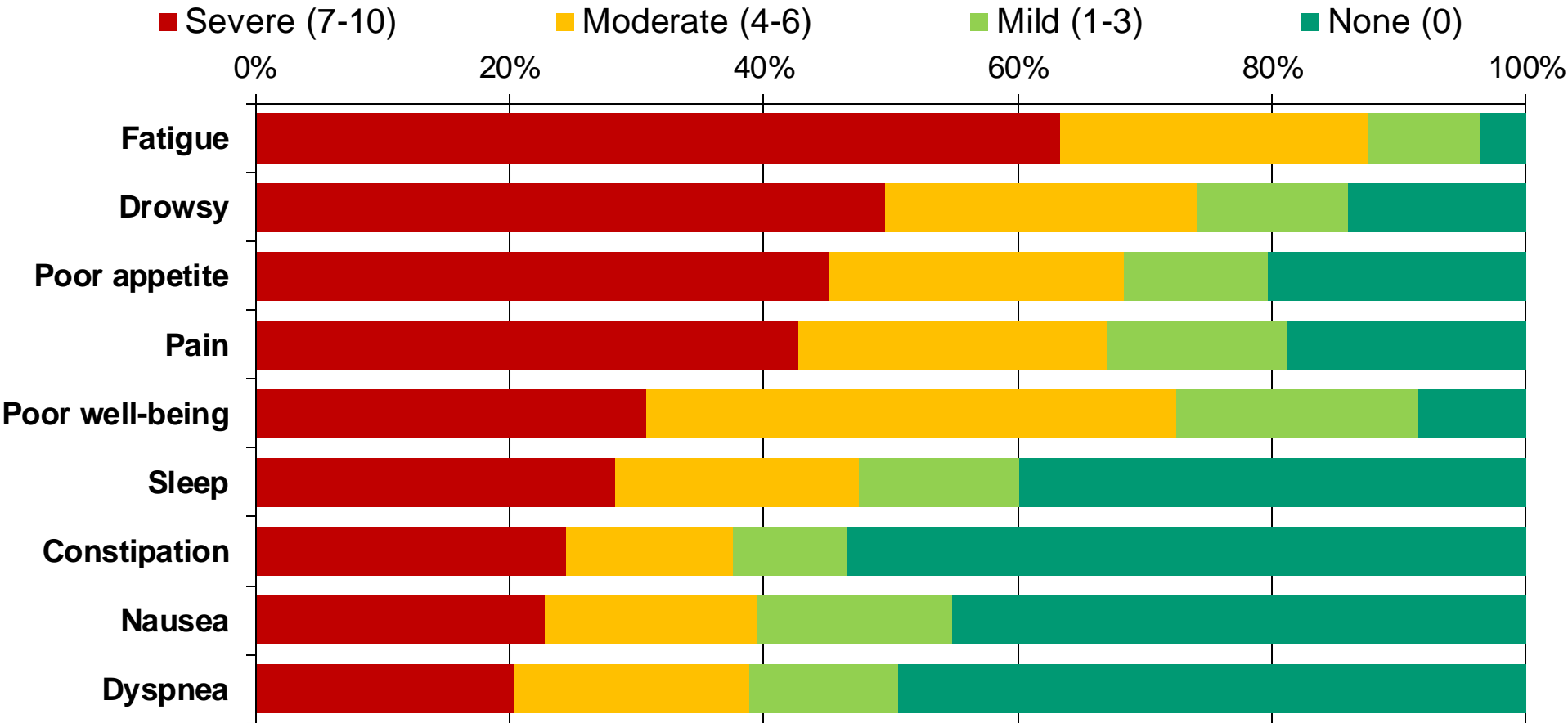
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# Symptom Burden in Hospitalized Patients



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# Burden for Family Caregivers

- The majority of caregivers of patients with cancer reported some depressive symptoms with 1/3 having high depression scores

**Table 4.** Predictors of Caregiver Depression by Multiple Logistic Regression Analysis

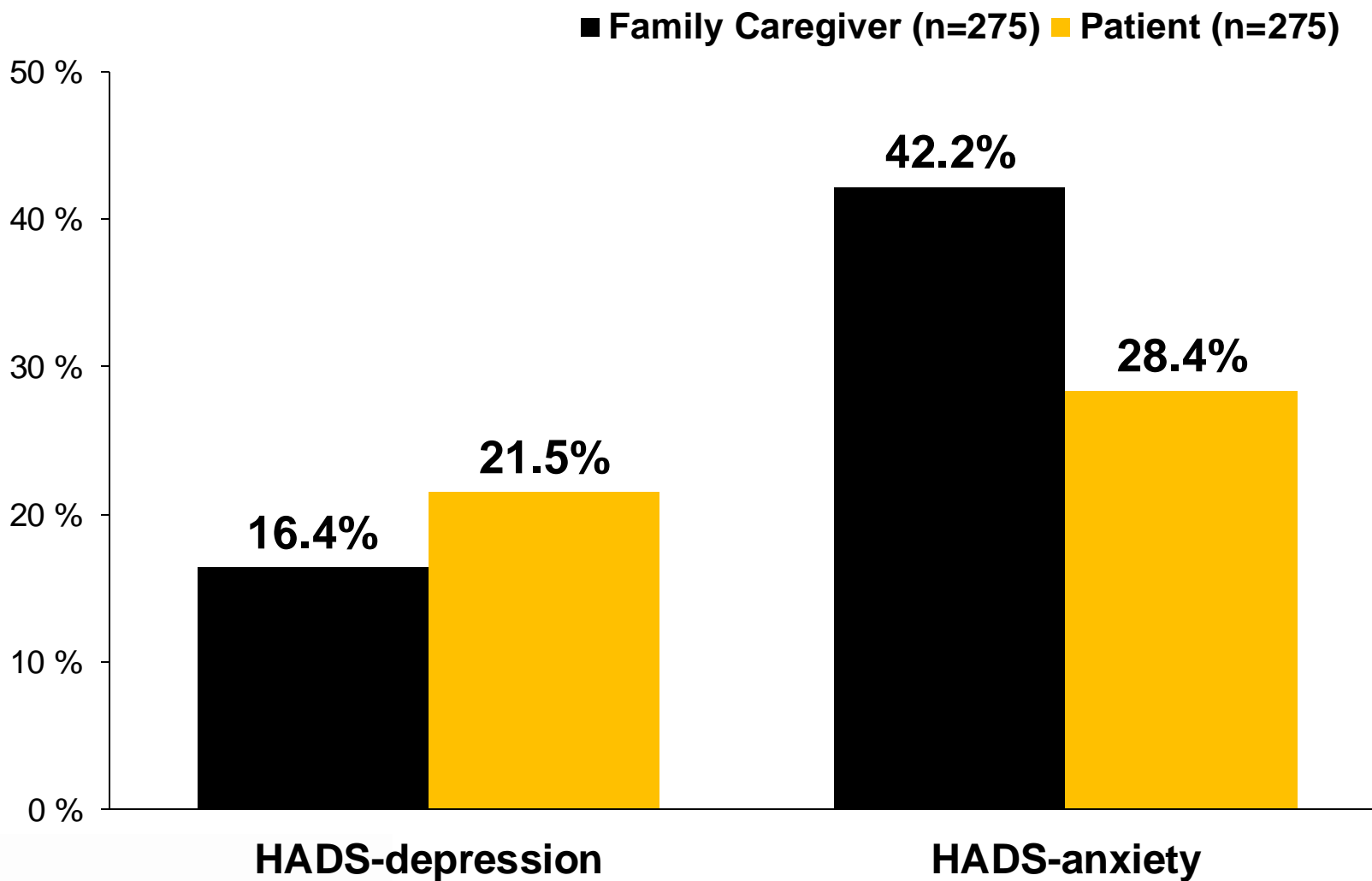
Predictive Variable	Analysis		
	OR	95% CI	P*
<b>Patient characteristic</b>			
ECOG PS 3 or 4	2.00	0.98 to 4.11	.058
<b>Family impact</b>			
Loss of ability to function normally	2.67	1.17 to 6.10	.019
<b>Caregiver characteristic</b>			
Sex, female	2.28	1.24 to 4.17	.008
Relationship with patient, spouse v other	1.90	1.05 to 3.46	.035
Overall health status, good	0.33	0.18 to 0.60	< .001
<b>CQOLC</b>			
Burden	6.06	3.33 to 11.03	< .001
Positive adaptation, bad	2.09	1.15 to 3.82	.016

Abbreviations: ECOG PS, Eastern Cooperative Oncology Group performance status; CQOLC, Caregiver's Quality of Life Index-Cancer.

\*Wald test, multiple logistic regression model.



# Distress in Family Caregivers



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# New Challenges in Cancer Care

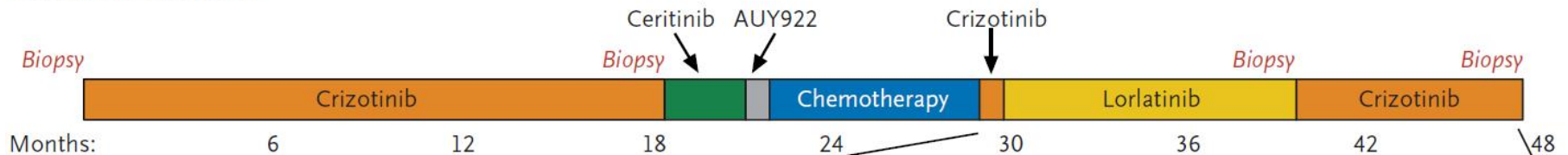
- It is more complicated and time consuming to care for patients with cancer with “personalized medicine”.
- Care has simply become more complex as there is not a “standard chemotherapy regimen”.
- Assessing patients for genotype-directed treatment and immunotherapy and managing patients on complex clinic trials requires significant time.





