City of Hope®

Interdisciplinary End of Life Symposium

Supportive Oncology: Early Integration of Palliative Care

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Disclosures

- I do not have any relevant financial relationships.

This presentation and/or comments will provide a balanced, non-promotional, and evidence-based approach to all diagnostic, therapeutic and/or research related content.

Cultural Linguistic Competency (CLC) & Implicit Bias (IB)

STATE LAW:

The California legislature has passed Assembly Bill (AB) 1195, which states that as of July 1, 2006, all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component. It has also passed AB 241, which states that as of January 1, 2022, all continuing education courses for a physician and surgeon **must** contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment.

The cultural and linguistic competency (CLC) and implicit bias (IB) definitions reiterate how patients' diverse backgrounds may impact their access to care.

EXEMPTION:

Business and Professions Code 2190.1 exempts activities which are dedicated solely to research or other issues that do not contain a direct patient care component.

The following CLC & IB components will be addressed in this presentation:

- *Using cultural humility to address differences in beliefs*
- *Using empathy, emotional regulation skills and partnership to increase awareness and avoid bias*

Welcome!

Who are we speaking to today??

Palliative Care

- "Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and to facilitate patient autonomy, access to information and choice."

Case Study

- 55 year old male with stage IV colon cancer, metastatic to the liver. He is feeling very fatigued and deconditioned, but has been ignoring the symptoms for months.
- Difficulty eating, irregular BMs with blood
- 30lb weight loss without explanation
- Presented to hospital with near bowel obstruction and had urgent surgery
- Post op, he has had significant pain and wound dehiscence
- Recovery is slow and there was initial concern that he may not be able to get cancer treatment.

Exercise

- Patient History: In groups of 2, take a moment to role play provider and our patient from the case study.
- Drawing on your experience, interact as one of the roles each, and ask “patient” role about their abdominal pain using the PQRST of pain (provocation, quality, region/radiation, severity, and timing)
- What are common comments/descriptions/mitigating factors in situations like this?

