The Role of Palliative Care and Hospice in Cancer Care

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CHI Memorial
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Disclosures

No disclosures
Palliative Care

...is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

Center for the Advancement of Palliative Care
What is the Difference Between Hospice and Palliative Care

Hospice is an insurance benefit - Palliative Care is a treatment philosophy

**Palliative Care**: Can be engaged in life-threatening illness much earlier in acute care when curative treatment still on-going.

**Hospice**: A 1982 Medicare benefit. For last six months of life. Usually home or residential based. Used when curative care no longer pursued.
What Does a Palliative Care Doctor Do?

• The Three ‘C’s **Comfort-Communication-Coordination**
  
• 1. Experts in relieving symptoms
  • pain, nausea, fatigue, constipation

• 2. Experts in Communication with patients
  • and families, and Care Team (Dx, Tx, Prognosis)

• 3. Coordination of care with providers and family oriented around goals of care

• Unit of Care of care is patient and family

• Work done as a team!

• Palliative Care Team usually includes physician, chaplain, nurse and social worker
“Palliative care sees the person beyond the cancer treatment.”
Palliative Care When?: Triggers

- The “surprise question”: You would not be surprised if the patient died within 18 months or before adulthood (Hospice 6 months)
- Frequent admissions: e.g., more than one admission for same condition within several months, or coming from SNF
- Complex care requirements: e.g., functional dependency; complex home support for ventilator/antibiotics/feedings/home O2
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)
- Move to, or from ICU
- Initiation of dialysis or ventilation
- PEG tube contemplated
- Pain or symptom control
- Goals of Care/advance directives/Code status
Key Messages for Physicians

(Source: CAPC/ACS-CAN Public Opinion Research Focus Groups, Conducted by POS 2011)

→ The palliative care team supports frontline physicians by devoting time to intensive family meetings and patient and family counseling.

→ It supports treating physicians by resolving questions and conflicts between families/patients and physicians on achievable goals for care.

→ It supports treating physicians by providing expertise in pain and symptom management.
1. Patients with advanced cancer should be referred to interdisciplinary palliative care teams (consultation) that provide inpatient and outpatient care early in the course of disease, alongside active treatment of their cancer

- Palliative care for patients with advanced cancer should be delivered through interdisciplinary palliative care teams, with consultation available in both outpatient and inpatient settings

- Patients with advanced cancer should receive palliative care services, which may include a referral to a palliative care provider. Essential components of palliative care include: rapport and relationship building with patient and family caregivers; symptom, distress, and functional status management (e.g., pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation); exploration of understanding and education about illness and prognosis; clarification of treatment goals; assessment and support of coping needs (e.g., provision of dignity therapy); assistance with medical decision making; coordination with other care providers; and provision of referrals to other care providers as indicated. For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement, starting early in the diagnosis process and ideally within 8 weeks of diagnosis

- Among patients with cancer with high symptom burden and/or unmet physical or psychosocial needs, outpatient programs of cancer care should provide and use dedicated resources (palliative care clinicians) to deliver palliative care services to complement existing program tools

- For patients with early or advanced cancer for whom family caregivers will provide care in outpatient, home, or community settings, nurses, social workers, or other providers may initiate caregiver-tailored palliative care support, which could include telephone coaching, education, referrals, and face-to-face meetings. For family caregivers who may live in rural areas and/or are unable to travel to clinic and/or longer distances, telephone support may be offered

*Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Guideline Update.*
Ferrell, BR; Temmel JS; Temin S; et al: Journal of Clinical Oncology. Vol 35#1 Jan 2017
Why Don’t We Have The Conversation

“I’m sending you to someone who’s less squeamish.”
Goals of Care Discussion

Subjects: terminal cancer patient - 4.4 month life expectancy

- 123 of 332 (37%) patients with terminal illness had end of life discussions
- “Have you and your doctor discussed any particular wishes you have about the care you would receive if you were dying?”
- These patients elected less aggressive care with fewer ICU admits 4.1% vs 12.4%, fewer ventilation episodes 1.6 vs 11%,
- More aggressive care was associated with poorer quality of life for the patient and higher risk of major depressive disorder for bereaved caregivers. (PTSD)
- Study showed that patients did not have increased depression or loss of hope.

