Supportive Oncology:
Benefits of Integrated Palliative Medicine for Advanced Cancer Care

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ACOi 2023 October 11-14 Tampa • Hybrid

Objectives

1. Define palliative medicine in the context of cancer care, citing the World Health Organization's official definition.
2. Discuss the importance of early integration of palliative medicine in patients with advanced cancer diagnoses.
3. Examine the guidelines and recommendations for integrating palliative medicine into standard oncologic care as presented by ASCO and NCCN.
4. Discuss Trauma Informed Cancer Care

Palliative Medicine

An approach to medical care that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. WHO

Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family. CAPC

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. CMS 2008

Disclosures: None

"There's no easy way I can tell you this, so I'm sending you to someone who can."

The Relief of Suffering

- *Physicians' failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.*

- *- Eric Cassel, 1982*

To cure sometimes,

To relieve often,

To comfort always.

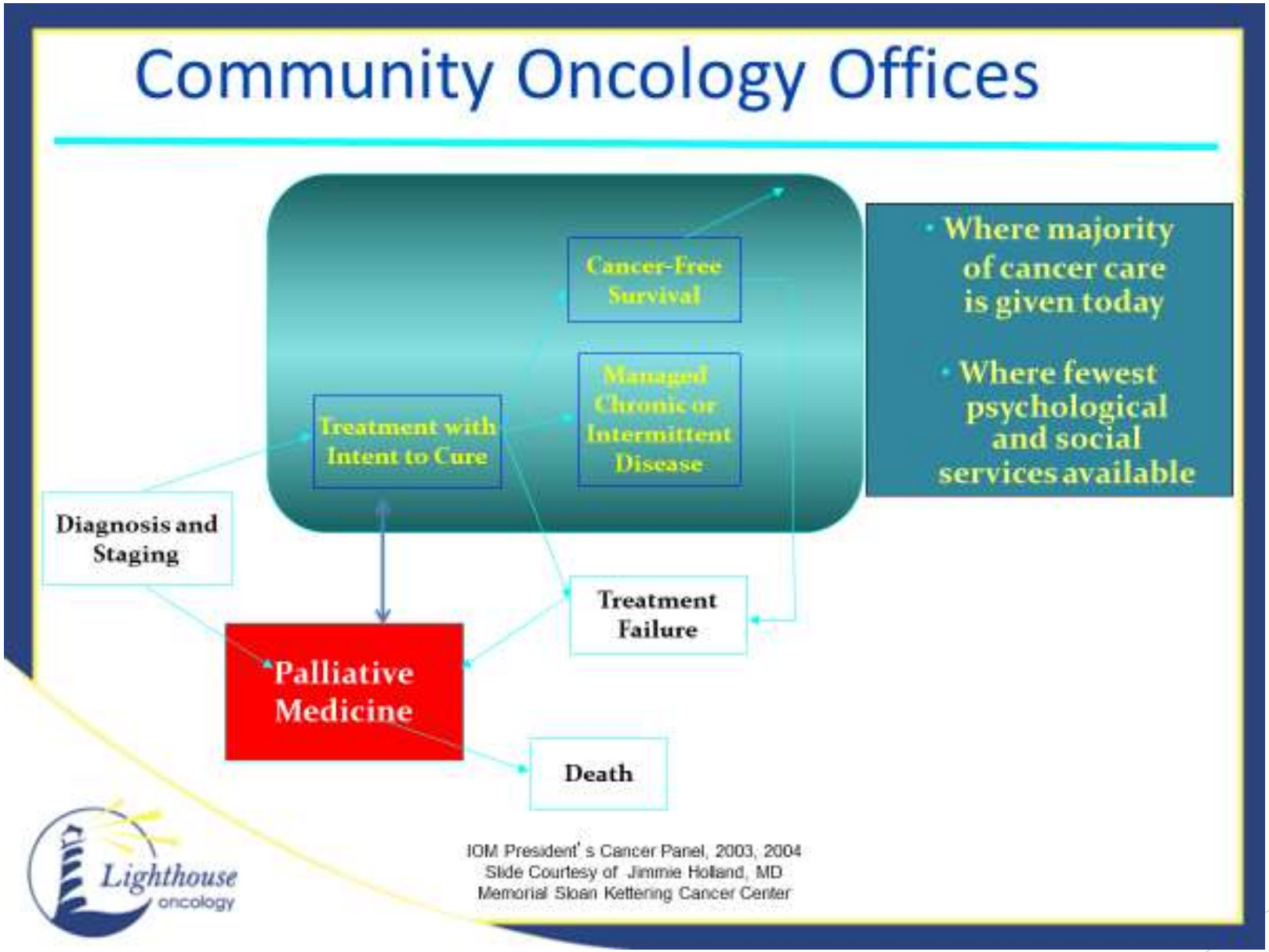
Supportive Oncology IS:

- Palliative care in the cancer setting.
- Alleviate the suffering associated with:
  - Cancer diagnosis
    - Spiritual/existential
    - Emotional/psychological
    - Physical
  - Cancer treatment side effects
- Sustain and improve quality of life.

Lighthouse oncology

Duke Cancer Care Research Program
Duke University Health System

Community Oncology Offices



IOM President's Cancer Panel, 2003, 2004
Slide Courtesy of Jimmie Holland, MD
Memorial Sloan Kettering Cancer Center

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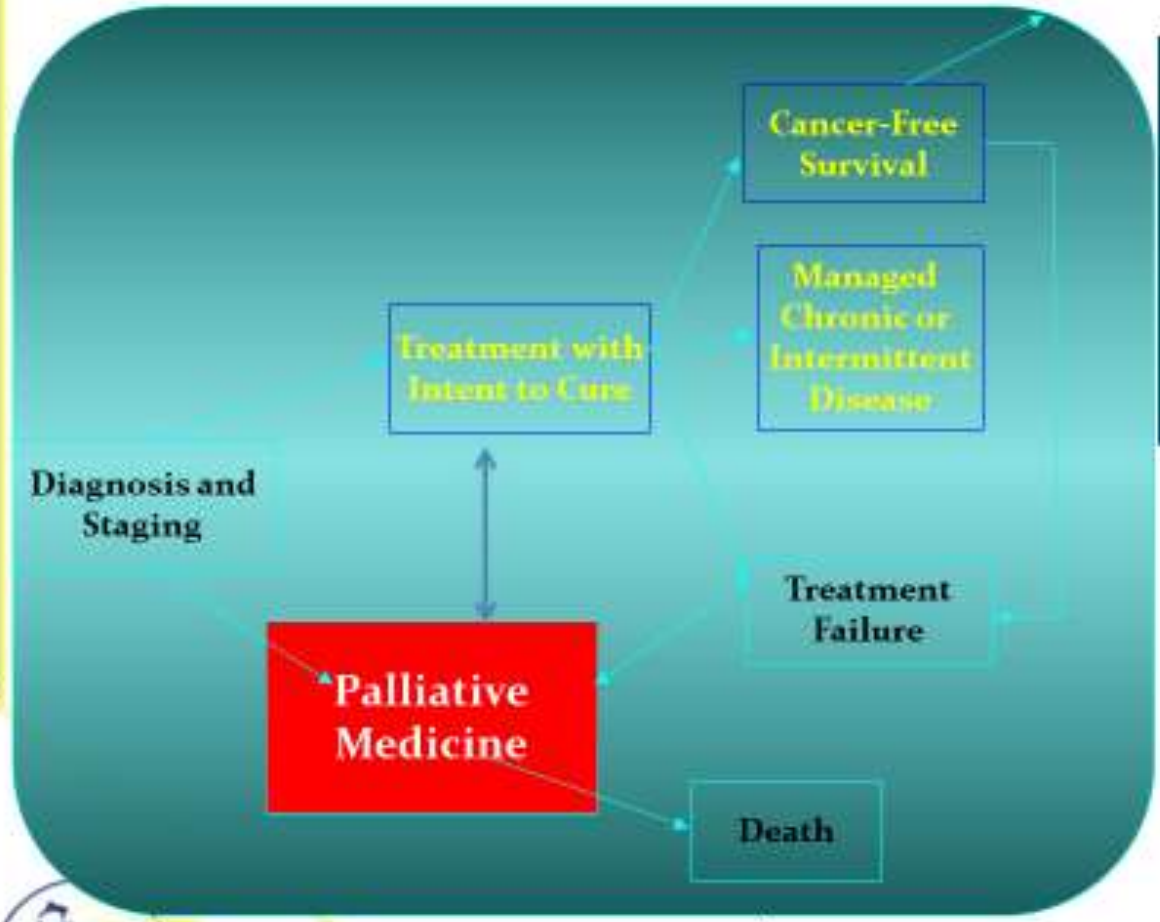
Community Oncology Offices