Exercise

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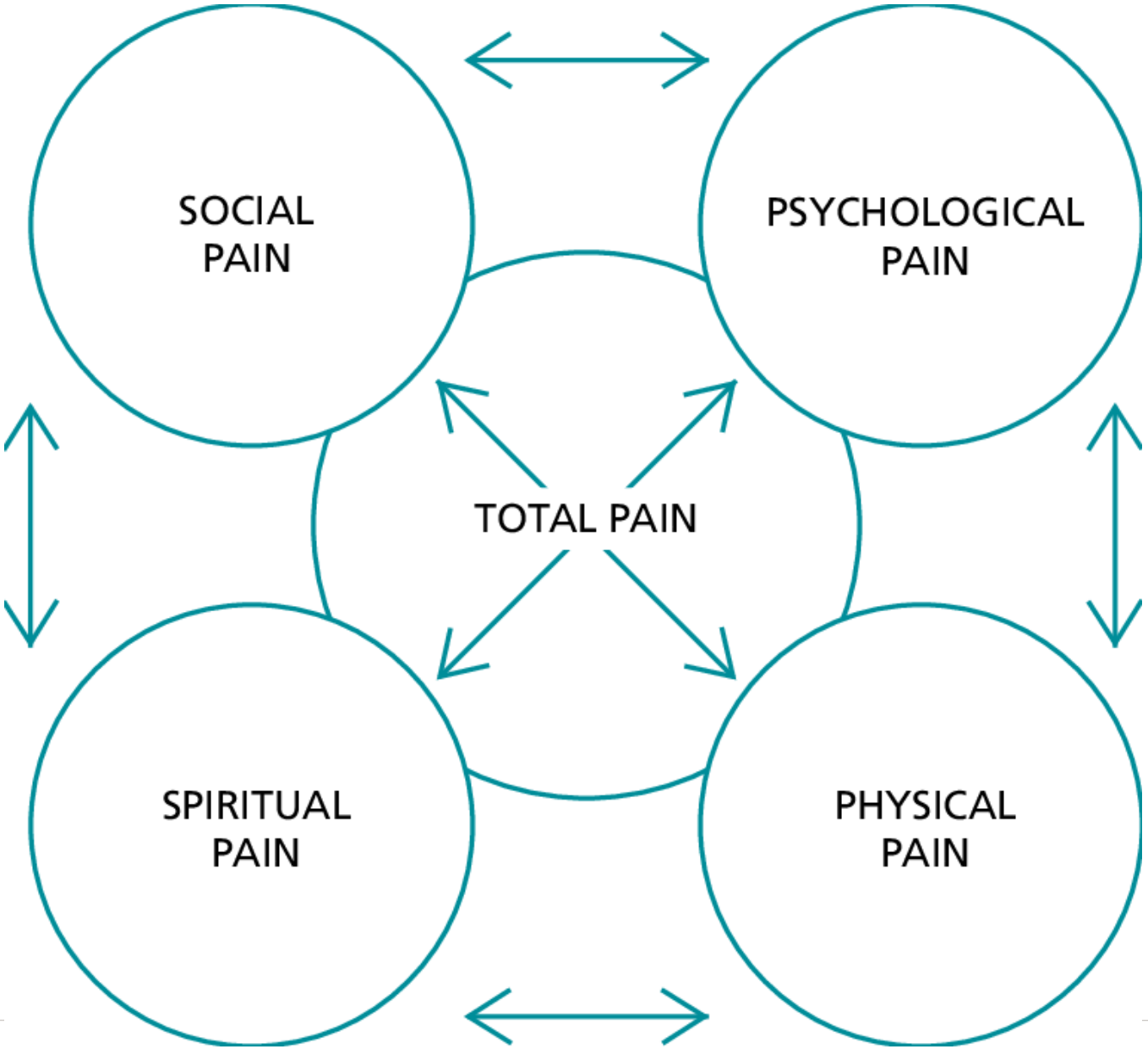
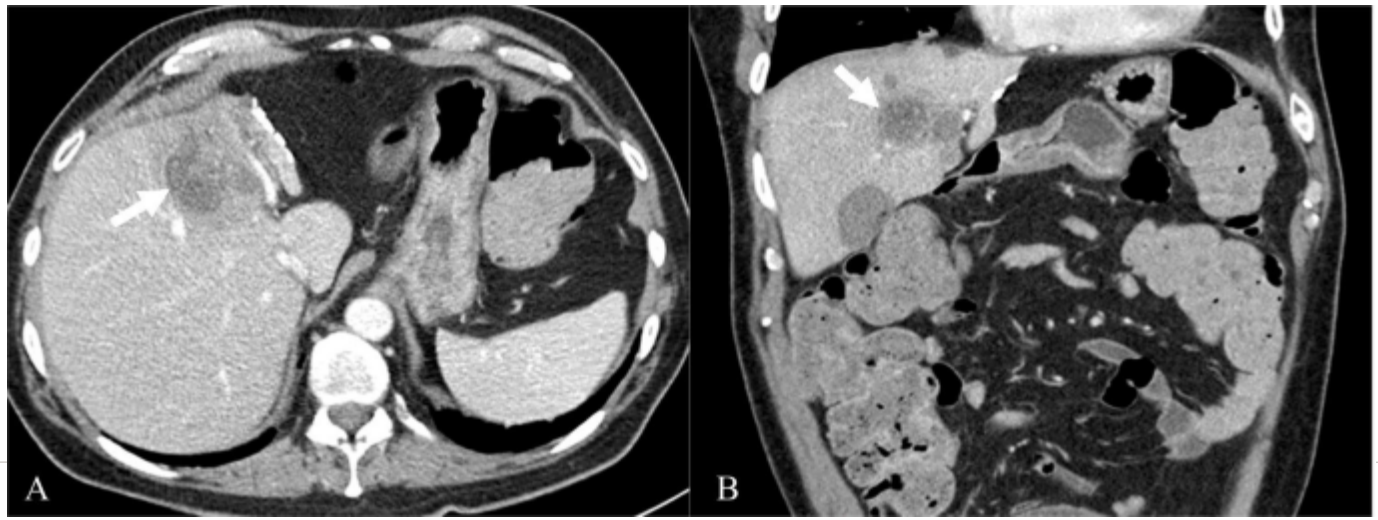
- Drawing on your experience, interact as one of the roles each, and ask “patient” role about their abdominal pain using the PQRST of pain (provocation, quality, region/radiation, severity, and timing)
- What are common comments/descriptions/mitigating factors in situations like this?
    - Is the patient able to clearly articulate the quality and location of pain?
    - Is he able to describe all the contributing factors to his pain?
    - Is there involvement of other comorbid symptoms?


