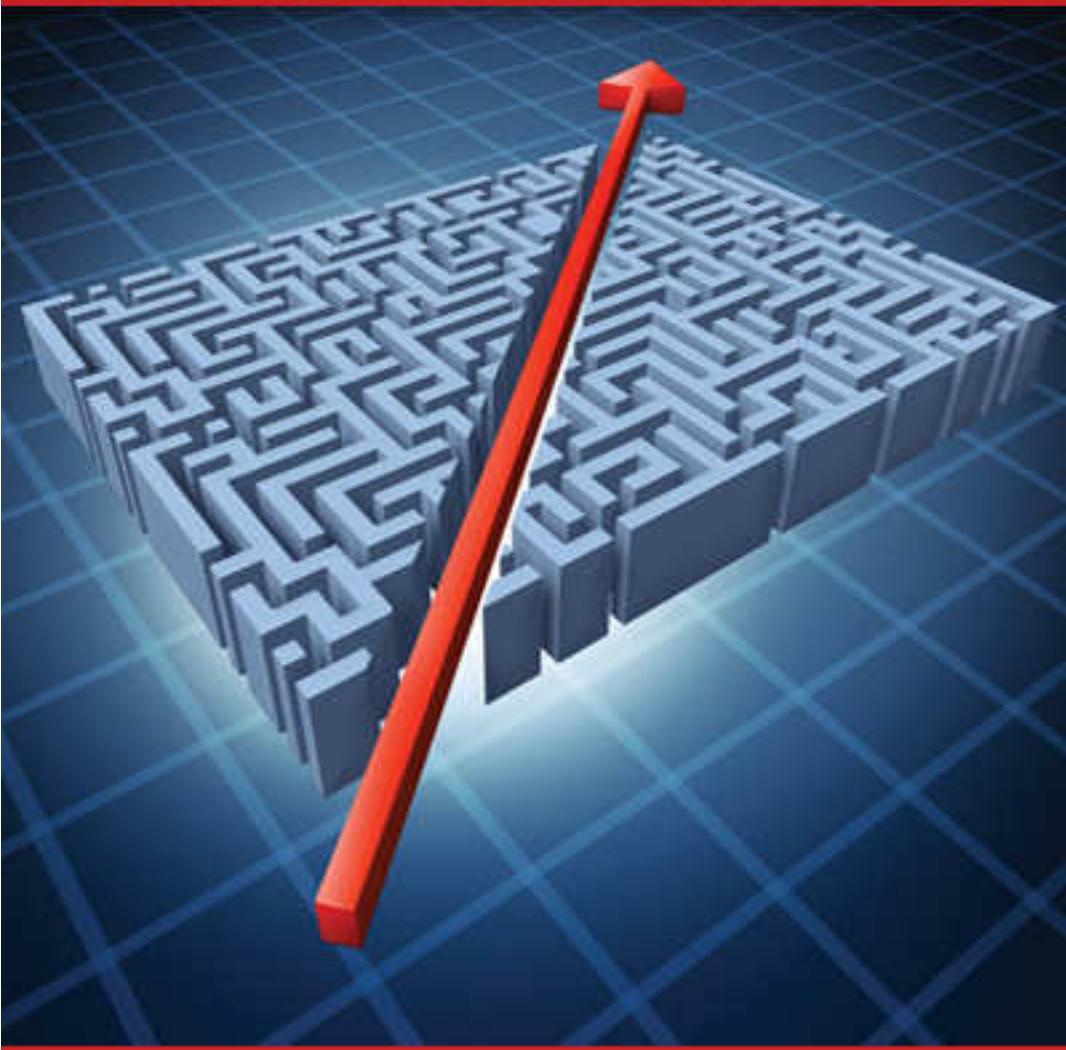




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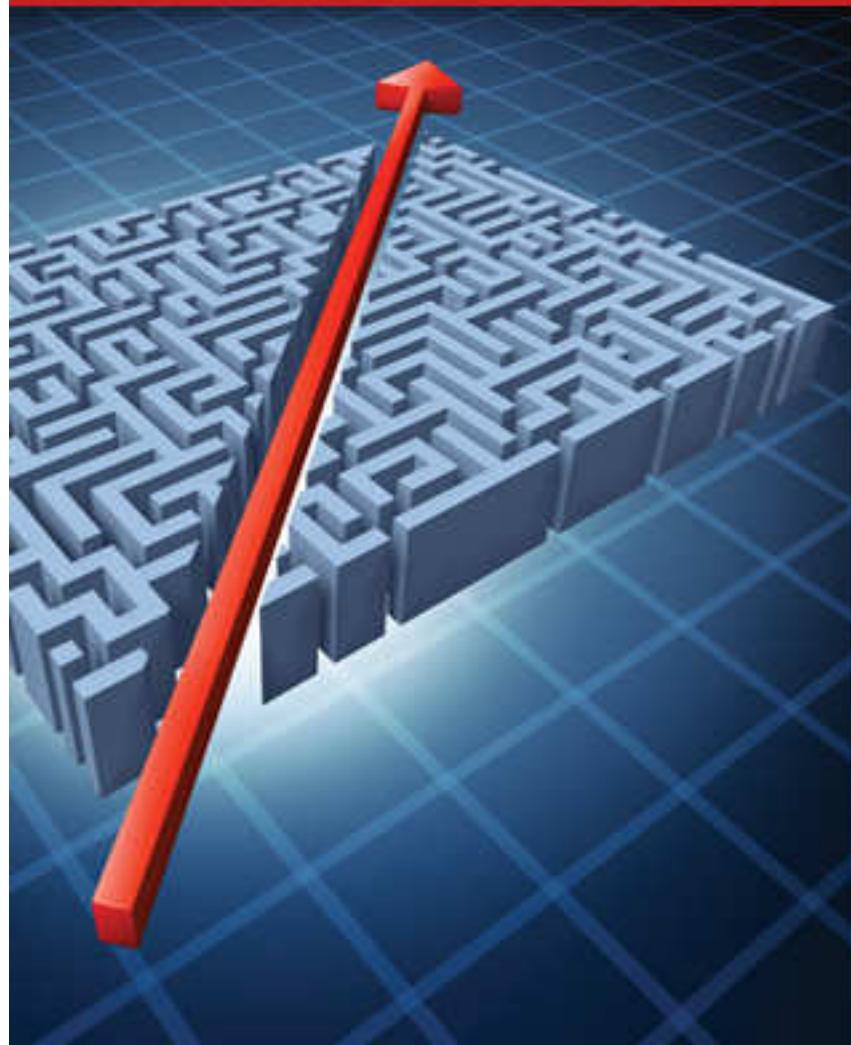


**Transforming the  
Business of Oncology  
through Science  
and Technology**



# 2017 CANCER CENTER BUSINESS SUMMIT

## Transforming the Business of Oncology through Science and Technology



If Palliative Care is the answer,  
what is the question?

J. Russell Hoverman, MD, PhD  
Vice President Quality Programs,  
Texas Oncology/Medical,  
Director, Managed Care McKesson Specialty Health  
& The US Oncology Network

## Themes in End of Life Care for Cancer Patients

- Cost
- Discordance
- Communication
- Palliative Care

## Costs

- Emanuel et al. Arch Intern Med 2002: One third of expenditures in the last year of life occurred in the last 30 days. Expenditures of patients using hospice were 30% lower
- Zhang et al. Arch Intern Med 2009: In patients reporting an EOL conversation with physician, costs were 35.7% lower. Higher costs were associated with worse QOP
- Earle et al. Int J Wual Health care 2005. Metrics for aggressive care: chemo in last 2 weeks of life, hospitalizations in last 30 days, death in hospital or ICU, hospice use, hospice use 3 days or less before death
- Nicholas et al. JAMA 2011. Advance Directives in regions with high levels of aggressive care significantly lowered spending
- Cheung et al Cancer 2015. Aggressive care in Cancer Care Ontario was associated with 43% higher costs. Chemo in the last 2 weeks predicted for costs. Aggressive palliative care reduced costs in the highest quintile

## Discordance: Prognosis

- Huskamp et al. Arch Intern Med 2009: 2 months before death, half of patients had no discussion about hospice
- Gramling et al. JAMA Oncol online 2016. 68% prognostic discordance between patient and physician. 96% of patients more optimistic. 89% of patients did not sense discordance
- Lamont and Christakis Ann Int Med 2001: Physicians overstated survival by 3.5x, accurate only 20% of time
- Epstein et al. J Clin Oncol 2016: Of 178 patients with advanced cancer, 38% had never had a discussion about expectations
- Weeks et al JAMA 1998 Discordance was present with some patients estimating 90% survival at 6 months with physician estimate at 10% - associated with aggressive care, with no improvement in survival