- Where majority of cancer care is given today
- Where fewest psychological and social services available

IOM President's Cancer Panel, 2003, 2004
Slide Courtesy of Jimmie Holland, MD
Memorial Sloan Kettering Cancer Center

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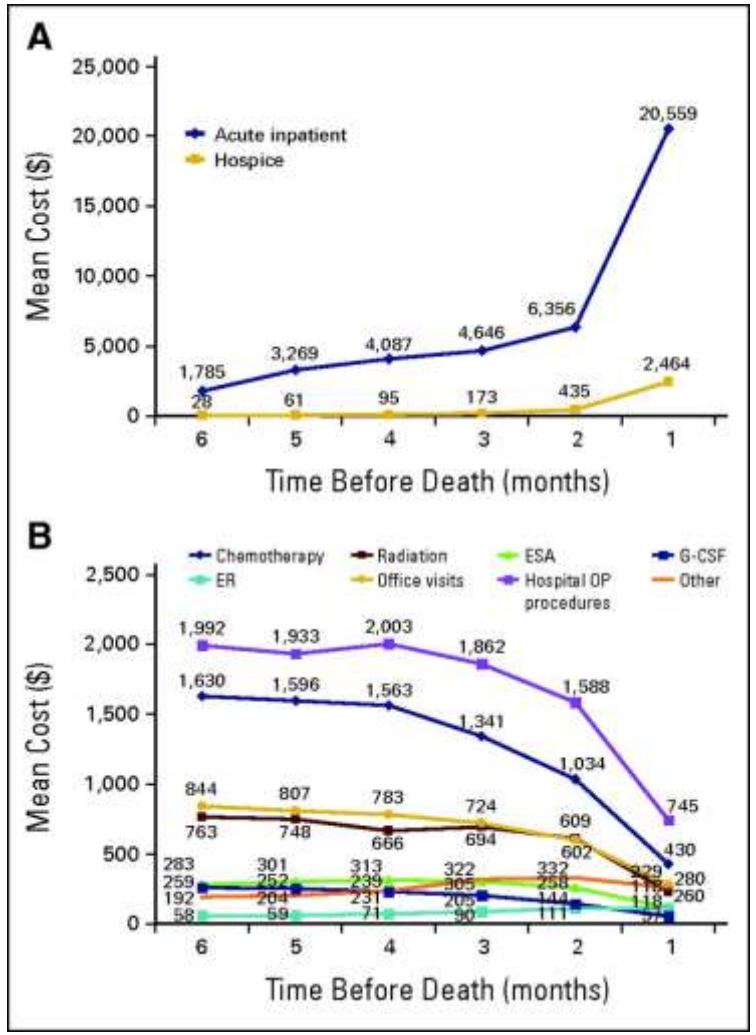
Benefits of Early Palliative Care

- Physical Symptom Mangement
  - Pain
  - Dyspnea
  - Nausea/Committing
  - Constipation
- Time savings for oncologist
- Office efficiency
- Emotional Symptom Management
  - Anxiety
  - Depression
  - Existential Crisis
- Advance care planning
- Quality of Life
- Quantity of Life

Muir, C. et al. 2010
Temel, J. et al. 2010

The Value of Palliative Providers

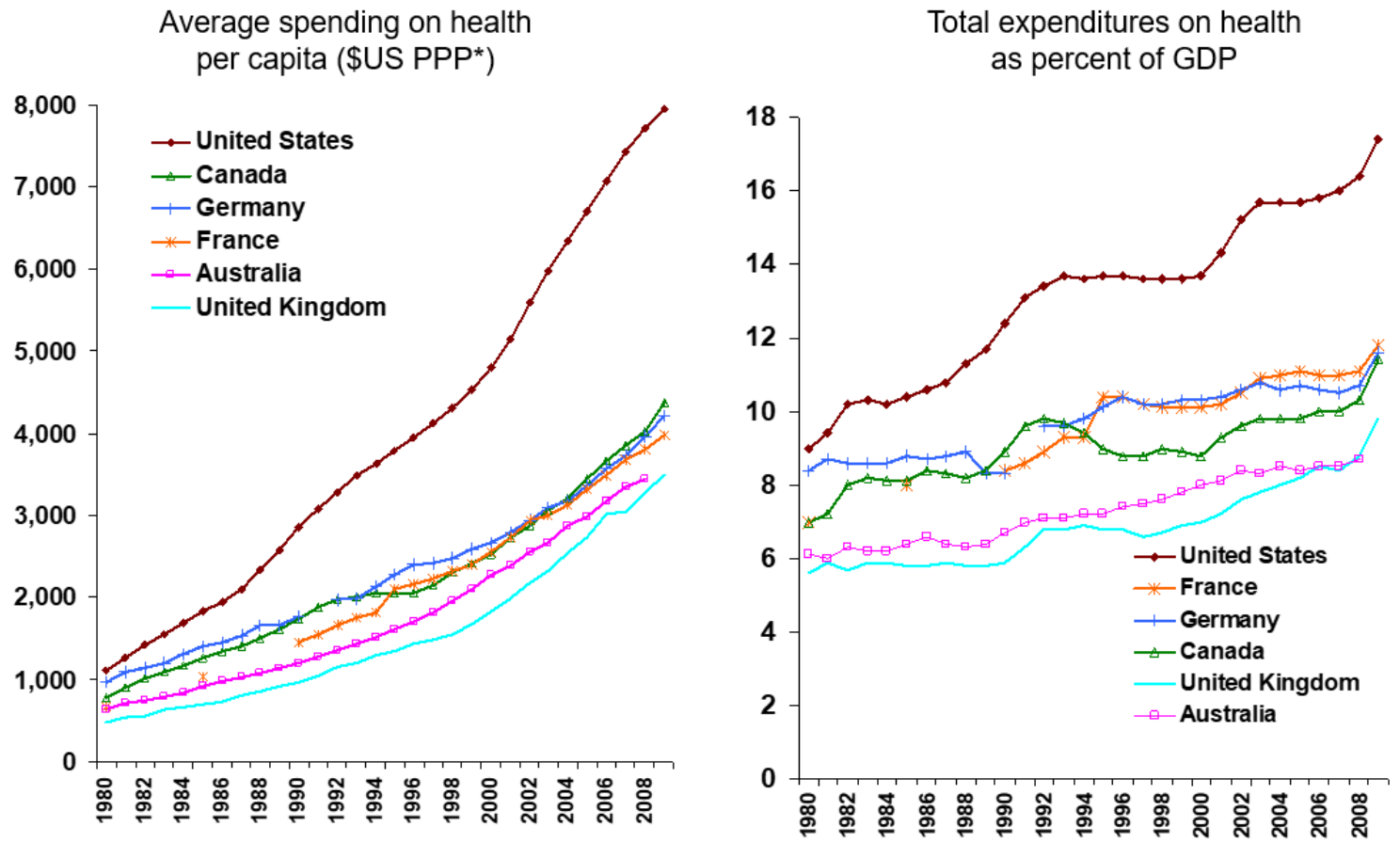
Mean total cancer-related costs for each of the last 6 months of life for (A) inpatient and hospice and (B) outpatient (OP) services.