SOCIAL PAIN
PSYCHOLOGICAL PAIN
TOTAL PAIN
SPIRITUAL PAIN
PHYSICAL PAIN

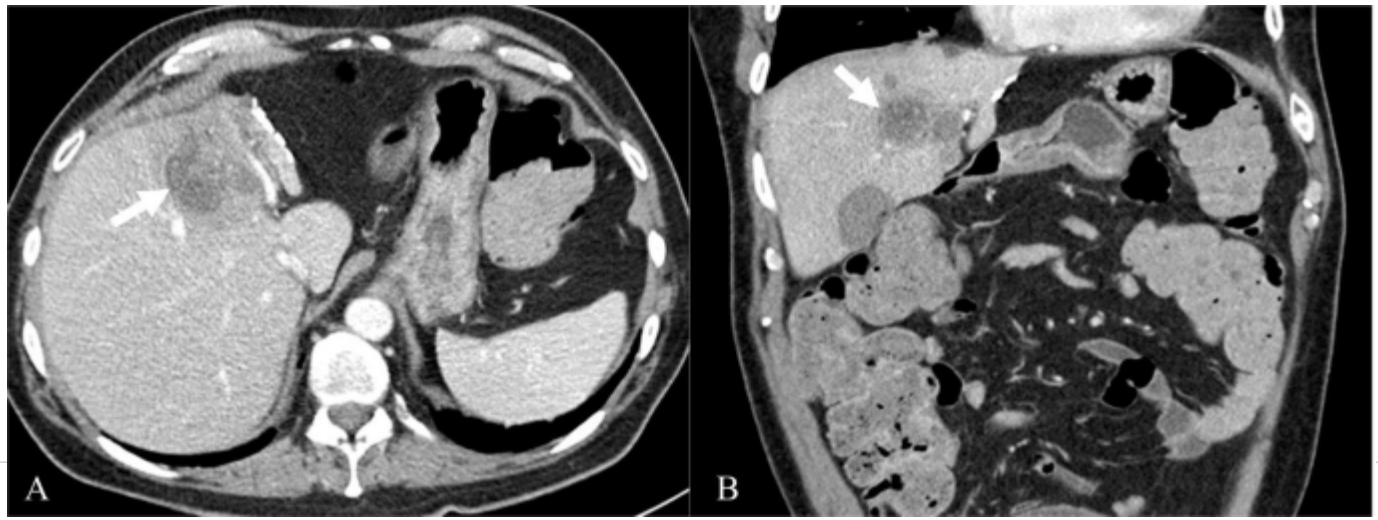
Case study continued: Symptoms

- **Physical symptoms**
  - *Bowel issues*
  - *Nausea*
  - *Fatigue*



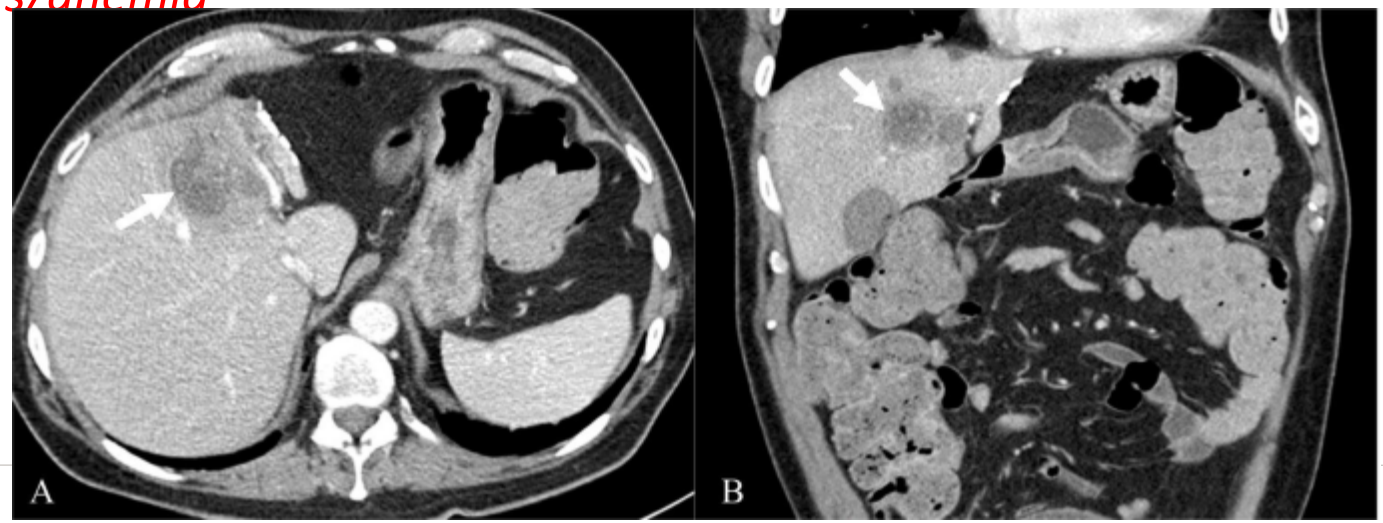
Case study continued: Symptoms

- **Physical symptoms**
  - *Pain*, both post op, organic cancer related pain and capsular stretch pain with liver metastasis
  - *Dyspnea*, Lung metastasis cause dyspnea



