Supportive Oncology: A Partnership in cancer care

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What's the need?
- Cancer patients have complex needs
  - Pain
  - Depression
  - Fatigue
  - Intimacy
  - Treatment related side effects
  - Psychosocial concerns
- Oncologists may not have the time, resources or training to manage the complex symptoms of disease and treatment as well as the emotional, practical and spiritual needs of the patient and family.

What's my prognosis?
Old School vs New School

Old School view:
- Death Squad
- Last resort when nothing else is possible
- Hastens death

New School view:
- Partners in Care
- The earlier the better
- Helps improve quality of life alongside active treatment

Palliative Care in the Continuum

Inpatient vs. Outpatient

Inpatient
- Skewed view of oncology patients “sickest of the sick”
- A snapshot in a patient’s journey – get input of providers outside of the hospital
- Very often involves acute issues near the end of life

Outpatient
- Majority of oncology care happens here with peaks and valleys
- Wide range view of continuum of care
- Chronic issues over a lifespan
Palliative Care in Oncology

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.

Current Recommendations

1. Patients with advanced cancer should be referred for interdisciplinary palliative care teams consultation early in the course of disease, alongside active treatment of their cancer in both outpatient and inpatient settings.

2. Essential components may include:
   - Rapport and relationship building with patients and family caregivers
   - Symptom, distress, and functional status management
   - Exploration of understanding and education about illness, prognosis, and treatment goals
   - Assessment/Support of coping needs and assistance with medical decision making
   - Coordination with other care providers

3. For patients with advanced cancer, early palliative care involvement within 8 weeks of diagnosis.

4. For patients with early or advanced cancer, nurses, social workers, or other providers may initiate caregiver-tailored palliative care support.

So what is the data?
Office-Based Palliative Care Models

- **Stand-alone**
  - Separate space
  - Challenging to fund

- **Co-located**
  - Shares office space and overhead with another specialty clinic, operates independently

- **Integrated**
  - Shares space and resources with another specialty clinic
Palliative Care’s Clinical Responsibilities – Four Roles

- **Consultative**
  - Team suggests treatment options but does not write orders or prescriptions
  - Rare among office-based practices
- **Co-Management**
  - Team collaborates with the specialty team on specific issues. Palliative care consultant is responsible for writing prescriptions for pain and symptom management
- **Primary Care**
  - Palliative clinician assumes responsibility for a patient’s comprehensive care needs
- **Mixed**
  - A combination of consultative, co-management and primary care roles

Creation of Northwell’s Supportive Oncology Program

- Divisions of Palliative Medicine and Hematology/Oncology came together to design program
- Creation of a mission statement
- Needs assessment performed of oncology staff
- Pilot program launched 1/2016 –
  - 1 palliative physician seeing referrals two ½ days per week
  - After two months expanded to two full days per week
  - New patient visit – 1 hour
  - Follow up patient visit – 30 minutes

Supportive Oncology Mission Statement

The Northwell Supportive Oncology Program provides comprehensive support for individuals and their families from cancer diagnosis throughout the continuum of their care. The interdisciplinary team is dedicated to listening and responding to personal concerns, promoting well-being and treating each person with respect and compassion with a culturally competent approach. Our focus is to improve the quality of life of individuals and families by helping with complicated healthcare choices, reducing physical symptoms and providing emotional and spiritual support. This unique perspective bridges all settings of care.
Case KE

59 y/oF with metastatic pancreatic neuroendocrine tumor diagnosed in 2014 on chemotherapy since then.

Course complicated by cord compression from spinal metastatic disease, underwent decompressive laminectomy 11/2016. Back pain and muscle spasms have been a constant issue since then impacting quality of life.

Referred for palliative care consultation 5/2017 primarily for help with symptom management.
Case continued

Multiple symptoms identified:

- Pain
- Depression/anxiety
- Constipation
- Appetite loss
- Marital stress

Case continued..

What was the experience with the Oncologist?

- “Doc, what are my treatment options?”
- “What side effects can I expect?”
- “How long do I have?”

What was the experience with the Palliativist?

- “I’m scared”
- “What about my husband?”
- “I’m in pain.”
- Body image / Intimacy

Case continued..

- KE was referred to home hospice 9/2017 and had an almost 5 month length of stay (LOS) on hospice.
  - In 2017, mean hospice LOS was 62 days, median LOS 18 days.
Benefits of Integrated Palliative and Oncologic Care

- Allows oncologist to focus on the complex management of cancer
- Patients can consolidate visits with both physicians and treatments
- Keeps with current standard of care
- Improved quality of life and patient satisfaction

Thank You

“The question is no longer whether palliative care should be provided to patients with cancer, but when and how it should be delivered to optimize patient outcomes.”

References

3. Temel JS, et al. Effects of Early Integrated Palliative Care in Patients With Lung and GI Cancer: A Randomized Clinical Trial. Journal of Clinical Oncology 2017 35(8), 834-841