Palliative Care And Oncology: Opportunities and Challenges.

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Objectives

1. Recognizing the problem:
   - Care is not optimal, and we are partly to blame.
   - Value is missing in some of our spending
   - Costs are rising at an unsustainable rate
2. Palliative care alongside oncology offers practical ways to improve health, quality of care, and value
   - What are the benefits of concurrent care?
   - What does PC do alongside ONC?
   - Having difficult conversations.
   - How can we integrate these best practices?

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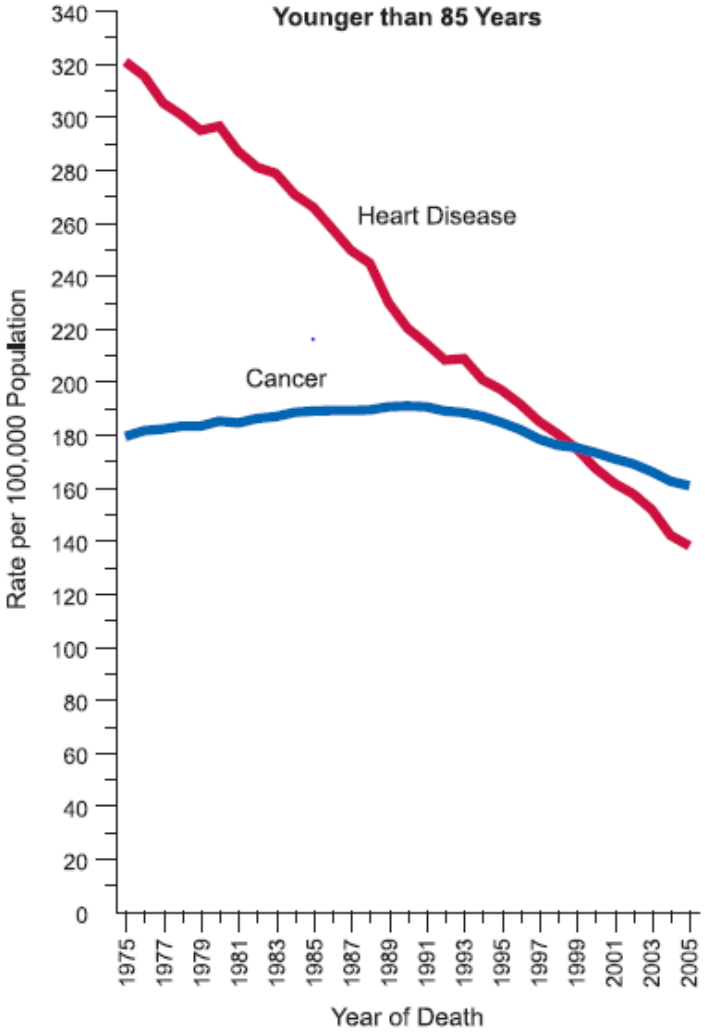
Value: The death rate from cancer is changing but not fast compared to other medical care – and use of the same money.



From Jemal, A. et al. Death Rates for Cancer and Heart Disease for Ages Younger than 85 Years and 85 Years and Older, 1975-2005
CA Cancer J Clin 2009;59:225-249.

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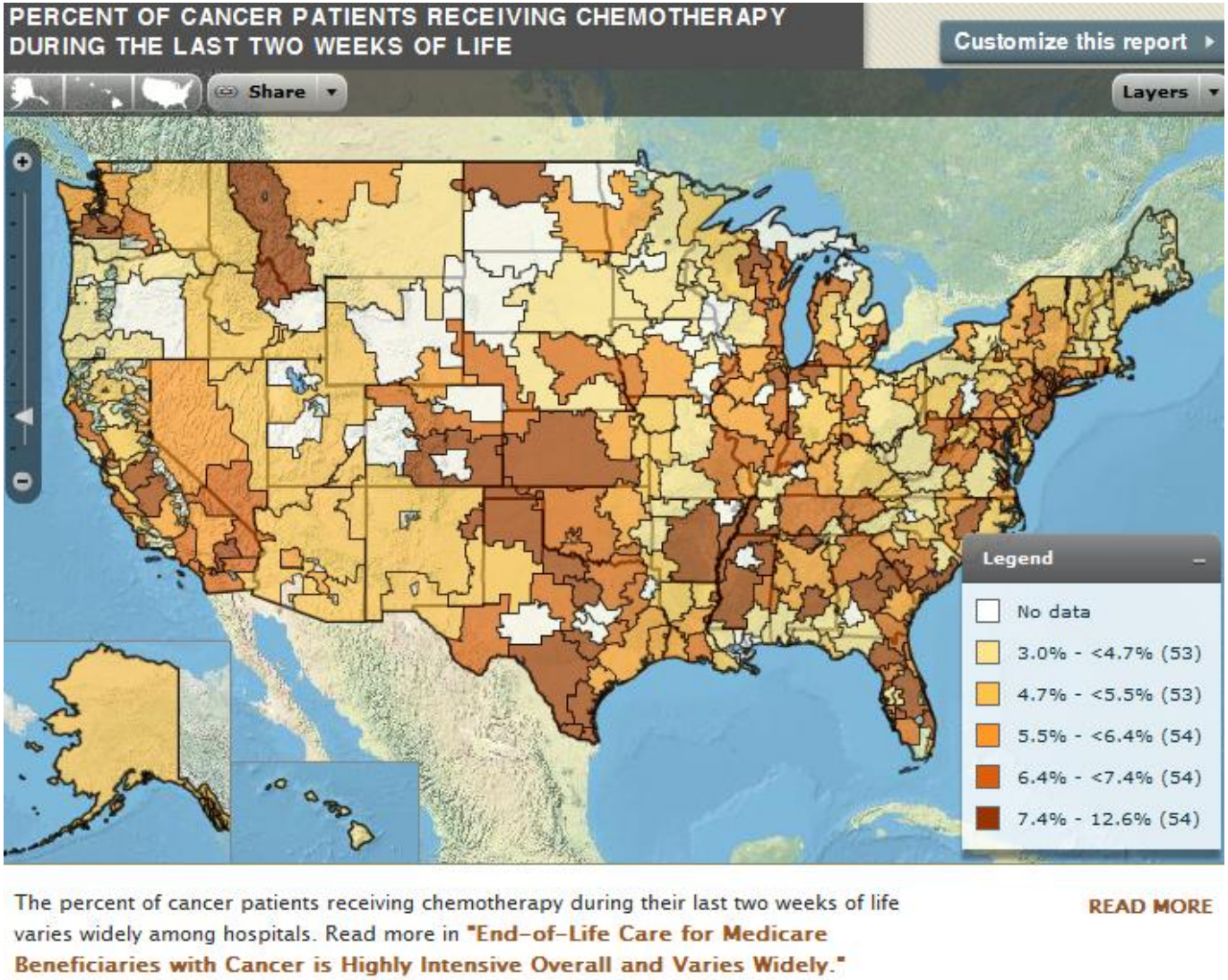
There is unwarranted practice variation in chemo at the end of life, up to >12%. Morden N, 2011



Morden NE, Chang CH, Jacobson JO, Berke EM, Bynum JP, Murray KM, Goodman DC. End-of-life care for Medicare beneficiaries with cancer is highly intensive overall and varies widely. Health Aff (Millwood). 2012 Apr;31(4):786-96.

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There are opportunities to change our practice

Medicare Patients, Unadjusted Cancer Care Measures, By Hospital Characteristics, Morden 2011

Measure	All	NCCN cancer centers	Non-NCCN NCI cancer centers	Academic hospitals	Community hospitals
Death in hospital (%)	30.2	32.6	32.4	33.8	29.7
Hospice use, last month of life (%)	53.8	53.4	52.4	50.3	54.2
Days in hospice, last month of life (per decedent)	8.4	8.6	8.1	7.6	8.5
Hospice initiated, last 3 days of life (%)	8.5	7.1	7.9	8.3	8.6
Hospitalized, last month of life (%)	64.9	60.2	61.7	64.4	65.1
Days in hospital, last month of life (per decedent)	5.3	5.6	5.6	5.9	5.3
ICU use, last month of life (%)	24.7	23.3	26.3	26	24.6

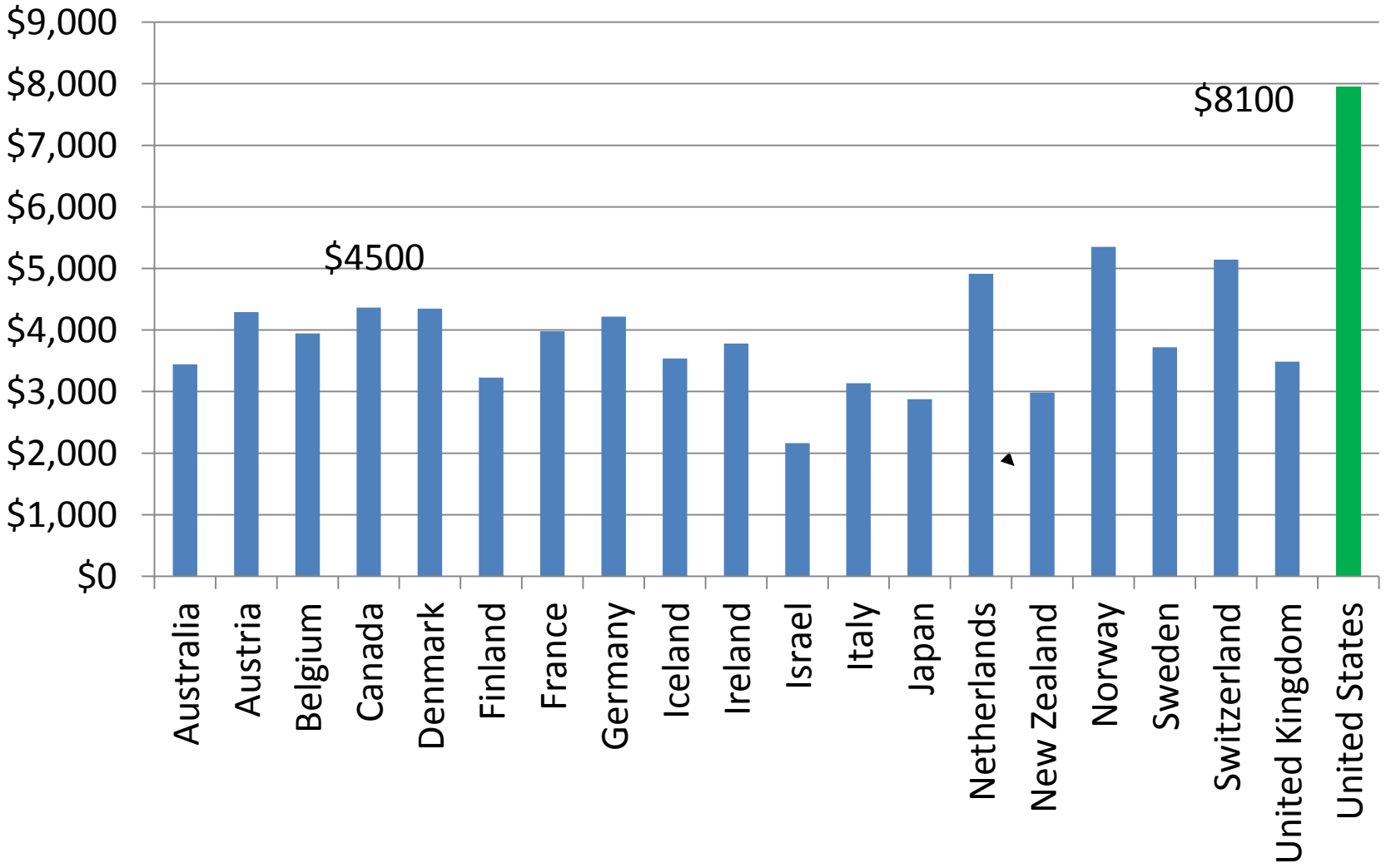
Morden NE, Chang CH, Jacobson JO, Berke EM, Bynum JP, Murray KM, Goodman DC. End-of-life care for Medicare beneficiaries with cancer is highly intensive overall and varies widely. Health Aff (Millwood). 2012 Apr;31(4):786-96.

