

End-of-Life Care Options for Patients with Cancer



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With thanks to Laura Hanson, MD, Megan DeMariano, and Jessica Heestand, MD

You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die.

-Dame Cicely Saunders



Objectives --

- How does teamwork enhance quality of end-of-life care for cancer patients?
- What is the difference between palliative care and hospice?
- What are the logistics of palliative care and hospice?
- What resources are available to patients and families to learn more about palliative and hospice care services?

Defining our terms.

We will discuss

Serious illness = not curable, life-limiting, life-altering

Palliative care = interdisciplinary care to improve the quality of life for patients living with serious illness, and their families

Supportive care = community based care to meet emotional, spiritual and practical needs

Hospice care = interdisciplinary care focused on comfort in those expected to have 6 months to live or less

We won't talk about

"Nothing more we can do"

"Treatment is futile"

"Withdrawing care"

"Comfort care"

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Teamwork at end-of-life in cancer care


- ASCO promotes interdisciplinary teamwork as the gold standard of cancer care
- Interdisciplinary teams result in better clinical and process outcomes for cancer patients.
- Consistency of the communication between team and patient is key

J Clin Oncol. 2006 Jul 20;24(21):3498-9.



Services of interdisciplinary teams in cancer care

- Clinicians specialized in oncology
- Pharmacists
- Psychosocial care
- Physical therapy
- Oncologic nurses




Benefits of teamwork at end-of-life

- Improvements in:
 - Planning of therapies
 - Pain control
- Adherence to recommendations about:
 - Preoperative assessment
 - Medications

Benefits on other clinical outcomes are pending.

Taplin SH. J Oncol Pract. 2015 May;11(3):239-46.
Prades J. Health Policy. 2015 Apr;119(4):464-74.
Pillay B. Cancer Treat Rev. 2016 Jan;42:56-72



Patients' perceived benefits

Patients perceive high-intensity interdisciplinary teams have higher rated:

- Prompt Access to Care
- Quality of patient-professional communication
- Person-centered response
- Continuity of care


Tremblay D. BMC Health Serv Res. 2017; 17: 218.

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Palliative Care ≠ Hospice






Palliative care

Interdisciplinary care to improve comfort and quality of life for a person with serious illness, and for their family.

- Pain and symptom management
- Decision-making
- Emotional, spiritual and practical support



How many might benefit?


Total US deaths (2016) = 2,626,418

- Cancer: 591,699

SEER Cancer Rates (2014) =

- 419.7 per 100,000 males
- 381.4 per 100,000 females

Lewis DR, Cancer 2017;123:2524-34.

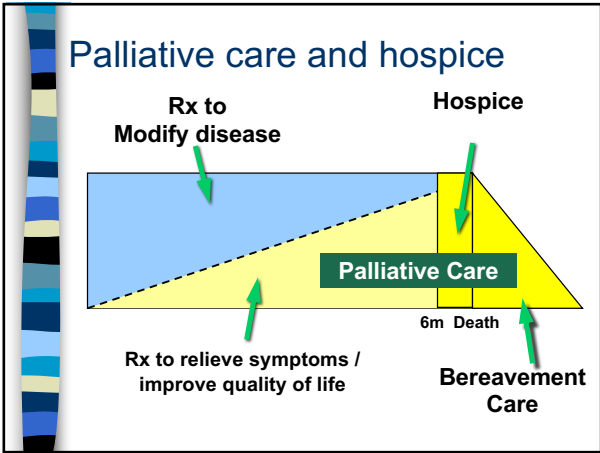


Who delivers palliative care?

1. Specialty palliative care team (MD, NP or RN, SW, Pharm D, chaplain)
2. Hospice team (RN, SW, NA, chaplain)
3. MD / NP primary care providers including oncologists

These do NOT equate to palliative care . . .


- “Comfort care only”
- “Withdraw care”
- “We’re not going to be aggressive anymore.”
- “So you’re not going to do anything for her?”
- Starting a morphine drip



Palliative care

Who are we talking about?

- Critical illness with high burden of suffering
- Eligible patients at all stages of life: childhood, pregnancy, older ages
- Life expectancy may be greater than 6 months.



Why is this important?


- Palliative care is frequently misconstrued as synonymous with end-of-life care
- Palliative care is important throughout the course of a patient's illness
- Approximately 75% of deaths in first world countries are caused by progressive advanced chronic conditions



Palliative care improves quality

- Improves family satisfaction with care (VA)
 - Improved pain, dignity, communication, treatment
 - Earlier consultations were associated with higher satisfaction
- Reduces in-hospital costs (\$1696-4908 per diem)
- Improves quality of communication, documentation of treatment preferences

Casarett JPSM 2010; Gade JPM 2008; Zimmerman JAMA 2008



Palliative care improves quality

RCT cancer care with early palliative care co-management vs standard cancer care

- Improved quality of life
- Reduced major depression
- Reduced 'aggressiveness' of care (chemo < 14d before death, no hospice care, or hospice < 3 d before death)
- Improved survival (11.6 mos. vs 8.9 mos.)

