Understanding the Role of Palliative Care in the Treatment of Cancer Patients

Palliative care is derived from the Latin word “palliare,” to cloak. This is a form of medical care or treatment that concentrates on reducing the severity of disease symptoms, rather than trying to halt or reverse the progression of the disease or to provide a cure. The World Health Organization (WHO) issued a statement that describes palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness.” The first hospital-based palliative care programs began in the late 1980s at facilities such as the Cleveland Clinic and the Medical College of Wisconsin. Since that time there has been a dramatic increase with over 55% of US hospitals having a program.

The Baptist Health System (BHS) began this journey in 2010 and beginning January 2014, all five (S) BHS had an operating palliative care service available. Reviews of current literature presented compelling evidence of improvements in the use of hospice services, inpatient mortality and hospital readmissions.

The American Society of Clinical Oncology (ASCO) in 2012 recommended offering palliative care alongside standard oncologic care to all patients with metastatic cancer. These recommendations were based on randomized clinical studies that showed that when palliative care was integrated into oncology services there were improvements in symptoms, quality of life, and greater patient satisfaction and reduced caregiver burden. Palliative care can be offered along with standard treatment to benefit the Cancer Patient.

A study was performed of BHS inpatients hospitalized in 2013 with a diagnosis of metastatic cancer. The purpose of this study was to determine the impact that a Palliative Care Consult can have on the outcomes of these patients.

Current State (All)

The palliative care program at BHS has seen tremendous growth over the past months. The highest volume to date was back in January 2014 with 177 patients receiving a palliative care consult.
March 2014, June 2014 and September 2014 are the three months with an above average Length of Stay (LOS) for this time period. March has a patient with a 116 day LOS and June has two patients that are both over 100 days LOS (106 and 132). September has patients with a LOS in the 50s. With the exception of September 2014, BHS has seen a steady decrease in LOS.

Viewing the overall LOS when a palliative care physician is brought in to a case early in the admission (within 3 days) as compared to being brought in later (4 days are greater) shows a remarkable difference. When a patient receives a palliative care consult early in their stay (within 3 days), on average there is a 66% reduction in overall LOS compared to receiving a consult after 4 or more days.

**Population Study**

There were a total of 2,107 inpatient records with a medical record coding of V66.7 (Encounter for Palliative Care) for 2013. Palliative Care, comfort care, end-of-life care or hospice care must have been written in the record to support the use of this code. Of these 2,107 BHS inpatients that were hospitalized in 2013 there were 243 (11.5%) with a metastatic cancer diagnosis. All of the BHS hospitals were included in the number of cases.
The average age of the study patients was 68 years with a median age of 69. The range of ages was 22 years to 96 years of age. The majority of the patients 73% (177) were over 60 years of age. There was an equal representation of males 48.6% (118) and females 51.4% (125). Each of the patients had been diagnosed with a metastatic cancer and symptoms requiring admission. Lung cancer was found in the majority of the sites at 27.9% (68) and 11% (26) were colorectal. Breast cancers made up 9.8% (24). There were four cases that were of unknown primary sites.

![Primary Sites](image1)

Of this population, 89% were admitted from home. 58% (142) had presented prior to this visit multiple times either as an admission and/or ED visit. The definition of multiple would be 3 or more visits within the year. Discharge dispositions after this visit was 72% (175) being discharged to a Hospice which included inpatient facilities and to home with hospice. Sadly, 21% (52) expired during this visit.

These patients were admitted with several different diagnoses. Respiratory problems made up 21% (50) of the population and significant pain was next at 16% (38). These were the physical issues identified.

![Top Admitting Diagnoses](image2)
In this 2013 study 32% (78) received a consult from the Palliative Care Team. This is significant as the program was in its early stages. 59% (144) of this population the physician directly ordered a hospice consult and did not use palliative care. Comfort care was used in the patients that were actively dying. There were four patients that either refused, decided to go home without further care or expired.

![End-of Life Care Services Ordered](chart1)

**Length of Stay**

Earlier in this study, data was shown for all patients that received a palliative care intervention. With that data there was a significant decrease in the overall LOS when a palliative care physician is brought in to a case early in the admission (within 3 days) as compared to being brought in later (4 days are greater). This overall data compares with the patients selectively studied here with a diagnosis of metastatic cancer. The results in the previous overall study depicted an average of 66% reduction in the overall LOS in the patient receiving early intervention (palliative care consults within 3 days). This particular population showed a 67% reduction in overall LOS when receiving a consult within 3 days.

![Palliative Care Consult](chart2)
Patient disposition in these populations (Consult with 3 days and Consult after 4+days) were similar. The majority of the patients were discharged to a Hospice. The impact on inpatient mortality was significant. When the patient had an earlier consult 13% (6) expired in the hospital as compared with the later consult of 37% (11) expired. This has a direct impact on the hospital’s inpatient mortality rate.

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<th>Discharge Disposition Compared with Timing of Palliative Care Consult</th>
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<tr>
<td>Expired</td>
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<td>Within 3 days</td>
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<td>After 4+ days</td>
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**Readmission**

Readmissions back to the facility within 30 days of discharge were part of this study. The review was notable in that only 4% (3) of the 78 patients that had a palliative care consult were readmitted. Review of these three cases showed that the first patient had opted to be discharged to home to seek palliative care at the Veteran’s Hospital but was unable to obtain these services prior to expiring. The second patient was seen in the ED with an eye infection requiring antibiotics. This was not related to his cancer diagnosis. The third patient had been discharged to Hospice at home but was subsequently sent to a nursing home. There had not been good communication within this transition. The nursing home sent the patient to the hospital instead of contacting the hospice agency. In reviewing these cases it was determined that the readmissions were not preventable due to the circumstances. However, when comparing the patients that did not have a palliative care consult 9% (19) were readmitted. Of the patients that had been discharged with hospice 74% (14) had revoked this service.

**Conclusions**

This study validated the improvements in the use of hospice care, length of stays, in-patient mortality and hospital readmissions in patients with a diagnosis of metastatic cancer. By reducing readmissions, and shortening LOS this will help to lower the cost for hospitals and payers.

Research has also shown that palliative care improves the quality of life by providing an extra support to the patients, caregivers and doctors. This is obtained with a focus on addressing symptoms, decision-making and coordinating care. Many physicians may see palliative care as only end-of-life care and believe that all treatment will need to be stopped. In fact patients that are receiving hospice can also receive chemotherapy as part of the palliative care philosophy.
Dr. Kerin Adelson of Mount Sinai Hospital (2013) as part of a study stated the following:

*Failure to identify patients who could most benefit from palliative care often results in inadequate pain control, emotional distress for patients and caregivers, and overuse of aggressive medical interventions. By increasing access to palliative care services, we hoped to help patients clarify their own treatment goals and, in turn, align our clinical goals with those of our patients.*

Research continues to show that integrating timely palliative care as part of a patient’s cancer care will result in improved outcomes. An important part of cancer care is the relief of symptoms and side effects, however, the physical and emotional effects of cancer may be different for every person. Palliative Care professional takes into consideration the age, cultural background or support systems these patients may have. The BHS Palliative Care Program continues to grow and mature. Incorporating the recent addition of a psychosocial distress screening tool for our cancer patients is an adjunct to palliative care in identifying not only the physical concerns but the financial, emotional, social and spiritual concerns.

**Disclaimer:**

This study is for informational use only. These findings are not intended to be used for budgeting purposes or to be incorporated into any contract or viewed as a commitment for targeted projections.
References