Biggest Concerns for Patients with Serious Illness

Concern	%
Doctors might not provide all of the treatment options or choices available	58%
Doctors might not talk and share information with each other	55%
Doctors might not choose the best treatment option for a seriously ill patient's medical condition	54%
Patients with serious illness and their families leave a doctor's office or hospital feeling unsure about what they are supposed to do when they get home	51%
Doctors do not spend enough time talking with and listening to patients and their families	50%

Source: ACS 2011 Public Opinion Research on Palliative Care
http://www.capc.org/tools-for-palliative-care-programs/marketing/public-opinion-research/2011-public-opinion-research-on-palliative-care.pdf

Medical care costs 2-fold more in the US than any other country



OECD Health Data 2011

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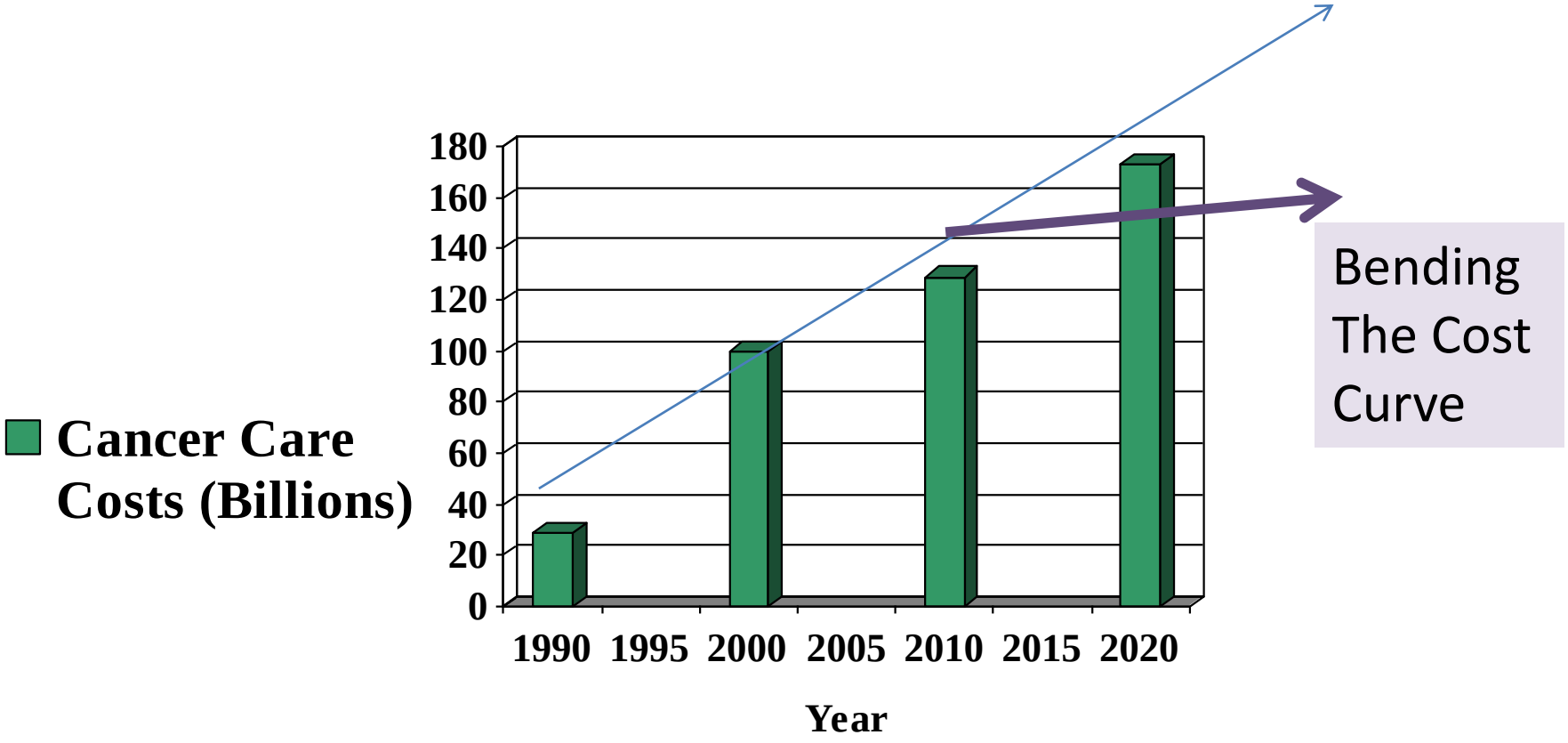
Cancer care costs are rising exponentially

- $173 billion at 2% growth rate



Mariotto AB, et al. Projections of the cost of cancer care in the United States: 2010-2020. J Natl Cancer Inst. 2011 Jan 19;103(2):117-28.

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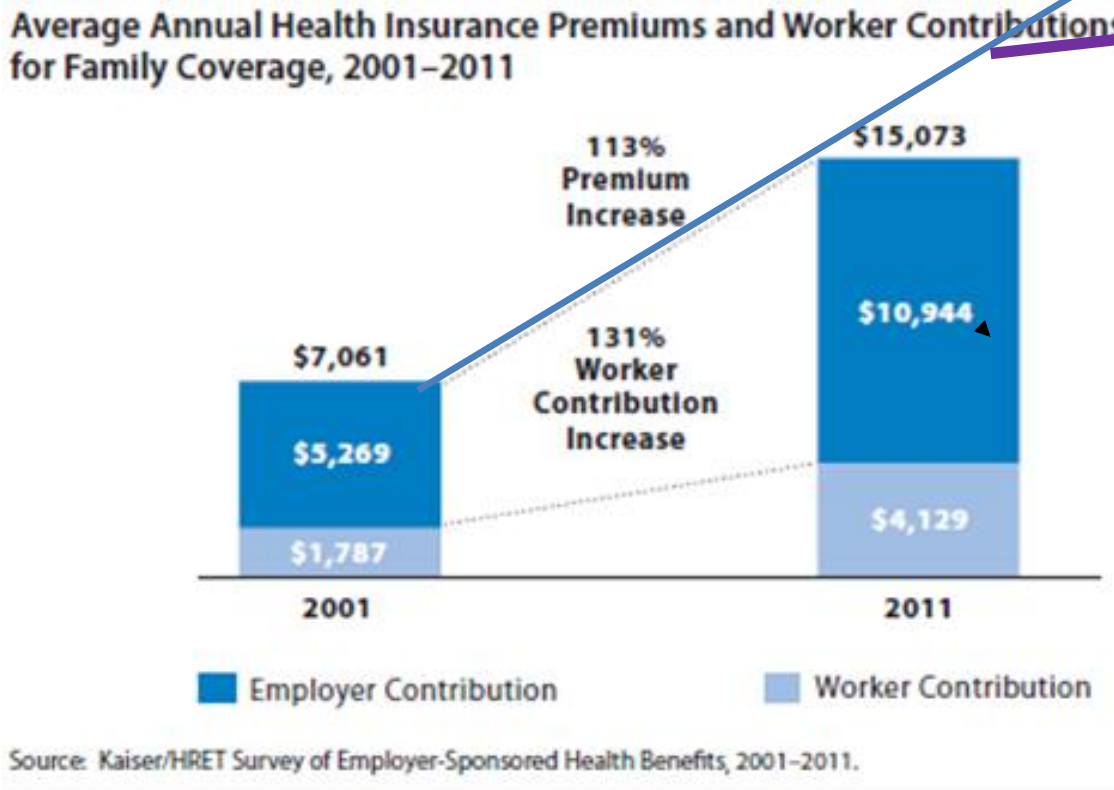
Insurance premiums are rising and fewer people can afford them

- Insurance premiums *doubled*
- Patient responsibility doubled
- 9% increase *last year*



Bending The Cost Curve

Claxton G, et al. Health Aff (Millwood). 2010 Oct;29(10):1942-50.

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Medical care cost increases are unsustainable, but some of them are under our control and fixable.

- As much as 30% of care is not evidence-based and does not add value. (Cong Budget Office.)
- About 25% of all Medicare funds are spent in the last year of life, and over 9% (over $50 billion) in the last MONTH of life (Riley and Lubitz, Health Services Research 45.2 (2010): 565-76.)
- Much of the pattern of care is under our control including **imaging, chemotherapy choices, surveillance after curative care, integration of palliative care, use of hospice, and avoiding chemotherapy and hospitalization near the end of life**.

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N ENGL J MED 364:21 NEJM.ORG MAY 26, 2011

The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

Bending the Cost Curve in Cancer Care

Thomas J. Smith, M.D., and Bruce E. Hillner, M.D.

Annual direct costs for cancer care are projected to rise — from $104 billion in 2006[1] to over $173 billion in 2020 and beyond.[2] This increase has been driven by a dramatic rise in both the cost of therapy[3] and the extent of care.[4] In the United States, the sales of anticancer drugs are now second only to those of drugs for heart disease, and 70% of these sales come from products introduced in the past 10 years. Most new molecules are priced at $5,000 per month or more,[5] no benefit to surveillance testing with serum tumor markers or imaging for most cancers, including those of the pancreas, ovary,[12] or lung,[13] yet these tests are commonly used in many settings. In breast cancer, randomized studies showed that scheduled (not symptom-guided) imaging does not detect curable recurrences or alter survival. Twenty years ago, the estimated cost of wasted medical resources in the United States for patients with breast cancer was $1 bil-

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Table 1: Five changes in oncologist behavior that will bend the cancer cost curve
1. Target surveillance procedures to those where there is proof or high likelihood of benefit. 2. For most solid tumors limit 2nd line and for all 3rd line for metastatic treatments to sequential mono-therapies. 3. For patients with cancer that has progressed on treatment limit future active therapy to patients with good performance status. 4. Dose reduction can replace white-cell stimulating factors in metastatic solid cancers. 5. For patients not responding to three consecutive regimens further cancer directed therapy should be limited to clinical trials.

Smith TJ, Hillner BE. Bending the cost curve in cancer care.
N Engl J Med. 2011; May 26;364(21):2060-5.

Table 2: Five Attitudes that require acknowledgement and change
1. Acknowledge that we drive the costs of care by what we do and don't do. 2. Both doctors and patients need more realistic expectations. 3. Realign compensation and rebalance cognitive services. 4. Better integration of end-of-life non-chemotherapy oriented palliative care. 5. Accept the need for cost-effectiveness analysis and some limits on care.

Smith TJ, Hillner BE. Bending the cost curve in cancer care.
N Engl J Med. 2011; May 26;364(21):2060-5.

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Ground Rules

1. Everything is on the table for discussion.
2. Accept data where it exists.
3. Clinical trials are exempt.
4. Curative/adjuvant care is exempt.
5. Recognize that this is going to be painful.
    - Supportive care and chemo “cost” is a main source of oncology income.
    - Hospitalizations for cancer patients are one of the main sources of hospital income.
    - Pharmaceutical companies must profit from drugs.
    - Doctors and patients do not like to have difficult discussions.
    - Not everyone can get everything they want.

Why palliative care?

- It is good and sometimes better clinical care.
- It may allow people to live longer, not the opposite.
- Hospitals are full, often of dying people who don't really want to be there.
- We need some rational ways to improve care at a cost we can afford.
- ***PC offers the trifecta of better quality of life, and better quality of care, at less cost.***
- ***There are ways to give better and more information.***

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The American Society of Clinical Oncology now recommends concurrent palliative care early in the course of illness for any patient with metastatic cancer and/or high symptom burden

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The latest version is at http://jco.ascopubs.org/cgi/doi/10.1200/JCO.2011.38.5161

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care into Standard Oncology Care

Thomas J. Smith, Sarah Temin, Erin R. Alesi, Amy P. Abernethy, Tracy A. Balboni, Ethan M. Basch, Betty R. Ferrell, Matt Loscalzo, Diane E. Meier, Judith A. Paice, Jeffrey M. Peppercorn, Mark Somerfield, Ellen Stovall, and Jamie H. Von Roenn

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Objectives

1. Recognizing the problem:
2. Palliative care alongside oncology offers practical ways to improve health, quality of care, and value
   - What are the benefits of concurrent care?
   - What does PC do alongside ONC?
   - Having difficult conversations.
   - How can we integrate these best practices?