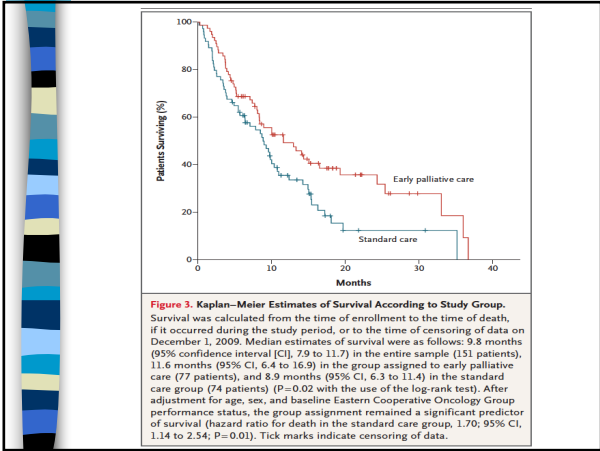
Temel NEJM 2010

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

Early integration of palliative care with standard oncologic care in patients with metastatic non–small-cell lung cancer resulted in:

- Survival that was prolonged by approximately 2 months
- Improvement in quality of life and mood
- Greater documentation resuscitation preferences
- Less aggressive care at the end of life



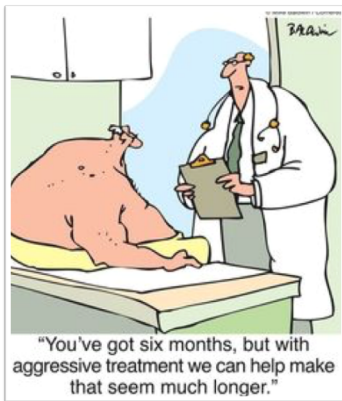
American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care

Thomas J. Smith, Sarah Temin, Erin R. Alazi, Amy P. Abernethy, Tracy A. Balboni, Eithan 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

- Palliative care, when combined with standard, leads to better patient and caregiver outcomes including:
 - Improvement in symptoms
 - Quality of life
 - Patient satisfaction
 - Reduced caregiver burden
- Reduced use of futile intensive care

Summary: palliative care

- Specialized medical care for people living with serious illness.
- Focus is on providing *relief from the symptoms* and the stress of a serious illness, helping with *medical decision making* and offering *support* to both patient and the family —whatever the diagnosis.
- The goal is to improve quality of life for both the patient and the family using an interdisciplinary team approach.
- It is appropriate at any stage in a chronic illness



Where do people die?

Site of death aged 65+ (2007-2009)

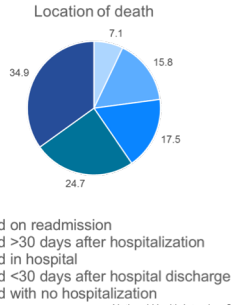
hospital	35-27%
home	24-34%
long-term care	28%

✓ ¼ include stay in ICU

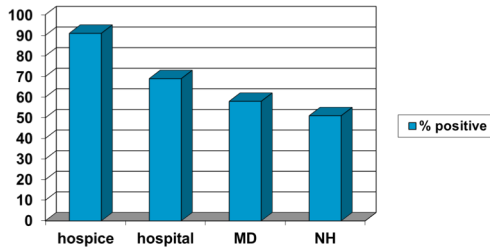
✓ 42% include hospice

Natl Center for Health Statistics 2010; Teno JM 2013 JAMA

Where do people die in relation to the hospital?




Where do people want to die? Family satisfaction after death



Is pain treated well?


- 40% of dying patients experience severe pain
- 26% of nursing home residents with advanced cancer *and* daily pain receive no analgesic medication
- 86% of oncologists believe cancer pain is undertreated



How many enroll in hospice?

In 2012 --

- 43.3% of US Medicare decedents (2007)
 - 38% cancer, 15% "debility NOS"
- Median LOS 18.7 days; average LOS 71.8 days
 - 1/3 of patients in hospice < 1 week
 - 11% in hospice >180 days
- 41% die in home, 17% in nursing home, 7% in residential care, 27% hospice inpatient facility, 7% die in hospital



Hospice care


Who are we talking about?

- Critical illness with low probability of survival
- Progressive incurable disease
- Frail elders with multi-morbidity
- Life expectancy of 6 months or less
- "Death in the next year wouldn't surprise me."