## Discordance: Values

- Apatira et al Ann Intern Med 2008. Surrogates of critically ill view withholding prognostic information as unacceptable
- Steinhauser KE et al. JAMA 2000: factors important to caregivers, patients and families – not be a burden to family or society and to help others
- Wright et al. J Clin Oncol 2010: dying in hospital associated with more physician and spiritual pain. ICU deaths associated with PTSD in caregivers. Hospital deaths associated with prolonged grief
- Mack et al J Clin Oncol 2010. 39% reported having a discussion about wishes for EOL care. These were more likely to have wishes met and have less aggressive care

## Communication:

- Mack et al. J Clin Oncol 2012: Lower likelihood of aggressive care in those who had EOL discussion before the last 30 days of life
- Wright et al. JAMA 2008: Reported EOL discussion with physicians were associated with less ventilation, less resuscitation, fewer ICU admits and earlier and longer hospice stays. Better caregiver quality as well
- Detering et al. BMJ 2010: ACP delivered by trained facilitators led to 86% of patients dying according to their wishes, 8% in control group. Caregivers with less stress and depression

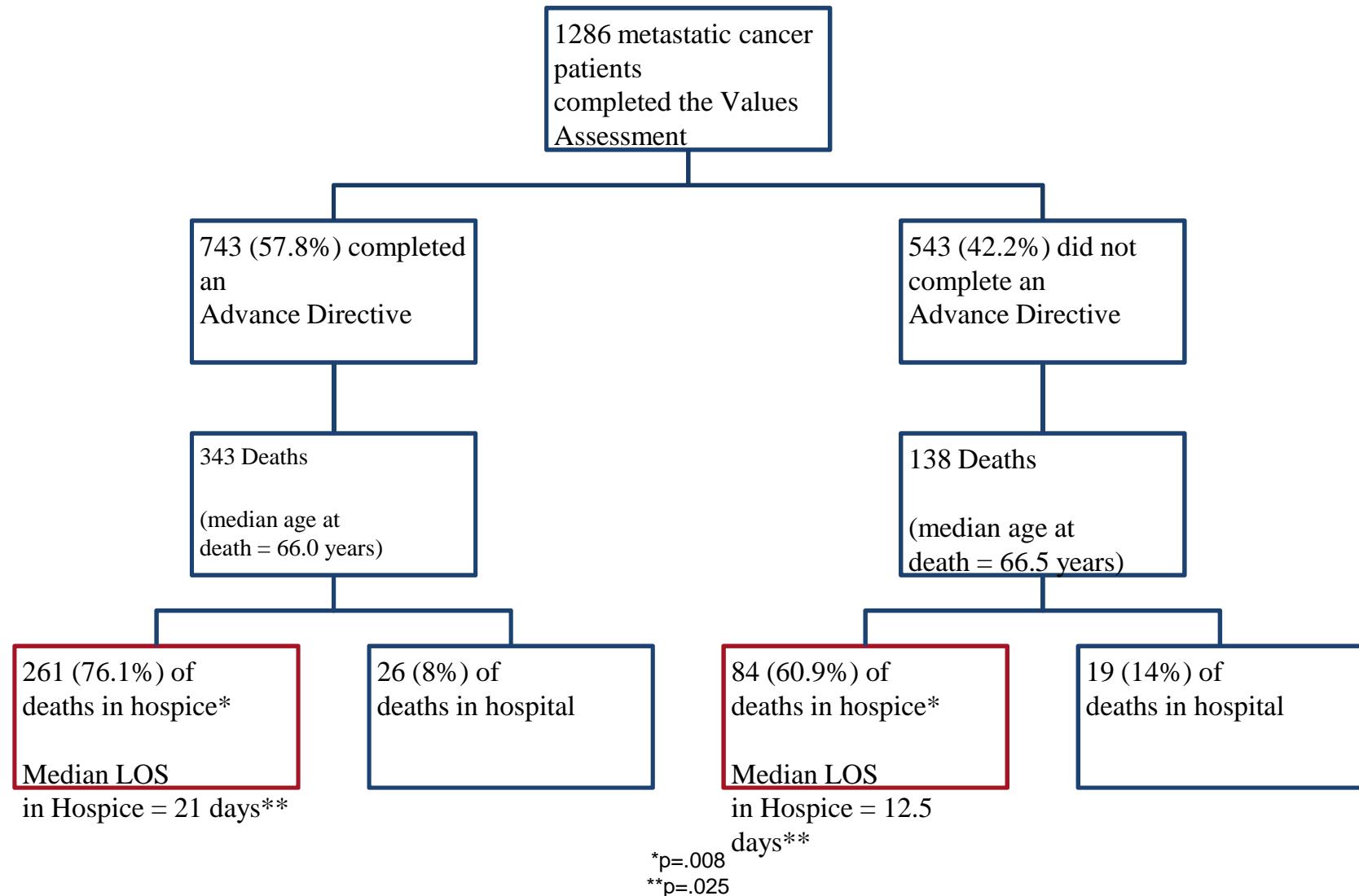
## What about

- SUPPORT?
- VOICE?

## Palliative Care Consultation

- Temel et al. NEJM 2010: Less aggressive care in PC arm 54% vs 33% in control arm.  
Almost exactly matches preferences documented: 53% vs 28%. Median days on hospice 4 in control arm, 11 in PC arm
- Reminder: Cheung et al, In Cancer Care Ontario, PC was effective in the highest quintile of costs
- Nicholas et al. Advance Directives effective in the highest resource utilizers
- **VOICE:** study group was of low to medium resource utilizers

# My Choices, My Wishes- results of 1,286 patient reports



# My Choices, My Wishes- advance care directive influence

Chemotherapy Utilization at EOL							
With Advance Directive				Without Advance Directive			
Last 14 Days***		Last 30 Days****		Last 14 Days***		Last 30 Days****	
22	8.8%	66	26.3%	17	15.5%	42	38.2%

CMS Feedback report: TxO  
13.9%, other OCM 10.6%

\*\*\*p=.060  
\*\*\*\*p=.023

Place of Death				
	With Advance Directive		Without Advance Directive	
	Raw Count	Percent	Raw Count	Percent
Home Hospice	136	39.7%	49	35.5%
Inpatient Hospice	39	11.4%	15	10.9%
Hospital	26	7.6%	19	13.8%
Other Facility	12	3.5%	5	3.6%
Unknown	130	37.8%	50	36.2%
TOTALS	343	100%	138	100%