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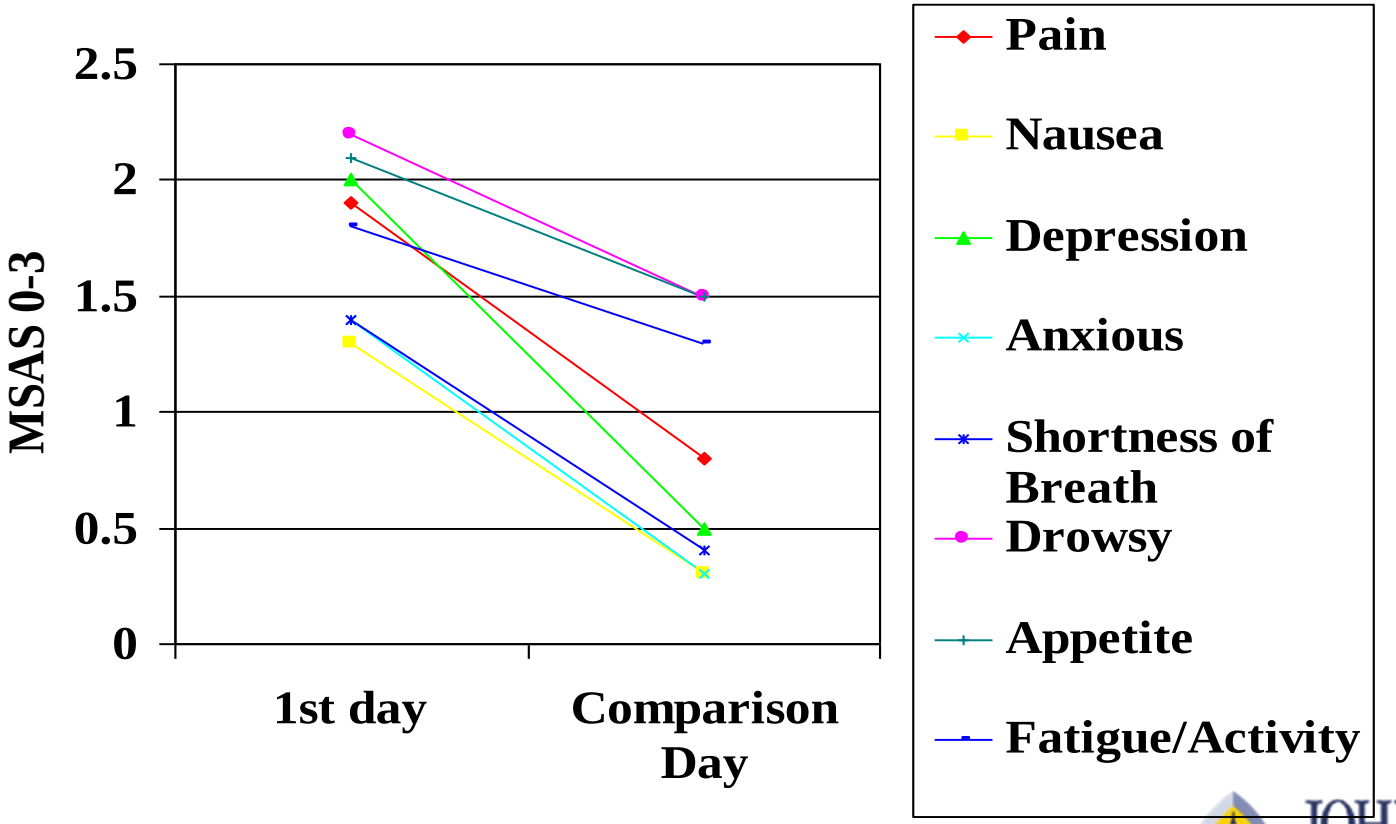
Cancer patient symptoms are improved by PC consultation or transfer

Memorial Symptom Assessment Scale, Condensed; 30 pts with at least 2 consult days and symptoms > 0. Khatcheressian J, et al. Oncology September 2005
ESAS scale 0-10; Elsayem A, et al. JCO 2004



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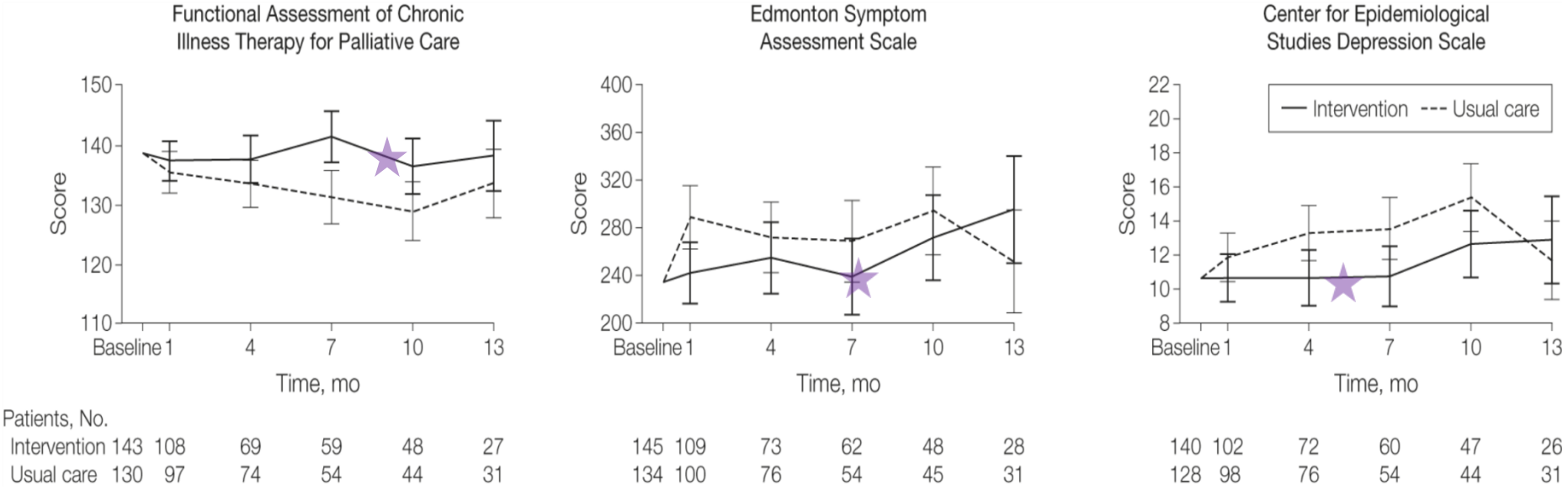
Palliative care nursing education in addition to usual oncology care – in RCT - allowed improved quality of life, fewer symptoms, and less depression. Bakitas M, et al. Project ENABLE. JAMA 2009



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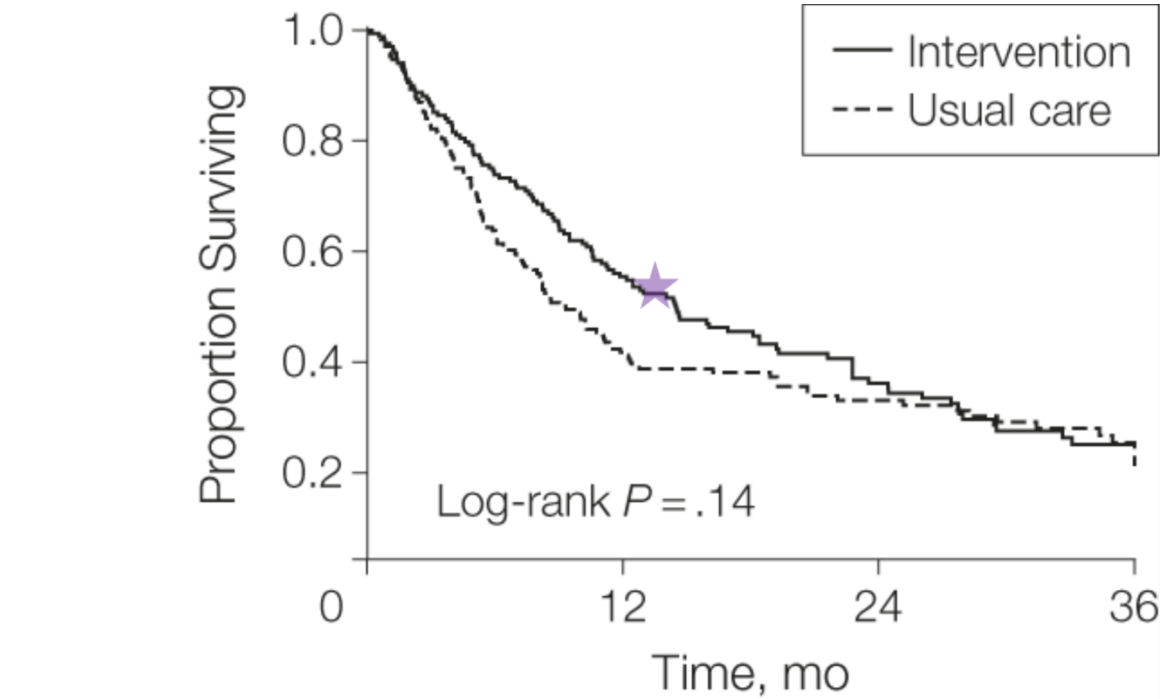
Palliative care in addition to usual oncology care allowed improved lifespan. Bakitas M, et al. Project ENABLE. JAMA 2009



No. at risk				
Intervention	161	83	35	16
Usual care	161	62	33	16

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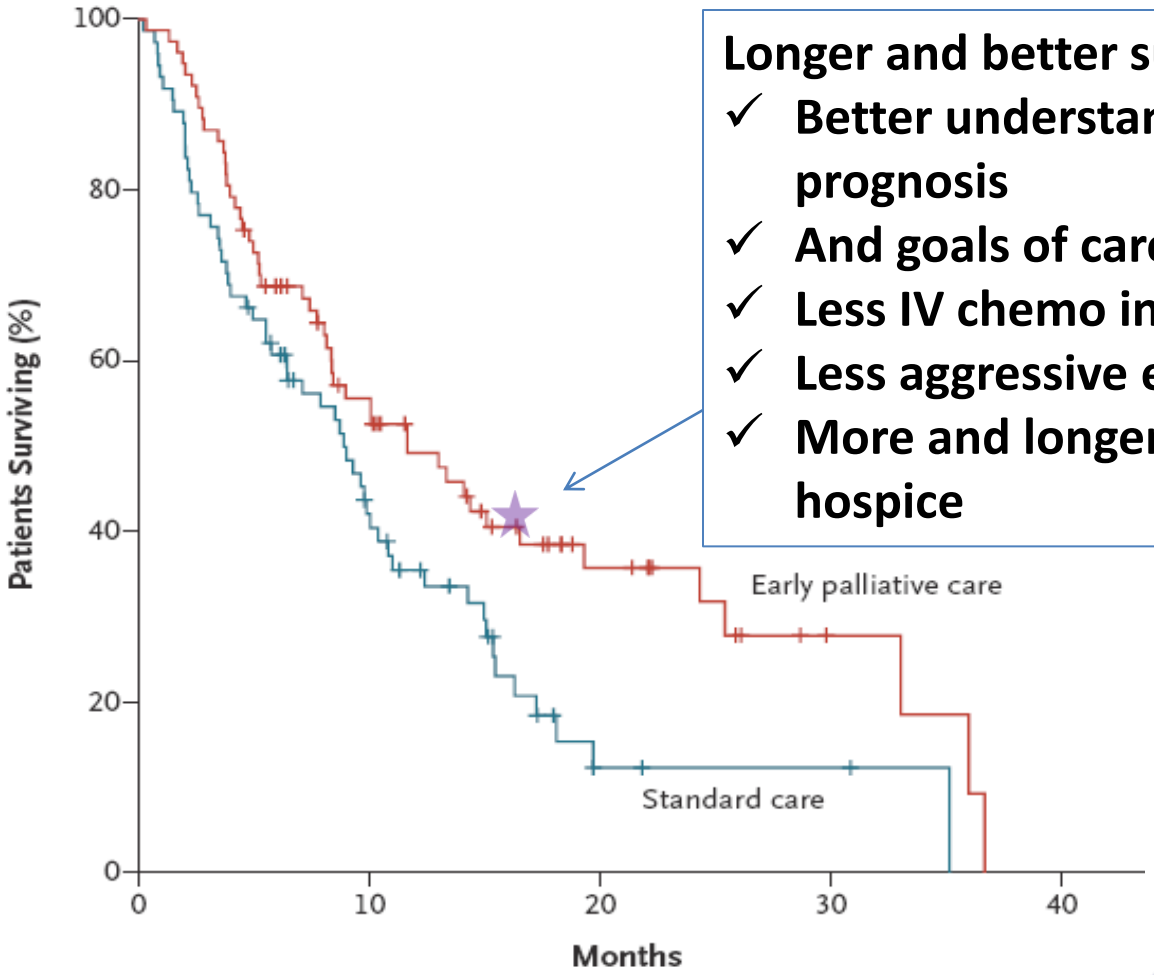
Palliative care in addition to usual oncology care allowed lung cancer patients to **live almost 3 months longer** than those who got usual oncology care.

