How to Determine the Optimum Time for Hospice Care Referral and Enrollment

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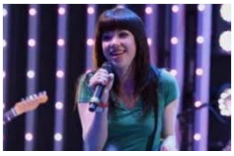
Disclosures and Motives

- I have funding from Ho-Chiang Foundation and Avon Foundation grants, and NCI Core Grant to SKCCC, but no private financial relationships to disclose.
- The off- label use of olanzapine, dexamethasone, lorazepam, diphenhydramine and haloperidol will be mentioned.
- Motive: "Call us, maybe." I am trying to get palliative care (PC) more involved sooner in more patients, with eventual transition to hospice.

Name	Number
Bayview Palliative Care Consult	410.283.5720
JHH Palliative Care Consult	Multiple
Pediatric Palliative Care Consult	410.283.6620
Weinberg Palliative Care Consult	Multiple



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Learning Objectives

At the end of this educational activity, participants should be able to:

1. Review the medical criteria for patient eligibility for hospice and know the available applications (apps) to confirm eligibility
2. Recognize when to begin end-of-life care conversations and discussions regarding hospice care with patients and families, and discuss why hospice is underutilized
3. Identify when a decision about entering a hospice program should be made, who should make the referral, and some “prompts” that increase referrals
4. Recognize the importance of timely referral to hospice and the impact this has on promoting the best possible quality of life (QoL) for patients as they near life’s end
5. Summarize the benefits of timely referral of patients for hospice care to clinicians, patients, and their families

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Today’s Outline

1. Definitions of Hospice and Palliative Care
2. When NOT to refer to hospice
3. How to integrate palliative care into hospice care
   - Hospice information visits with 3-6 months left to live.
   - How to work with your oncologists. “Make their life easier”
   - Find out about Expanded Access programs available through insurers

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Definition of Hospice

- 11th century—places of hospitality for the sick, wounded, or dying
- Pioneered in the 1950s by Dame Cicely Saunders
- **Hospice** is a type and philosophy of care that focuses on the palliation of a terminally ill patient's symptoms
- Physical, emotional, spiritual, or social in nature
- Providing care, not curing
- When there are no longer curative options or reasonable options
- *In Baltimore, thought of as a place you go—Joseph Richey Hospice*

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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;33(3):238-246

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People who use hospice live longer.

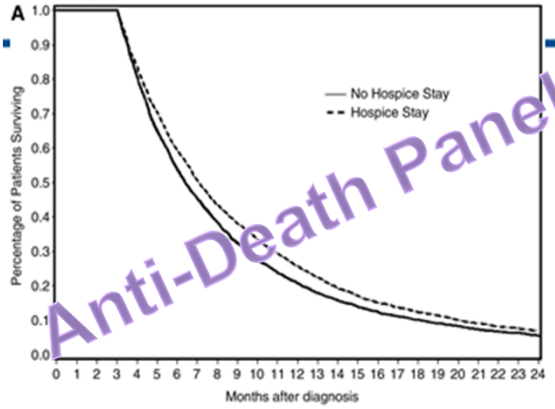

FIG. 1. Kaplan-Meier Survival Curves after diagnosis of advanced non-small cell lung cancer (NSCLC) by the hospice utilization

A: A matched cohort A of 3186 nonhospice patients and 3186 hospice patients after controlling for baseline characteristics

B: A matched cohort B of 379 short-term hospice patients and 379 longer-term hospice patients after controlling for baseline characteristics

Saito AM, et al. *J Palliat Med*. 2011;14(8):929-939

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Definition of palliative care

"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.**"

Diane Meier, MD, Director, Center to Advance Palliative Care, July 1, 2011

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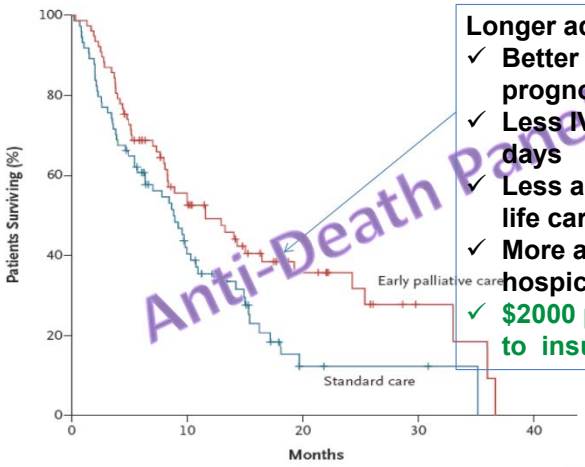
Palliative care in addition to usual oncology care allowed lung cancer patients to live almost 3 months longer than those who got usual oncology care.