# Complexity of Cancer Care

## Timeline of Treatment



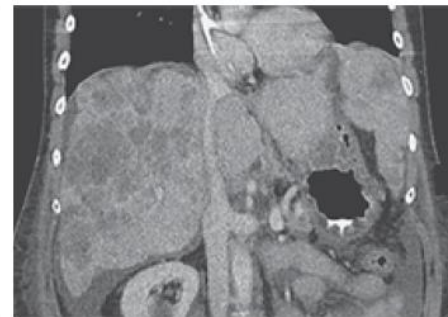
## Effect of Therapy



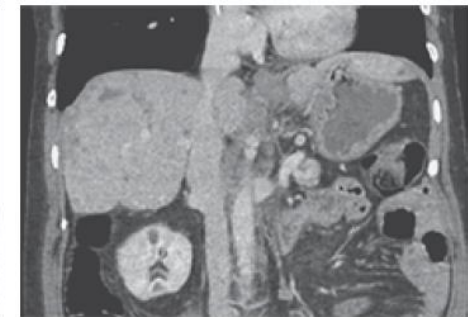
Before Lorlatinib



Response to Lorlatinib



Resistance to Lorlatinib



Response to Crizotinib



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# Complexity of Cancer Care

- Cancer therapies are becoming more effective and less toxic.
- Newer FDA approved therapies, such as immunotherapy, can be effective even in patients with poor functional and performance status.
  - Unclear if the “no chemotherapy for PS3 rule” is relevant with these newer therapies



# Importance of Patient-Clinician Communication

- While cancer therapies are improving and patients are living longer – the majority of patients with advanced cancer still have incurable disease.
- Despite the increasing complexity of cancer care and greater uncertainty about the benefits of treatment and prognosis, we still need to communicate with our patients about their prognosis and end-of-life care preferences.



# The Importance of Communication in Cancer Care

**Table 3.** Medical Care Received in the Last Week of Life by End-of-Life Discussion

	No. (%)			Adjusted OR (95% Confidence Interval) <sup>a</sup>	P Value
	Total (N=332)	End-of-Life Discussion			
		Yes	No		
Medical care received in the last week	332	123 (37.0)	209 (63.0)		
ICU admission	31 (9.3)	5 (4.1)	26 (12.4)	0.35 (0.14-0.90)	.02
Ventilator use	25 (7.5)	2 (1.6)	23 (11.0)	0.26 (0.08-0.83)	.02
Resuscitation	15 (4.5)	1 (0.8)	14 (6.7)	0.16 (0.03-0.80)	.02
Chemotherapy	19 (5.7)	5 (4.1)	14 (6.7)	0.36 (0.13-1.03)	.08
Feeding tube	26 (7.9)	11 (8.9)	15 (7.3)	1.30 (0.55-3.10)	.52
Outpatient hospice used	213 (64.4)	93 (76.2)	120 (57.4)	1.50 (0.91-2.48)	.10
Outpatient hospice $\geq$ 1 wk	173 (52.3)	80 (65.6)	93 (44.5)	1.65 (1.04-2.63)	.03



# The Importance of Communication

	No. (%)			Adjusted OR (95% Confidence Interval) <sup>a</sup>	P Value
	Total Sample (N = 332)	End-of-Life Discussion			
		Yes (n = 123)	No (n = 209)		
Mental disorders					
Major depressive disorder <sup>b</sup>	22 (6.7)	10 (8.3)	12 (5.8)	1.33 (0.54-3.32)	.53
Major depressive disorder-Endicott <sup>c</sup>	20 (6.1)	7 (5.8)	13 (6.3)	0.73 (0.26-2.06)	.56
Generalized anxiety disorder <sup>b</sup>	7 (2.1)	4 (3.3)	3 (1.4)	2.50 (0.51-12.1)	.26
Panic disorder <sup>b</sup>	10 (3.1)	2 (1.7)	8 (3.9)	0.55 (0.16-1.90)	.34
Posttraumatic stress disorder <sup>b</sup>	9 (2.7)	4 (3.3)	5 (2.4)	0.95 (0.24-3.75)	.94
Any mental disorder <sup>b</sup>	33 (10.2)	11 (9.2)	22 (10.7)	0.73 (0.35-1.55)	.41
McGill psychological subscale, adjusted least square means (SE) <sup>d</sup>					
Depressed	7.4 (2.9)	7.3 (0.2)	7.4 (0.2)		.79
Nervous or worried	6.9 (3.2)	6.5 (0.3)	7.0 (0.3)		.19
Sad	7.2 (3.0)	7.3 (0.2)	7.2 (0.2)		.79
Terrified	7.2 (3.1)	7.1 (0.3)	7.2 (0.3)		.68
Any psychological distress	5.4 (0.1)	5.3 (0.2)	5.4 (0.2)		.55
Acceptance, preferences, and planning					
Accepts illness is terminal	125 (37.7)	65 (52.9)	60 (28.7)	2.19 (1.40-3.43)	<.001
Wants to know life expectancy	242 (72.9)	103 (83.7)	139 (66.5)	2.40 (1.43-4.04)	<.001
Values comfort over life-extension	245 (73.8)	105 (85.4)	140 (70.0)	2.63 (1.54-4.49)	<.001
Against death in ICU	118 (35.5)	60 (48.8)	58 (27.8)	2.13 (1.35-3.37)	<.001
Completed DNR order	134 (41.1)	75 (63.0)	59 (28.5)	3.12 (1.98-4.90)	<.001
Completed living will, durable power of attorney, or health care proxy	181 (55.2)	86 (71.7)	95 (46.1)	1.96 (1.25-3.07)	.003



# Patients' Prognostic Understanding Impacts Their Decision-Making

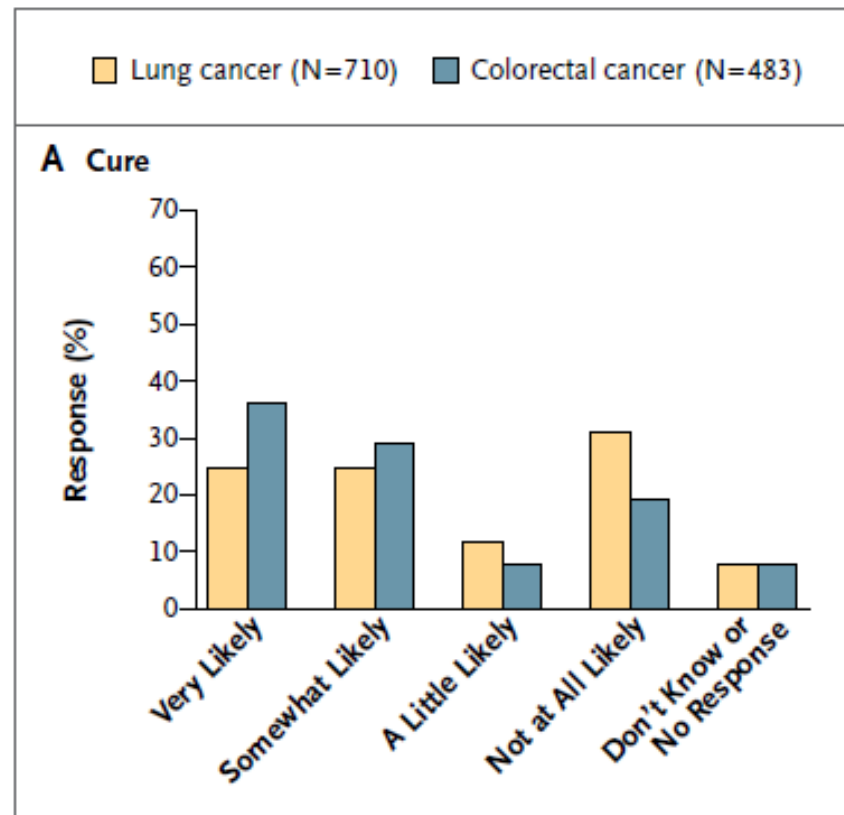
**Table 2.—Patient Treatment Preferences and Survival by Their 6-Month Survival Estimates (n = 917)**

<b>Patient Estimate of Chances for 6-mo Survival, %</b>	<b>No. of Patients (% of Total)</b>	<b>Proportion of Patients Favoring Life-extending Therapy* (% of Row)</b>	<b>No. of Patients Alive at 6 mo (% of Row)</b>
≥90	543 (59)	198/390 (51)	314/543 (58)
≈75	238 (26)	37/128 (29)	74/238 (31)
≈50	96 (11)	16/56 (29)	20/96 (21)
≈25	18 (2)	4/13 (31)	6/18 (33)
≤10	22 (2)	4/19 (21)	3/22 (14)

