THE UNIVERSITY OF HONG KONG
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# "Proactive" palliation
# The benefit of early palliative care intervention in advanced cancer patients

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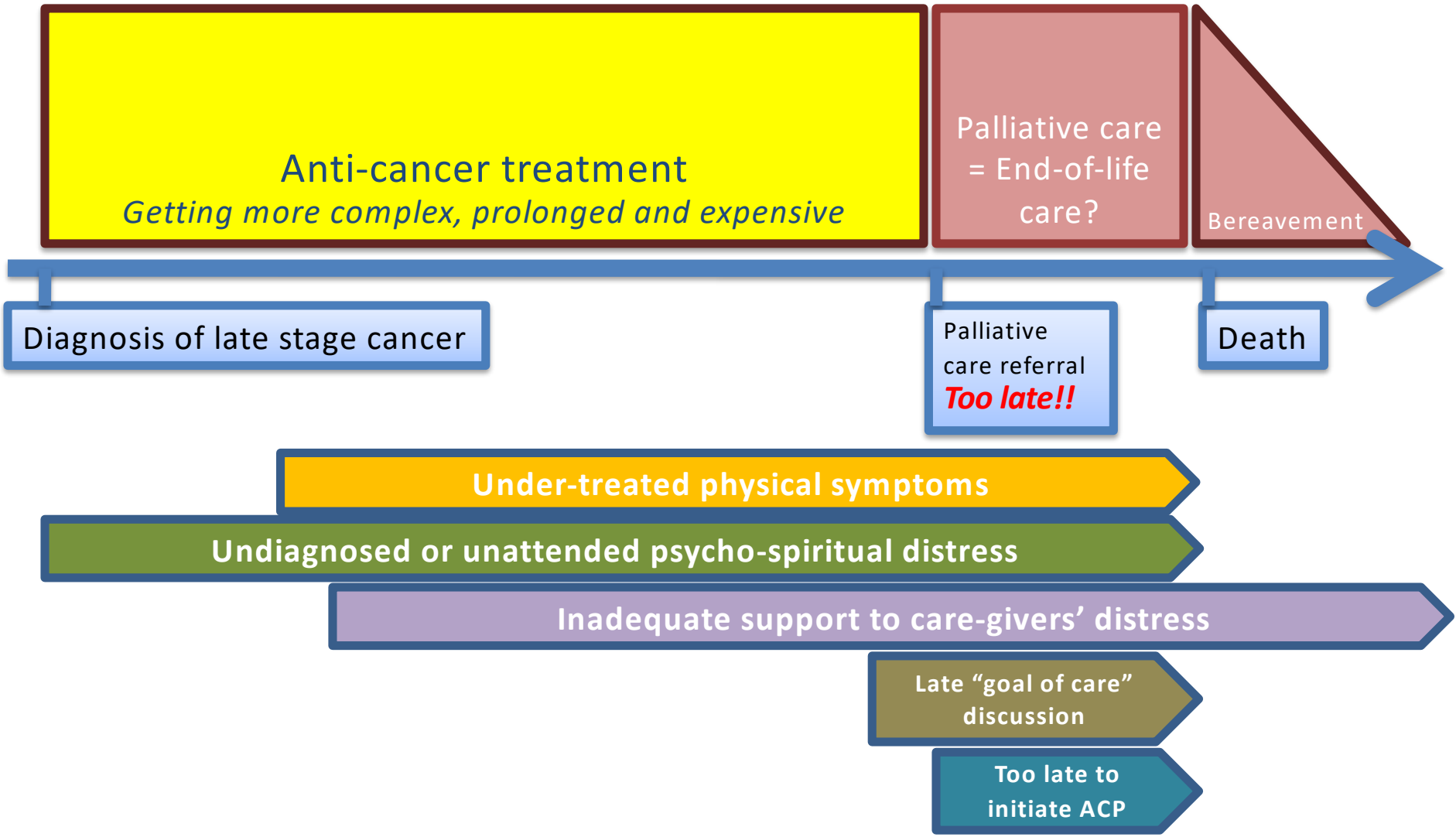
# Outline

- Early palliative care in oncology service: the evidence
- The current model of palliative care for cancer patients in Hong Kong: achievement and limitations
- Early palliative care for cancer patients in Hong Kong: the future development

# The segregated model



# Integration of palliative care and oncology service


- No conflicts between palliative care and anticancer treatments. Both can be provided at the same time
- What is the impact of early palliative care provision?
- Who / when / how / where / what to provide such early palliative care?