Hospice criteria for cancer patients

- Clinical findings of malignancy with widespread, aggressive or metastatic disease
- Decline in performance status and/or significant unintentional weight loss




Hospice criteria for cancer patients

- Patient may still receive disease-specific treatment if it is palliative
- Transfusions or life prolonging chemotherapies aren't often indicated.
- Neither is laboratory studies.



Hospice improves quality


- Higher family satisfaction compared to terminal care in hospital, nursing home
 - Better pain management, care for emotional / spiritual
- Decreases hospital transfer and increases use of pain management
- Hospice probably reduces Medicare costs – more so if cancer, younger pt, service > 7 wks – but increases family caregiving costs
- Hospice does NOT increase mortality risk



Hospice improves quality


- Longer duration in hospice (at least 22 days) improved quality of dying in terminal cancer patients
- Decreases hospital transfer and increases use of pain management
- Hospice probably reduces Medicare costs – more so if cancer, younger pt, service > 7 wks – but increases family caregiving costs
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Choi JY Eur J Cancer Care. 2017;e12771.




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Referral to palliative care


- Many home hospices and home health agencies have started home palliative care programs
- Patients can be referred to these programs just like they can be referred to home health



Referral to hospice


All hospice care is palliative, but not all palliative care is hospice . . .

- Prognosis 6 months or less "if disease follows expected course" by 2 MDs
 - attending + hospice MD (not NP / PA)
 - most referrals are < 1 month prior to death
 - NEW face-to-face visit required before 180 d. to re-certify eligibility
- Patient / family elect only palliation
 - agencies vary in willingness to provide specific types of "non-palliative" treatment




Hospice basics

- Medicare benefit Part A
- 6 month life expectancy if disease runs its normal course – needs to be certified and documented by 2 physicians
- Focus of treatment is now exclusively comfort
- Initially there are two 90 day certification periods and then every 60 days thereafter



Hospice basics continued

- Does not require a person to give up their primary doctor
- It is possible to “graduate” from hospice if stabilize
- It is possible for a person to revoke hospice at any time.
- It is still possible for people to go to the hospital if necessary



Hospice basics continued

- Capitated system (half are for-profit)
 - 2015 received \$162.10 per day per patient
 - 2016 reimbursement \$187.08 for first 60 days and \$147.02 thereafter
- Payment distributed by third party Medicare intermediaries. Here in NC it is Palmetto. Palmetto dictates what clinical findings (for each hospice diagnosis) equate to a 6 months of fewer prognosis
- Hospice pays for all medications related to primary diagnosis and associated conditions, but not for unrelated conditions.

Hospice 100% covered services

- Nursing care
 - Symptom assessment, skilled treatments, case management
 - 24 hour call service
- Medication & supplies for terminal illness
- Durable medical equipment
- Home health aide and homemaker services
- Therapy services if in care plan
- Chaplain
- Bereavement support

Associated conditions

- Require one of the three following criteria
 - It is a condition that is caused by the principle diagnosis
 - It is a condition that is made worse by the principle
 - E.g. Pancreatic CA and depression
 - It is a condition that on its own impacts a person's prognosis

Summary: palliative care v. hospice

Palliative Care

- Not limited to last 6 months of life
- May be combined with curative, disease-specific treatments
- Primarily in hospitals
- Varied services

Hospice

- < 6 months prognosis "if the disease follows its expected course"
- Palliation only
- In homes, nursing homes, and assisted living
- Defined services




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Resources for palliative care


If they have cancer:

- At UNC, refer to the CCSP (comprehensive cancer support program) or the outpatient symptom management program at the Cancer Hospital
- Refer to local home palliative care programs
- Local communities also often have supportive care groups as well




Online resources

- North Carolina Palliative Care Resource Guide
<https://www.communitycarenc.org/media/related-downloads/nc-palliative-care-resource-guide.pdf>
- <https://www.ahhcnc.org/>
- www.eprognosis.org
- <https://www.gofarcalc.com/>
- <https://www.mypcnw.org/fast-facts>



Resources for hospice

- Hospice by the Bay app
- Consider referral for a hospice informational visit
 - Consider if you think they will need inpatient hospice
 - Will you be willing to sign orders?

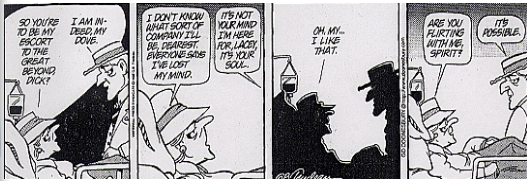


Resources for hospice

- If you are considering a hospice referral: first ask yourself if they have uncontrolled symptoms
 - If yes, consider inpatient hospice
 - If no and they have family, home-based
 - If no, but they don't have family and they have Medicaid, assisted living or skilled nursing facility

Other questions?

Thank you for your time.



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Stephen Young, MD

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