Temel J, et al. NEJM 2010; Temel J, et al, JCO 2011



Longer and better survival

- ✓ **Better understanding of prognosis**
- ✓ **And goals of care**
- ✓ **Less IV chemo in last 60 days**
- ✓ **Less aggressive end of life care**
- ✓ **More and longer use of hospice**

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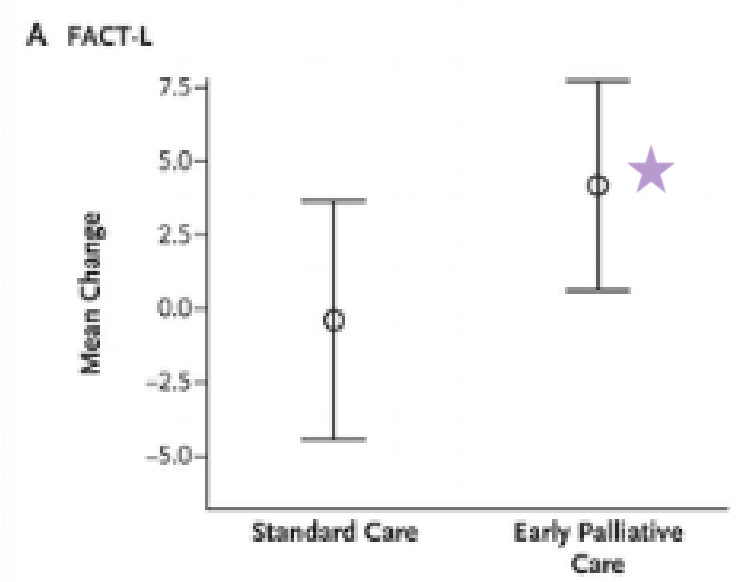
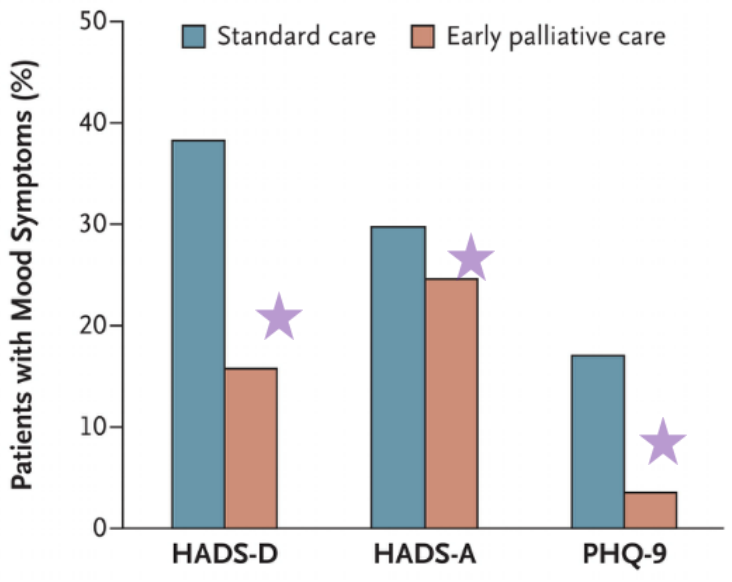
Palliative care in addition to usual oncology care allowed lung cancer patients to have much better quality of life (FACT) and less anxiety and depression.

Temel J, et al. NEJM 2010; Temel J, et al, JCO 2011





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People who use hospice for even one day live longer.

Matched cohort study: hospice use or not. 4493 Medicare patients, 2095 (47%) received hospice care for at least one day, 1999	
Disease	**Added survival**
CHF	+ 81 days, P = 0.0540
Lung cancer	+ 39 days, P < 0.0001
Pancreatic cancer	+ 21 days, P = 0.0102
Colon cancer	+ 33 days, P = 0.0792
Breast	+ 12 days, P = 0.6136
Prostate	+ 4 days, P = 0.8266

Connor SR, et al. J Pain Symptom Manage. 2007 Mar;33(3):238-46.

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THE WALL STREET JOURNAL.

WEDNESDAY, MARCH 10, 2004 - VOL. CCXLIII NO. 48 - ★★ $1.00

Final Days

Unlikely Way to Cut Hospital Costs: Comfort the Dying

$7000 less in last 5 days of life if PC involved.

With equal survival.

And better symptom control.

Care, Not Cure

Average cost for terminally ill patients in palliative and nonpalliative programs during their final five days at one hospital

	NON-PCU	PCU
Drugs and chemotherapy	$2,267	$511
Lab	1,134	56
Diagnostic imaging	615	29
Medical supplies	1,821	731
Room & nursing	4,330	3,708
Other	2,152	278
Total	**$12,319**	**$5,313**

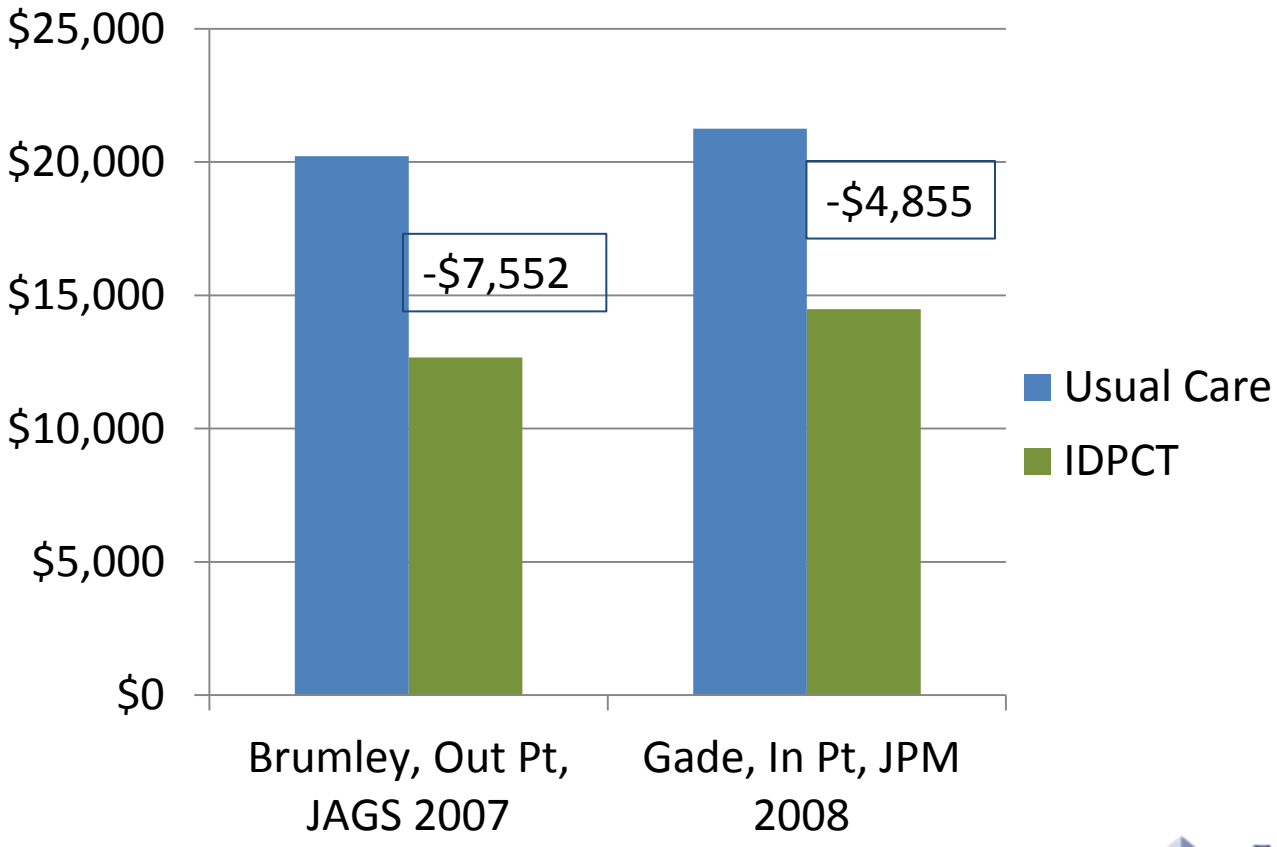
Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002.

Source: Virginia Commonwealth University medical center

KINS

Kaiser Permanente System *randomized* clinical trials of IDPCTs

- equal survival
- better communication and quality of care
- **Net savings of $5-7000/person, *now standard in all KP markets.***



JOHNS HOPKINS MEDICINE

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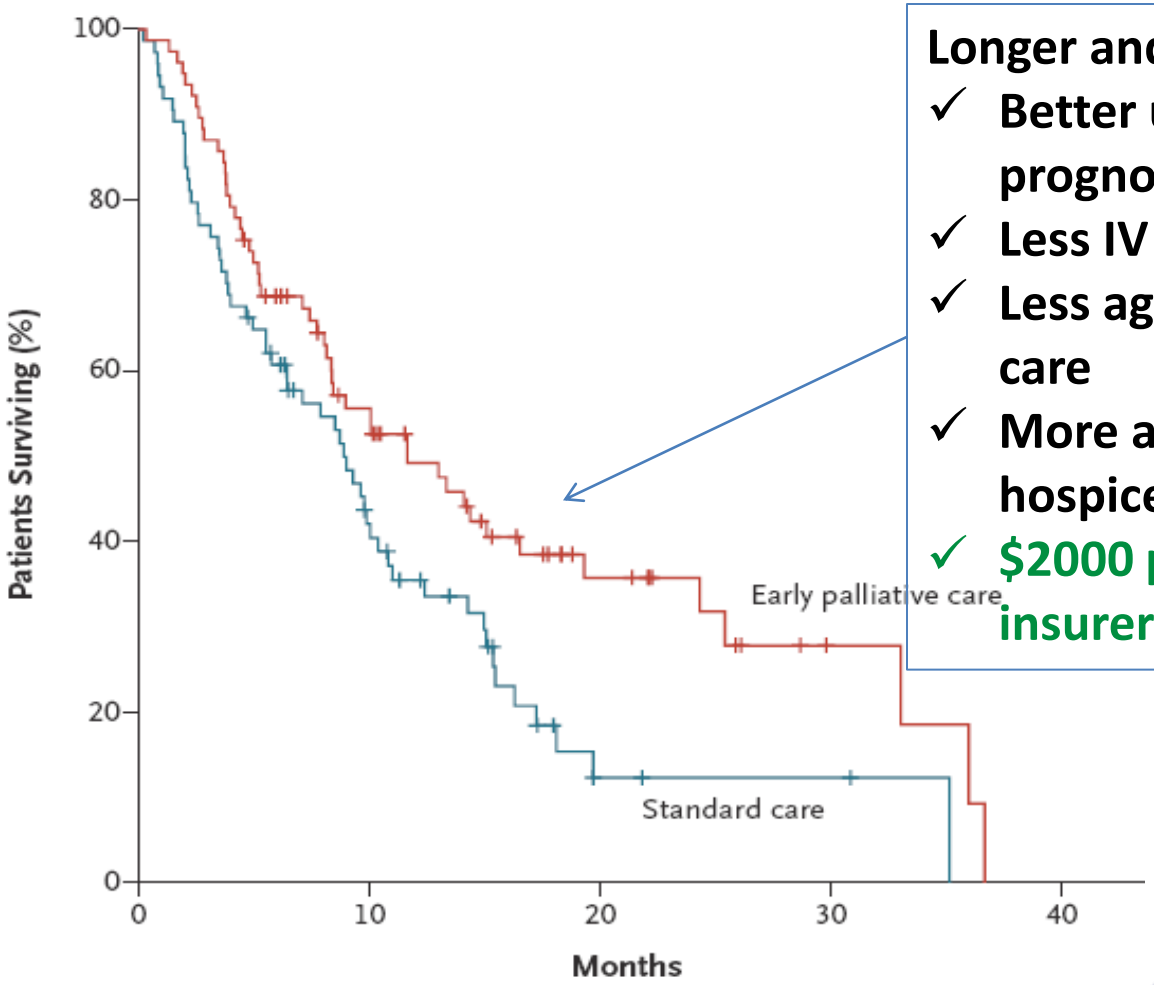

Longer and better survival

- ✓ **Better understanding of prognosis**
- ✓ **Less IV chemo in last 60 days**
- ✓ **Less aggressive end of life care**
- ✓ **More and longer use of hospice**
- ✓ **$2000 per person savings to insurers and society**