# Integration of palliative care into oncology service: Summary of randomized controlled clinical trials

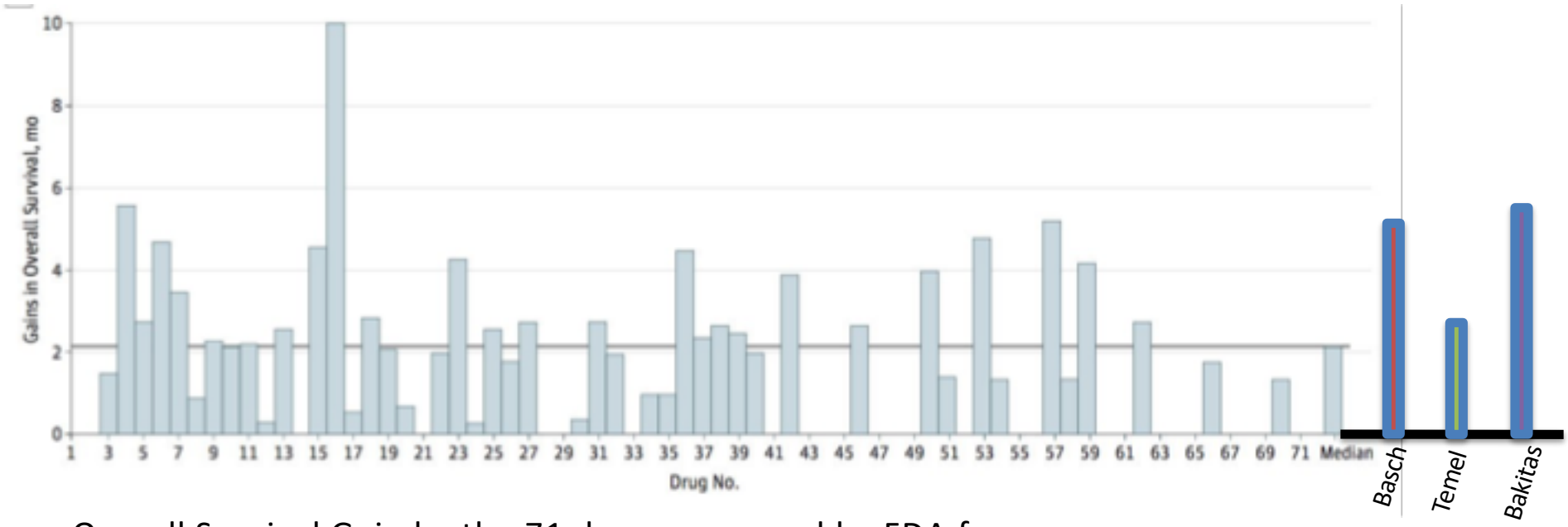
| Studies | Population | Intervention / Control arm |
|---|---|---|
| Gade<br>JPM 2008 | Colorado and SF, USA | Inpatient palliative care consultation *vs*<br>*Standard inpatient care* |
| Temel<br>NEJM 2010 | Massachusetts, USA | Palliative Care Specialist clinic *vs*<br>Standard oncology clinic |
| Zimmermann<br>Lancet 2014 | Ontario, Canada | Palliative care clinic & nurse phone follow-up, community services *vs*<br>Standard oncology practice |
| Bakitas<br>JCO 2015 | New England, USA | 4-week course by nurses, monthly phone follow-up *vs*<br>Standard oncology practice |
| Lancet Oncology 2018 | Belgium | Palliative team intervention *vs*<br>Standard oncology practice with routine psychologist support |
| Basch<br>JCO 2017 | Carolina and NY, USA | Weekly web-based self-reports of symptoms and rapid response by nurses *vs*<br>Standard oncology practice |