“Hope for the Best/Plan for the Worst “
The Goals of Care Discussion

• Pre-planning and semiotics
• Introductions
• Purpose
• Tell me about the patient
• What do you understand about the diagnosis??
• WARNING SHOT (I wish statements)
• Explain diagnosis
• Await reaction

• Validate emotions
• Keep the focus on the patient
• Did you (r)... ever talk/advance directives
• What would they want (substituted judgment)
• CPR/AND/ DNAR
• Summarize and record.

Success of a GOC is based on how much family and patient talk!
Two new CPT advanced care planning codes (99497 and 99498) are used to report the face-to-face service between a physician or other qualified healthcare professional (QHP) and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. The use of these codes requires a face-to-face visit, however, the patient may not be present.

**99497**
First 30 min of the conversation (must be at least 16 minutes)  
wRVU 1.50-Proposed reimbursement $80.16  
In addition to problem visit with modifier 25  
In addition to wellness visit with modifier 33

**99498**  
Additional 30 min  
wRVU 1.40-Proposed reimbursement $75.11  
In addition to problem visit with modifier 25  
In addition to wellness visit with modifier 33
Tennessee Advance Directive Coalition (TADC),
Launched April 16th, 2017 (National Advanced HealthCare Decisions Week
www.advancedirectivestn.org    www.HonoringchoicesTN.org
“It is Always Too Early Until it is Too Late”

An Advance Directive is a written statement of a person's wishes regarding medical treatment, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.
• Early specialty palliative care is the gold standard for patients and their caregivers, and all oncologists should be educated in primary palliative care competencies. — VJ Periyakoil, MD

• **In patients with cancer** and a high symptom burden and/ or unmet physical or psychosocial needs, ASCO recommends that outpatient cancer care programs provide and use palliative care clinicians to deliver palliative care services to complement existing program tools.
Metastatic Non-Small Cell Lung Cancer 151 Patients

- Palliative Care sample had life expectancy closer to one year *(control 9 months)*

- Patients in Palliative Care arm of study had less pain, less depression less anxiety.

JS Temel, JA Greer, A Muzikansky. *Early Palliative Care for Metastatic Non-Small Cell Lung Cancer.* NEJM Aug 19, 2010 733-742
It’s NOT JUST CANCER!
Illnesses with ~ 50% Mortality at Five Years

COPD

Solid Cancers

Heart Failure

End Stage Renal Disease- Dialysis
The first large randomized trials of usual care versus usual care plus an interdisciplinary palliative care team were conducted by a vertically integrated health care organization—Kaiser-Permanente—involving more than 800 patients. Avoided hospital and intensive care unit days in the last month of life led to **equal survival, better satisfaction and communication, and cost savings** of $7,55058 and $4,88559; the savings were sufficient to convince Kaiser-Permanente to have interdisciplinary palliative care teams at all its major sites.

Similar savings were observed at eight centers, with 14% direct cost savings in discharges of living patients ($2,374 in 2014 dollars) and 22% direct cost savings for decedent discharges ($6,871 in 2014 dollars).

The Veterans Administration also observed 38% direct cost savings for patients receiving palliative care, overall, compared with matched patients who did not receive palliative care, which led it to emphasize palliative care across its systems.

*Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Guideline Update.* Ferrell, BR; Temmel JS; Temin S; et al: Journal of Clinical Oncology. Vol 35#1 Jan 2017
Everyone is entitled to SOME Palliative Care
Symptoms
Total Suffering

• Pain: 50% of all cancer patients suffer pain and >70% of terminal cancer patients suffer pain
• 40-70% suffer unnecessary pain
• Fatigue 70-95%
• Shortness of Air: 21-78%
• Delirium 28-83%
• Constipation/Bowel Obstruction 5-28%
• Nausea/vomiting 15-40%
• Dry mouth/mouth sores
• Depression
• Spiritual angst
•
The Pendulum Swings Both Ways

“We have two public health crises going on at the same time: One is the under treatment of pain and the other is prescription drug abuse.” Dr Scott Fishman  JAMA

- 1994- Agency for Heath Care Policy and Research disseminates guidelines for Cancer Pain then Non-chronic pain 1996
- 2001 JCAHO establishes “Pain as the Fifth Vital Sign” campaign.
- 2001 Bergman v Chin 1.5 million dollar judgment against Dr. Chin for allowing patient to die in pain (10/10)
- And then the pendulum swings back
- New focus on overdose deaths, doctor shopping criminal penalties .
- Average 390 “for cause” surrenders of DEA licensure annually
- June 2011 IOM releases study on cost of pain and it’s under-treatment

New State rules on prescription quantities do NOT apply to hospice and palliative care, must put “exempt and ICD 10 code
The Hasting Center Guidelines for Decisions on Life Sustaining Treatment and Care Near the End of Life

• ....patients will benefit from health care leaders who see **end of life care as part of health care** rather than a failure of health care... (p 23)

• “There are powerful incentives for hospitals to define care in terms of reimbursable treatment interventions and diagnostic testing to prioritize quantity over quality and set lower value on ...services that are non-income generating. These incentives have a large role in shaping the delivery of end-of-life care.” (p29)
So What Happens to the Elderly
(Survey 4158 Seniors)

Non-Hospice Patients
• Elderly patients avg. age 83
• 75% visit ER in final 6 months (40% more than once)
• >50% visit ER final month
• Of those in ER, 75% admitted
• 39% admitted to ICU
• 68% admitted died in hospital

Hospice patients
• Hospice Patients
• Less than 10% seen in ER
• Vast majority die at home

*Smith AK, McCarthy E, Weber E et al; Half Of Older Americans Seen In Emergency Department In Last Month Of Life; Most Admitted To Hospital, And Many Die There. Health Affairs. June 2012 31:61277-1285.*
How DO I Sleep at Night?

My patient’s live longer than matched patients outside hospice.

My patients suffer less:
- Less pain, less depression, less dyspnea, less angst, etc.

My patients find peace, meaning and healing with family.

My families struggle with and suffer less PTSD, stress and depression.

My care costs are less.

We keep hospitals happy by keeping readmissions lower.
Reading List!

• Being Mortal- Atul Gawande MD
• Modern Death: Haider Warraich MD
• When Breath Becomes Air: Paul Kalanithi MD
• Less Medicine/More Health: Gilbert Welch MD
• Extreme Measures: Jessica Zitter MD
• The Conversation: Angelo Volandes MD
Resources

- Blogs: Pallimed, Geripal, Medicalfutility (great for keeping up)
- Fast Facts [www.mypcnnow.org](http://www.mypcnnow.org)
- [www.HonoringchoicesTN.org](http://www.HonoringchoicesTN.org)
- [www.theconversationproject.org](http://www.theconversationproject.org)
- American Academy of Hospice and Palliative Medicine - [AAHPM.org](http://AAHPM.org)
- Hospice and Palliative Nurses Association [www.hpna.org](http://www.hpna.org)
- National Hospice and Palliative Care Organization - [NHPCO.org](http://NHPCO.org)
- Center for the Advancement of Palliative Care - [CAPC.org](http://CAPC.org)
- [Palliativedoctors.org](http://Palliativedoctors.org) (AAHPM’s website for patients)
- Hospice and Palliative Care Formulary USA (Palliativedrugs.com)
- Greg Phelps MD  Greg_Phelps@hospiceofchattanooga.org
The End
Thank You

"Hey, Gramps, is ‘deathbed’ one word or two?"