Chastek B et al. JOP 2012;8:75s-80s

JOURNAL OF ONCOLOGY PRACTICE

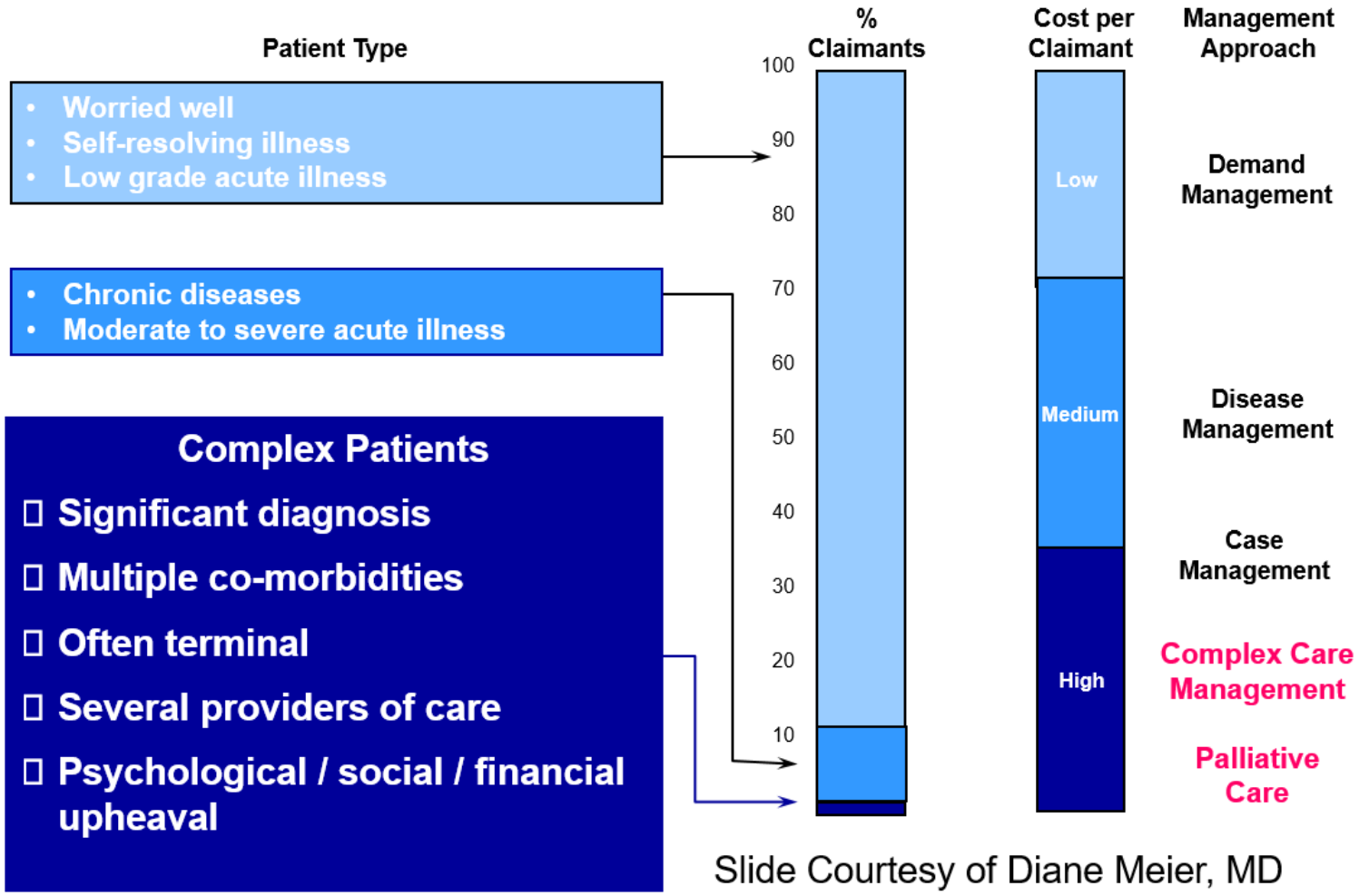
International Comparison of Spending on Health, 1980–2009



* PPP=Purchasing Power Parity.
Data: OECD Health Data 2011 (database), version 6/2011.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011. Slide courtesy of Diane Meier

Payer Perspective:
Care Management Targeted to Needs of Patients



Slide Courtesy of Diane Meier, MD

Supportive Oncology ABCs

- A-Demonstrate Allyship
- B-Build Rapport
- C- Cede Control

- Respect for patients' values, preferences, and expressed needs.
- Coordination of care and integration of services within the clinical setting.
- Communication between patient and providers: dissemination of accurate, timely, and appropriate information and education about the long-term implications of disease and illness.

Allshouse, KD et al 1993

- Enhancing physical comfort.
- Enhancing emotional support and safety.
- Involvement of family and friends.
- Transition and continuity from one locus of care to another.
- Emotional support and alleviation of fears, anxiety and suffering.

Allshouse, KD et al 1993

WHAT IS MOST IMPORTANT TO YOU?

WHAT IS MOST SACRED TO YOU?

- Answer may be medical in nature, and it may not.
- Educating patients on their situation and options.
- Empowering patients to make treatment choices most appropriate for them at this most critical time.

Supportive Oncology Care Interventions

Palliative Care Guidelines

Illness understanding, education

- Inquire about illness and prognostic understanding
- Offer clarification regarding treatment goals

Distress Management

Symptom management
- Pain
- Pulmonary symptoms
- Fatigue and sleep disturbance
- Mood
- Gastrointestinal

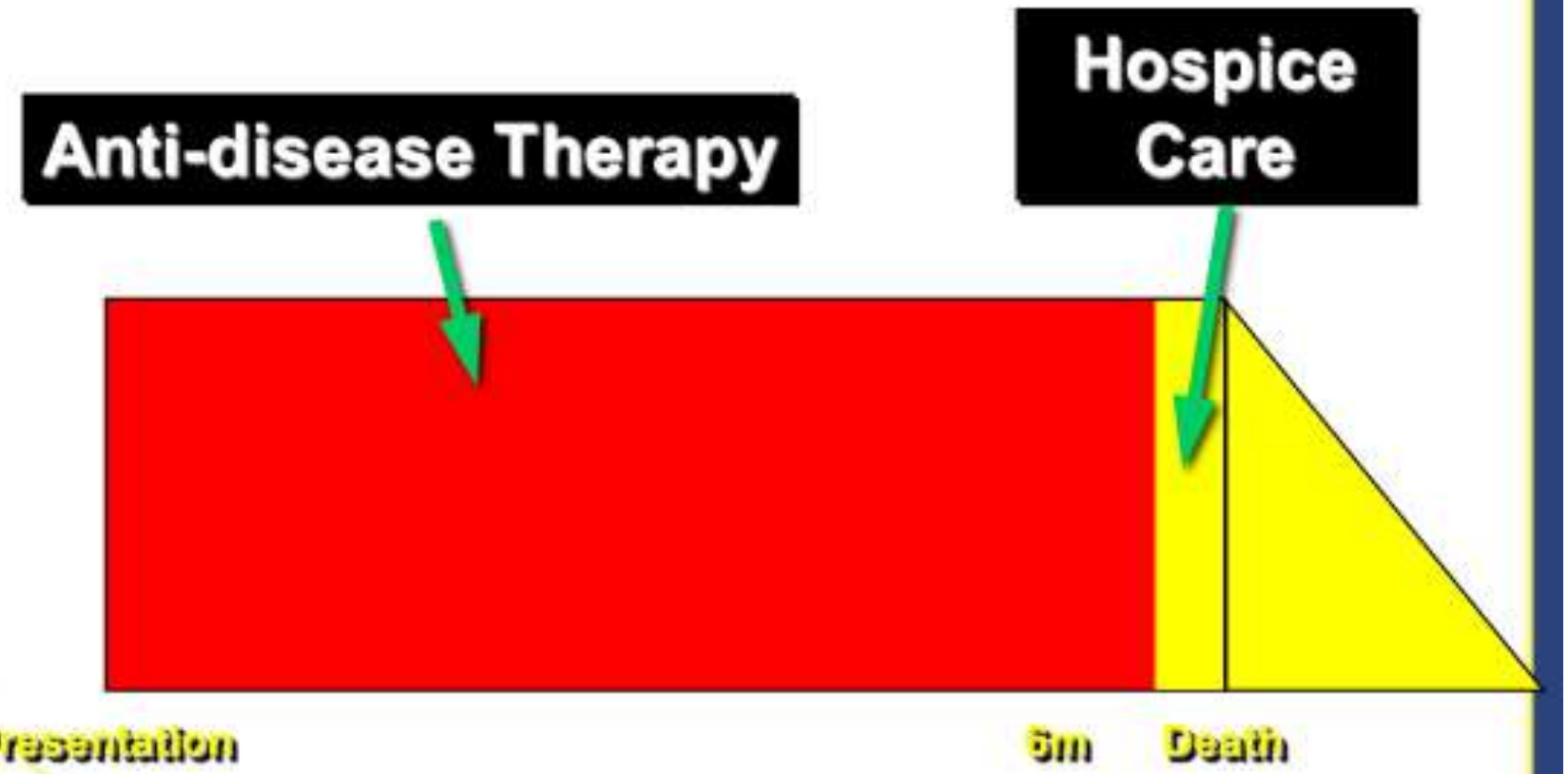
Decision-making
- Assess mode of decision-making
- Assist with treatment decision-making