# Integration of palliative care into oncology service: Summary of randomized controlled clinical trials

| Studies | Intervention / Control arm | Outcome, *Remarks* |
|---|---|---|
| Gade<br>JPM 2008 | Inpatient palliative care consultation *vs*<br>*Standard inpatient care* | Lower cost, better satisfaction to health care team. Same symptoms, QoL and survival<br>***Late service reduced cost but could not improved patients outcome*** |
| Temel<br>NEJM 2010 | Palliative Care Specialist clinic *vs*<br>Standard oncology clinic | Improved quality of life (QoL), less depression, **improved survival**<br>***Specialist early palliative care improved outcome*** |
| Zimmermann<br>Lancet 2014 | Palliative care clinic & nurse phone follow-up, community services *vs*<br>Standard oncology practice | Improved quality of life and symptom control<br>***Specialist palliative care + nurse-led service + community service improved outcome*** |
| Bakitas<br>JCO 2015 | 4-week course by nurses, monthly phone follow-up vs<br>Standard oncology practice | Improved QoL, less depression, **improved survival**<br>***Early nurse-led educational program improved outcome*** |
| Lancet Oncology 2018 | Palliative team intervention *vs*<br>Standard oncology practice with routine psychologist support | Improved QoL, less depression<br>***Palliative multidisciplinary team improved outcome beyond psychological support*** |
| Basch<br>JCO 2017 | Weekly web-based self-reports of symptoms and rapid response by nurses *vs*<br>Standard oncology practice | Better QoL, less AED visits and hospitalization. **Improved survival**<br>***Web-based symptom control program integrated well in chemotherapy clinic*** |

# The magnitude of benefit of early palliative care

Basch et al: 5.2 months; Temel et al: 2.7 months; Bakitas et al: 5.5 months




Overall Survival Gain by the 71 drugs approved by FDA from 2002 to 2014 for metastatic solid cancers*

*T. Fojo et al. JAMA Otolaryngology – Head & Neck Surgery 2014 (140), 1225

# Evidence-based early palliative care for cancer patients

- Who
  - Patients of all cancer types
- When
  - Within 3 months after the diagnosis of incurable cancer
- How
  - Specialist palliative physician (secondary care)
  - Nurse-led program
  - Web-based monitoring plus rapid response team
- Where
  - Palliative care ambulatory clinic
  - Ward consultation
  - Community
  - Web-based

# Evidence-based early palliative care for cancer patients

- What to provide? *(Temel NEJM 2010)*
  1. Illness understanding/education
     - Inquire about illness and prognostic understanding
     - Offer clarification of treatment goals
  2. Symptom management
     - Inquire about uncontrolled symptoms with a focus on: Pain
     - Systemic symptoms monitoring (pulmonary / GI / GU)
     - Fatigue and sleep disturbance
     - Mood (depression and anxiety)
  3. Decision-making
     - Inquire about mode of decision-making
     - Assist with treatment decision-making, if necessary
  4. Coping with life threatening illness
     - Patient education / support
     - Family/family caregivers
  5. Referrals/Prescriptions
     - Identify care plan for future appointments
     - Indicate referrals to other care providers
     - Note new medications prescribed

- Other possible integrations: Advanced care planning, Family therapy / counselling, spiritual support, dignity-conserving therapies

# Oncology – Palliative Care integration in Hong Kong

- There are 7 public oncology centers in Hong Kong covering 7 million population
- Each center offers full range oncology service including medical oncology, radiation oncology and palliative care
- Public services cover 90% of all oncology care
- In 2015, Clinical oncologists with palliative care diploma: 44 out of total 150.
- Oncologists to patients ratio in Hong Kong: ~30% of USA


# The Integrative Service Model

- Multidisciplinary palliative care team were set-up within each oncology centers
  - Led by clinical oncologists with dual qualification
  - Three departments were accredited as ESMO designated centers


ESMO Designated Centres of Integrated Oncology and Palliative Care

# The Impact of the Current Integrative Service Model

- Compared with standard practice, the integrative model* led to

| Outcome measures | Integrative model | Standard practice | P value |
|---|---|---|---|
| Higher palliative care coverage | 68.9% | 19.9% | <0.001 |
| Longer use of palliative care service | 65 days | 24 days | <0.001 |
| More frequent prescription of strong opioid | 51.0% | 28.9% | <0.001 |
| Less ICU admission | 0.67% | 5.13% | 0.02 |
| Death at palliative care beds or hospice units | 36.4% | 21.2% | 0.003 |