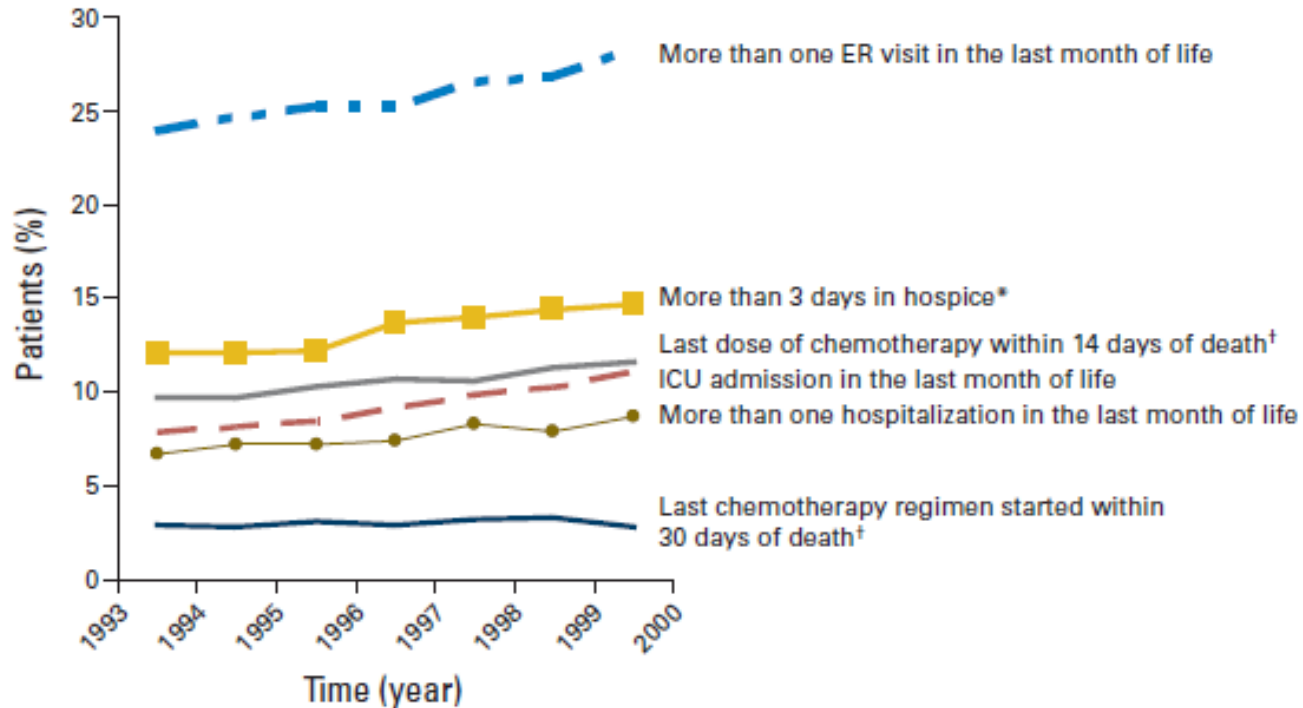
\*Preference for life-extending therapy data were missing from 311 patients.



# Many Patients Hold Inaccurate Perceptions About Their Illness and Prognosis



# Intensive or “Aggressive” Care Near the EOL



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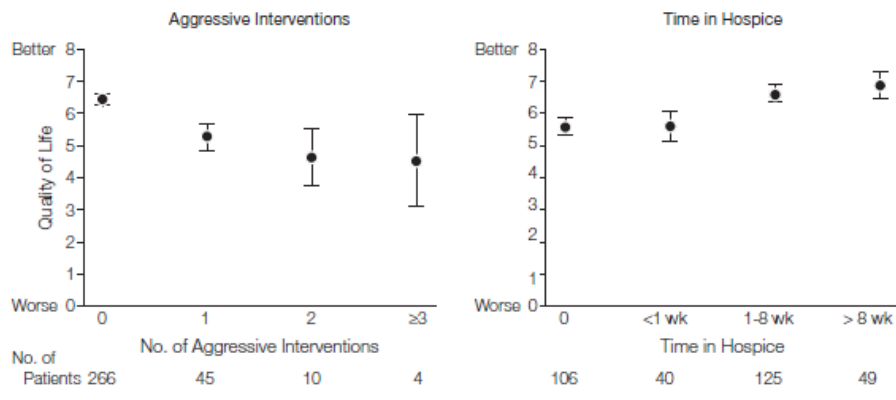
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# Aggressive Care Near the EOL Has Negative Consequences for Patient and their Family

## Patient QOL

**Figure.** Relationship Between Quality of Life and End-of-Life Care



## Caregiver Outcomes

Caregiver Bereavement Outcomes	Aggressive Medical Care	
	Standardized $\beta$ Coefficient <sup>a</sup>	P Value
Health-related quality of life <sup>b</sup>		
Overall	-0.15 <sup>c,d</sup>	.004
Self-reported health	-0.12 <sup>c</sup>	.04
Physical function	-0.10 <sup>c,g</sup>	.05
Mental health	-0.11 <sup>c,i</sup>	.06
Role limitation	0.17 <sup>c,k</sup>	.008
Change in health adjusted OR, (95% CI)	0.57 (0.29 to 1.11) <sup>c</sup>	.10
Grief reaction		
Felt prepared for death	-0.30 <sup>c,l</sup>	<.001
Regret	0.17	0.01
Mental disorders <sup>m</sup>		
Any mental disorder adjusted OR (95% CI)	2.25 (0.81 to 6.23) <sup>c,n</sup>	.12
Major depressive disorder adjusted OR (95% CI)	3.37 (1.12 to 10.13) <sup>c,n</sup>	.03



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# What are the necessary elements of comprehensive cancer care?

1. Focus on management of patients' physical and psychological distress.
2. Include the family as recipients of care.
3. Engage patients in discussions about the illness, prognosis and (eventually) their end-of-life care preferences.

**While providing the best possible cancer-directed therapies.**



# What is Palliative Care?

- Multidisciplinary approach to symptom management, psychosocial support, and assistance with treatment decision-making for patients with serious illness and their families.
- Emphasizes the well-being of patients and families at any point along their disease trajectory, regardless of their illness state.



# What is Palliative Care?

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# Moving Palliative Care Upstream

- The role of palliative care in the hospital or home setting for patients near the end of life has been well established.
- However, transitioning the timing and focus of palliative care toward patients receiving cancer therapy in the ambulatory care setting is a newer phenomenon.
- We now have several randomized controlled trials demonstrating that early palliative care integrated with cancer care is feasible and beneficial for patients with advanced cancers.



# Randomized Trials of Early Palliative Care in Oncology

1. Project ENABLE II (JAMA 2009)
2. Lung Cancer Trial (NEJM 2010)
3. Zimmermann Study (Lancet 2014)
4. Project ENABLE III (JCO 2015)



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# Project ENABLE

322 patients within 8-12 weeks of a new diagnosis of GI, lung, GU or breast cancer with a prognosis of approximately one year

ENABLE intervention

Usual Care

## Outcome Measures

### Patient-reported Outcomes

1. QOL
2. Symptoms
3. Depression

### Health Service Utilization

1. Use of advanced directives
2. Referral to palliative care or hospice
3. Number of days in hospital, intensive care unit and emergency department



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Bakitas JAMA 302(7) 2009

# Nature of the Intervention in ENABLE

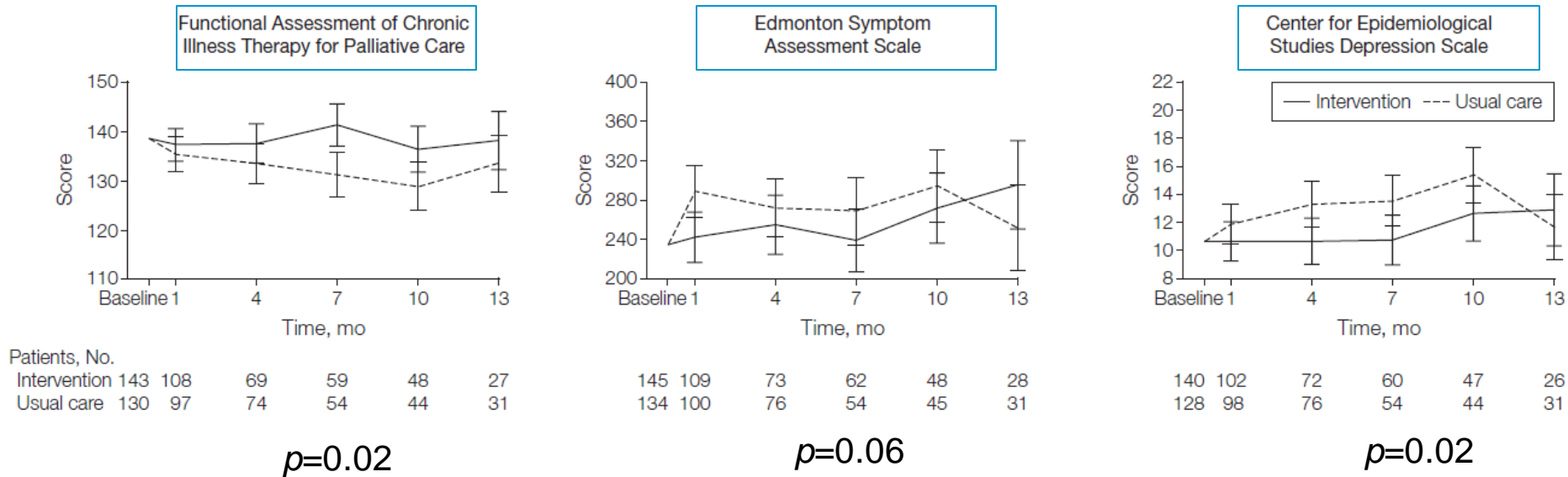
- Manualized psycho-educational intervention with 4 structured educational and problem-solving sessions and at least monthly telephone follow up.
  - Problem solving
  - Advance care planning
  - Communication strategies
  - Symptom management
  - Timely referral to palliative care and hospice resources.
- Delivered in a telephone-based format (to administer to a rural population) by advanced practice nurses with palliative care training.