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



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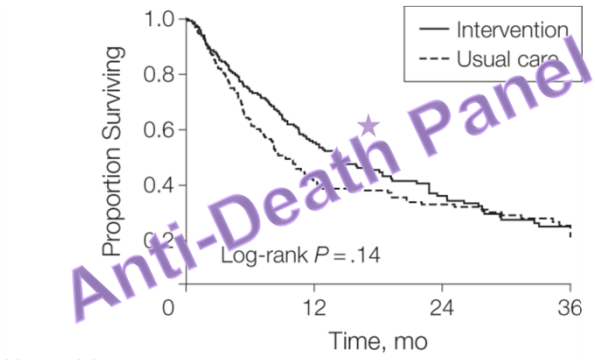
Palliative care in addition to usual oncology care allowed improved lifespan. Bakitas M, et al. Project ENABLE. JAMA 2009



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

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PC Consults improve QOL for MS patients.

PC team covered SE England
Saw people at home 3 times, then turned over services to local PC if available

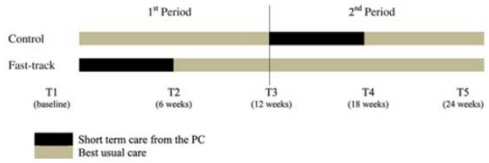

Figure 1 Study design and period of PC in the fast-track group and the control (delayed-start) group. PC, palliative care.

Higginson I J et al. Postgrad Med J 2011;87:769-775

Results

- The group that received PC at 12 weeks had:
  - improvement in five key symptoms (mean change: −1.0), compared to deterioration in the control group (mean change: 1.1; F=4.75, p=0.035);
  - improvement in care giver burden, as assessed with the ZBI, compared to deterioration in the control group (F=7.6, p=0.013);
  - lower costs (£1789; bootstrapped 95% CI −£5224 to £1902) compared to the control group.

PMJ

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Randomized trials of non-cancer palliative care show improved outcomes

First Author, Year Citation	Outcomes			
	Satisfaction	Resource Use	Advance Care Planning	Survival
Brumley, R: 2007 J Am Geriatr Soc 55: 993. randomized trial of **in-home** palliative care	Improved, P < .05	**Cost $7500 less**	Not measured	NS
Gade, G: 2008 J Pall Med 11: 180. **inpatient** palliative care team: a randomized trial	Improved, (P=0.04) and providers' communication (P=0.0004)	**Cost $6,766 less**	IPCS patients had more ADs at discharge than UC patients (91.1% vs. 77.8%; P< 0.001)	NS

Abbreviations: OR, odds ratio; ED, emergency department; IPCS, Interdisciplinary palliative care service; UC, usual care; AD, advance directive; PC, palliative care

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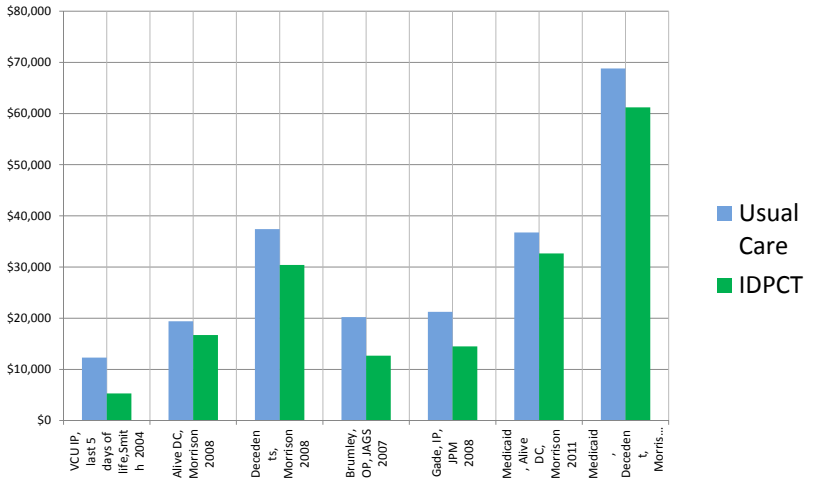
Every IDPCT study to date shows significant savings – in addition to better care