- This was achieved without compromising the use of anti-cancer treatment

**Lam PL, Lam TC. Supp Care Cancer Nov 2017*

# The Limitation of the Current Model

- The early phase of palliative care is mainly provided by oncologists (doctors-oriented)
- Multidisciplinary team intervention still occurred relatively late
- Limited collaboration between hospitals and community health care providers
- Marked heterogeneity of service provision across different service clusters / hospitals

# The Limitation of the Current Model
## Insufficient hospital-community collaboration

| Last 6 months of life | 2006 | 2009 | 2012 | 2015 |
|---|---|---|---|---|
| Total admission days (median, interquartile range) | 30 (15-51) | 28 (14-49) | 27.5 (14-44) | 27 (15-48) |
| Total number of unplanned admissions (median, interquartile range) | 3 (2-4) | 3 (2-4) | 3 (2-4) | 3 (2-5) |
| Total SOPD visit (median, interquartile range) | 4 (2-8) | 5 (2-8) | 5 (2-9) | 5 (2-9) |
| Number of AED visit (median, interquartile range) | 2 (1-3) | 2 (1-4) | 2 (1-3) | 2 (1-3) |

- Frequent unplanned admissions and total admission length in the last 6 months of life showed no improvement in the past decade*
- Palliative care resources (or health care resources in general) were concentrated at hospital units – ward, AED, SOPD
- Home death rate very low (<<3%)**

**Comprehensive review of palliative care service coverage, clinical resources burden and palliative care outcome indicators for advanced cancer patients in Hong Kong, 2006-2015. Supported by Li Ka Shing Foundation. Jan 2018*

***Lam PT. HK Pract 2013;35:52-58*

# The Limitation of the Current Model

## The need of a designated palliative care team

| Hospital with emergency admissions | Designated palliative care team | Palliative care coverage for cancer patients (%) |
|---|---|---|
| Hospital 1 | Yes | 63.9 |
| Hospital 2 | Yes | 66.7 |
| Hospital 3 | Yes | 80.8 |
| Hospital 4 | No | 3.5 |
| Hospital 5 | No | 16.7 |
| Hospital 6 | No | 11.4 |

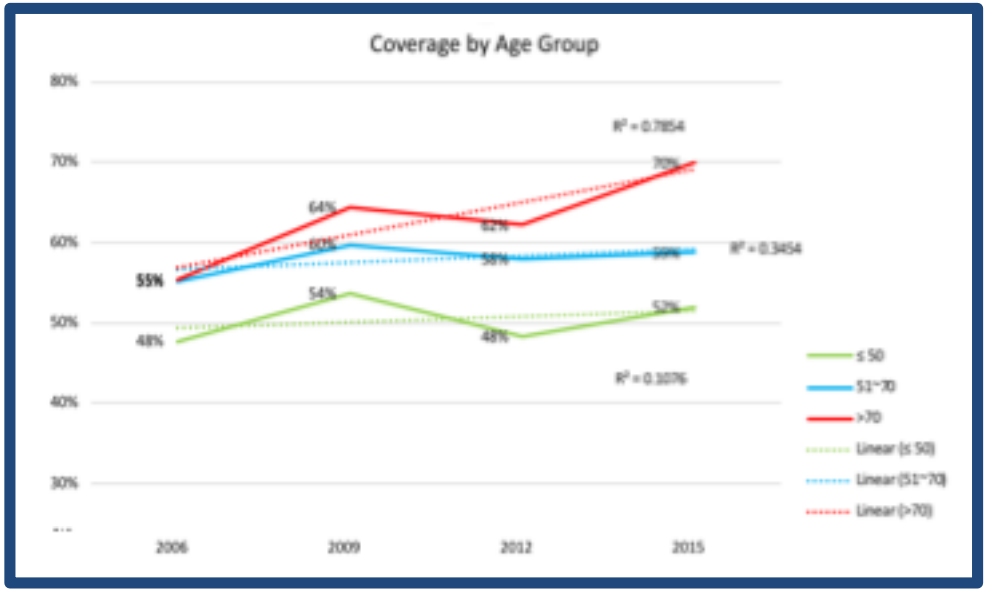
- All 6 acute hospitals admitted cancer patients with similar socio-economical background
- The huge difference in palliative care coverage signified the importance of in-house palliative care team and adequate designated palliative beds in acute hospitals