Coping with life-threatening illness
- Patient
- Family/family caregivers

Lighthouse oncology

www.nationalconsensusproject.org

Treat or Quit



Slide Courtesy of Charles von Gunten, MD
Provost, San Diego Hospice

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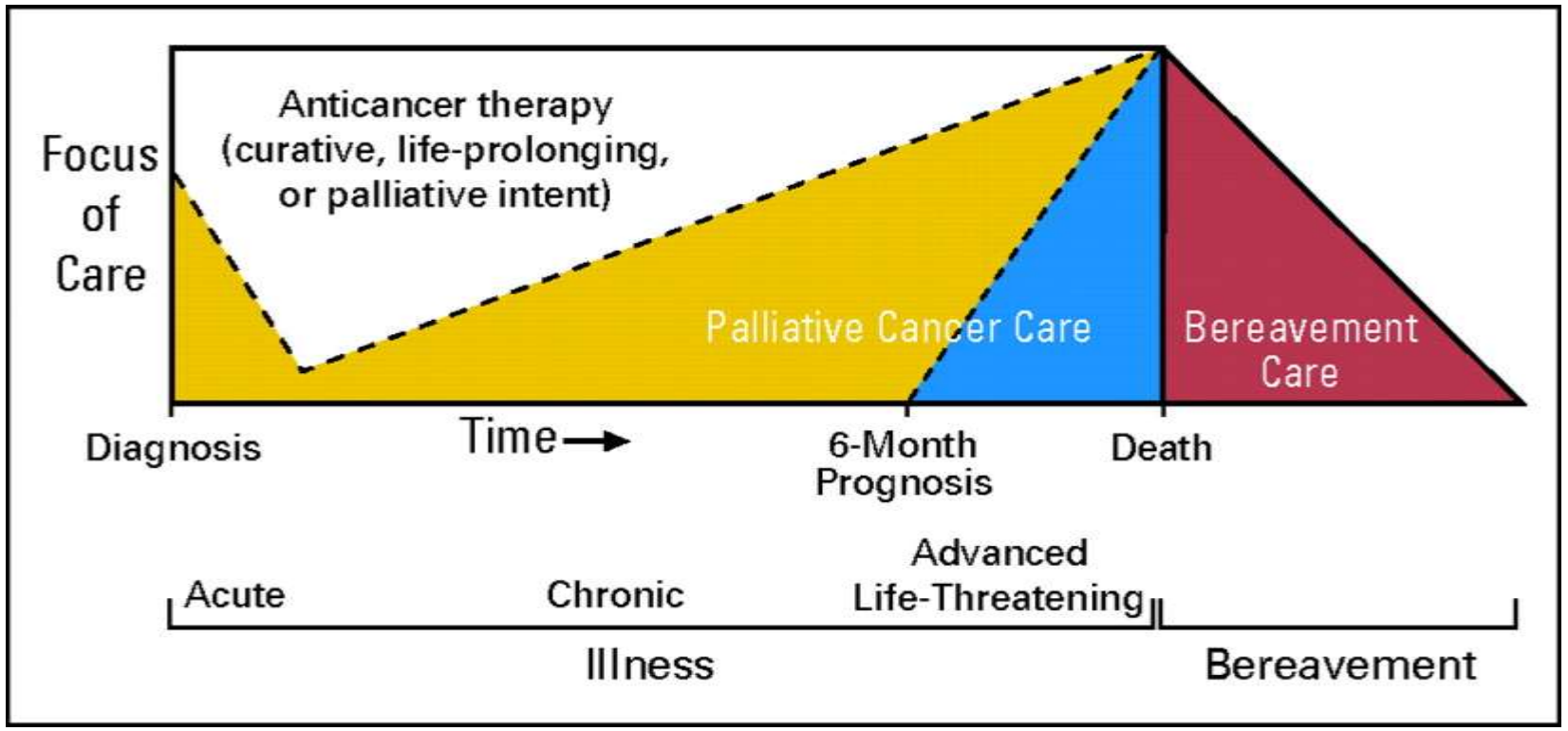
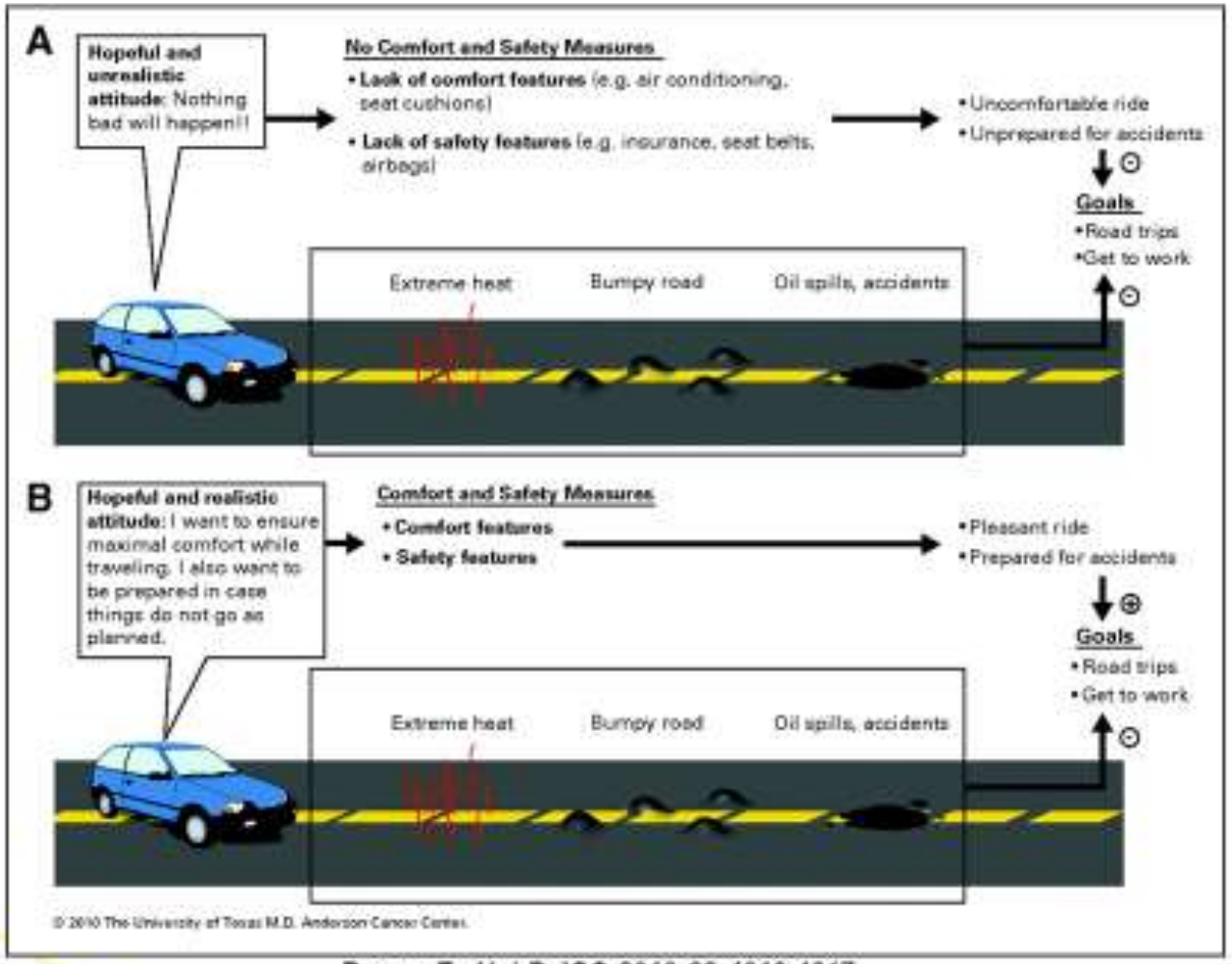
The Power of the Pause Button



Ferris F D et al. JCO 2009;27:3052-3058

JOURNAL OF CLINICAL ONCOLOGY

The use of a car is an analogy for setting goals of care.