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What is the optimal LOS in hospice?

- There are NO controlled trials on which to make decisions.
- NHPCO, current data. (http://www.nhpco.org/sites/default/files/public/Statistics_Research/2012_Facts_Figures.pdf)
  - 46% of all deaths
  - Mean 69 days, median 19, 36% less than 7 days.
- "At least 3 months". N.A. Christakis, T.J. Iwashyna Med Care, 38 (2000), pp. 528–541
- Some patients are content with "late" referrals, Family Evaluation of Hospice Care (FEHC). Teno JM, Shu JE, Casarett D, Spence C, Rhodes R, Connor S. J Pain Symptom Manage. 2007 Aug;34(2):120-5. Epub 2007 Jun 21.
  - Hospice lengths < 1 month, only 16.2% reported they were referred "too late."
  - "family members' perception of the timing of hospice referral-not the length of stay-is associated with the quality of hospice care."

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Quality of care is not optimal, with short hospice stays

Care patterns for cancer patients who died at a major medical center, Summer 2011 (see Dy S et al, JPM 2011; *Dow and Smith, JCO 2010)		
Process measure	N (%)	Targets
Seriously ill	61	
Use of ventilator	16 (26)	10%
Deceased	35 (57)	
***Any* goals of care discussion**	26 (43)	95%
Advance directives on file	4 (7)	90%
Oncologist brought up Advance directives*	2/75 (1%)	100%
Death in hospital	21 (34)	10%
Discharged with hospice	14 (23)	60%
Chemo with 2 weeks of death, solid tumor patients	28-35%	<10%

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There are opportunities to improve our practice on hospice referrals

Medicare Patients, Unadjusted Cancer Care Measures, By Hospital Characteristics, Morden N, Health Affairs 2011		
Measure	All	NCCN cancer centers
Hospice use, last month of life (%)	53.8	53.4
Days in hospice, last month of life (per decedent)	8.4	8.6

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Much of this comes from a JOP article we wrote based on the Cancer Business Summit 2012. Business understands that the current system is unsustainable.

2012 Cancer Center Business Summit

Perspective

Doing Palliative Care in the Oncology Office

By M. Jennifer Cheng, MD, Lauren M. King, CRNP, Erin R. Alesi, MD, and Thomas J. Smith, MD

Johns Hopkins Medical Institutions, Baltimore, MD; and Virginia Commonwealth University, Richmond, VA

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How to do palliative care in the office.

Cheng J, King L, Alesi ER, Smith TJ. J Oncol Practice, 2013

Table 1: Components of Office-based Primary Oncology Palliative Care
1. Ask, Tell, Ask. Always ask people how much they want to know, and what they do know. Then tell them, in understandable words. Ask "What is your understanding of your situation?"
2. At each transition point (when changing treatments or prognosis) DO ask, tell, ask. "What are you hoping for?" and "What is your understanding of your situation?"
3. Always do a symptom assessment.
4. At least some of the time, do a spiritual assessment.
5. Make a "hospice information referral" when the patient still has 3-6 months left to live.
6. Audit hospice referrals, like QOPI does.
7. Set up "best practices" for seriously ill patients who have less than a year to live.
8. Take advantage of decision aids to help those patients who want to know their prognosis. Use www.Eprognosis.org
9. Use some "palliative care pearls" in your practice, such as olanzapine* for nausea, ginger for nausea, ginseng for fatigue, dexamethasone* for fatigue.
10. Use chart prompts in your EMR. Advance Directive __Yes __ No __ Not discussed Code status __Full ___DNR Other _____ DPMA _____

*off-label uses; herbal products

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When DO oncologists refer to hospice?