# Project ENABLE II

**Figure 2.** Quality of Life, Symptom Intensity, and Mood Scores for All Patients



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Bakitas JAMA 302(7) 2009

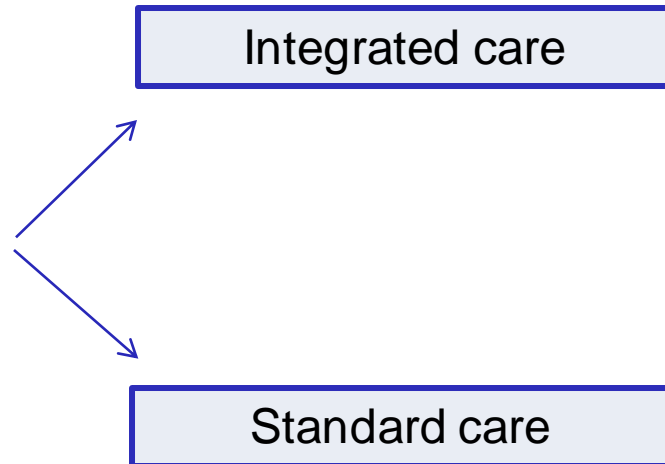
# Project ENABLE II

	Full Study Cohort			Deceased Cohort		
	Intervention n=161	Usual Care n=161		Intervention n=145	Usual Care n=134	
Type of advance directive <sup>e</sup>						
Living will	69 (42.9)	76 (47.2)	.50	63 (43.4)	66 (49.2)	.34
Durable power of attorney for health care	68 (42.2)	78 (48.4)	.31	62 (42.8)	67 (50.0)	.23
Do not resuscitate order	13 (8.1)	10 (6.2)	.67	11 (7.6)	7 (5.2)	.47
Referral to hospice <sup>e</sup>	6 (3.7)	4 (2.5)	.75	4 (2.8)	2 (1.5)	.68
Referral to palliative care <sup>e</sup>	42 (26.1)	51 (31.7)	.32	34 (23.4)	39 (29.1)	.34
Resource use in prior 3 mo, mean (median) [maximum] <sup>f</sup>						
Hospital days <sup>e</sup>	2.8 (0) [25]	3.1 (0) [25]	.06	2.6 (0) [25]	2.8 (0) [24]	.60
Intensive care unit days <sup>e</sup>	0.02 (0) [2]	0.04 (0) [2]	.41	0.03 (0) [2]	0.05 (0) [2]	.36
Emergency department visits <sup>e</sup>	0.27 (0) [3]	0.41 (0) [5]	.37	0.28 (0) [3]	0.38 (0) [4]	.62



# Randomized Trial in Patients with Lung Cancer

150 patients  
within 8 weeks of  
diagnosis of  
metastatic  
NSCLC with an  
ECOG PS 0-2



## Outcome Measures

### Patient-reported Outcomes

1. QOL
2. Mood
3. Depression
4. Prognostic awareness

### Health Service Utilization

1. Documentation of resuscitation preferences
2. Hospice utilization
3. Chemotherapy administration



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Temel NEJM 363(8) 2010

# Nature of the Intervention

- Palliative care visits within 3 weeks of enrollment and at least monthly.
- Visits performed by physicians or advanced practice nurses within the Cancer Center (medical oncology or chemotherapy visits).
- If patients were admitted to the hospital, they were also followed by the palliative care team.

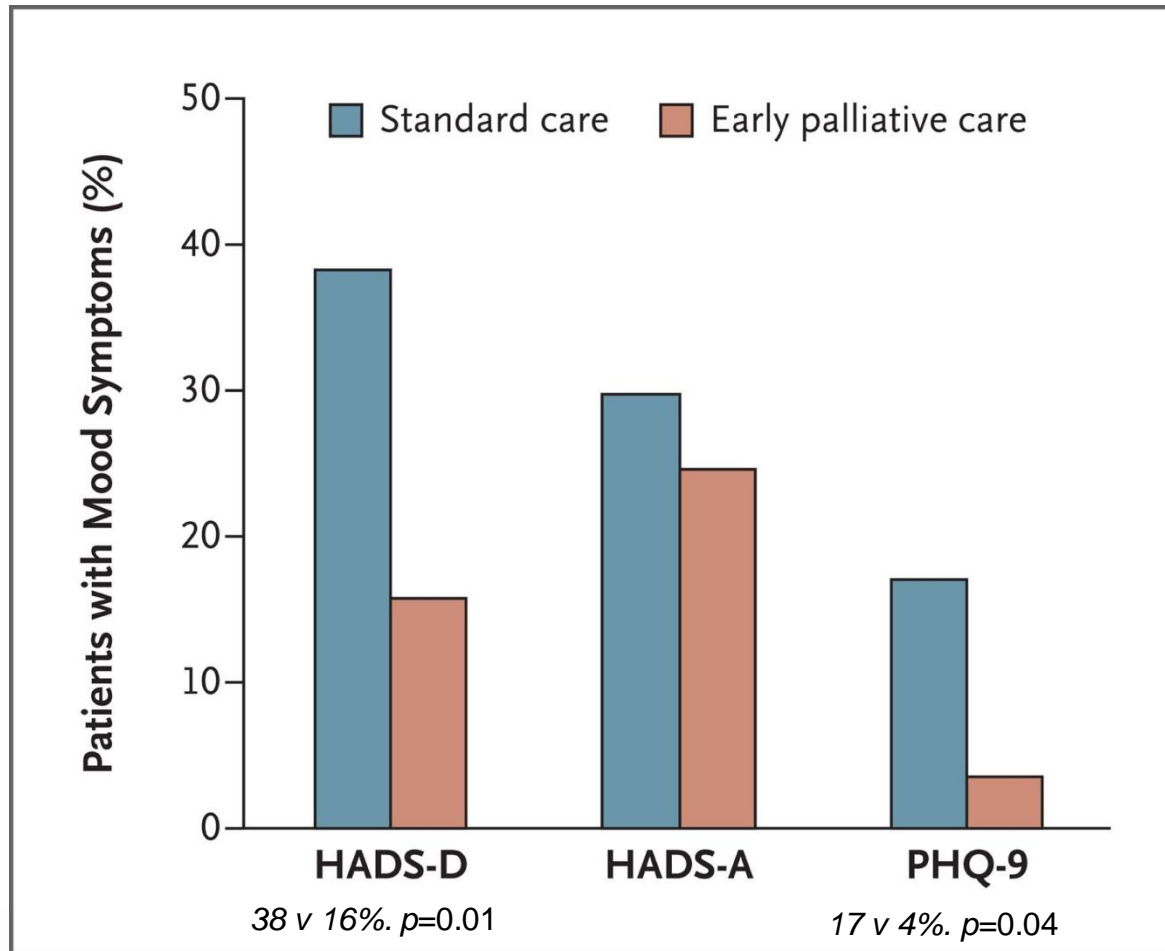


# Impact of Palliative Care on QOL

**Table 2.** Bivariate Analyses of Quality-of-Life Outcomes at 12 Weeks.\*

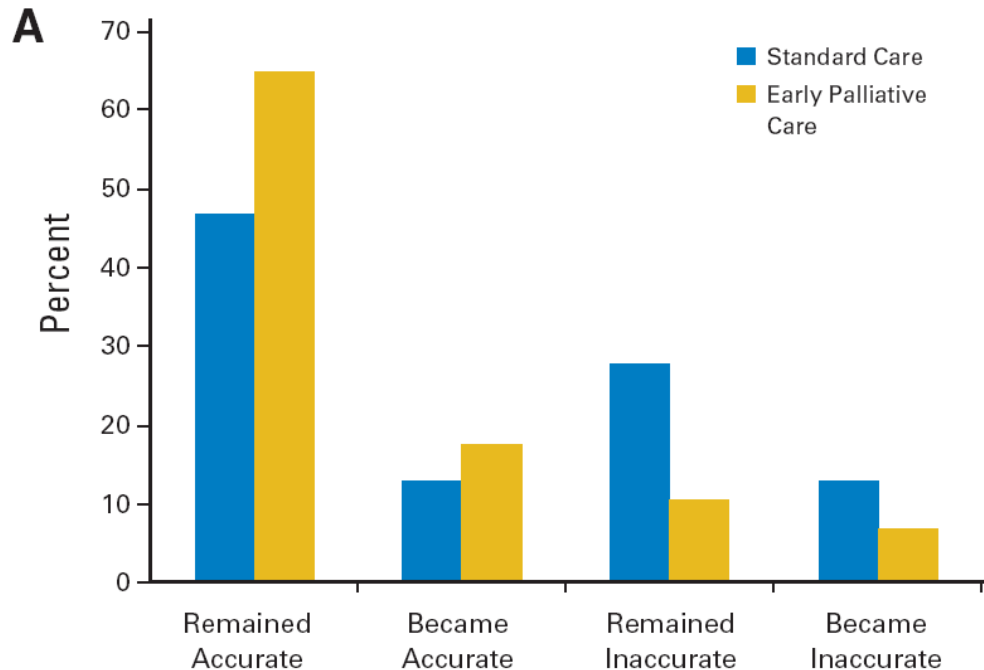
Variable	Standard Care (N=47)	Early Palliative Care (N=60)	Difference between Early Care and Standard Care (95% CI)	P Value†	Effect Size‡
FACT-L score	91.5±15.8	98.0±15.1	6.5 (0.5–12.4)	0.03	0.42
LCS score	19.3±4.2	21.0±3.9	1.7 (0.1–3.2)	0.04	0.41
TOI score	53.0±11.5	59.0±11.6	6.0 (1.5–10.4)	0.009	0.52

# Impact of Palliative Care on Mood



# Improvement in Prognostic Awareness

My cancer is curable: Yes or No



Palliative care v Standard care  
82.5% v 59.6%,  $p=0.02$



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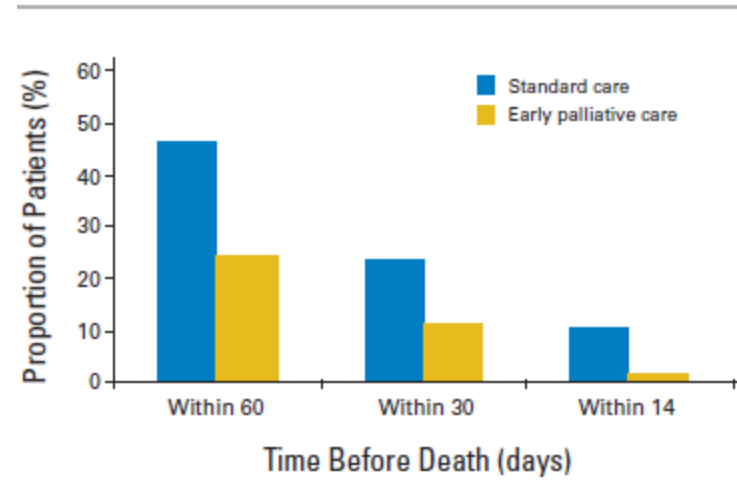
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# Health Service Utilization

Variable11	Standard Care N (%) or Median	Early Palliative Care N (%) or Median	P- Value
Documented Code Status	11 (28)	18 (53)	0.05
Hospice Care			
Received hospice care	44/67 (66)	44/62 (71)	0.57
Length of Stay > 7 days	21/63 (33)	36/60 (60)	0.004
Median days	9.5 (1-268)	24 (2-116)	0.02



IV chemo within 60 DOD  
46% v 24% p=0.01



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# Canadian Study

461 patients with stage IV cancer (including hormone refractory breast and prostate) or stage III with poor prognosis and ECOG PS 0-2 with a clinical prognosis of 6-24 months

Early Palliative Care Intervention

Usual Care

Outcome Measures

Patient-reported Outcomes

1. QOL
2. Symptoms
3. Quality of Life at EOL
4. Satisfaction



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# Nature of the Intervention

- Consultation (within one month) and at least monthly follow up in the oncology palliative care clinic by a physician and nurse.
- Routine telephone contact from nurse one week after consult and as needed.
- If patients were admitted to the hospital, they were admitted to palliative care unit.