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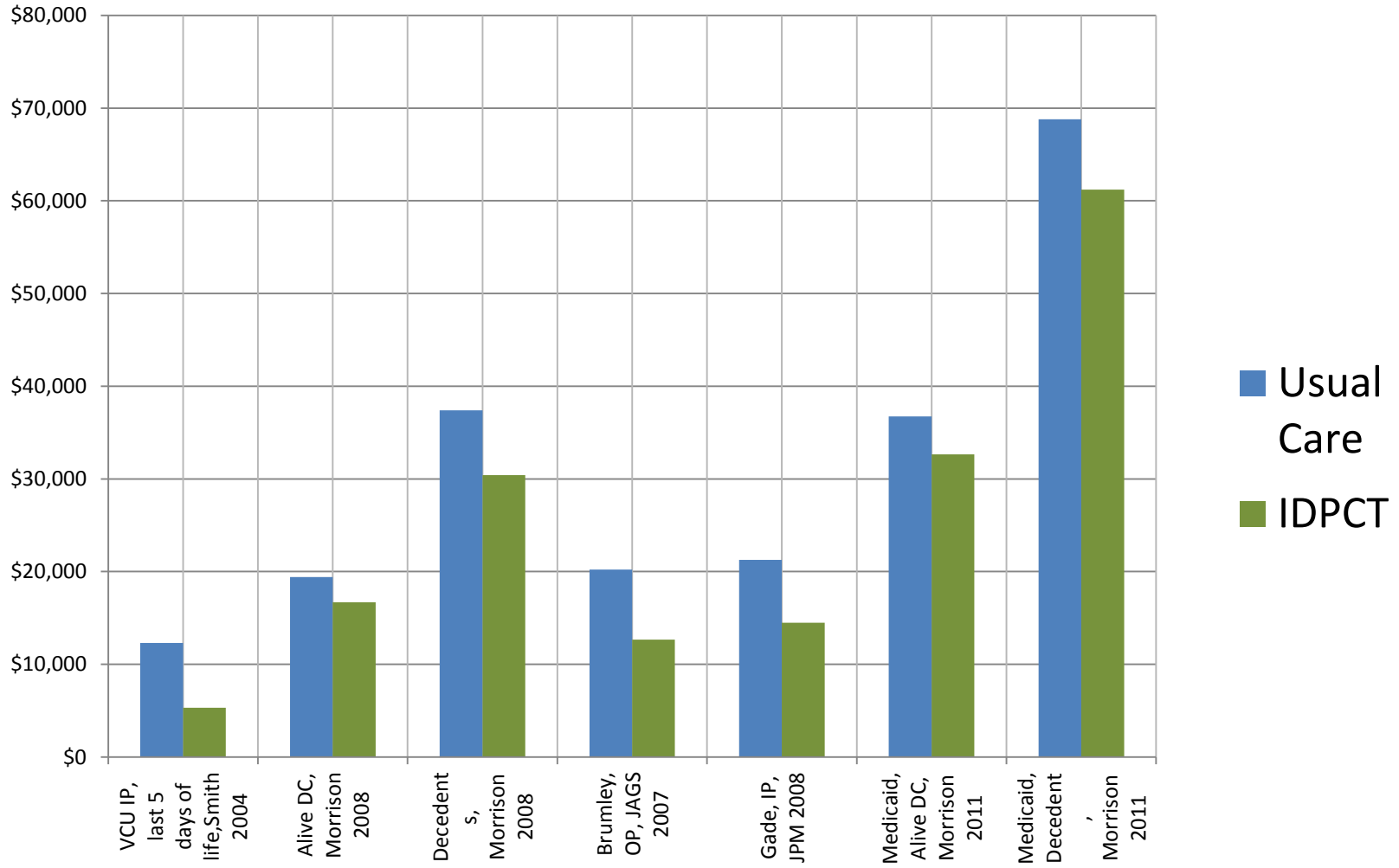
Every study to date shows significant savings – in addition to better care



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What is the source of the cost savings?

- Avoided hospitalizations.
- Avoided ICU days.
- Less chemotherapy, imaging, and complications at the end of life.
- If palliative care consults, the chances of appropriate discharge to hospice rises from 1% to 30%.
- Hospice saves about $2300 per person in the last month of life

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Palliative care is possible, practical, reimbursable, and should pay for itself, mostly.

Table 3. Median Time for Components of Initial Outpatient Palliative Care Clinic Visit (Temel et al, JPM 2011)

PC consultation	Median time (range) minutes
Total time	55
Illness understanding	10
Symptom management	20
Decision making	0
Coping	15
Planning and referrals	0

Number of visits	3-4 TOTAL in 3 months

Reimbursement	DEPENDS - Who does the service (MD, NP, MSW) - How we bill – extended service codes, time, counseling - standardized forms - efficiency

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So, how do we do this?

1. **Recognize that we don't do this.**
2. **Learn key concepts about communication.**
3. **Make guidelines for care.**

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1. Recognize that we don't do this.

- 60% of us prefer not to have "hard conversations" (DNR, AMDs, hospice) until "there are no more treatment options left". Keating NL, et al. Cancer. 2010
- Half of all lung cancer patients have had NO discussion with any of their doctors about hospice 2 months before they die. Huskamp HA, et al. Arch Intern Med. 2009
- Oncologists document EOL discussions with 27% of NSCLC patients; 55% happen in the hospital, mean 33 days before death; 49% with oncologists. Mack J, et al. Ann Intern Med 2012

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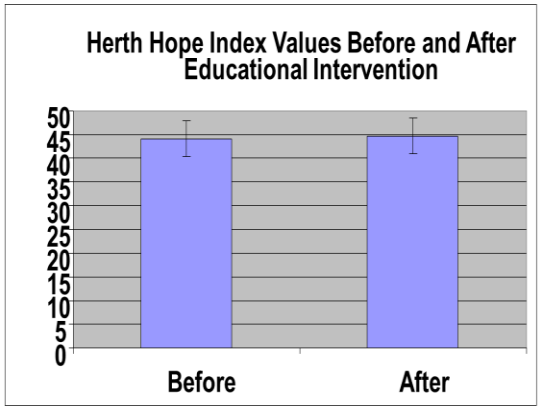
2. Some key concepts, and key misconceptions.



1. People DO want this information.
2. It won't make people depressed.
3. It won't take away their hope.
4. It won't make them die sooner.
5. We CAN give realistic forecasts for survival.
6. It is always culturally appropriate to ask "How much do you want to know about your illness?"

The main reason we don't do this is US.

1. There are good and simple ways for us to learn how to do this. (EPEC, EPEC-O, ELNEC, Oncotalk.)
2. There may be ways to learn how to integrate and survive this. Krasner et al, JAMA 2009 - mindfulness.

Mack JW, Smith TJ. Reasons why physicians do not have discussions about poor prognosis, why it matters, and what can be improved. J Clin Oncol. 2012 Aug 1;30(22):2715-7. Epub 2012 Jul 2. \

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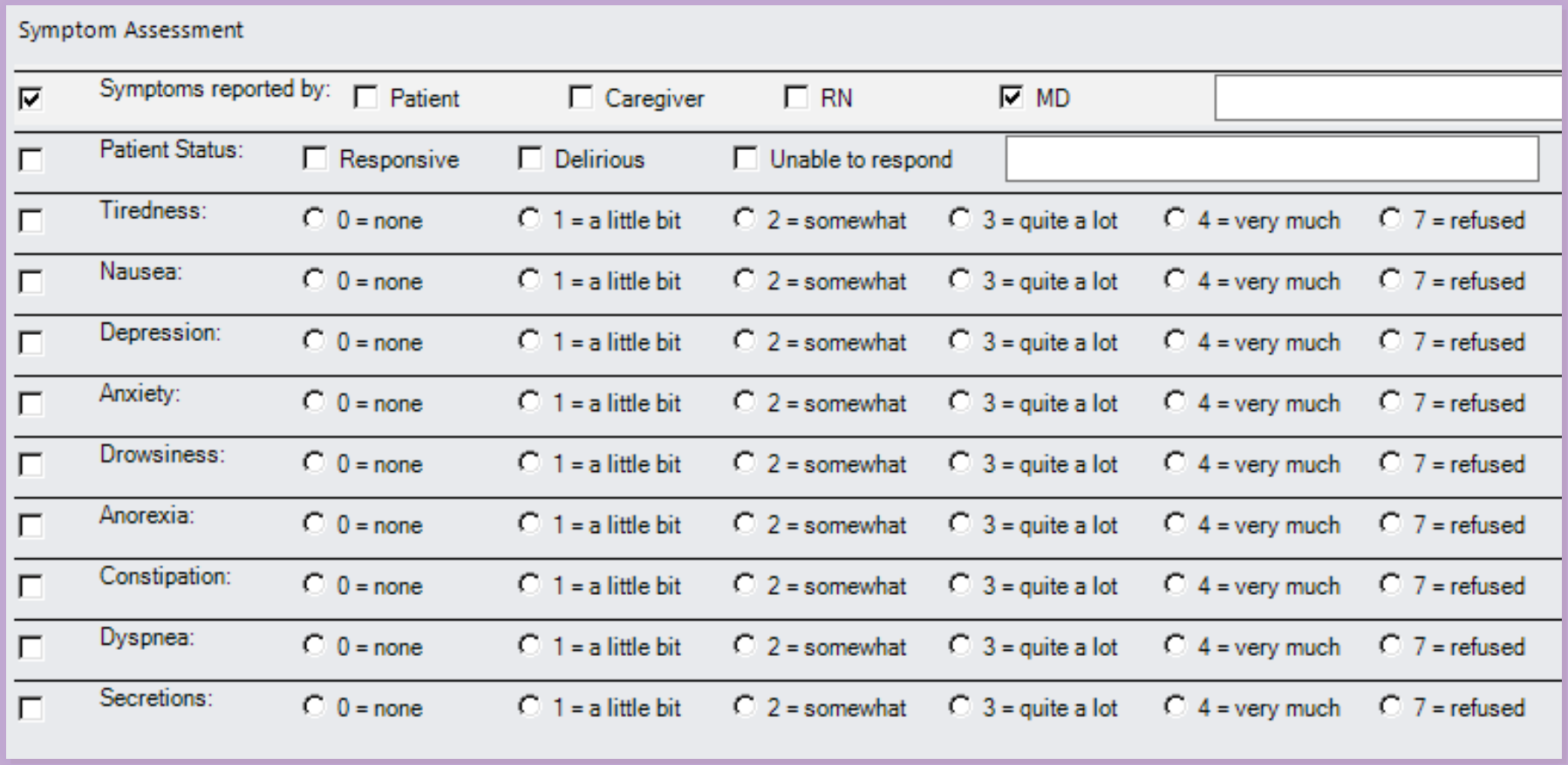
2. Always do a symptom assessment – and have standard algorithms to treat the problems.



Symptom Assessment

☑	Symptoms reported by:	☐ Patient	☐ Caregiver	☐ RN	☑ MD		
☐	Patient Status:	☐ Responsive	☐ Delirious	☐ Unable to respond			
☐	Tiredness:	○ 0 = none	○ 1 = a little bit	○ 2 = somewhat	○ 3 = quite a lot	○ 4 = very much	○ 7 = refused
☐	Nausea:	○ 0 = none	○ 1 = a little bit	○ 2 = somewhat	○ 3 = quite a lot	○ 4 = very much	○ 7 = refused
☐	Depression:	○ 0 = none	○ 1 = a little bit	○ 2 = somewhat	○ 3 = quite a lot	○ 4 = very much	○ 7 = refused
☐	Anxiety:	○ 0 = none	○ 1 = a little bit	○ 2 = somewhat	○ 3 = quite a lot	○ 4 = very much	○ 7 = refused
☐	Drowsiness:	○ 0 = none	○ 1 = a little bit	○ 2 = somewhat	○ 3 = quite a lot	○ 4 = very much	○ 7 = refused
☐	Anorexia:	○ 0 = none	○ 1 = a little bit	○ 2 = somewhat	○ 3 = quite a lot	○ 4 = very much	○ 7 = refused
☐	Constipation:	○ 0 = none	○ 1 = a little bit	○ 2 = somewhat	○ 3 = quite a lot	○ 4 = very much	○ 7 = refused
☐	Dyspnea:	○ 0 = none	○ 1 = a little bit	○ 2 = somewhat	○ 3 = quite a lot	○ 4 = very much	○ 7 = refused
☐	Secretions:	○ 0 = none	○ 1 = a little bit	○ 2 = somewhat	○ 3 = quite a lot	○ 4 = very much	○ 7 = refused

What can I do? Recommendations for responding to issues identified by patient-reported outcomes assessments used in clinical practice.