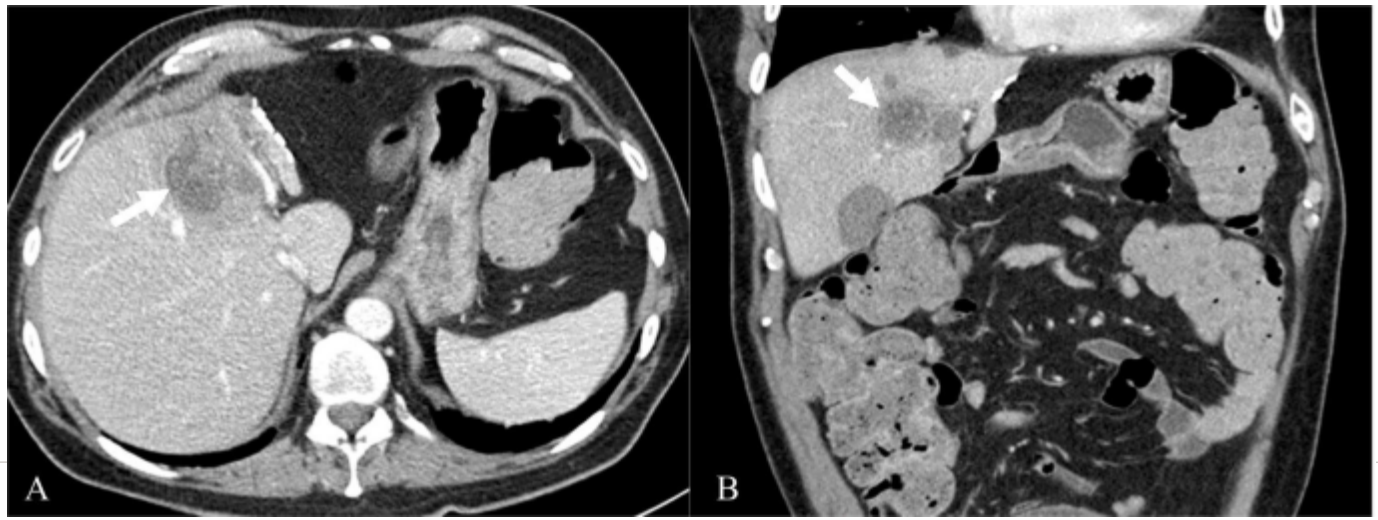
Focus on the individual symptoms

- **Physical symptoms- Things to consider**
  - *Bowel issues- laxative use, constipating drugs, activity level, hydration status, PO intake, anatomical*
  - *Nausea- motility problems/constipation, drug effect, anxiety, uncontrolled pain*
  - *Fatigue- activity level/exercise, sleep habits, mood or motivation issues, nutrition, electrolytes/anemia*