**Comprehensive review of palliative care service coverage, clinical resources burden and palliative care outcome indicators for advanced cancer patients in Hong Kong, 2006-2015. Supported by Li Ka Shing Foundation. Jan 2018*

# The Limitation of the Current Model

## The need of universal screening of patients

- Younger age patients paradoxically received less palliative care??
- Younger patients' management may be overwhelmed by active anti-cancer treatment planning
- Referral to palliative care typically occurred late, or simply did not occur
- Need to have a designated team member to do palliative care screening, instead of completely relying on primary oncologists

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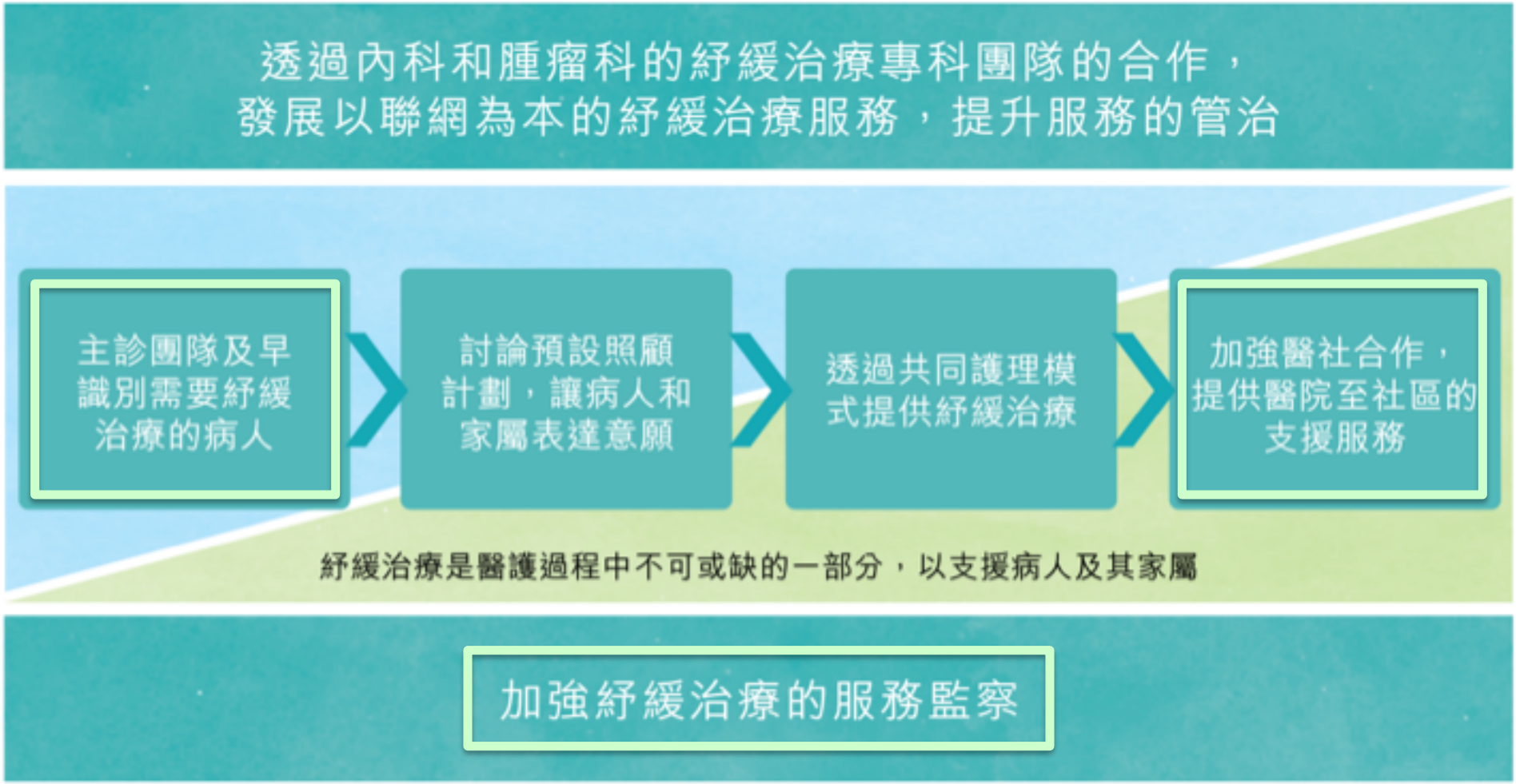
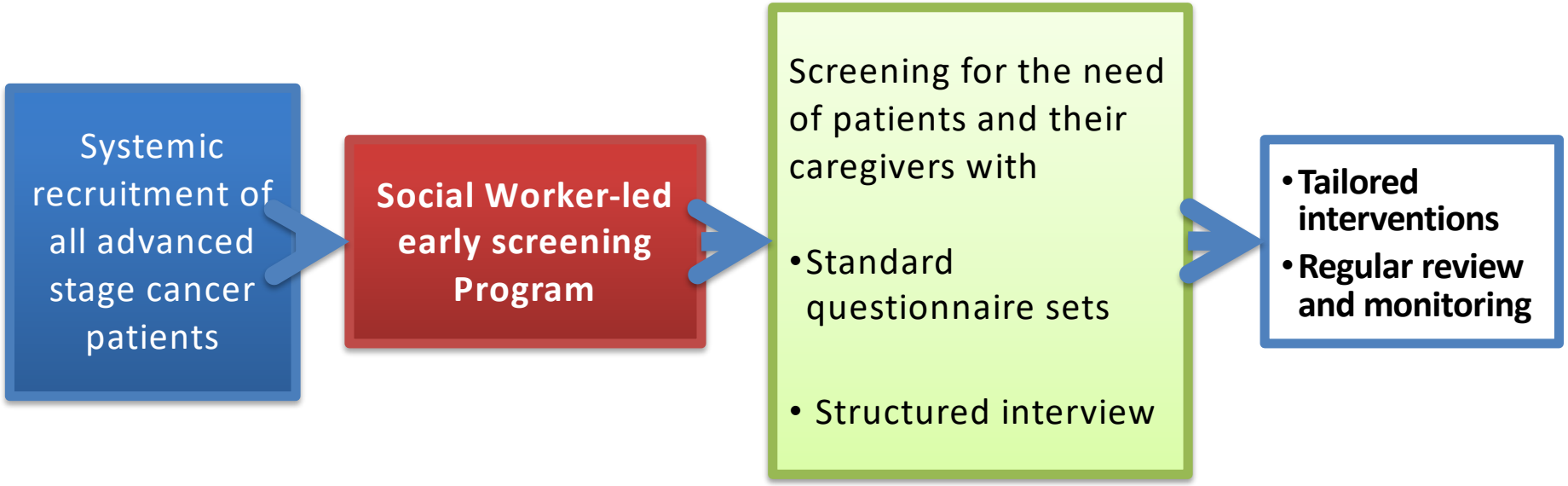
# Palliative Care Strategic Service Framework of Hospital Authority: 2017



# Pilot Project at Queen Mary Hospital

## Social Worker-led early screening program

1. **Who**: all cancer patients with incurable cancers
2. **When**: Within 3 months after the diagnosis of incurable cancers
3. **What**: screening for the need of both patients and care-givers with qualitative interviews + quantitative instruments. Need-based individualized interventions
4. **Where**: QMH clinical oncology chemotherapy clinic
5. **How**: regular social worker-led interview, app-based symptoms monitoring, rapid response by clinical team