# Impact of Early Palliative Care on Patient Outcomes

Zimmermann Lancet 383(9930) 2014

	Intervention		Control		Available cases analysis*			
	n	Mean observed change from baseline (SD)	n	Mean observed change from baseline (SD)	Adjusted difference between change scores (95% CI)	p value	Effect size†	ICC
<b>FACIT-Sp</b>								
1 month	154	1.86 (11.99)	168	-1.34 (10.12)	..	..	..	..
2 months	138	0.58 (13.09)	151	-2.71 (12.92)	..	..	..	..
3 months	140	1.60 (14.46)	141	-2.00 (13.56)	3.56 (-0.27 to 7.40)	0.07	0.26	0.035
4 months	122	2.46 (15.47)	149	-3.95 (14.21)	6.44 (2.13 to 10.76)	0.006	0.44	0.024
<b>QUAL-E</b>								
1 month	154	1.09 (6.79)	162	-1.19 (7.22)	..	..	..	..
2 months	137	1.38 (7.49)	151	-0.61 (8.13)	..	..	..	..
3 months	139	2.33 (8.27)	139	0.06 (8.29)	2.25 (0.01 to 4.49)	0.05	0.28	0.036
4 months	121	3.04 (8.33)	148	-0.51 (7.62)	3.51 (1.33 to 5.68)	0.003	0.45	0.015
<b>ESAS</b>								
1 month	180	-0.72 (13.01)	172	1.13 (10.79)	..	..	..	..
2 months	158	0.89 (14.83)	160	1.45 (14.08)	..	..	..	..
3 months	151	0.14 (16.93)	149	2.12 (13.88)	-1.70 (-5.26 to 1.87)	0.33	-0.13	0.067
4 months	131	-1.34 (15.98)	155	3.23 (13.93)	-4.41 (-8.76 to -0.06)	0.05	-0.31	0.034
<b>FAMCARE-P16</b>								
1 month	160	1.77 (8.14)	169	-2.64 (7.96)	..	..	..	..
2 months	140	1.95 (9.12)	157	-2.26 (7.36)	..	..	..	..
3 months	142	2.33 (9.10)	145	-1.75 (8.21)	3.79 (1.74 to 5.85)	0.0003	0.47	<-0.0001
4 months	121	3.70 (8.58)	153	-2.42 (8.33)	6.00 (3.94 to 8.05)	<0.0001	0.73	-0.018

# Palliative Care Service/Hospice Utilization

	Intervention group (n=228)	Control group (n=233)
Palliative care clinic visits		
None	0	213 (91.4%)
1	23 (10.1%)	9 (3.9%)
2	30 (13.2%)	5 (2.1%)
3	28 (12.3%)	3 (1.3%)
4	68 (29.8%)	0
≥5	79 (34.6%)	3 (1.3%)
Palliative care unit admissions*	17 (7.5%)	0
Inpatient palliative care consultations*	18 (7.9%)	2 (0.9%)
Palliative home nursing referrals*	39 (17.1%)	7 (3.0%)
Home palliative care physician referrals*	18 (7.9%)	7 (3.0%)

Data are n (%). \*Numbers for admissions, consultations, and referrals are not exclusive (ie, one patient might have a consultation and a palliative care unit admission).

**Table 3: Palliative care intensity for intervention and control groups**



# What about family caregivers?

- Collecting data from family caregivers within the context of a clinical trial is challenging.
- Recent data from ENABLE III suggested a benefit to family caregivers with early versus delayed palliative care with improvements in QOL and depression.



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# What do these three studies tell us?

- Early palliative care improves patients' QOL, mood and other aspects of care including prognostic awareness, satisfaction and quality of EOL care.
- Many palliative care delivery models work, including telephone based interventions.
- A more “intensive” palliative care model may be needed to impact EOL care measures, such as discussions about EOL care preferences and hospice utilization.



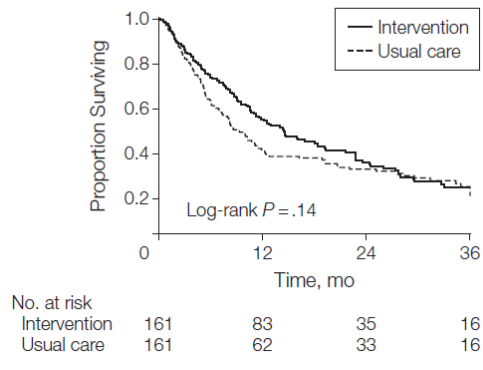
# Unanswered Questions

1. What about survival with early palliative care?
2. Can we disseminate early palliative care models?
3. How should we design palliative care interventions for other populations, including those being treated for cure?
4. What role can primary palliative care play?

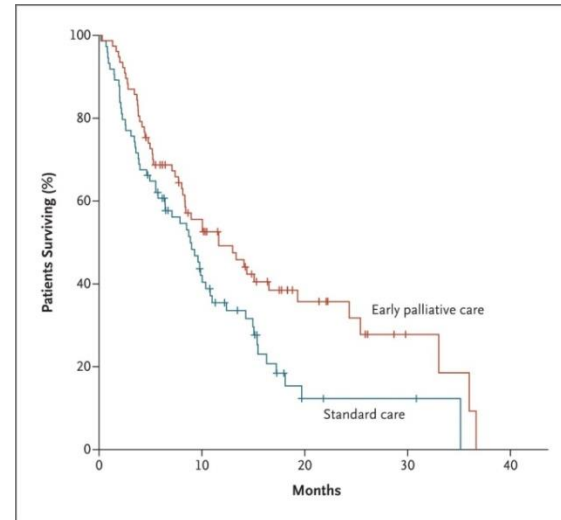


# What about the possible survival benefit?

**Figure 4.** Kaplan-Meier Estimates of Survival According to Treatment Group



Bakitas JAMA 302(7) 2009



Temel NEJM 363 (8) 2010

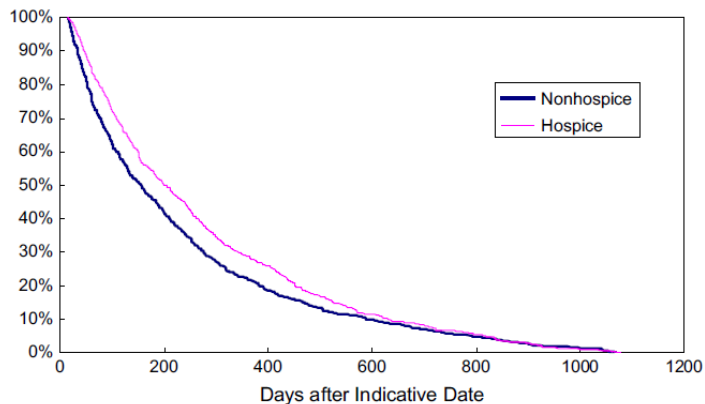
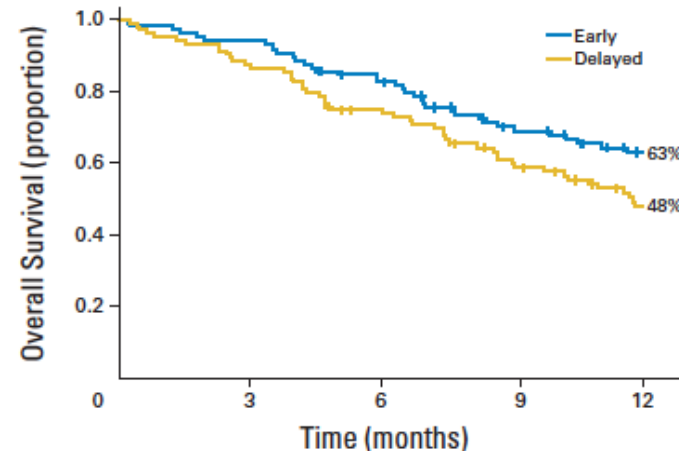


Fig. 3. Survival curve for patients with lung cancer.

Connors JPSM 33 (3) 2007



Bakitas JCO 33(13) 2015



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# What about disseminability?

- Even with an adequate workforce and resources, the PC models studied, other than in Project ENABLE, are unlikely to be disseminable across a variety of health care settings.
- Although currently, telephone-based care is not reimbursed, so a telephone based model may not be as financially viable.