Focus on individual symptoms

- **Physical symptoms- Things to consider**
  - *Pain*, both post op, organic cancer related pain and capsular stretch pain with liver metastasis- nociceptive, inflammatory, nerve damage/neuropathy
  - *Dyspnea*, Lung metastasis cause dyspnea- masses, effusions, atelectasis, shallow breathing, anemia, changes in cardiovascular fitness



Focus on individual symptoms

- **Emotional/Non physical symptoms or barriers- Things to consider**
  - Difficulty managing constipation and diarrhea can lead to fear of eating
  - Noticing physical changes to appearance with weight loss affects body image
  - Anxiety about “letting family down”
  - Insomnia began in hospital and continued at home
  - Developing depression symptoms
  - Struggle with being a “burden” on family
  - Health related anxiety about future

Back to the case study… (physical symptoms)

- Bowel issues in our patient
  - Post op ileus, with slow return to function
  - Limited activity as he recovers from surgery in the hospital
  - Limited PO intake
- Interventions for the Non-Clinician:
  - Advocate and make the key issues known
  - Are there non-traditional ways to get the patient moving?
  - Can we help with food choices? Favorite or home cooked?
  - Can we try alternative ways to promote bowel function?

Back to the case study… (physical symptoms)

- Nausea in our patient
  - Low motility related to ileus
  - Pain medications for post op/cancer pain
  - Anxious being in the hospital, still adjusting to knowledge of diagnosis
- Interventions for the Non-Clinician :
  - Advocate and make the key issues known
  - Distraction methods for pain/nausea?
  - Companionship, caring words/actions

Back to the case study… (physical symptoms)

- Fatigue in our patient
  - Poor sleep in the hospital and ongoing difficulties at home
  - Anemia related to cancer
  - Poor oral intake
  - Presence of cancer in his body is a very metabolically active state
  - Sedentary
  - Overwhelmed
- Interventions for the Non-Clinician :
  - Advocate and make the key issues known
  - Ensure PT and OT are onboard early
  - Thoughtful food choices, reassurance and optimism

Back to the case study… (non physical symptoms)

- Emotional/psychological symptoms in our patient
  - Recognize presence of fear, anxiety, stress
  - Provide an empathetic ear if patient shares
  - Ask questions about mental health history. Is this new or worsened?
  - Plan together
  - Mental health support
- Interventions for the Non-Clinician :
  - Advocate and make the key issues known
  - Recognize and acknowledge financial insecurity and offer resources
  - Assist with employment related stress, disability
  - Facilitate Caregiver support

Asking the right questions

- Essential to ensuring that the quality of life is optimized
- Talking the patients and family through the problems
- Setting expectations
- Providing education

Be a source of comfort and information

- This provides substantial benefit to the patient

ASCO: Palliative Care

Key Recommendation

Patients with advanced cancer, whether inpatient or outpatient, should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referring patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer caregivers of patients with early or advanced cancer to palliative care services.

American Society of Clinical Oncology Clinical Practice Guideline Update, 2017

National Consensus Project Domains for Quality Palliative Care Applied to COPD

Physical Aspects of Care (Domain 2)