- A sobering survey of U S Oncologists: Keating NL, et al. Cancer. 2010 Feb 15;116(4):998-1006. doi: 10.1002/cncr.24761.
  - "when there are no more nonpalliative treatment options" - ~60% of Med Oncologists (this gives about 2 weeks)
  - "at the time of diagnosis of incurable disease" ~18% of Med Oncologists
  - Half of all US lung cancer patients have had NONE of their doctors mention hospice 2 months before death. Huskamp HA, et al. Arch Intern Med. 2009 May 25;169(10):954-62
- Why is that?

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- **This is why ¾ 's of incurable cancer patients think there is a chance they could be cured with chemotherapy. (Weeks J, et al. NEJM 2012)**
- We enable this avoidant behavior by concentrating on the chemotherapy.

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What Hospice isn't…to counter Oncologist arguments

- They won't drug you up just to keep you quiet.
- Or, kill you off sooner.
- You can still have CPR.
- They won't stop your medications, unless they aren't doing you any good.
- You can still see your regular doctors, but you can't do all the usual tests "just because". (Bodurtha's rule of diagnostic testing)
- Hospice is revenue neutral to the Medicare budget, so costs matter. Hospice gets $150/day to cover everything. Many physicians have no idea.

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We miss opportunities to recognize hospice-eligible patients, they are readmitted, and cost more.

U of Iowa Hospitals.

- 688 in-hospital deaths
- 209 decedents had preceding admission
- 60% of decedents were eligible for hospice on the *penultimate* admission, based on NHPCO, National Hospice and Palliative Care Organization worksheets.

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

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

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We are still hospital oriented and not hospice oriented near the predictable end of life.

Medicare Patients, Unadjusted Cancer Care Measures, By Hospital Characteristics, Morden N, Health Affairs 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
Hospitalized, last month of life (%)	64.9	60.2	61.7	64.4	65.1
ICU use, last month of life (%)	24.7	23.3	26.3	26	24.6

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So how do we convince oncologists to refer to hospice sooner and more often?

1. "Co-brand" with other initiatives like reducing re-admissions, making care accountable and less costly, and creating medical homes.
2. Give us the tools to use and the words to say.
   a) Scripts
   b) Hospice in a Minute
   c) ePrognosis.org
3. Give us actionable information.

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Co brand

The American Society of Clinical Oncology now recommends "…combined standard oncology care and palliative care should be considered early in the course of illness for *any* patient with metastatic cancer and/or high symptom burden."

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

Smith TJ, et al. J Clin Oncol. 2012 Mar 10;30(8):880-7. doi: 10.1200/JCO.2011.38.5161

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Co brand

AAHPM *Choosing Wisely* Task Force and ASCO *Choosing Wisely* Converging

1. Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead, offer oral assisted feeding.
2. Don't delay palliative care for a patient with serious illness who has physical, psychological, social, or spiritual distress because they are pursuing disease-directed treatment.
3. Don't leave an implantable cardioverter-defibrillator (ICD) activated when it is inconsistent with the patient/family goals of care.
4. Don't recommend more than a single fraction of palliative radiation for an uncomplicated painful bone metastasis.[6%->80%]
5. Don't use topical lorazepam (Ativan), diphenhydramine (Benadryl), haloperidol (Haldol) ("ABH") gel for nausea.

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Co brand: ASCO University

Solutions: Learn a New Script, and have a hospice "information visit"

- This is NOT "Three strikes and you're OUT!"
- It is "The cancer has now grown through 3 of our best chemotherapy regimens. I wish it was different, but it is time to stop trying to treat the cancer.
- Remember when we first discussed your pancreas cancer, I said there might be time when chemotherapy would cause more harm than good…that time is now.
- ***I am going to call those hospice people that you met 3 months ago to discuss enrollment.*** Let's talk about some important issues…."

Peppercorn J, et al. J Clin Oncol. 2011: 29:755-760;
Smith TJ, Hillner BE. Bending the Cancer Care Cost Curve. NEJM 2011.