# The IOM Care Management Plan: 13 Elements

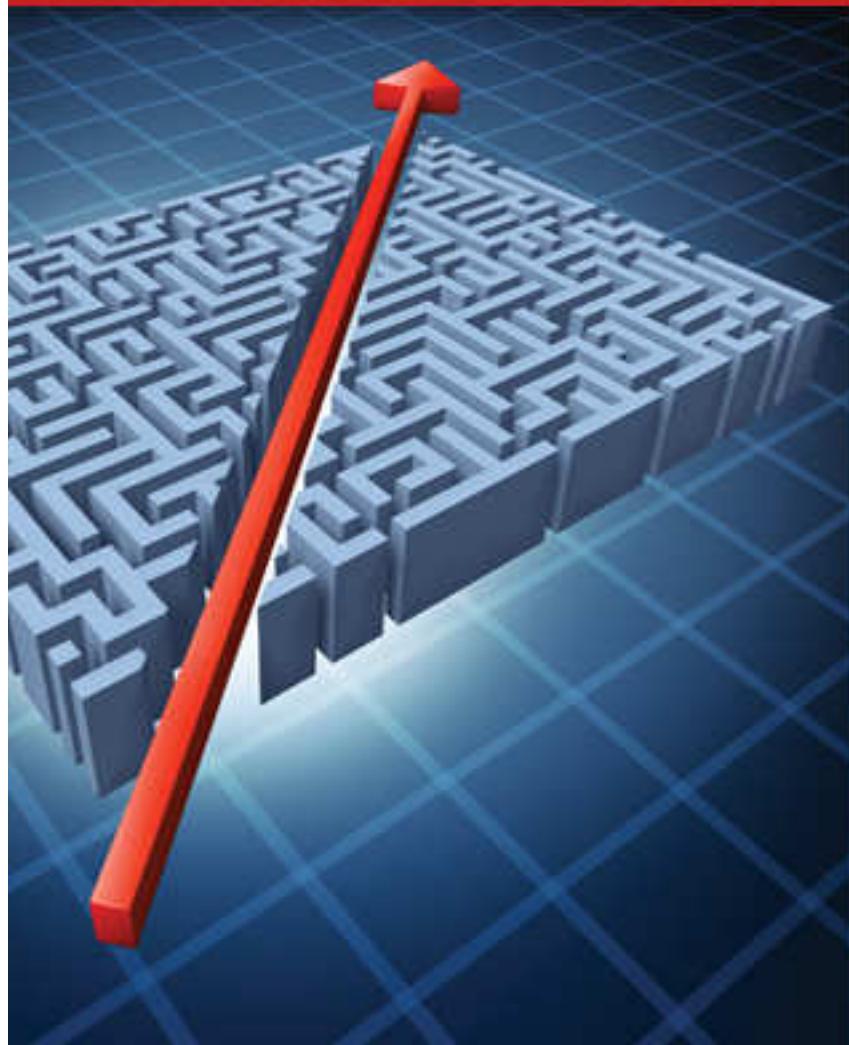
1. Relevant patient information
2. Diagnosis, specific tissue information, relevant biomarkers, and stage
3. Prognosis
4. Treatment goals
5. Initial plan for treatment and proposed duration
6. Expected response to treatment
7. Treatment benefits and harms, including common and rare toxicities
8. Information on quality of life & patient's likely treatment experience
9. Who will take responsibility for specific aspects of a patient's care
10. Advance Directives
11. Estimated total and out-of-pocket costs of treatment
12. A plan for addressing a patient's psychosocial health needs
13. Survivorship Plan





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ASCO Guidelines – Integration of Palliative Care

- Christian T Sinclair, MD,  
FAAHPM
  - President, American Academy of Hospice and Palliative Medicine
  - Editor, Pallimed
  - Asst professor, University of Kansas
  - Upstream outpatient palliative care in BMT and Med Onc

## 2012 ASCO Provisional Clinical Opinion

- Based on 2010 Temel NEJM article & other RCTs
- Highlighted improved patient & caregiver outcomes

“Patients with metastatic NSCLC  
***should be offered***  
concurrent palliative care and  
standard oncologic care  
at initial diagnosis.”

# 2012 ASCO Provisional Clinical Opinion

- Focused more on symptom burden & QOL
- Did not overemphasize survival benefit
  - Secondary analysis in Temel
- Emphasized lack of harm
- Other key studies were diverse
  - Bakitas – ENABLE (rural)
  - Brumley – In-home PC, incl non-CA
  - Meyers – Pt/CG dyads in clinical trials
  - Rabow – Outpatient clinics, incl non-CA

# 2016 Integration of PC in Standard Onc Care

- Clinical Practice Guideline >>> Prov Clinical Opinion
- The question:
  - What: Should concurrent PC/Onc be standard practice
  - Who: For people with advanced cancer and caregivers
- Expert panel
- Review of the medical literature
- Specific call out to patients in clinical trials
- Nine new RCTs (16 total)

# 2016 Clinical Practice Guidelines Focus

- Effective symptom control
- Practical models of palliative care
- Defining palliative care in oncology
- Relation of PC to existing or emerging services
- Interventions for caregivers
- Which patients benefit and at what time in illness

# Defining Advanced Cancer

- Those with distant metastases, late-stage disease, or cancer that is life limiting, and/or with prognosis of 6 to 24 months.
- Notice the lack of focus on end of life

# Defining Palliative Care

- 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.

## 2016 Integration of PC in Standard Oncology Care

Patients with advanced cancer  
***should receive***  
concurrent dedicated palliative care (inpatient or  
outpatient)  
and  
standard oncologic care  
early in the disease course.