Hughes EF, Wu AW, **Carducci** MA, **Snyder** CF.

J Support Oncol. 2012 Jul-Aug;10(4):143-8. Epub 2012 May 18. Review

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2. Always do a symptom assessment – and have standard algorithms to treat the problems.

MSAS-C: 0=none, 1=a little bit, 2=somewhat, 3=quite a lot, 4=very much, 7=refused

Reported by: Patient Caregiver RN MD

Unable to respond: Yes No

Delirious: Yes No **[NB. Use haloperidol or Seroquel (Quetiapine), NOT BENZODIAZEPINE.]**

	Pain	Tired ness	Nausea	Depres- sion	Anxiet y	Drowsi- ness	Ano- rexia	Consti- pation	Dysp- nea	Secre- tions
0				"Are you depressed?"						
1										
2										
3				Anti-D's Methylphen Ketamine – single dose				Methyl- naltrexone		
4		Dexameth Ginseng	Ginseng							
7										

*Dexamethasone 4 mg bid. Yennurajalingam S, et al. J Clin Oncol 30, 2012 (suppl; abstr 9002)

** Ginseng. Barton D, et al. J Clin Oncol 30, 2012 (suppl; abstr 9001)

Ginger 0.5-1.0 g/day. Ryan et al. Support Care Cancer. 2012

+ Chochinov H, et al. 1997.

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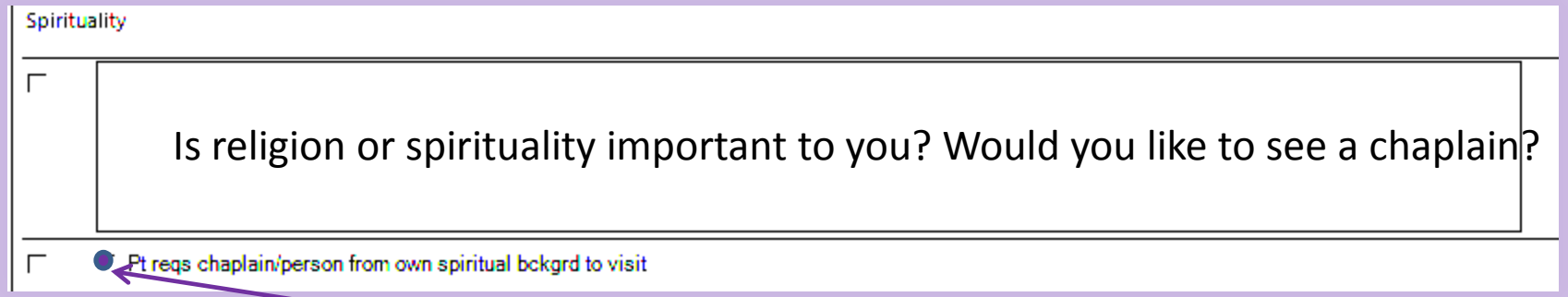
2. Always do a religious/spiritual assessment – and get some help.

Table 1. FICA© tool for clinicians	
Item	Question for health care practitioner to ask
F Faith	Do you consider yourself to be spiritual or religious?
I Importance	Do you consider yourself to be a person of faith? Where do you find your strength? How important is this to you?
C Community	Are you a member of a faith community?
A Address	How would you like your health care team to address these issues?



Generates referral to Pastoral Care

FICA* Spiritual History *Tool
*www.gwumc.edu/gwish/clinical/**fica**.cfm*

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2. Always do a prognosis assessment.

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days (a)	(b)	(c)
100	Full	Normal *No Disease*	Full	Normal	Full			
90	Full	Normal *Some Disease*	Full	Normal	Full	N/A		
80	Full	Normal with Effort *Some Disease*	Full	Normal or Reduced	Full		N/A	
70	Reduced	Can't do normal job or work *Some Disease*	Full	As above	Full	145		108
60	Reduced	Can't do hobbies or housework *Significant Disease*	Occasional Assistance Needed	As above	Full or Confusion	29	4	
50	Mainly sit/lie	Can't do any work E*xtensive Disease*	Considerable Assistance Needed	As above	Full or Confusion	30	11	
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion	18	8	41
30	Bed Bound	As above	Total Care	Reduced	As above	8	5	
20	Bed Bound	As above	As above	Minimal	As above	4	2	
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma	1	1	6
0	Death	-	-	-	--			

 # 125 The *Palliative Performance Scale* (*PPS*) - *EPERC* - Medical ...

www.eperc.mcw.edu › EPERC › Fast Facts › Fast Facts Documents

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Have a referral script.
Write it down at diagnosis, revisit at each transition, have that hospice information visit 3-6 months before death.

- Palliative care is about **improving quality of life**, providing an **extra layer of support**, and having a team focus on your care.
- Hospice is about **improving quality of life**, providing an **extra layer of support**, and having a team focus on your care. Hospice is not a place you go (usually) but specially trained nurses who can come to your house to fix pain and other symptoms, keep you up and going. We will still be involved in your care.

Cancer Action Network™ American Cancer Society®

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3. Guidelines for care.

- Establish best practices, just like for curative R-CHOP.
- Identify people with average survival less than 6 months.
- Not hard, and has not changed. Saltpeter et al. JPM 2012)
  - Performance status 2 and declining.
  - Anorexia, hypercalcemia, any effusion.
  - Metastatic cancer progressed on one line of treatment.

ASCO "Choosing Wisely" gives us some practical helps:

1. ECOG PS 2 or higher "Did this person walk into the clinic?"
2. 2nd or 3rd line chemo for MOST cancers: breast, colon, lung, prostate, pancreas, etc.

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JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

American Society of Clinical Oncology Identifies Five Key Opportunities to Improve Care and Reduce Costs: The Top Five List for Oncology

Lowell E. Schnipper, Thomas J. Smith, Derek Raghavan, Douglas W. Blayney, Patricia A. Ganz, Therese Marie Mulvey, and Dana S. Wollins

Lowell E. Schnipper, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA; Thomas J. Smith, Sidney Kimmel Comprehensive Cancer Center, Johns Hopkins School of Medicine, Baltimore, MD; Derek Raghavan, Levine Cancer Institute, Carolinas HealthCare System, Charlotte, NC; Douglas W.

INTRODUCTION

Advancements in the prevention, diagnosis, and treatment of cancer have contributed to improved survival, better quality of life, and declining death rates in the United States. With these successes have come in-

and family members understandably want "everything done," despite not having sophisticated awareness of the evidence base that should be guiding the physician. Concerns about litigation regularly factor into physician's decision making, especially in situations in which the outcome might be limited sur-

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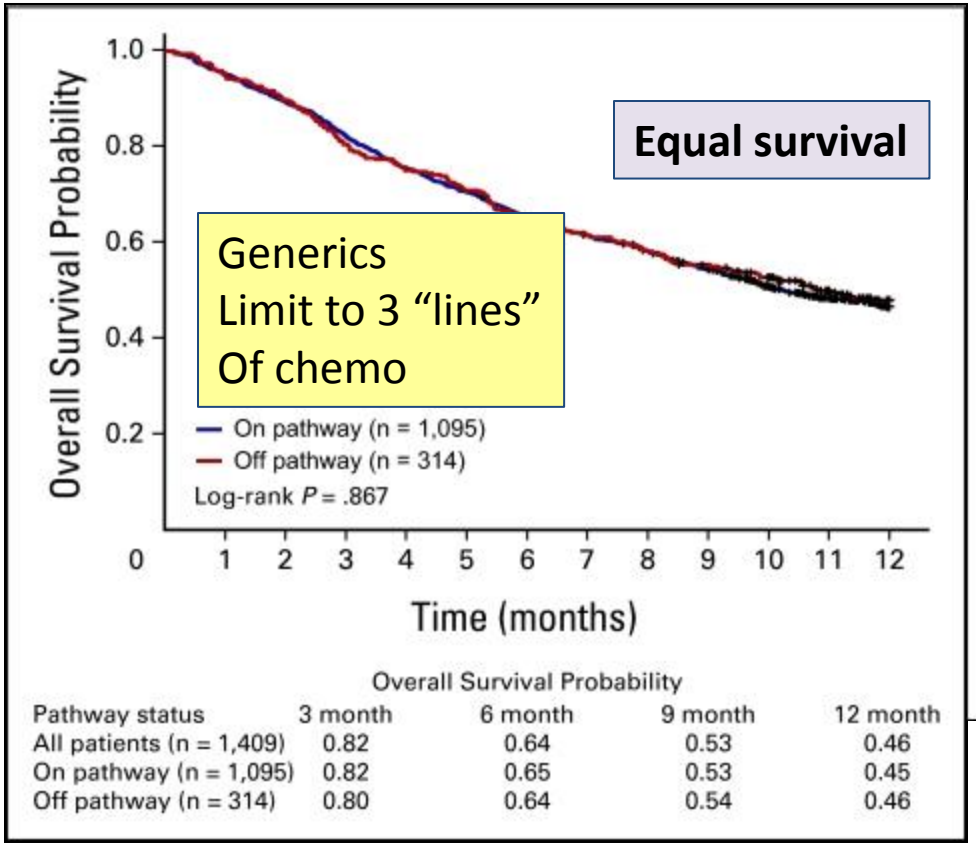
3. Set guidelines like the U S Oncology pathways that preserve survival, reduce cost by 35% in lung cancer by evidence-based choices, better communication.



Equal survival

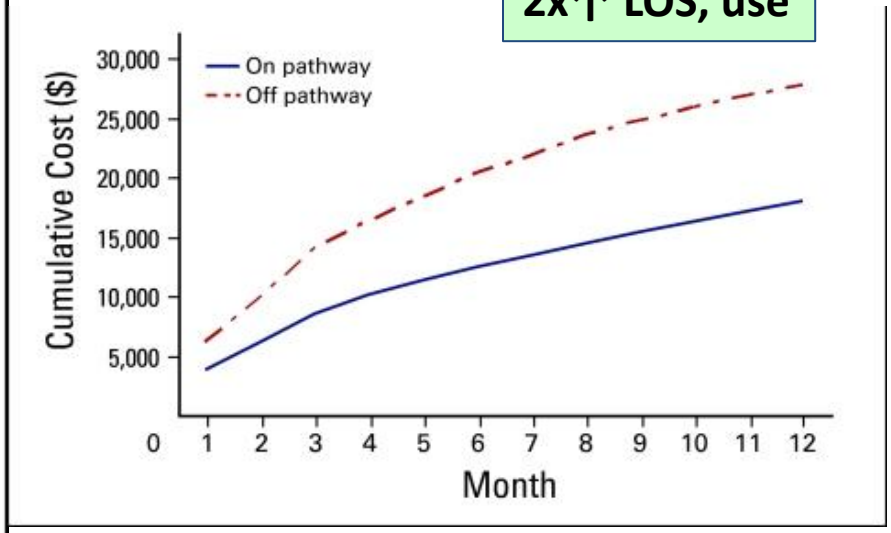
Generics
Limit to 3 "lines"
Of chemo

Overall Survival Probability

Pathway status	3 month	6 month	9 month	12 month
All patients (n = 1,409)	0.82	0.64	0.53	0.46
On pathway (n = 1,095)	0.82	0.65	0.53	0.45
Off pathway (n = 314)	0.80	0.64	0.54	0.46

Less chemo
Less hospital

More hospice
2x↑ LOS, use



For NSCLC and colon cancer, equal results, less toxicity, less cost.
Neubauer M, et al. J Oncol Pract. 2010 Jan;6(1):12-8.
Hoverman JR, et al. J Oncol Pract. 2011 May;7(3 Suppl):52s-9s

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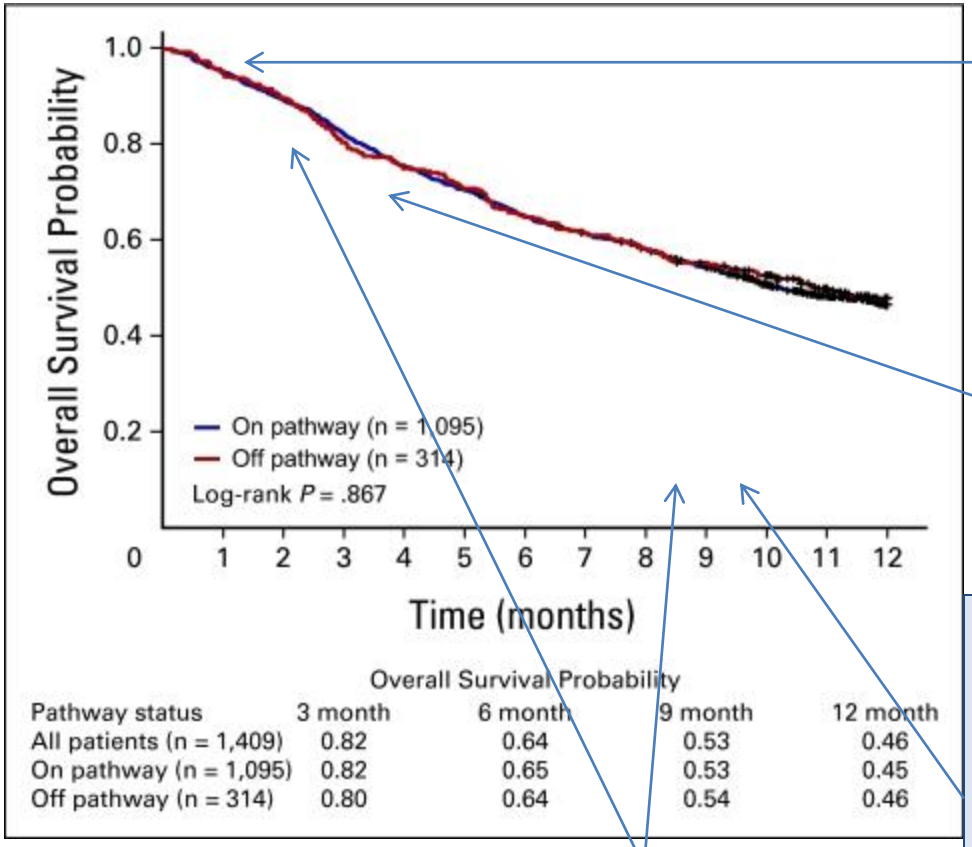
3. Change our standards of care to incorporate national guidelines and best practices about palliative care.