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Co brand: readmission initiatives

People who use hospice are re-admitted less often, use less medical resources, and get better care.

Better care, ***consistent with what people would choose. ASCO.***

Smith TJ, Schnipper LJ. The American Society of Clinical Oncology program to improve end-of-life care. J Palliat Med. 1998 Fall;1(3):221-30.

Hospice saves Medicare $2-6000 per decedent, and the longer the hospice Length of stay, the bigger the savings. *ADMIN.*

Taylor DH Jr, eit al. Soc Sci Med. 2007 Oct;65(7):1466-78.
Kelley AS, Morrison RS. Health Aff (Millwood). 2013 Mar;32(3):552-61

Table 2. Readmission Rate by Post-discharge Medical Service Use

Post-discharge medical services	Ratio of readmissions	Percent
Hospice	11/240	4.6
Home-based palliative care	5/60	8.3
Home health	2/15	13.3
Nursing facility	14/58	24.1
Home no care	9/35	25.7

Enguidanos S, Vesper E, Lorenz K. 30-Day Readmissions among Seriously Ill Older Adults. J Palliat Med. 2012 Dec;15(12):1356-61.

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Co brand

We miss opportunities to recognize hospice-eligible patients, they are readmitted, and cost more.

Enrolled in hospice before last admission n = 7/14		Not enrolled in hospice, all diagnoses, n = 202/209
Cost		
Mean	$4963	$52 219
Median	$3690	$23 322
Palliative Care Consultation		YES $41,859 NO $58,386 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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Doing Palliative Care in the Oncology Office. M. Jennifer Cheng, Lauren M. King, Erin R. Alesi, and Thomas J. Smith. *JOP Mar 1, 2013:84-88.*

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2. Tools
Help us learn to Assess Hospice Eligibility routinely

- Some centers are screening for THESE TRIGGERS:
  - Failure to thrive: BMI < 22, involuntary weight loss
  - CHF NYHA Class IV, EF < 20%
  - COPD: hypoxemia at rest, FEV1 < 30%
  - Dementia < 6 words
  - Liver disease: INR > 1.5, albumin < 2.5
- The SURPRISE QUESTION: "Would you be surprised if this person were to die in the next 6 months?"
- Cancer – much easier. Salpeter et al. J Palliat Med. 2012 Feb;15(2):175-85
  - Hypercalcemia, *any* malignant effusion, spinal cord compression, ECOG PS 2 or higher, multiple brain mets

Doing Palliative Care in the Oncology Office. M. Jennifer Cheng, Lauren M. King, Erin R. Alesi, and Thomas J. Smith. *JOP Mar 1, 2013:84-88.*

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2. Tools
Help us learn to Assess Hospice Eligibility routinely

- This is a great tool for iPads and iPhones
- It gives us the WORDS to say…. "A service offered to patients when cure is no longer possible or sought, and the prognosis is 6 months or less…."
- Give it with the Salpeter JPM article! That documents the 6 month or less….

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2. Tools

Talking Point Definition of Hospice

- Hospice provides "an extra layer of support to help you and your family maintain your quality of life"
- Team that includes *specially trained nurses* who can help control pain, shortness of breath, and other symptoms
- Your oncologist can still be in charge of your care (HOW TO COMMUNICATE – ask us)
- Spiritual support for families that don't have that
- The most support you can get to be *at home*

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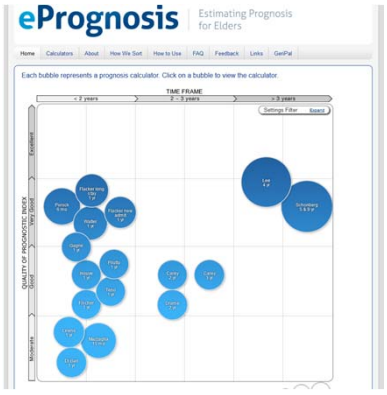
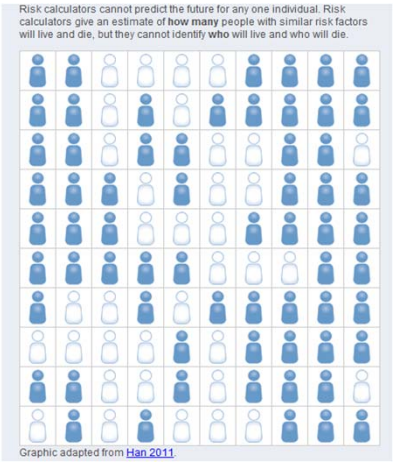
2. Tools

Take advantage of decision aids to help those patients who want to know their prognosis. Use www.Eprognosis.org





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2. Tools

Better integrate hospice into our care.