# ASCO Provisional Care Opinion

VOLUME 30 · NUMBER 8 · MARCH 10 2012

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

## American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care

*Thomas J. Smith, Sarah Temin, Erin R. Alesi, Amy P. Abernethy, Tracy A. Balboni, Ethan M. Basch, Betty R. Ferrell, Matt Loscalzo, Diane E. Meier, Judith A. Paice, Jeffrey M. Peppercorn, Mark Somerfield, Ellen Stovall, and Jamie H. Von Roenn*

“....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”



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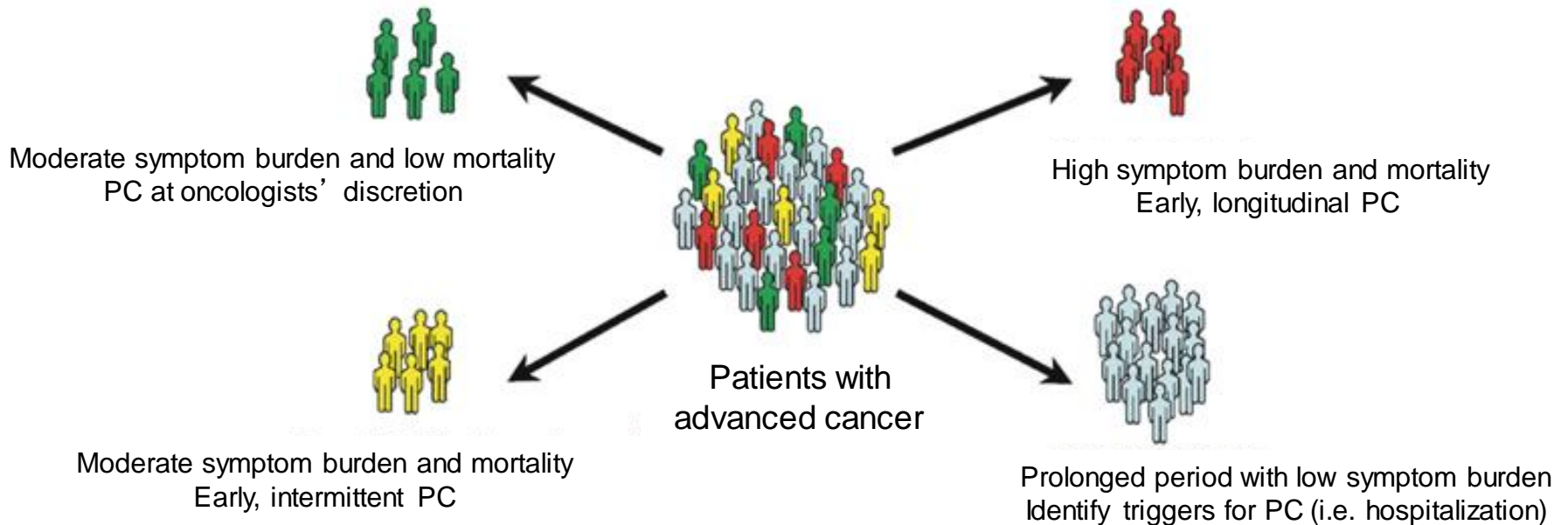
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# Key Unanswered Questions

Is early palliative care for patients with advanced cancers a one-size-fits all?



# Randomized Trial in Patients with Advanced Lung and non-Colorectal Gastrointestinal Cancers

350 patients within 8 weeks of diagnosis of advanced/incurable lung and non-colorectal GI cancers with an ECOG PS 0-2 (and their family caregivers)

**Integrated care**  
- Palliative care visits (or phone calls if visit not feasible) every 3-4 weeks in conjunction with oncology visits.

**Standard care**  
- Palliative care visits only upon request.

## Outcome Measures

### Patient-reported Outcomes

1. **FACT**
2. **HADS**
3. **PHQ-9**
4. **Prognostic awareness**
5. Coping

### Family-reported Outcomes

1. SF-36
2. HADS
3. Prognostic awareness

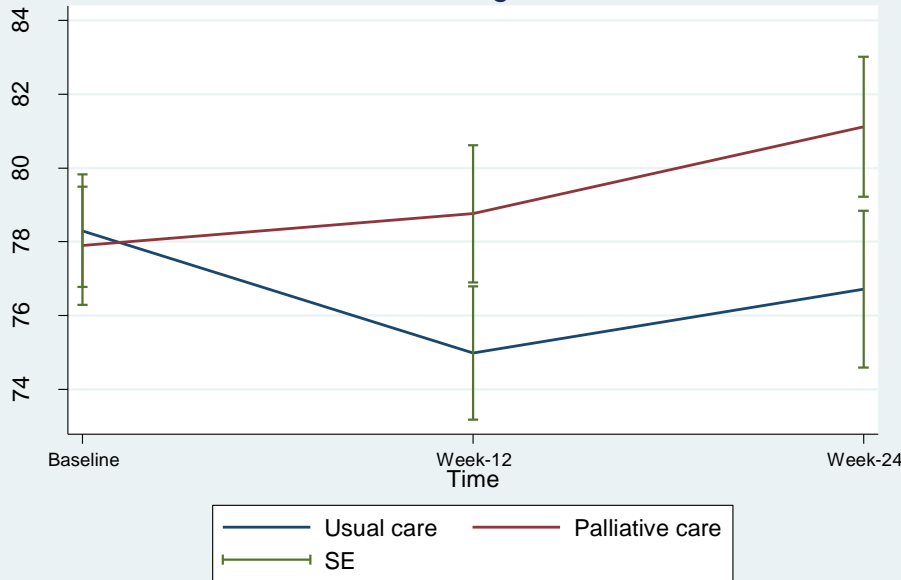
### Health Service Utilization

1. Chemotherapy administration
2. Documentation of resuscitation preferences
3. Hospital utilization
4. Hospice utilization

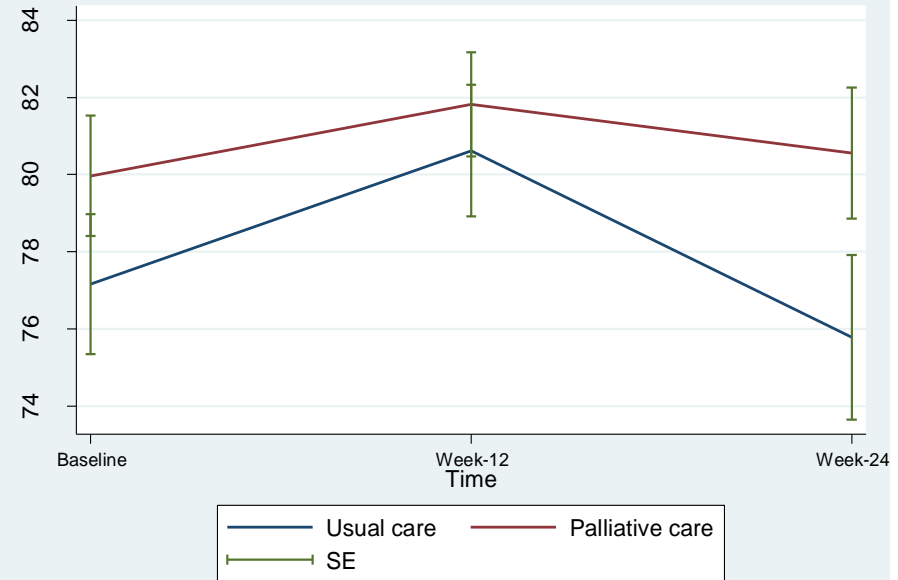


# Quality of Life Trajectory by Cancer Type

QOL in Lung Cancer



QOL in GI Cancer



# Moving the Research Agenda Forward

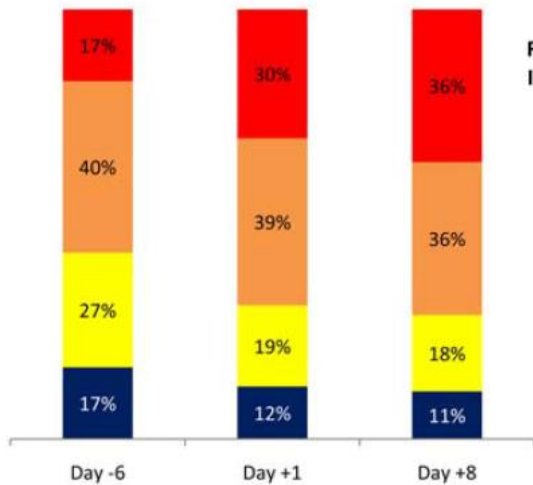
- Developing palliative and supportive care interventions targeted to the needs and experiences of a patient population and may be a more effective strategy than a one-size-fits all approach.
- Translating the concept of personalized cancer care to providing palliative care.