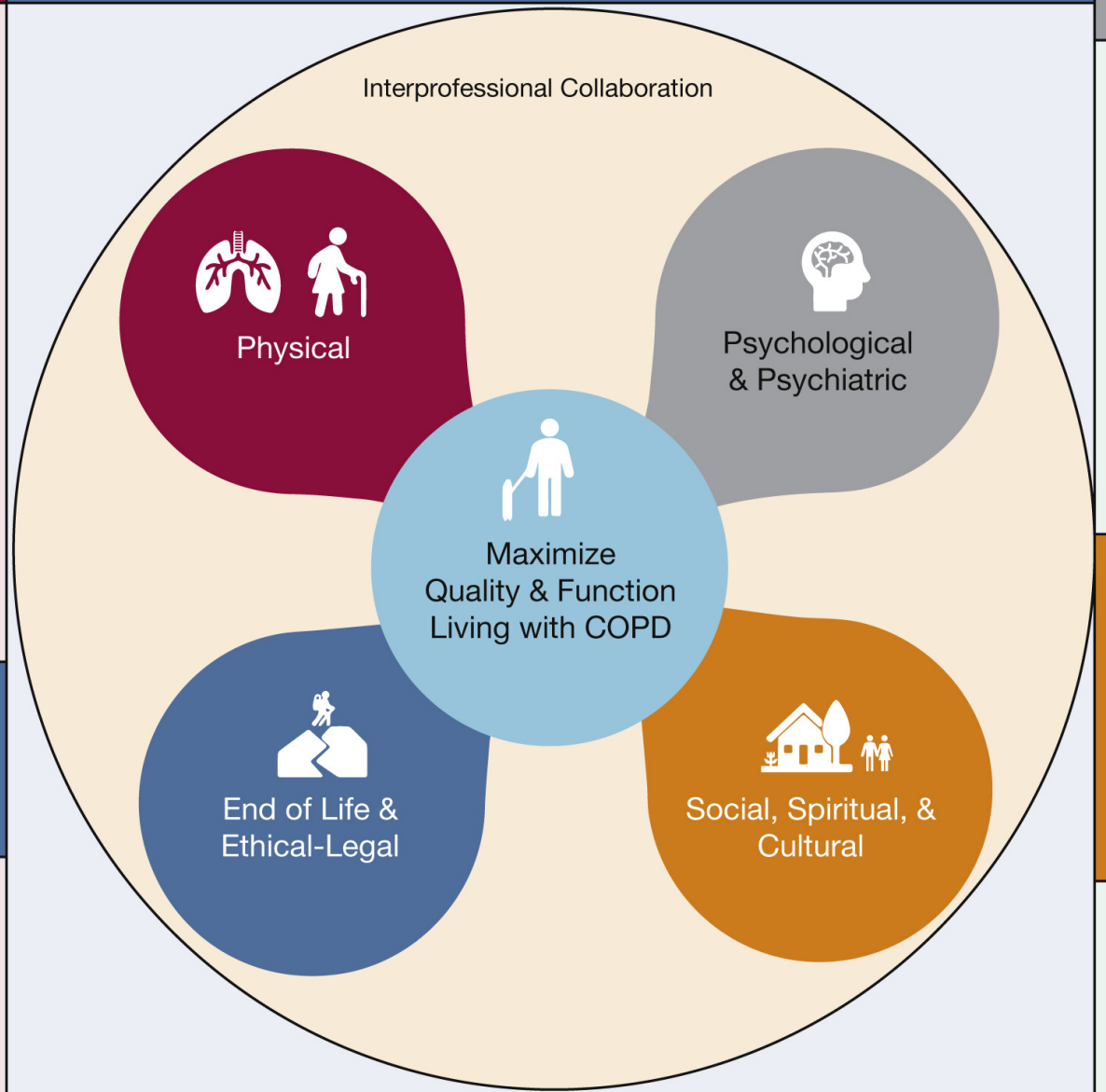
- Optimize COPD therapies (inhalers, nebs, orals) & assess inhaler technique
- Regularly assess & address symptoms/needs
- Counsel on tobacco cessation & provide therapies
- Evaluate & titrate supplemental oxygen
- Initiate fan therapy & low-dose opioids (consider specialist palliative care comanagement)
- Reduce polypharmacy
- Evaluate impact of multimorbidity
- Refer to pulmonary rehabilitation
- Initiate advanced COPD therapies if indicated (eg. NIV, endobronchial valves, transplant referral) with concurrent palliative care
- Evaluate functional status (ADLs, IADLs), mobility, & assistive device needs
- Start home health & physical/occupational therapy
- Assess frailty, sarcopenia, cachexia, & malnutrition
- Involve geriatrics & nutrition if needed

Care of the Patient Nearing the End of Life (Domain 7)

Ethical and Legal Aspects of Care (Domain 8)

- Prognosticate (BODE, Surprise Question)
- Engage patients & care partners in early values-based conversations
- Discuss NIV/IMV time-limited trials
- Complete advance care planning
- Prepare for hospice & end-of-life care
- Identify respite/bereavement/survivorship needs

Structure and Processes of Care (Domain 1)