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Off pathway (n = 314)	0.80	0.64	0.54	0.46

Communication: Appoint someone in the office to discuss ADs, DPMA, hospice in first 3 visits – and document.

Limit to 3 rounds
Of chemo and good PS – follow our own guidelines.
Give feedback by doctor.

Insist on hospice referral with 3-6 months to live (not 2 weeks)

Audit referrals with < 14 days, give feedback to physician

Every guideline should have a set point to add PC, and stop chemo based on evidence.

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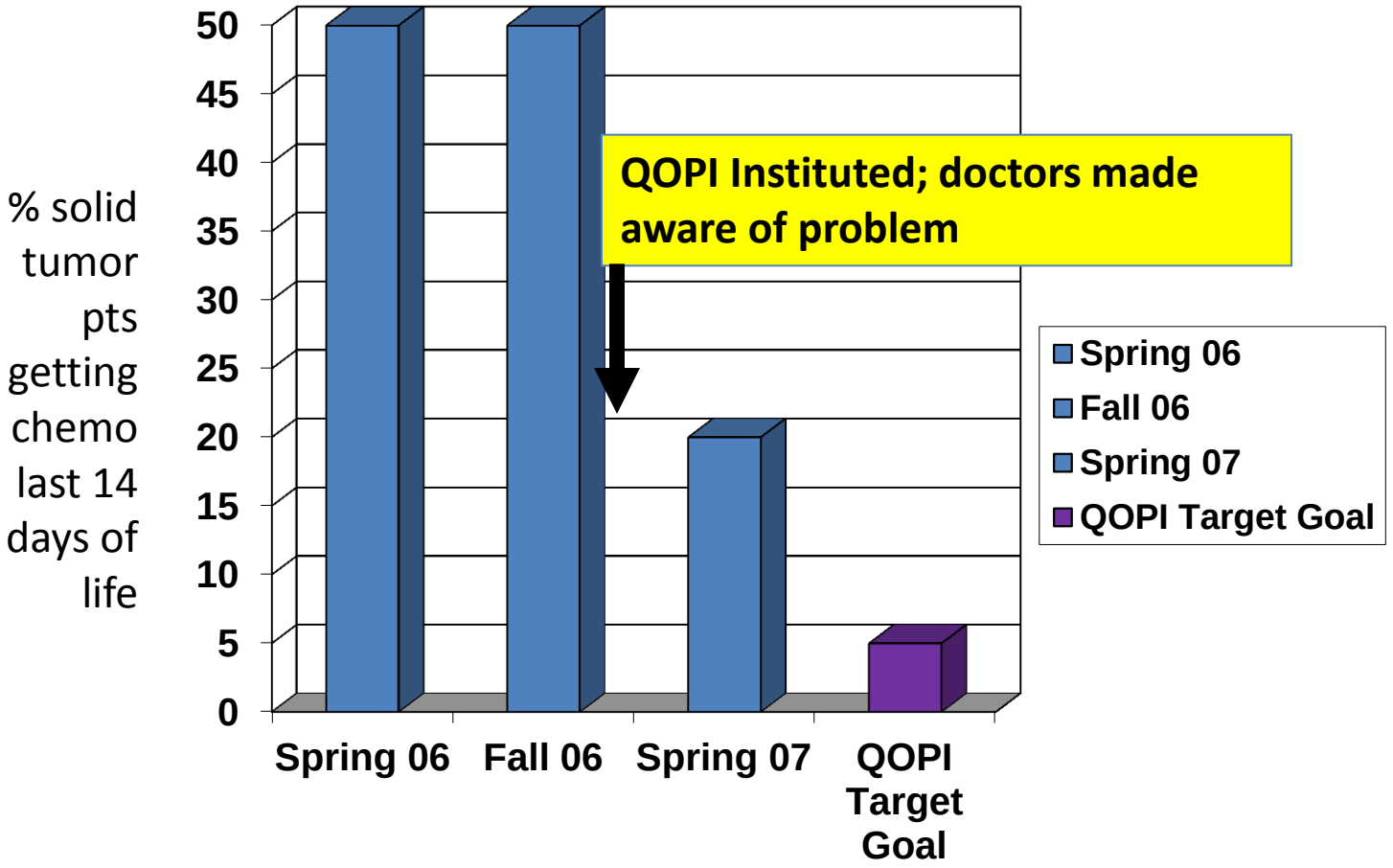
QOPI works to reduce overuse: Oncologists who receive feedback give less chemo at the end of life.

Blayney D, et al. JCO 2009



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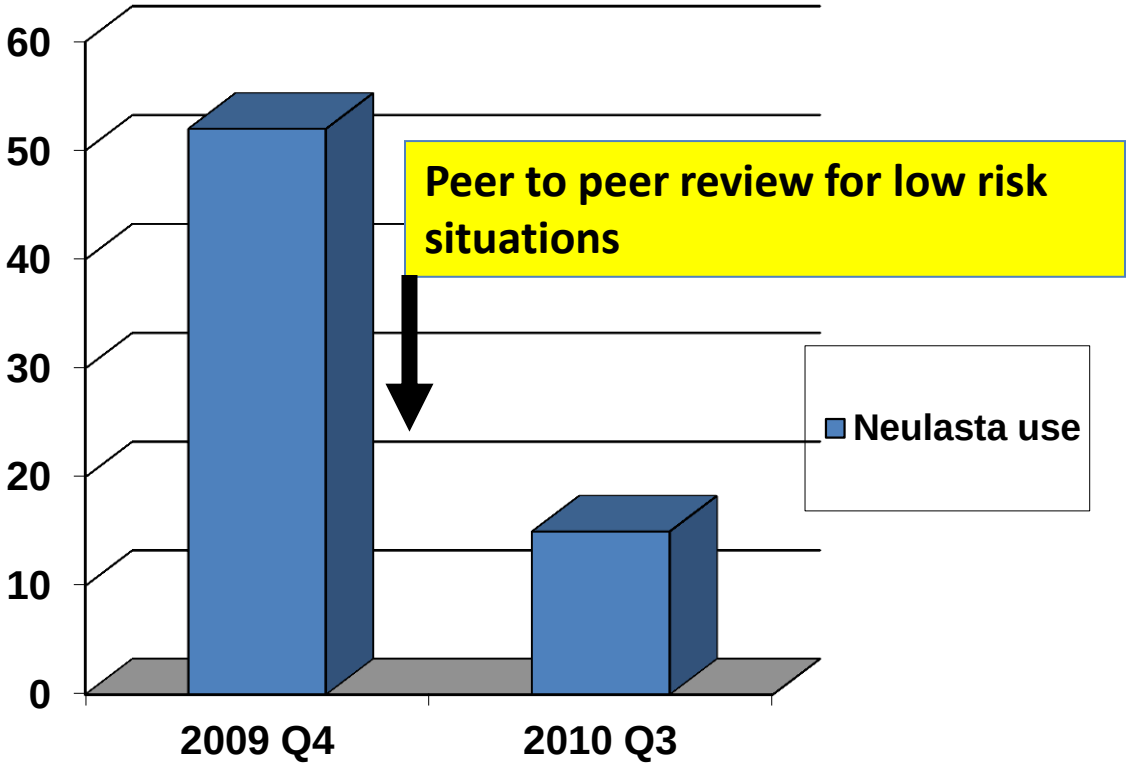
Pegfilgrastim use can be cut by 75% in low risk situations with peer to peer review.
Reduces PMPM by ~75¢

Fishman ML, Kumar A, Davis S, Shimp W, Hrushesky WJ. Guideline-based peer-to-peer consultation optimizes pegfilgrastim use with no adverse clinical consequences. Am J Manag Care. 2012 May 1;18(5):e168-72.



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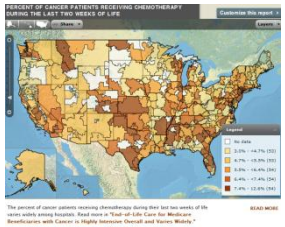
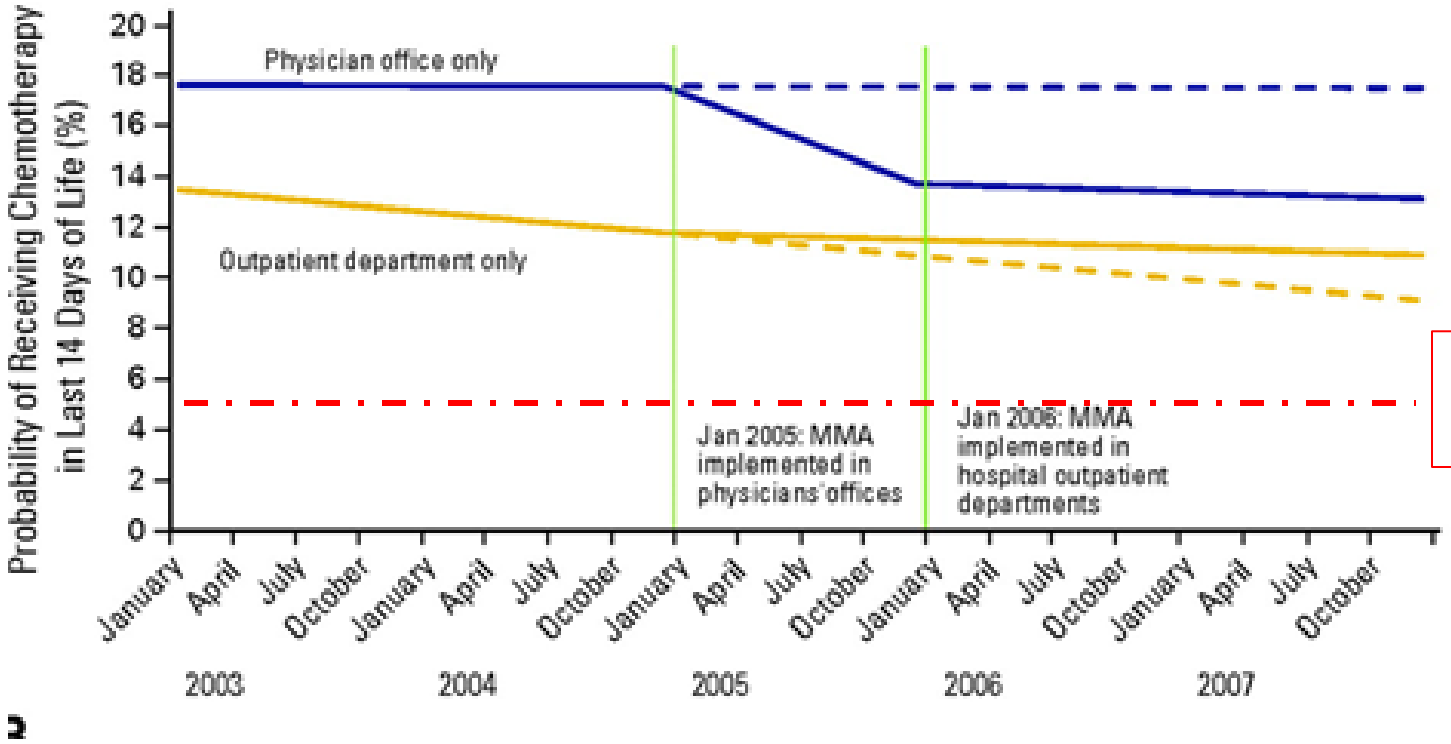
The probability of receiving chemotherapy in last 14 days of life was reduced after Medicare Payment Reform.