# Links and Resources

- ASCO - [www.asco.org/palliative-care-guideline](http://www.asco.org/palliative-care-guideline)
- Palliative Oncology Symposium – [pallonc.org](http://pallonc.org)
  - Oct 27-28, 2017 – San Diego, CA
- American Academy of Hospice & Palliative Medicine
  - [aahpm.org](http://aahpm.org)
- Twitter – [#pallonc](#) and [@pallonc](#)

# RCTs Cited

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- Dionne-Odom JN, Azuero A, Lyons KD, et al: Benefits of early versus delayed palliative care to informal family caregivers of patients with advanced cancer: Outcomes from the ENABLE III randomized controlled trial. *J Clin Oncol* 33:1446-1452, 2015
- Dyar S, Lesperance M, Shannon R, et al: A nurse practitioner directed intervention improves the quality of life of patients with metastatic cancer: Results of a randomized pilot study. *J Palliat Med* 15: 890-895, 2012

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- Grudzen CR, Richardson LD, Johnson PN, et al: Emergency department-initiated palliative care in advanced cancer: A randomized clinical trial. JAMA Oncol [epub ahead of print on January 14, 2016]]
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- Uitdehaag MJ, van Putten PG, van Eijck CH, et al: Nurse-led follow-up at home vs. conventional medical outpatient clinic follow-up in patients with incurable upper gastrointestinal cancer: A randomized study. J Pain Symptom Manage 47:518-530, 2014

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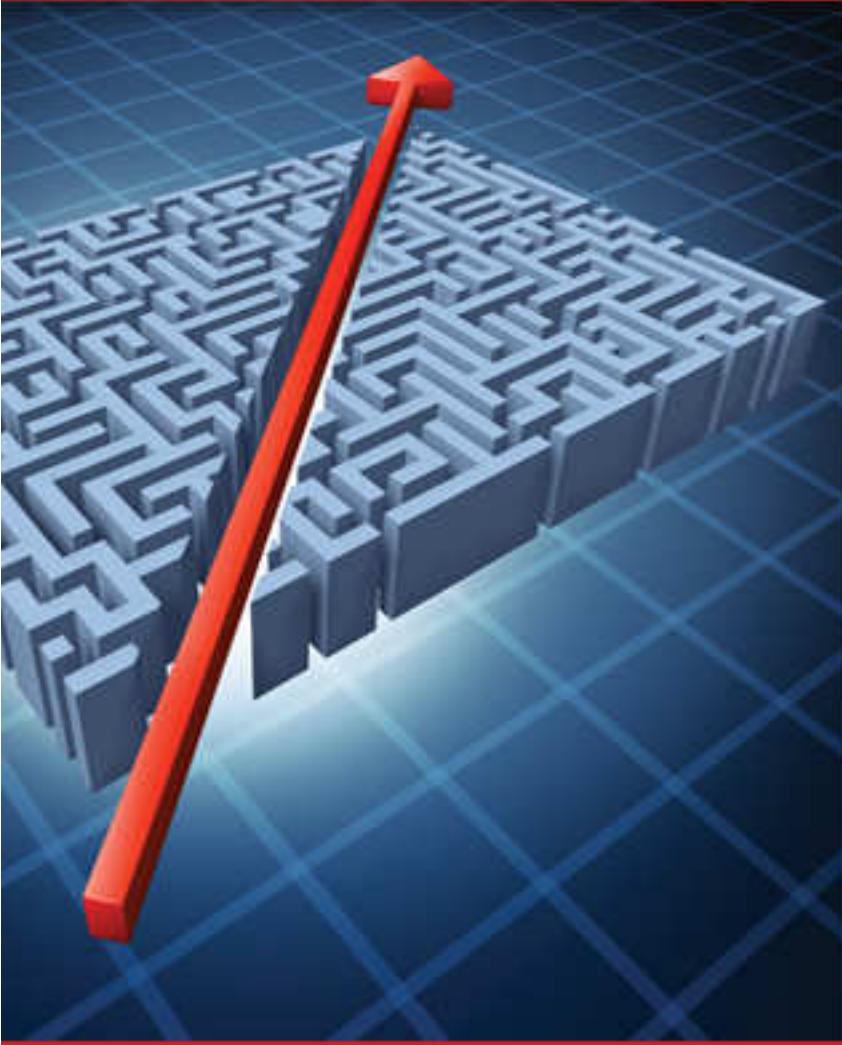
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- Pantilat SZ, O’Riordan DL, Dibble SL, et al: Hospital-based palliative medicine consultation: A randomized controlled trial. *Arch Intern Med* 170: 2038-2040, 2010
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Palliative Care in the  
COMEHOME model