# Developing Population Specific Interventions

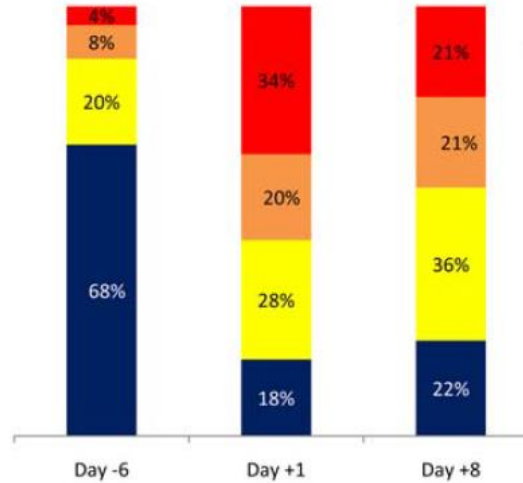
**Figure 1A  
Insomnia**

■ Severe  
■ Moderate  
■ Mild  
■ None



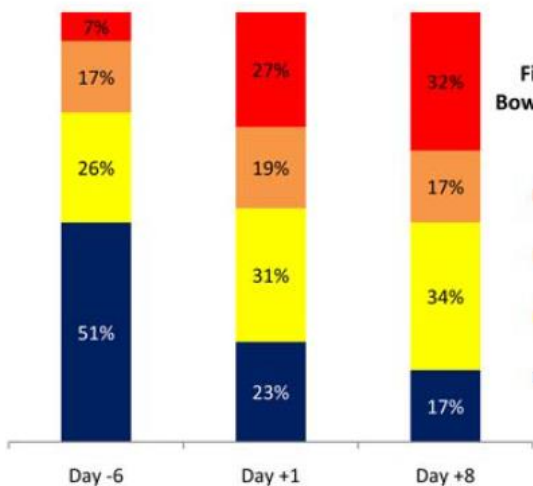
**Figure 1B  
Nausea**

■ Severe  
■ Moderate  
■ Mild  
■ None



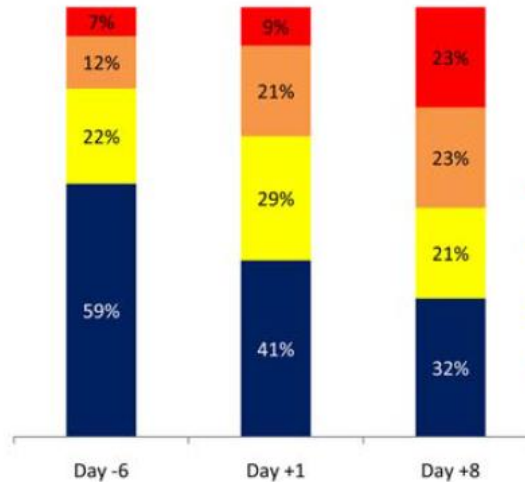
**Figure 1C  
Bowel Trouble**

■ Severe  
■ Moderate  
■ Mild  
■ None

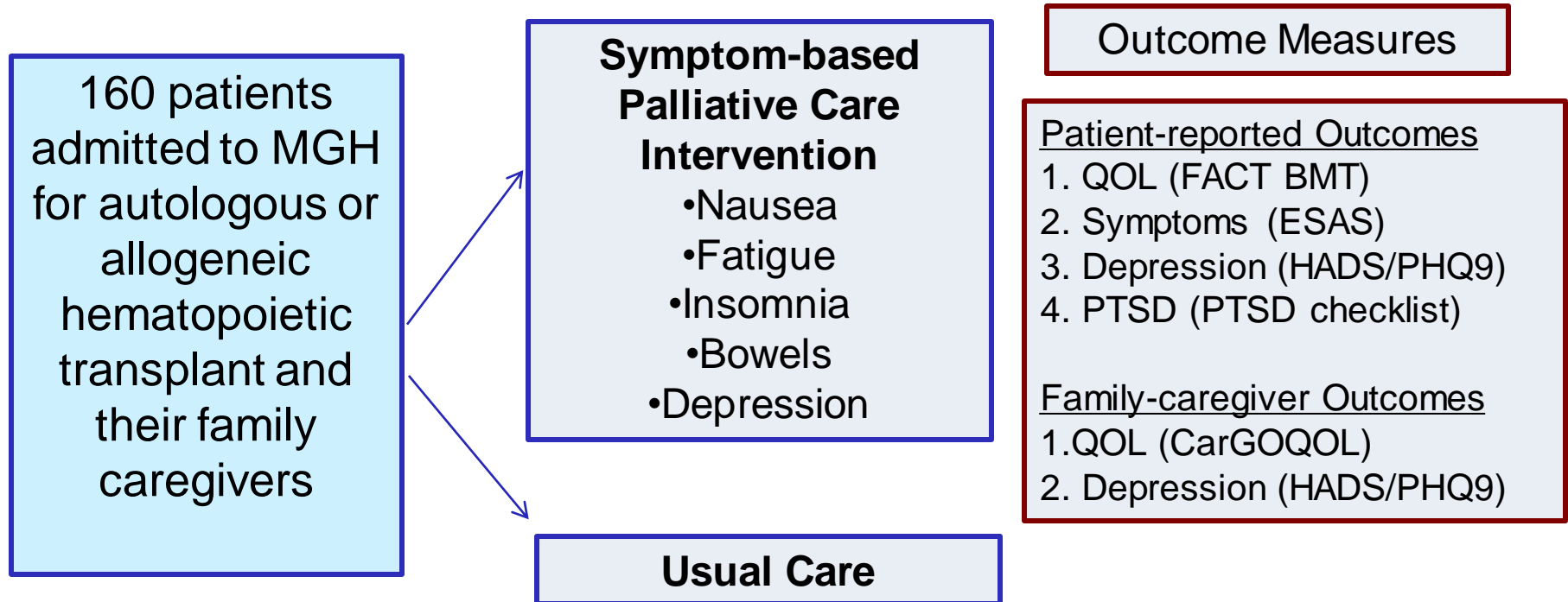


**Figure 1D  
Pain**

■ Severe  
■ Moderate  
■ Mild  
■ None

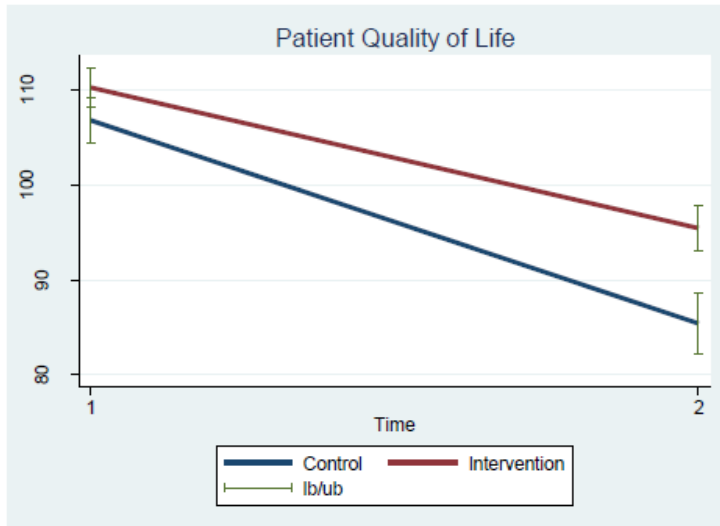


# Inpatient Palliative Care Intervention

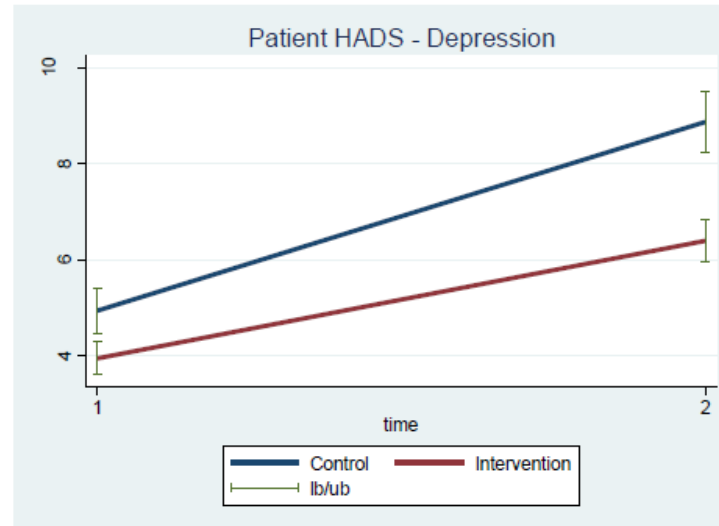




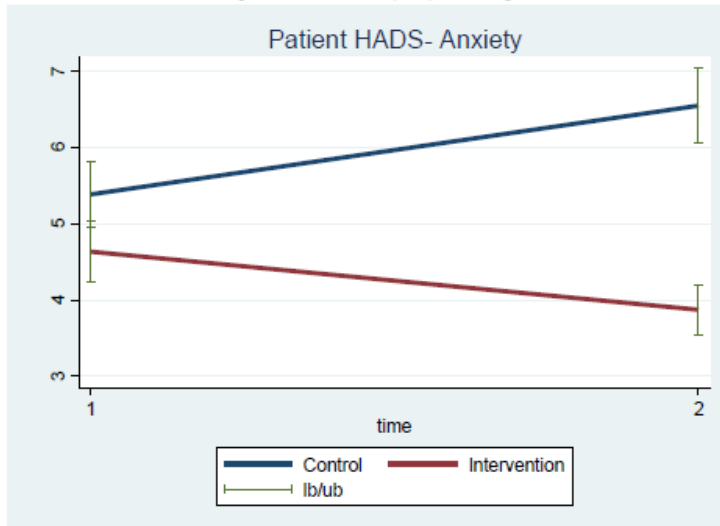
# Inpatient Palliative Care Intervention



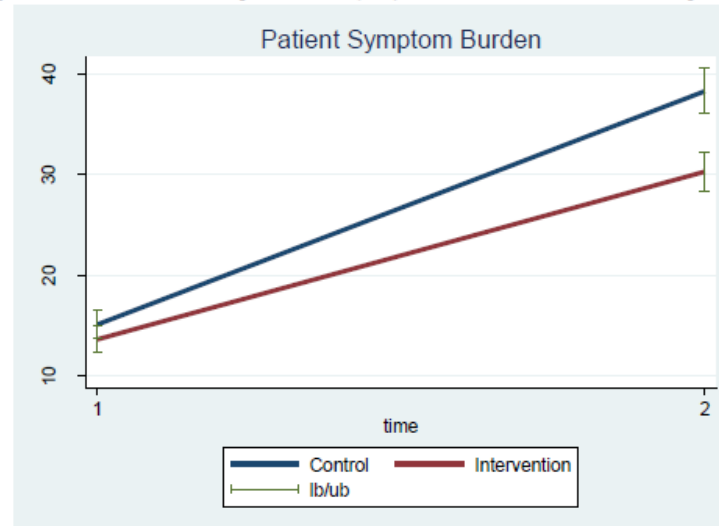
3A: Mean  $\Delta$  FACT-BMT: [-14.7 vs. -21.5,  $t(155) = -2.0$ ,  $p = 0.04$ , Cohen's  $d = 2.9$ ]



3B: Mean  $\Delta$  HADS-D: [2.4 vs. 3.9,  $t(155) = 2.3$ ,  $P = 0.02$ , Cohen's  $d = 0.4$ ]



3C: Mean  $\Delta$  HADS-A: [-0.8 vs. 1.1,  $t(155) = 3.5$ ,  $P = 0.0006$ , Cohen's  $d = 0.6$ ]



3D: Mean  $\Delta$  ESAS: [17.3 vs. 23.1,  $t(150) = 2.2$ ,  $P = 0.03$ , Cohen's  $d = 0.4$ ]

# How much can oncology do?

The role of “primary palliative care” by oncology i.e. skills that all clinicians should have has gained recent attention

## Representative Skill Sets for Primary and Specialty Palliative Care.

### Primary Palliative Care

- Basic management of pain and symptoms
- Basic management of depression and anxiety
- Basic discussions about
  - Prognosis
  - Goals of treatment
  - Suffering
  - Code status

### Specialty Palliative Care

- Management of refractory pain or other symptoms
- Management of more complex depression, anxiety, grief, and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment
  - Within families
  - Between staff and families
  - Among treatment teams
- Assistance in addressing cases of near futility

But do oncologists have these basic skills?