Psychiatric and Psychological Aspects of Care (Domain 3)

- Measure anxiety/depressive symptoms
- Refer for psychological counseling, music therapy, pet therapy
- Consider cognitive behavioral therapy or antidepressants/anxiolytics
- Comanage severe symptoms with primary care & specialist palliative care
- Measure cognitive impairment

Social Aspects of Care (Domain 4)

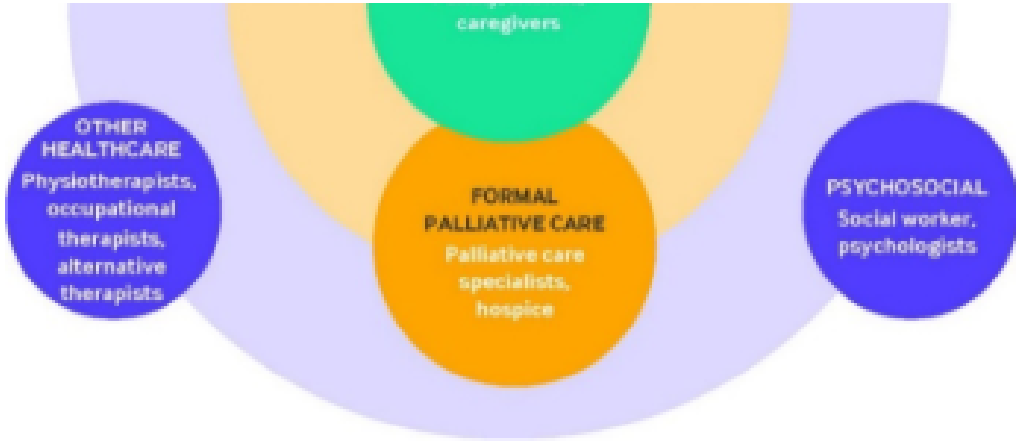
Spiritual, Religious, and Existential Aspects of Care (Domain 5)

Cultural Aspects of Care (Domain 6)

- Identify social determinants of health
- Screen for social isolation
- Assess caregiver needs
- Address spiritual care needs
- Understand role of culture in illness understanding & end-of-life care
- Ensure equitable palliative care access

American Heart Association 2022

Palliative care helps patients and families face the long-term challenges and burden of advanced cardiovascular disease (CVD) and stroke.[1] It is appropriate for many cardiovascular diseases, including heart failure, congenital syndromes, and congenital anomalies, and their associated symptoms of fatigue,[1] depression,[3,4] shortness of breath,[5] pain,[5] edema,[5] insomnia,[6] anxiety,[5] cognitive impairment,[7] anorexia,[5] and social isolation.[5] Stroke survivors and patients with advanced heart failure in particular sometimes experience poor HRQOL as a result of deteriorating health, symptom distress, and complex care regimens.[1,8,9] Family members, who often act as primary caregivers, can experience psychological stress as they deal with physical, emotional, and cognitive changes in their loved one.[1,10] Intended to alleviate symptoms and to manage pain at any stage of disease, palliative care should be incorporated early in the disease trajectory by the patient's primary care team or specialty palliative care providers[1] and as an ongoing component of disease-modifying treatment.[11]



Consideration of MAID/EOLOA

- Key role of palliative care- to specifically and aggressively address suffering of all types
- Ensure that if chosen, patients do so not out of desperation due to inadequately addressed symptoms

Back to Case Study…

- In Palliative care IDT, social worker shares that the patient reported that “he used to be religious.”
    - Patient stopped attending church about 20 years ago after the death of his father. He felt that “God had abandoned him.”
- PC nurse adds that he mentioned it would be nice to speak to a chaplain but was concerned that it could upset his wife who “doesn’t like religion.”
- Patient also noted that “I probably deserve this cancer.”

Take Aways

Take Aways

- It is absolutely possible to care for a patient in a way that addresses and honors the entire scope of their pain and suffering
- This can be acknowledged and put into practice by any member of the team providing care to the patient simply by having the background to know that there are many ways a patient can experience suffering, especially at the end of life, and optimal care addresses them all
- On many occasions these are interdependent. The caregiver that keeps this in mind is more likely to ensure they are all addressed.