Mark Wrona, MD  
New England Cancer Specialists

# Early Specialty Palliative Care in Oncology

**Table 1.** Randomized Trials of Early Specialty Palliative Care Interventions in Patients with Cancer.

Trial	Population	Intervention	Results
Brumley et al. <sup>6</sup>	298 homebound patients with a prognosis of <1 yr to live and a recent hospital or ED visit; included 138 patients with cancer	Usual care + in-home multidisciplinary PC (frequency of visits based on individual needs of patients) vs. usual care	Patients assigned to PC had lower rates of ED visits ( $P=0.01$ ) and hospital admissions ( $P<0.001$ ) and lower medical costs (difference in mean cost, \$7,552; $P=0.004$ ) and were more likely to die at home ( $P<0.001$ ). There was no significant between-group difference in hospice enrollment.
Gade et al. <sup>9</sup>	517 patients with $\geq 1$ life-limiting diagnosis and their physician "would not be surprised" if the patient died $\leq 1$ yr; included 159 patients with cancer	Usual care + inpatient multidisciplinary PC consultation vs. usual care	Patients receiving PC reported more satisfaction with care ( $P<0.001$ ), had fewer ICU stays on hospital readmission ( $P=0.04$ ), and had a 6-mo net cost savings of \$4,855 per patient ( $P=0.001$ ). There were no significant between-group differences in hospice use, completion of advanced directives, symptoms and quality of life, or survival.
Bakitas et al. <sup>10</sup>	322 patients with a life-limiting cancer and a prognosis of approximately 1 yr to live	Usual care + phone-based PC administered by advanced-practice nurse in 4 structured sessions and at least monthly follow-up vs. usual care	Patients assigned to PC reported better quality of life ( $P=0.02$ ) and mood ( $P=0.02$ ). There were no significant between-group differences in symptom burden or intensity of service (hospital and ICU days or number of ED visits).
Temel et al. <sup>11</sup>	151 patients within 8 wk after diagnosis of metastatic lung cancer	Usual care + outpatient PC (provided by physician or advanced-practice nurse) at least monthly and PC consultation if patient hospitalized vs. usual care	Patients receiving early PC had better quality of life ( $P=0.03$ ), lower rates of depression ( $P=0.01$ ), less aggressive end-of-life care ( $P=0.05$ ), and longer median survival ( $P=0.02$ ).
Zimmermann et al. <sup>12</sup>	442 patients with metastatic cancer and a physician-provided prognosis of 6 mo to 2 yr to live	Usual care + early ambulatory PC at least monthly vs. usual care with routine PC	Patients receiving early PC reported greater satisfaction with care ( $P<0.001$ ), better quality of life ( $P=0.008$ ), and less severe symptoms ( $P=0.05$ ) at 4 mo.

\* ED denotes emergency department, ICU intensive care unit, and PC palliative care.

## Community Oncology Medical Home COME HOME

- The patient centered medical home is a well established model of care for primary care providers, but adoption by specialty providers has been relatively limited.
- There has been particular interest in developing specialty medical homes in medical oncology because of practice variation, care fragmentation, and high overall costs of care.
- In 2012, the Center for Medicare and Medicaid Innovation awarded Innovative Oncology Business Solutions a 3 year grant for the program.

## COME HOME

- The purpose of the grant was to show that community oncology practices can become a medical home for patients with cancer, manage the care of these patients in a cost-effective manner that produces improved outcomes, and provide better patient satisfaction and cost savings.

# COME HOME

- Incorporates best practices care driven by triage and clinical pathways, team-based care, active disease management, enhanced access and care, as well as financial support for the medical home infrastructure.
- Information technology plays a central role, supporting both delivery of care and performance monitoring.
- Implemented in seven oncology practices across the country.