Bruera E , Hui D JCO 2010;28:4013-4017

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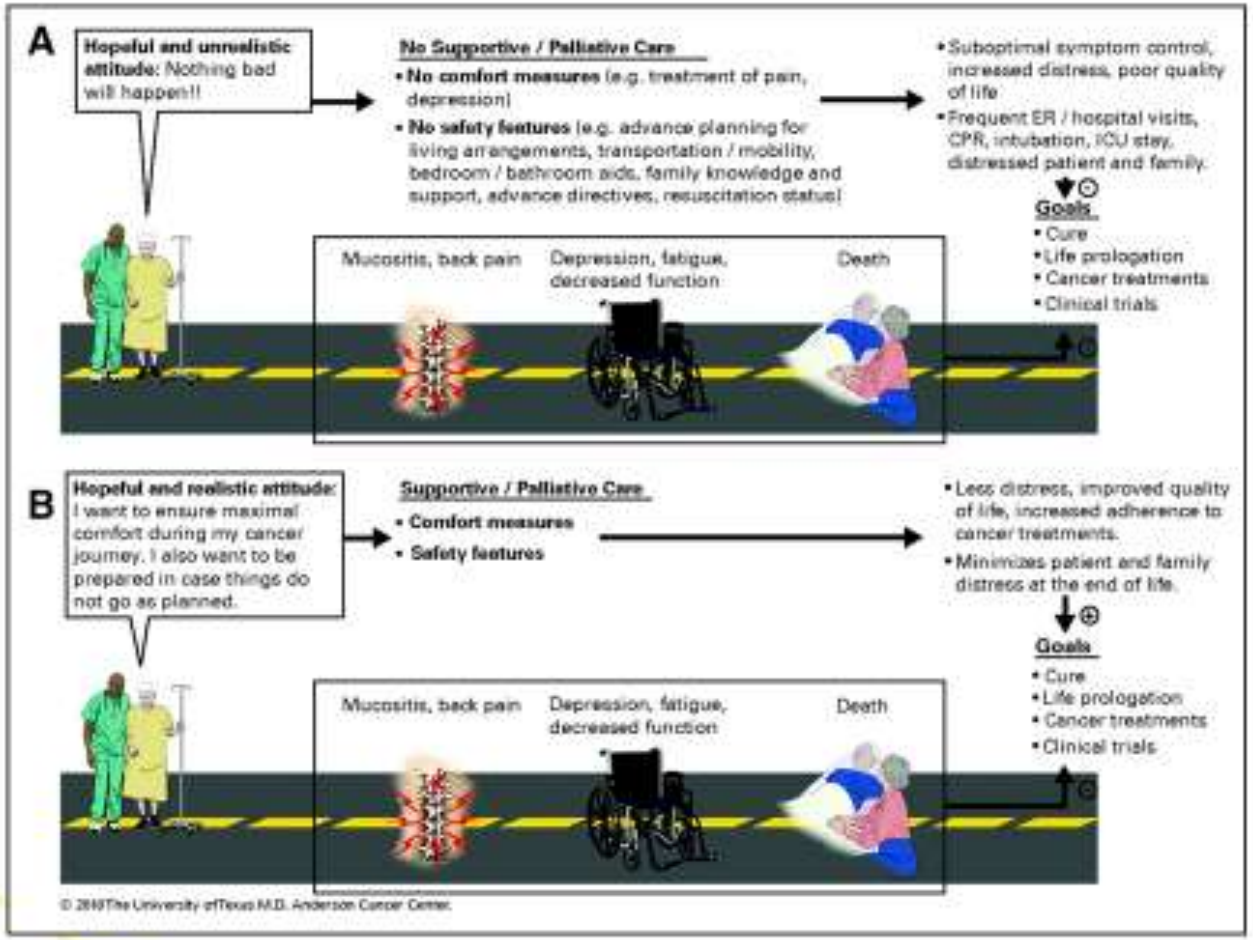
(A) A hopeful and unrealistic patient focuses on cancer cure and life-prolongation measures, without paying attention to her symptoms and advance care needs.



Bruera E , Hui D JCO 2010;28:4013-4017

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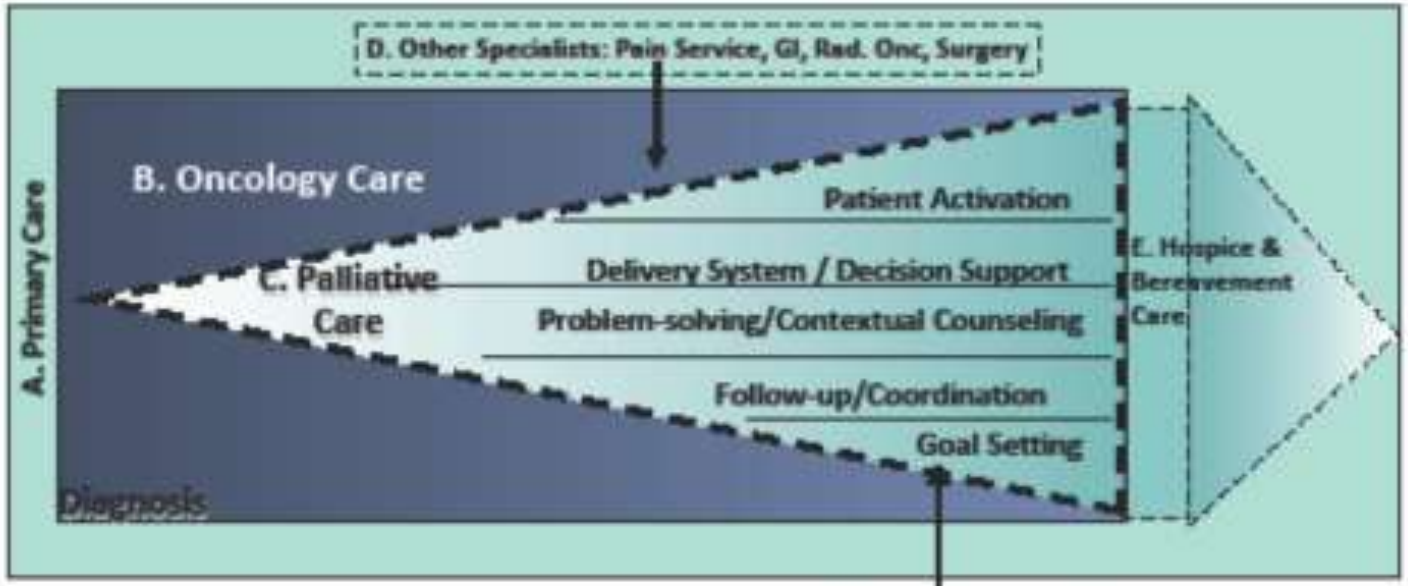
Conceptual Foundation of the ENABLE III Concurrent Oncology Palliative Care Intervention



Goals of phone-based palliative nurse coaching

Bakitas et al. Sem Oncology Nursing. 2010

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Definition of Palliative Care[a,b]

Palliative care is an approach to patient-/family-/caregiver-centered health care that focuses on optimal management of distressing symptoms, while incorporating psychosocial and spiritual care according to patient/family/caregiver needs, values, beliefs, and cultures. The goal of palliative care is to anticipate, prevent, and reduce suffering; promote adaptive coping; and support the best possible quality of life for patients/families/caregivers, regardless of the stage of the disease or the need for other therapies. Palliative care can begin at diagnosis; be delivered concurrently with disease-directed, life-prolonging therapies; and facilitate patient autonomy, access to information, and choice. Palliative care becomes the main focus of care when disease-directed, life-prolonging therapies are no longer effective, appropriate, or desired. Palliative care should be provided by the primary oncology team and augmented as needed by collaboration with an interprofessional team of palliative care experts.

Standards of Palliative Care[c,d]

- **Institutions should develop processes for integrating palliative care into cancer care, both as part of usual oncology care and for patients with specialty palliative care needs.**
- **All patients with cancer should be screened for palliative care needs at their initial visit, at appropriate intervals, and as clinically indicated (See PAL-2 and PAL-3).**
- **Patients/families/caregivers should be informed that palliative care is an integral part of their comprehensive cancer care.**
- **Educational programs should be provided to all health care professionals and trainees so that they can develop effective palliative care knowledge, skills, and attitudes.**
- **Interprofessional palliative care teams, including but not limited to board-certified palliative care physicians, advanced practice providers, nurses, social workers, chaplains, and pharmacists, should be readily available to provide consultative or direct care to patients/families/caregivers and/or health care professionals who request or require their expertise.**
- **Quality of palliative care should be monitored by institutional quality improvement programs.**

[a] Hui D, et al. J Pain Symptom Manage 2012;43:582-592.
[b] Seaman JB, et al. J Palliat Med 2020;23:1157-1158.
[c] Ferris FD, et al. J Clin Oncol 2009;27:3052-3058.
[d] IOM (Institute of Medicine). 2014 Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press. Available at: www.nap.edu/read/18748/chapter/1.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

Patient Communication:

Discussing Serious News

Serious News vs. Bad News

- Any information likely to alter drastically a patient's view of his or her future.
- Results in a cognitive, behavioral, or emotional deficit in the person receiving the news that persists for some time after the news is received.
- Alternative term for "breaking bad news" is "sharing life-altering information".

Back AL et al 2011
Ptacek JT et al 1996

Patient Communication, Research and Training: Discussing Serious News

Patient Preferences:

- Most want to know, but how much?
- Cross cultural differences.
  - Racial, gender, economic, age, etc.
  - Respect power gradient.
- How serious news is delivered is as important as what is conveyed.
  - In person vs. distant communication.
  - Direct and clear vs. euphemism.
  - Honesty vs. hope and optimism.
  - Effect on clinicians.
- All efforts augmented by relationship and rapport.

Back AL et al 2011
Ptacek JT et al 1996

Patient Communication, Research and Training:

Discussing Serious News: SPIKES

- Setting
- Perception
- Invitation
- Knowledge
- Emotions
- Strategy and Summary

Back AL et al 2011
Ptacek JT et al 1996

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Trauma Informed Cancer Care

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Disclosures:

None

Objectives:

1. Define trauma and discuss the prevalence in populations and impact on cancer care.
2. Review the present state of Trauma Informed Care (TIC) in the cancer setting.
3. Discuss post-traumatic growth and ways to foster resiliency.