# Pilot Project at Queen Mary Hospital

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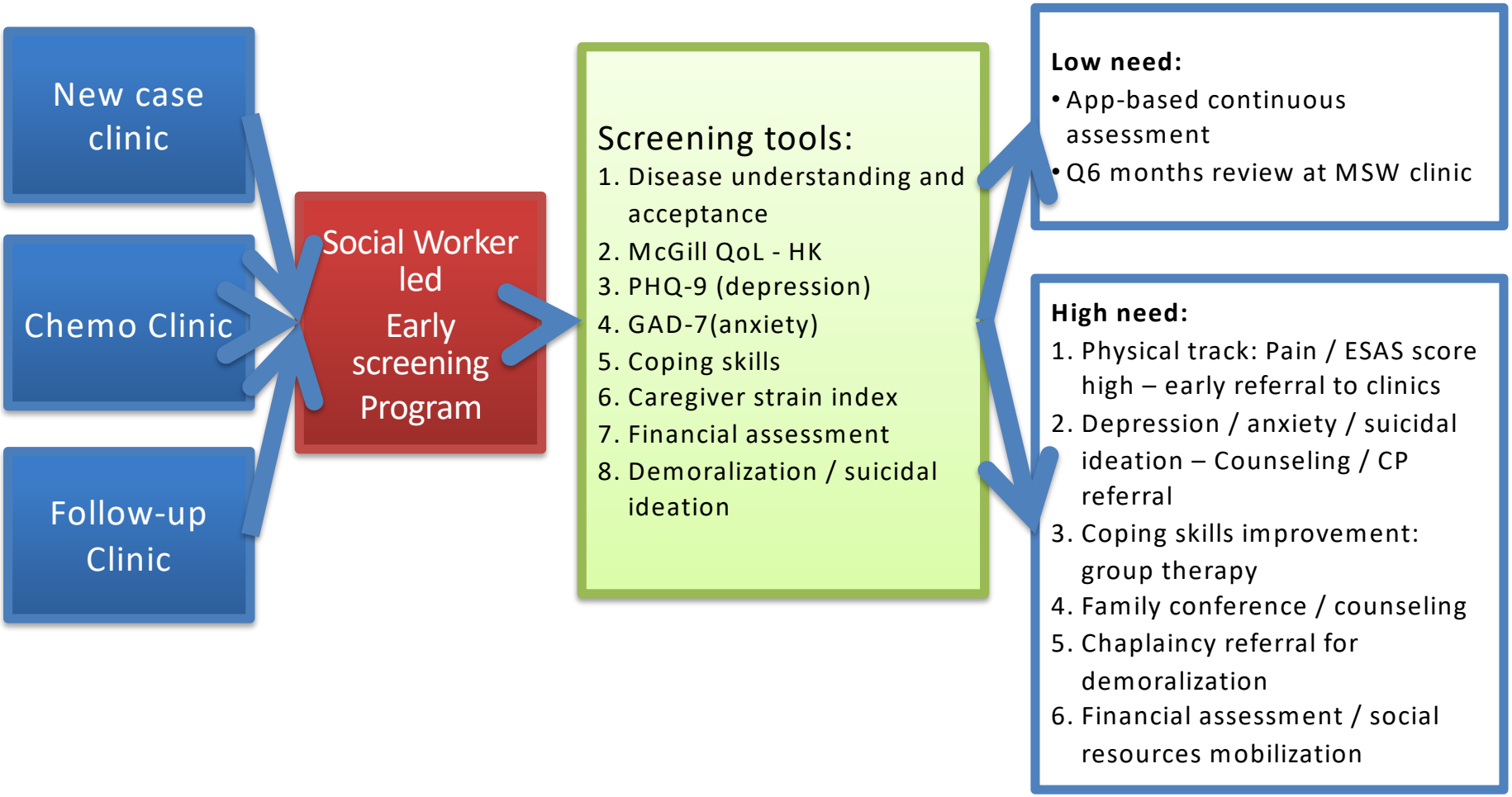

# Conclusions

- Early integration of palliative care into oncology service is the new standard of care with strong evidence to improve QoL, decrease depression and probably prolong survival
- Multidisciplinary teams for palliative care are available in all public cancer centers
- Further improvement of service awaited,
  - earlier universal screening and palliative care intervention
  - better integration of hospital and community resources
  - Continuous symptoms monitoring and rapid response, aided by advance technology