- Have a "hospice information visit" when we think the person has 3-6 months to live.
- IF we are thinking hospice, set up the information visit NOW.
- Why?
  - Informs family that the situation is serious and their loved one is dying
  - Moves the angst upstream
  - Makes *us* address difficult issues like "code status"
  - TIME to address Will, Living Will, DPMA, Life Review, Dignity therapy, MOLST

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.

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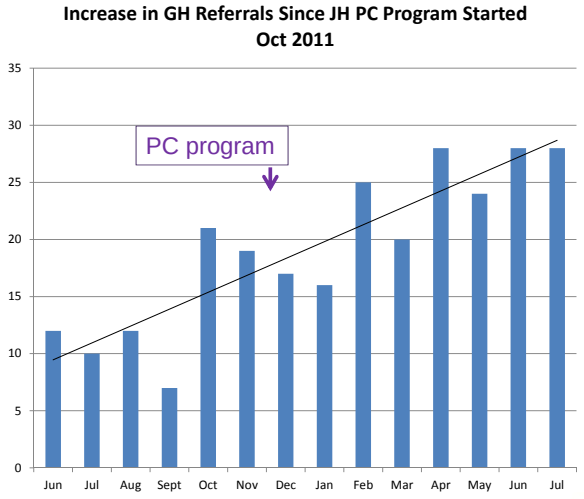
Identifying hospice eligible patients allows more and sometimes earlier referrals



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

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3. Better Information.

- Identify patients from the ER, trigger PC consult. Bridget Highet, MD, PGY-4.
  - See them Day 1 rather than Day 12
  - Discharge before admission, from ER (CMS Hospital Compare)
  - PC consult increases likelihood of hospice use by 10-fold. Morrison RS, Health Affairs 2011.
- Give Feedback to your referring physicians
  - Average LOS in hospice
  - %-age under 1 week
  - Compare to NHPCO and local norms
- Only 3 ways to change
  - Culture
  - Beliefs
  - Incentives

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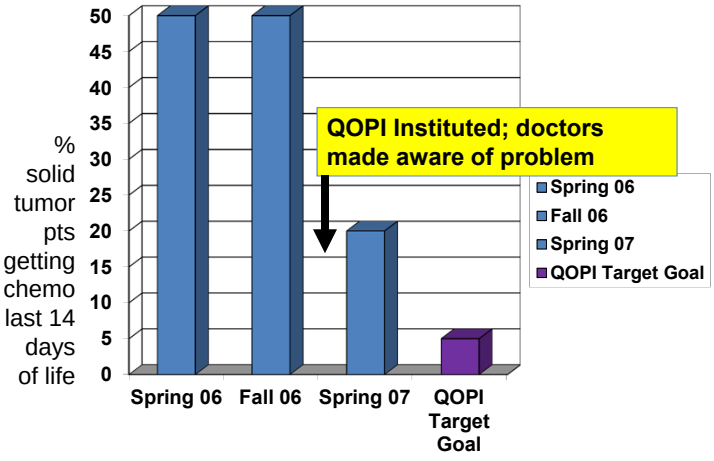
QOPI works to reduce overuse: Oncologists who receive feedback give less chemo at the end of life.



Blayney DW. J Clin Oncol. 2009 27:3802-7. doi: 10.1200/JCO.2008.21.6770
Neuss MN. J Clin Oncol. 2013 31(11):1471-7. doi: 10.1200/JCO.2012.43.3300.