Trauma Defined:

1. An event, either witnessed or experienced, that represents a fundamental threat to an individual's physical safety or survival.
2. The meaning attributed to the event is often as important as the physical experience.
3. Trauma by definition is unbearable, intolerable and overwhelming.
4. Related emotions include entrapment, helplessness, and futility in escape or stopping the event from happening.

Van der Kolk, B. 2014

Trauma Defined:

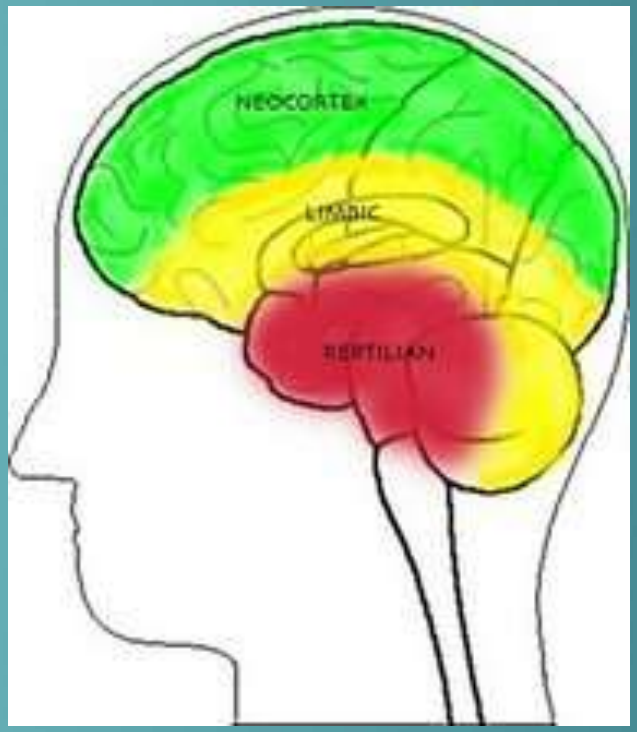
"Trauma is an emotional response to a terrible event like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea."

American Psychological Association 2014

Examples of Trauma:

1. Abuse
   - Physical
   - Sexual
   - Emotional/Verbal
   - Neglect
2. Witnessing violence
3. Experiencing death
4. Victim of terrorism or natural disaster
5. Childhood illness or hospitalization
6. Profound changes in family dynamics such as divorce or domestic violence
7. Life threatening medical diagnosis

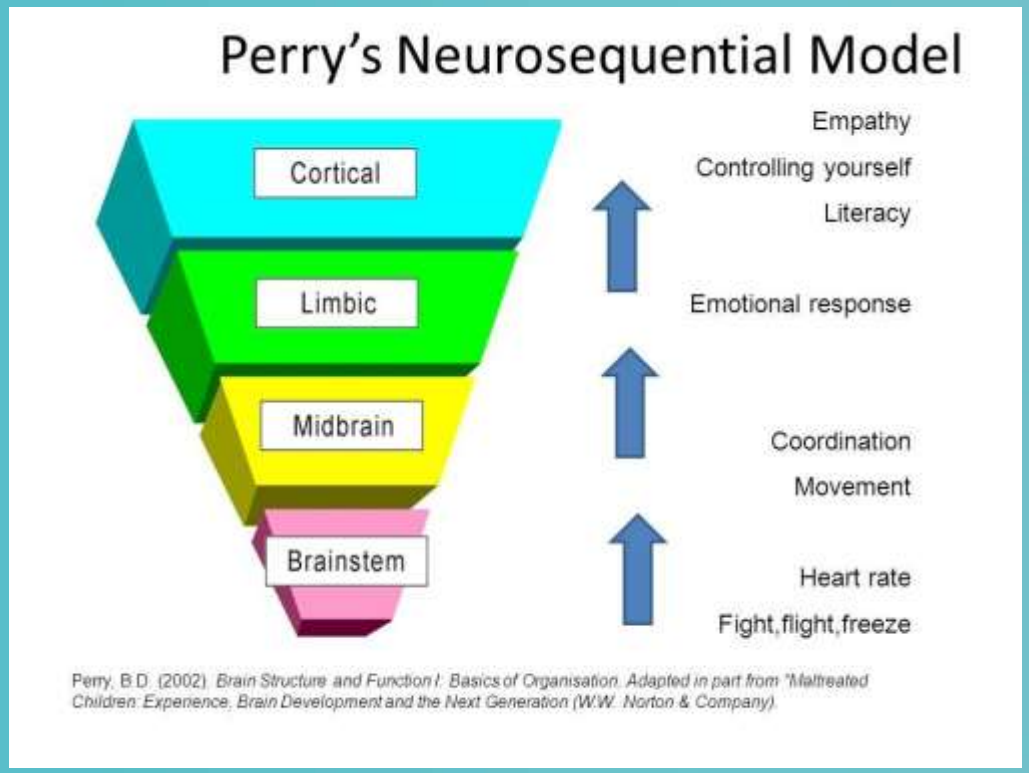
Anatomy of Trauma, Brain Basics:

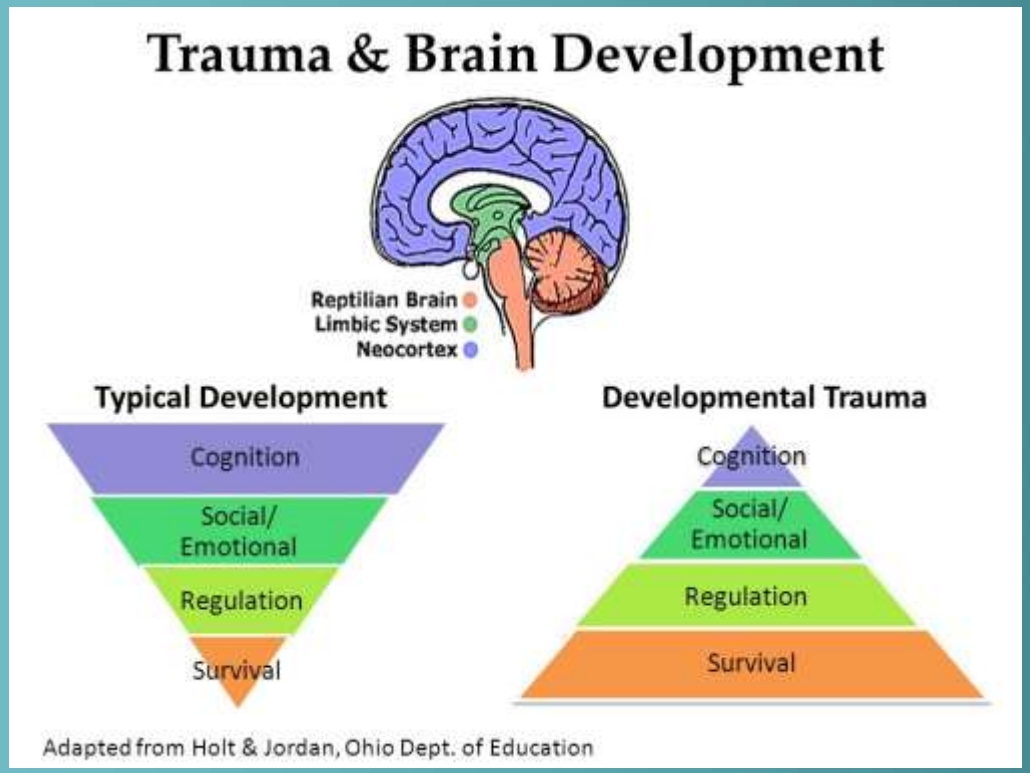


1. Brain Stem: Primitive functions of the brain.
   - SNS ANS
   - Fight, Flight or Freeze
2. Limbic System: Sensory intake, and memory.
   - Amygdala (smoke detector)
   - Thalamus (cook)
3. Brain Stem and Limbic System for our Emotional Brain
4. Prefrontal Cortex (Watch Tower)
5. Does sensory information get sent up to the cortex or down to the brain stem?

Van der Kolk, B. 2014

Anatomy of Trauma - Brain Basics:





Perry, B. 2021

Likelihood of Experiencing Trauma:

Sexual molestation as a child:	1 in 5
Beaten by a parent to the point of leaving a mark:	1 in 4
Physical violence within the family at least once:	1 in 3
Witnessing mother being beaten:	1 in 8
Growing up with alcoholic relatives:	1 in 4

CDC 2014

I've never assumed that all my patients have experienced life-altering trauma, but now I do assume that they may have. JRB 2023

Cancer Diagnosis as Trauma:

1. Trigger of past trauma
2. The trauma of knowing, not knowing, and waiting
   - Diagnostic tests
   - Surgical procedures
   - Chemo/RT
3. New traumatic experience
   - Existential crisis
   - Identity crisis
   - Timing is highly variable
   - Pre-post or in between

Cordova et al. 2017

Trauma's Impact on Cancer Care:

1. Trust and attachment challenges
   - Care team
   - Therapeutic implications
     1. Hopelessness
     2. Trust in treatment plan
     3. Adherence to treatment plan
   - Social services
     1. Financial
     2. Support groups
2. Altered and/or impaired decision-making capacity
3. Trauma responses to cancer are normal, not pathological
   - Life threatening circumstance
   - Trauma becomes problematic when it negatively affects cancer and other health outcomes

Cordova et al. 2017

Trauma Informed Cancer Care (TIC):

1. "Realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."