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# We Can Train Oncologists

Oncotalk 4 day residential communication skills workshop for medical oncology fellows.

Participants acquired 5.4 bad news skills (SPIKES) and 4.4 transitions skills (NURSE).

Table 5. Communication Skill Changes for Giving Bad News Encounter

Coding Scheme	Participant Behavior Code	% of Fellows With Skill		P Value
		Before Retreat	After Retreat	
SPIKES				
Setting	Not assessed			
Perception	Assesses the patient's perception of the situation	25	59	<.001
Invitation	Requests the patient's permission to proceed before giving news	5	42	<.001
Knowledge	Uses the specific word <i>cancer</i> when giving bad news	16	54	<.001
Emotion	Waits at least 10 s after giving bad news	45	73	<.001
	Makes an empathic statement as the first response after giving bad news	52	81	<.001
	Asks for the patient's emotional reaction to the bad news	17	38	<.001
Summary	Summarizes the follow-up plan	57	51	.35
Empathic verbal skills (NURSE)				
Naming	Names an emotion that the patient seems to be experiencing but has not explicitly articulated at any point	39	71	<.001
Understanding	Expresses understanding or appreciation of a patient emotion	97	100	.25
Respecting	Expresses respect or praise about how the patient is handling the situation	6	41	<.001
Supporting	Makes a statement of support or nonabandonment	54	70	.007
Exploring	Explores the patient's emotional state at any point	59	83	<.001



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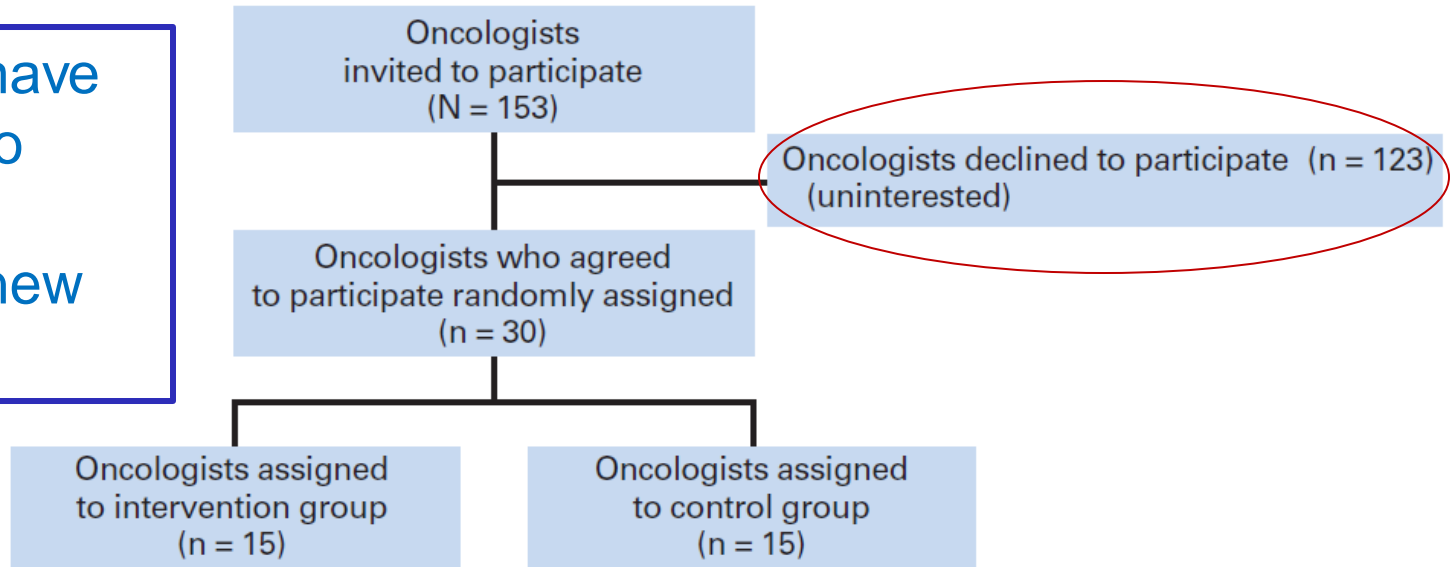
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# Or can we??

•BUT...they have to be willing to participate in learning the new skills.....



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Fujimori JCO 32(20) 2014

# Primary Palliative Care

- Primary PC by oncology is a wonderful concept and training programs for oncology fellows will ensure that the next generation of oncologists has these essential skills.
- We do not yet have data to suggest that primary PC can serve the same role as specialty PC.



# Are the nature of the differences between palliative care and oncology care clinician or patient-driven?

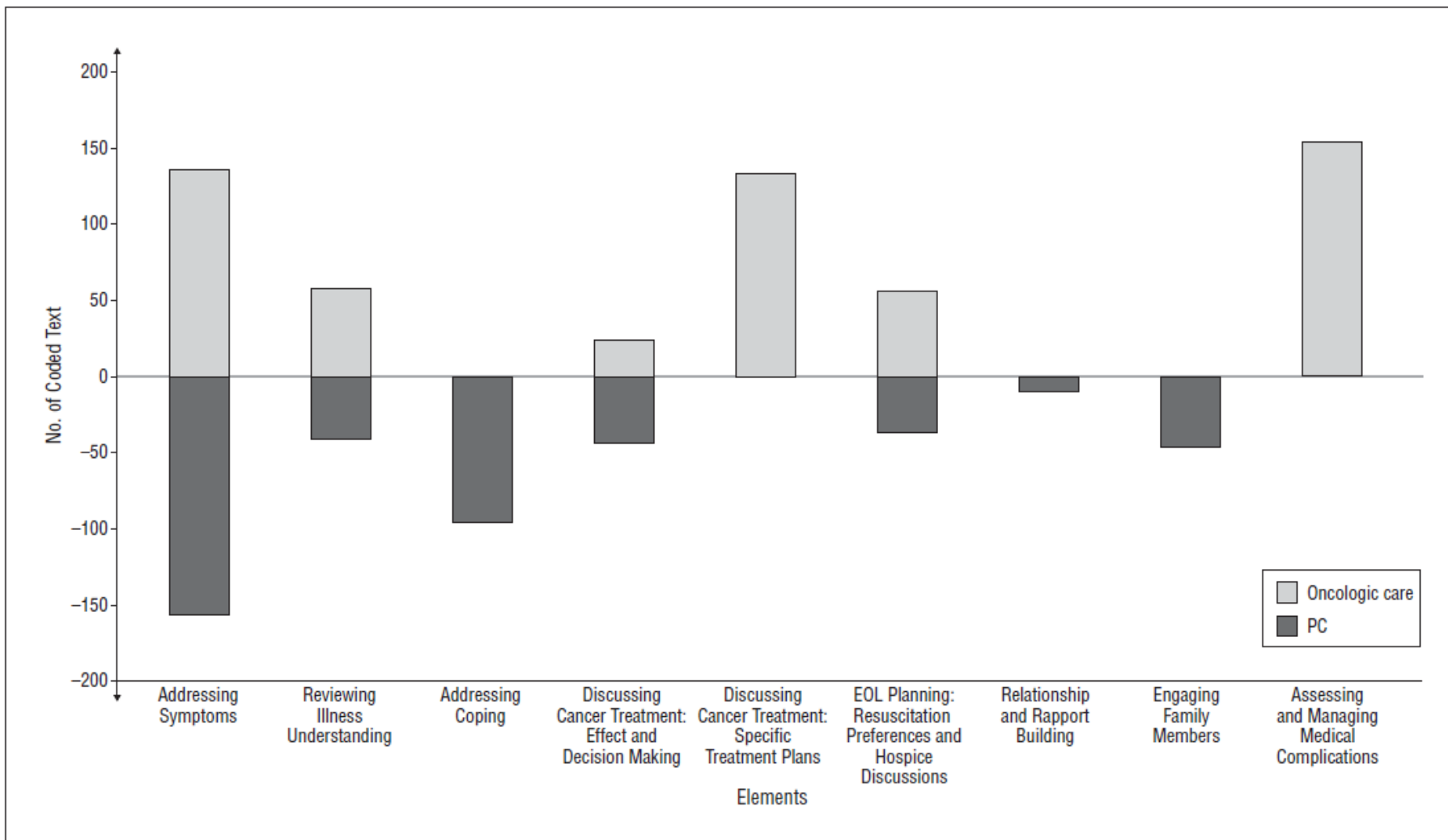


Figure 2. Elements of palliative care (PC) vs oncologic care visits at clinical turning points. EOL indicates end of life.

# Summary

- We now have compelling data demonstrating a range of benefits for early palliative care in patients with poor prognosis, advanced cancers.
- We must now turn our attention to studying how to best disseminate early palliative care (and primary palliative care) throughout the practice of oncology.



# Thank you

- Massachusetts General Hospital Cancer Center
  - Cancer Outcome Research Program
  - Thoracic Oncology
  - Palliative Care
- Funding from the National Institute of Nursing Research and the National Cancer Institute
  - R01 NR012735
  - K24 CA181253



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