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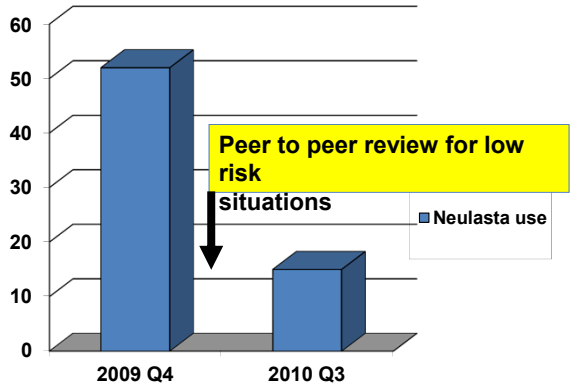
Pegfilgrastim use can be cut by 75% in low risk situations with peer to peer review. Reduces PMPM by ~75¢



Fishman ML, et al. Am J Manag Care. 2012 May 1;18(5):e168-72.

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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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Use transition programs *alongside* usual oncology care improved care and saved money. (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 last 40 days of life.

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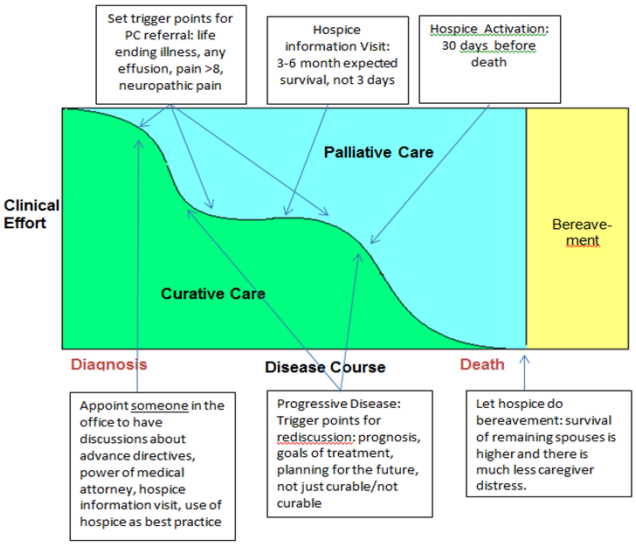
Let the Natural History of the Cancer Help Us Remember Triggers



Doing Palliative Care in the Oncology Office. M. Jennifer Cheng, Lauren M. King, Erin R. Alesi, and Thomas J. Smith. *JOP Mar 1, 2013:84-88.*

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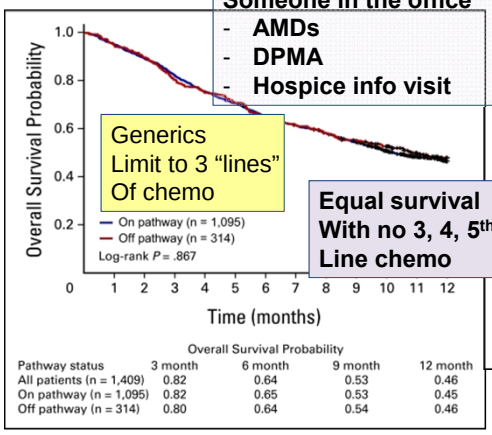
U S Oncology pathways preserve survival, increase hospice use, reduce cost by 35% in lung and colon cancer.

Someone in the office
- **AMDs**
- **DPMA**
- **Hospice info visit**

Generics
Limit to 3 "lines"
Of chemo

Equal survival
With no 3, 4, 5th Line chemo

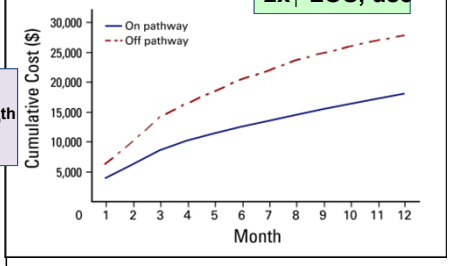


Overall Survival Probability

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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Conclusions

1. Palliative care alongside usual care, with transition to hospice care when appropriate, 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. There is still a LOT of research to be done to improve "trigger points", symptoms, integration of PC and hospice care into usual care, identification of patients and families who can benefit, and communication.

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