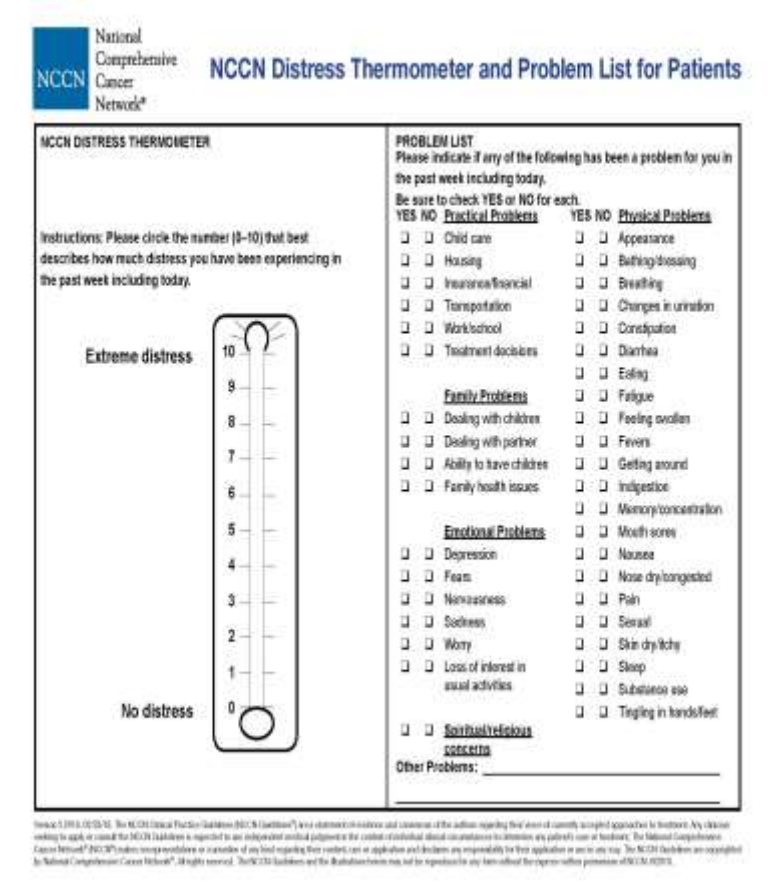
2. Five Guiding Principles
    1. Safety
    2. Choice
    3. Collaboration
    4. Trustworthiness
    5. Empowerment

SAMHSA 2014

TIC: Screening:

1. What will we do with the information once we have it?
   - Infrastructure concerns
   - Limited support services

2. Need for more research.



National Comprehensive Cancer Network®

NCCN Distress Thermometer and Problem List for Patients

NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress — 10 9 8 7 6 5 4 3 2 1 0 — No distress

PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

YES	NO	Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

YES	NO	Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	Spiritual/religious concerns

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: _____

ACEs and PEARLS

for deeper insights into childhood adversity

ACEs

1. VERBAL ABUSE
2. PHYSICAL ABUSE
3. SEXUAL ABUSE
4. EMOTIONAL NEGLECT
5. PHYSICAL NEGLECT
6. DIVORCE OR SEPARATION
7. PHYSICAL ABUSE OF A PARENT
8. ALCOHOL OR DRUG ABUSE BY A PARENT
9. MENTAL ILLNESS OF A PARENT
10. INCARCERATION OF PARENT

PEARLS

1. EXPERIENCED VIOLENCE OR BULLYING
2. EXPERIENCED DISCRIMINATION
3. EXPERIENCED HOUSING INSECURITY
4. EXPERIENCED FOOD INSECURITY
5. EXPERIENCED SEPARATION FROM PARENT OR CAREGIVER DUE TO FOSTER CARE, OR IMMIGRATION
6. EXPERIENCED SERIOUS PHYSICAL ILLNESS OR DISABILITY OF PARENT OR CAREGIVER
7. EXPERIENCED THE DEATH OF A PARENT OR CAREGIVER