# COME HOME

- Seven features to ensure safe, efficient and high quality care:
  - 1. Electronic Health Records
  - 2. Best-Practices Care Driven by Triage and Clinical Pathways
  - 3. Team-Based Care
  - 4. Active Disease Management.
  - 5. Enhanced Access
  - 6. Enhanced Care
  - 7. Financial Support for the Medical Home Infrastructure

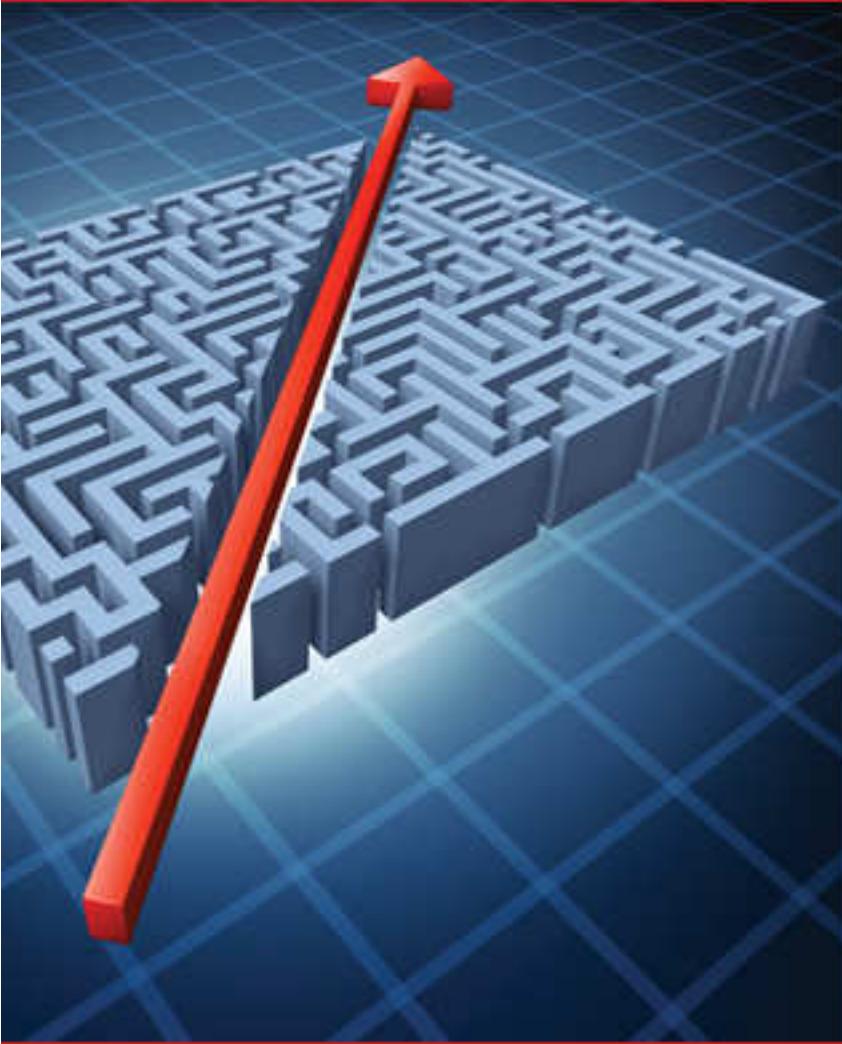
# COME HOME

- Opportunities for Early Palliative Care Integration in Community Oncology
- 1. Primary Palliative Care
- 2. Specialty Palliative Care



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### Final Thoughts

John Hennessy

# The Caregiver in Palliative Care

- Highlights from the 2016 Palliative Care in Oncology Symposium
  - Oral Abstract A, 2015 Caregiving in the U.S. report, National Alliance for Caregiving: caregivers for cancer patients were 62% more likely to have a higher burden of care than other disease states. More likely to communicate with healthcare professionals. More felt the need to advocate on behalf of the patient

# The Caregiver in Palliative Care

- Highlights from the 2016 Palliative Care in Oncology Symposium
  - » Oral Abstract Session B, Van Dusen, et al, JCO: twice weekly visits with palliative care team during transplant hospitalization. Improvements in some quality-of-life domains including better coping and lower depressions symptoms

# The Caregiver in Palliative Care

- Highlights from the 2016 Palliative Care in Oncology Symposium
  - » General Session 2, The Caregiver in Palliative Care, Dionne-Odom, UAB: ENABLE (Educate, Nurture, Advise Before Life Ends). Outbound phone calls by APNs. Early-intervention group had lower depressed mood and lower stress burden.

# The Caregiver in Palliative Care

- » How critical is role of the caregiver in palliative care; how can the caregiver influence ER and hospital utilization?
- » How have your pilot programs and your regular practice settings reached out to educate and strengthen care givers?
- » Do we need reimbursement models to encourage this? Do we need more data?