Colla C H et al. JOP 2012;8:e6s-e13s

JOURNAL OF ONCOLOGY PRACTICE
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4. Use Expanded Access Programs that allow hospice/palliative care alongside usual care.

Aetna's Compassionate Care Program maintained survival but doubled hospice use. (Spettell CM, et al. J Palliat Med. 2009 Sep;12(9):827-32.)

Hospice use increased

- **Enrollees doubled from 31% to 72% , p<0.0001**
- **Hospice days increased 15.9 to 28.6 , p<.0001**

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Aetna's Compassionate Care Program maintained survival, doubled hospice use, and reduced IP days. Use transition programs *alongside* usual oncology care. (Spettell CM, et al. J Palliat Med. 2009 Sep;12(9):827-32; Krakauer R, et al. Health Affairs, 2011)

IP days reduced
-Medicare 15,217 down to 2309 per thousand members
-…@ $2500/day

-ICU days reduced
-Medicare CM Group; 9840 down to 1189 per thousand members
-…@ $3500/day

-Overall, at least 22% savings in 40 days of life.

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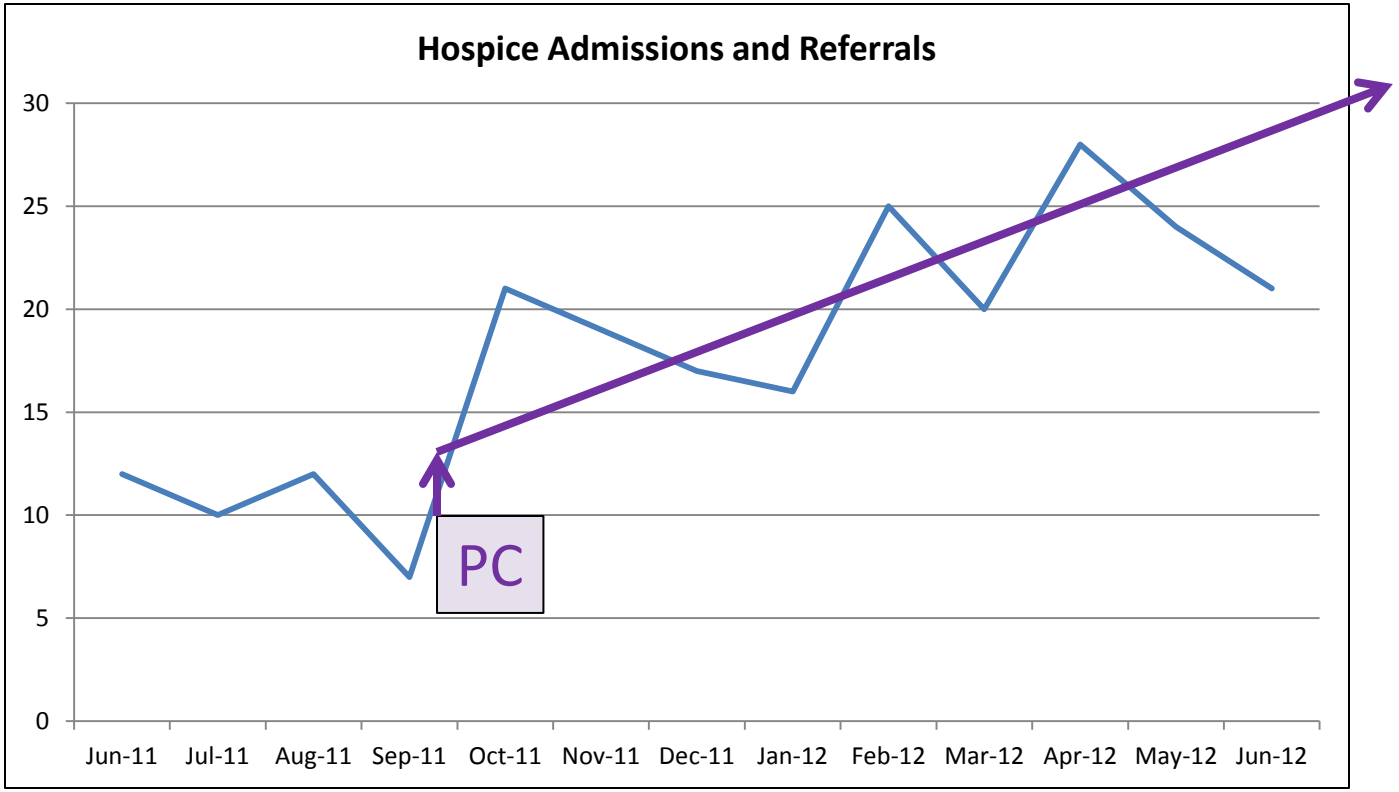
5. Identify hospice eligible patients earlier

- better care with that extra layer of support
- fewer readmissions
- less cost per readmission



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We can recognize hospice-eligible patients, prevent readmissions, honor choices, and save money.

U of Iowa Hospitals. 688 in-hospital deaths. 209 decedents had preceding admission; NHPCO, National Hospice and Palliative Care Organization worksheets.

- 60% eligible for hospice on PENULTIMATE admission

-Only 14% had any discussion of hospice, despite being eligible; 14 of 17 enrolled, all from ONE service

Table 1. Comparison of Cost and Length of Stay Between Patients Enrolled and Not Enrolled in Hospice During a Terminal Hospital Admission

	Enrolled in hospice before last admission n = 7	Not enrolled in hospice, all diagnoses, n = 202
Cost		
Mean	$4963	$52 219
Median	$3690	$23 322
Standard deviation	$3250	$85 101
Standard deviation	4.47	25.05
Palliative Care Consultation		IF PC involved, LOS equal but $$ ↓↓ $41,859 P<0.04

Freund K, et al. J Hosp Med. 2012 Mar;7(3):218-23. doi: 10.1002/jhm.975. Epub 2011 Nov 15.
Weckmann MT, et al. Am J Hosp Palliat Care. 2012 Sep 5.

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Barriers

1. Finding good PC personnel. Shortage of 10,000 NPs and MDs. So, we have to learn to do this ourselves.
2. Shifting funds from current to projected uses, and current to projected incomes.
3. Helping people to be efficient.
4. Setting realistic but necessary goals for productivity.
5. One EPR that all can use.
6. Coordinated care takes effort….

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Conclusions

1. Palliative care alongside oncology care is now the accepted best practice.
2. All the evidence suggests equal or better quality of life, fewer symptoms, equal or better survival, and less cost, with no harms.
3. It is possible to create such programs and have them be expert, sustainable, and even break even.

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Selected references

1. Chochinov HM, Wilson KG, Enns M, Lander S. "Are you depressed?" Screening for depression in the terminally ill. Am J Psychiatry. 1997 May;154(5):674-6.
2. Colla CH, Morden NE, Skinner JS, Hoverman JR, Meara E. Impact of payment reform on chemotherapy at the end of life. Am J Manag Care. 2012 May 1;18(5):e200-8.
3. Dow LA, Matsuyama RK, Ramakrishnan V, Kuhn L, Lamont EB, Lyckholm L, Smith TJ. Paradoxes in advance care planning: the complex relationship of oncology patients, their physicians, and advance medical directives. J Clin Oncol. 2010 Jan 10;28(2):299-304. Epub 2009 Nov 23.
4. Dy SM, Asch SM, Lorenz KA, Weeks K, Sharma RK, Wolff AC, Malin JL. Quality of end-of-life care for patients with advanced cancer in an academic medical center. J Palliat Med. 2011 Apr;14(4):451-7. Epub 2011 Mar 10.
5. Harrington SE, Smith TJ. The role of chemotherapy at the end of life: "when is enough, enough?". JAMA. 2008 Jun 11;299(22):2667-78.
6. Hoverman JR, Cartwright TH, Patt DA, Espirito JL, Clayton MP, Garey JS, Kopp TJ, Kolodziej M, Neubauer MA, Fitch K, Pyenson B, Beveridge RA. Pathways, outcomes, and costs in colon cancer: retrospective evaluations in two distinct databases. J Oncol Pract. 2011 May;7(3 Suppl):52s-9s.
7. Jacobsen J, Jackson V, Dahlin C, Greer J, Perez-Cruz P, Billings JA, Pirl W, Temel J. Components of early outpatient palliative care consultation in patients with metastatic nonsmall cell lung cancer. J Palliat Med. 2011 Apr;14(4):459-64. Epub 2011 Mar 18.
8. Krasner MS, Epstein RM, Beckman H, Suchman AL, Chapman B, Mooney CJ, Quill TE. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. JAMA. 2009 Sep 23;302(12):1284-93.
9. Mack JW, Cronin A, Taback N, Huskamp HA, Keating NL, Malin JL, Earle CC, Weeks JC. End-of-life care discussions among patients with advanced cancer: a cohort study. Ann Intern Med. 2012 Feb 7;156(3):204-10.
10. Mack JW, Smith TJ. Reasons why physicians do not have discussions about poor prognosis, why it matters, and what can be improved. J Clin Oncol. 2012 Aug 1;30(22):2715-7. Epub 2012 Jul 2.
11. Morden NE, Chang CH, Jacobson JO, Berke EM, Bynum JP, Murray KM, Goodman DC. End-of-life care for Medicare beneficiaries with cancer is highly intensive overall and varies widely. Health Aff (Millwood). 2012 Apr;31(4):786-96.
12. Neubauer MA, Hoverman JR, Kolodziej M, Reisman L, Gruschkus SK, Hoang S, Alva AA, McArthur M, Forsyth M, Rothermel T, Beveridge RA. Cost effectiveness of evidence-based treatment guidelines for the treatment of non-small-cell lung cancer in the community setting. J Oncol Pract. 2010 Jan;6(1):12-8. Epub 2009 Dec 30.
13. Peppercorn JM, Smith TJ, Helft PR, Debono DJ, Berry SR, Wollins DS, Hayes DM, Von Roenn JH, Schnipper LE; American Society of Clinical Oncology. American society of clinical oncology statement: toward individualized care for patients with advanced cancer. J Clin Oncol. 2011 Feb 20;29(6):755-60. Epub 2011 Jan 24.
14. Ryan JL, Heckler CE, Roscoe JA, Dakhil SR, Kirshner J, Flynn PJ, Hickok JT, Morrow GR. Ginger (Zingiber officinale) reduces acute chemotherapy-induced nausea: a URCC CCOP study of 576 patients. Support Care Cancer. 2012 Jul;20(7):1479-89. Epub 2011 Aug 5.
15. Salpeter SR, Malter DS, Luo EJ, Lin AY, Stuart B. Systematic review of cancer presentations with a median survival of six months or less. J Palliat Med. 2012 Feb;15(2):175-85. Epub 2011 Oct 24. Review.
16. Schnipper LE, Smith TJ, Raghavan D, Blayney DW, Ganz PA, Mulvey TM, Wollins DS. American Society of Clinical Oncology identifies five key opportunities to improve care and reduce costs: the top five list for oncology. J Clin Oncol. 2012 May 10;30(14):1715-24. Epub 2012 Apr 3.
17. Smith TJ, Hillner BE. Bending the cost curve in cancer care. N Engl J Med. 2011 May 26;364(21):2060-5.
18. Spettell CM, Rawlins WS, Krakauer R, Fernandes J, Breton ME, Gowdy W, Brodeur S, MacCoy M, Brennan TA. A comprehensive case management program to improve palliative care. J Palliat Med. 2009 Sep;12(9):827-32.
19. L Scott Wilner MD and Robert Arnold MD # 125 The Palliative Performance Scale (PPS) http://www.eperc.mcw.edu/EPERC/FastFactsIndex/ff_125.htm
20. Hughes EF, Wu AW, Carducci MA, Snyder CF. What can I do? Recommendations for responding to issues identified by patient-reported outcomes assessments used in clinical practice. J Support Oncol. 2012 Jul-Aug;10(4):143-8. Epub 2012 May 18. Review

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