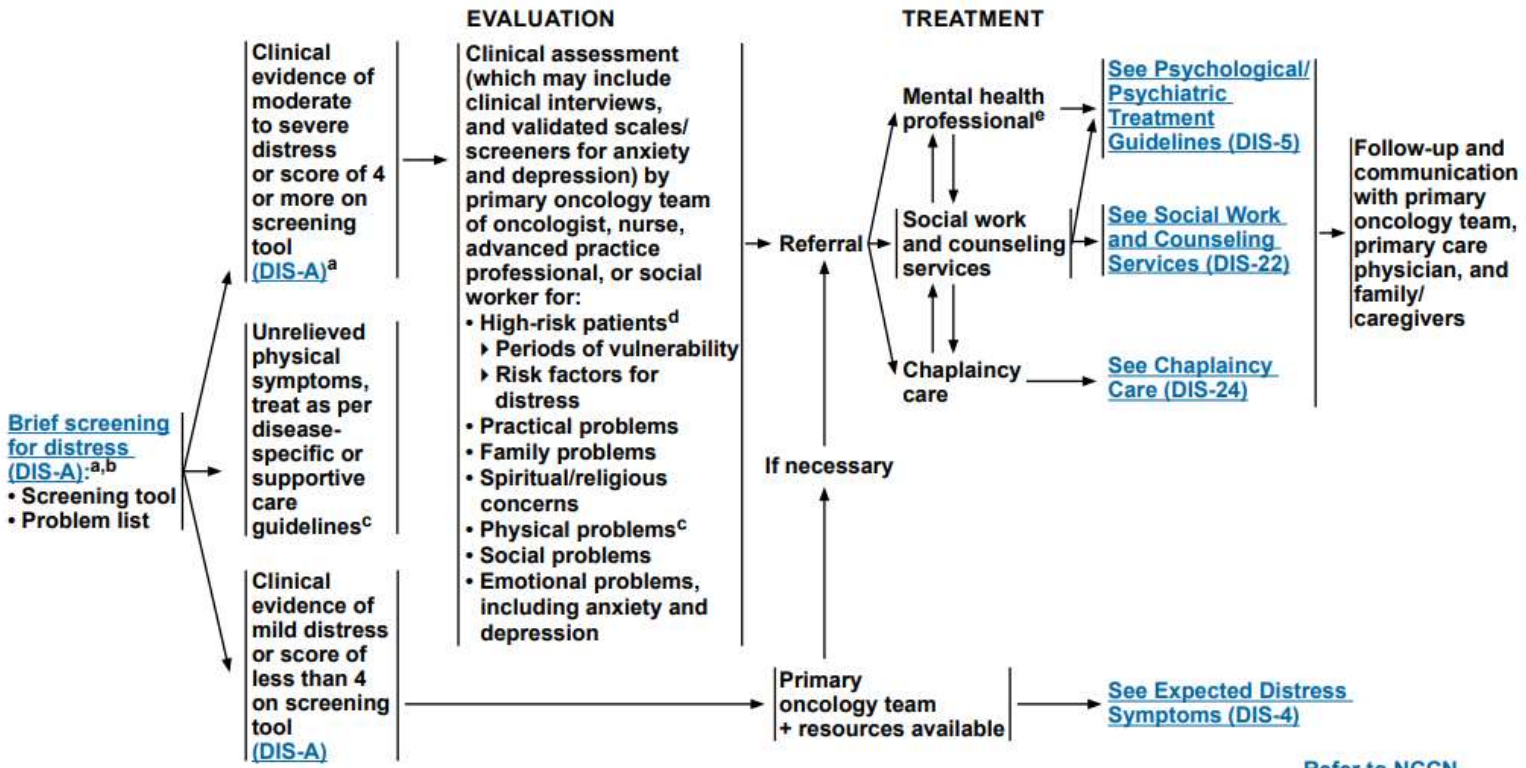
WYS WESTERN YOUTH SERVICES

aces aware GRANTEE

Davidson, C. 2022

NCCN Guidelines Version 2.2023
Distress Management

OVERVIEW OF EVALUATION AND TREATMENT PROCESS



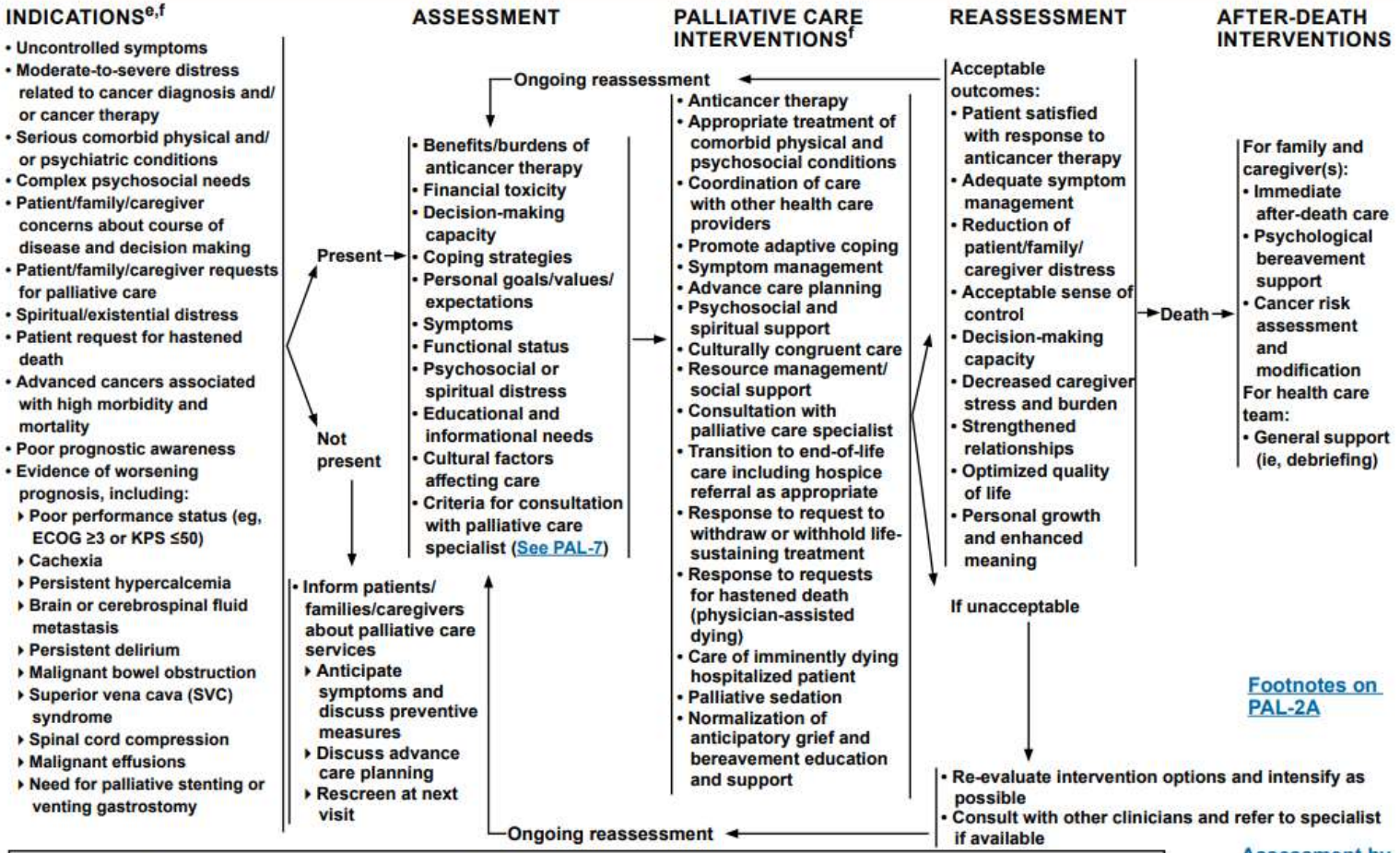
[a] The NCCN Problem List and the NCCN Distress Thermometer Screening Tool may be modified to fit the needs of the local population.
[b] See Discussion (MS-8) for information about other validated screening tools.
[c] Consider referral for palliative care management (See NCCN Guidelines for Palliative Care and NCCN Guidelines for Adult Cancer Pain).
[d] See Psychosocial Distress Patient Characteristics (DIS-B).
[e] Psychiatrist, psychologist, advanced practice clinicians, or social worker.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

Refer to NCCN Guidelines Table of Contents for Supportive Care Guidelines

NCCN Guidelines Version 2.2023
Palliative Care

NCCN Guidelines Index
Table of Contents
Discussion



Footnotes on PAL-2A

Note: All recommendations are category 2A unless otherwise indicated.
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Assessment by Oncology Team (PAL-3)

Trauma's Impact on Cancer Survivorship:

1. Poor emotional health is twice as likely in cancer survivors compared to the general population
   - Cancer Related PTSD (7.3-13.8 %)
   - Subsyndromal levels of PTSD 10-20%
   - Residual anxiety
   - Failure to re-enter prior life roles
   - Financial well being
2. Physical concerns
3. Existential concerns
4. Relationship challenges

Weaver, K. et al 2012
Kirchhoff, A. 2012

Post-Traumatic Stress Disorder and Cancer:

1. Trauma of diagnosis
   - Acute fear
   - Sadness
   - Anger
   - Adjustment
   - Anxiety
   - Depression

Cordova et al. 2017

Post-Traumatic Stress Disorder and Cancer:

1. Trauma of workup
   - Screening
   - Follow up studies
   - Biopsy
   - Staging
2. Time to completion
3. Heightened alertness/anxiety
4. Trauma of treatment
   - Surgery
   - Chemotherapy
   - Radiation
   - Immunotherapy
   - Hormonal therapy

Cordova et al. 2017

Post-Traumatic Stress Disorder and Cancer:

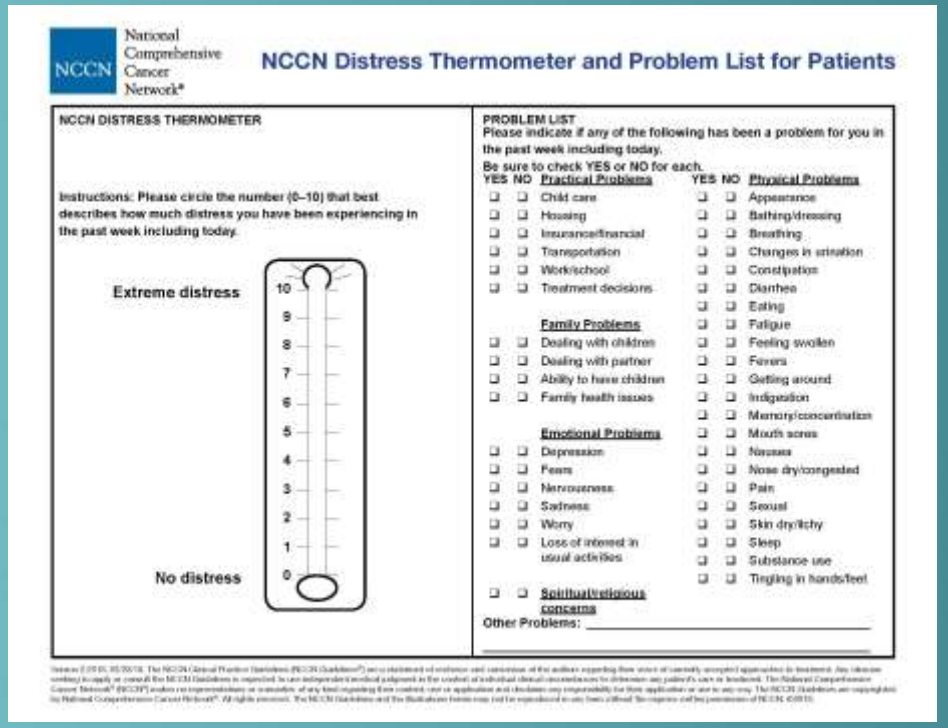
1. Risk factors
   - Pre cancer trauma history
   - Young age
   - Low socioeconomic status
   - Limited social support
   - Advanced disease
   - Invasive treatment

Prior psychiatric condition
- PTSD
- Depression
- Bi-Polar
- Personality disorder
- Dissociative symptoms

Cordova et al. 2017

Post-Traumatic Stress Disorder and Cancer:

1. Interventions
   - Integrated screening
   - Support Groups
   - Embedded psycho-oncology teams
     1. Psychopharmacology
     2. EMDR
     3. CBT
     4. Neurofeedback



National Comprehensive Cancer Network®

NCCN Distress Thermometer and Problem List for Patients

NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress — 10 9 8 7 6 5 4 3 2 1 0 — No distress

PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

YES	NO	Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

YES	NO	Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	Spiritual/religious concerns

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: _____

Cordova et al. 2017
Stanton et al 2015
Van der Kolk, B. 2014

Post Traumatic Growth:

1. Relating to others
2. New possibilities
3. Personal strength
4. Appreciation for life
5. Spiritual change

Menger, F. 2021

References:

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Thank you!

Questions?

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