INTEGRATING PALLIATIVE CARE & ONCOLOGY

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Agenda

• Introduction
• The Need for Integrated Care
• Making Integrated Care a Part of Your Practice
• Triggers for Integrated Care
• Conclusion
Integrated Care

Integrated Care includes:

- Extensive discussion of goals of care
- Superb symptom management
Current State of Cancer Care

• US spends 2x more on cancer care than any other country
  • US exhibits same survival statistics
• 20-30% of $55 billion is spent in last 6 months of life
  • No evidence of improvement in quality of life
The Benefits of Integrated Care

- Any EOL conversation with doctor shown to significantly lower costs in last week of life
- Higher costs associated with lower quality of death

Patients Reporting EOL Discussion (n=627)

- 31% Yes
- 69% No

Cost of Care – Last Week of Life (n=627)

- No EOL Discussion: $2,917
- EOL Discussion: $1,876
Oncologists want to help patients.

Are we?
Diagnoses

1. Invasive ductal carcinoma of left breast, Stage T1cN0M0; Diagnosed 11/95
   • Status: Post-lumpectomy, Radiation Tx, CMF x six and adjuvant tamoxifen

2. Bone and liver metastases; Diagnosed 12/98
   • Status: Post dox/docetaxol with excellent response
   • Status: Post bone marrow transplant

3. Lung metastases; Diagnosed 07/00, switched to exemestane and zoledronic acid
Diagnoses

4. Chronic neutropenia and thrombocytopenia secondary to transplant
   • No evidence of progression of disease at this time

5. Isolated biliary obstructing lesion in the liver, stented; cytology negative
   • Further evaluation continues. No other evidence of disease at this time.

6. Probable progression of bony disease
Diagnoses

7. Status: Post resection of liver 8/11/03
   • Metastatic adenocarcinoma of left lobe of liver; tumor present at cauterized margin

8. Metastatic lesion of liver; ER positive, PR negative, HER-2/Neu 3+ positive

9. Thrombocytopenia w/ splenomegaly
   • Clinical Diagnosis: ITP
   • Trial of prednisone 1/14/04

10. Voluntary discontinued therapy, 2/06
Diagnoses

11. Extensive recurrence, diffuse liver and lung metastases w/ ascites and pleural effusions
   • Presented Mallory-Weiss tear and GI bleed w/ vomiting 9/08
   • Restarted treatment w/ letrozole, trastuzamab, weekly docetaxol, lapatanib;

12. BRCA negative

13. Maintained on letrozole, pamidronate, trastuzamab and lapatanib
Diagnoses

   - No evidence of metastatic disease to hip as cause
   - Not spontaneous from bisphosphonates

15. Possible progression of bony disease 10/13 by MRI and back pain

16. Lapatinib dropped and pertuzumab added to trastuzumab, denosumab and letrozole 11/13
Treatment - Mrs. MP

1. Carboplatin and gemcitabine, followed by local radiation therapy (completed 1/11)
2. Recurrence, started on erlotinib 12/11
3. Intolerant of erlotinib, switched to vinorelbine 2/1/12
4. Weekly docetaxol started 3/13/13
5. Recurred-tx stopped by me, restarted elsewhere
The Need for Integrated Care

- NSCLC Therapy Response Rate:
  - 3rd Line: 2%
  - 4th Line: 0%

A – Early Disease
B – Advanced Disease
C – Late-Stage
The Need for Integrated Care

• Cancer diagnosis is the most common cause of personal bankruptcy in the US, regardless of insurance coverage

• Cost of Later Lines of Therapies:
  • erlotinib: $7,000/month
  • crizotinib: $12,000/month
The Need for Integrated Care

• NC Study
  • 7.7% of cancer patients went to ER over a year
  • 45% of ER visits during office hours
• Most Common Reasons:
  • Pain
  • Trouble Breathing
  • GI Symptoms
The Need for Integrated Care

- Palliative Chemotherapy frequently causes hospitalizations
- Northshore MC Study:
  - 9% of palliative chemo patients hospitalized
    - Lung, GI cancers
  - Mean LOS: 5 Days
The Need for Integrated Care

- Patients do not understand goals of palliative chemo or XRT

Patient Expectations of Likeliness
Chemotherapy Will Cure Cancer

![Bar chart showing patient expectations of likelihood chemotherapy will cure cancer for Lung (n=710) and CRC (n=483).]
The Need for Integrated Care

• Patients express feelings of abandonment when oncologists are not part of their EOL care.

• Concurrent care utilizing palliative-integrated care allows a transition from active therapy to supportive care.
Make It a Part of Your Practice

- Must have buy-in from physicians
  - Show how it can positively impact income
  - Savings tied to decreased utilization

<table>
<thead>
<tr>
<th>Total Cost per Admission</th>
<th>Palliative Care</th>
<th>Total Cost per Admission</th>
<th>Palliative Care</th>
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<td>for Live Discharges</td>
<td>$16,637</td>
<td>for Hospital Deaths</td>
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<td>Usual Care</td>
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Make It a Part of Your Practice

Future Business Case for Outpatient Palliative Care

Palliative Care Can:
- Bundled Payment
  - Decrease Utilization
  - Increase Profits
- Shared Savings
  - Decrease Utilization
  - Improve Outcomes
  - Increase Bonus Payment
- Readmission Penalties
  - Reduce Avoidable Admissions
Make It a Part of Your Practice

“More and more medical providers are incorporating end of life care into ACOs, which are contracting with Medicare, Medicaid and private insurers to achieve better outcomes.”

Bruce Japsen
Forbes, 1-1-14
Triggers for Integrated Care

- Stage IV solid tumor
  - Stage III pancreas or lung cancer
- When starting 2\textsuperscript{nd} or 3\textsuperscript{rd} line therapy for solid tumors
- Patients are unable to walk into office unaided
- ECOG PS \( \geq 3 \)
  - Confined to bed, chair > 50% of waking hours
- Hospitalized in last 30 days
  - > 7 days or in ICU
- Uncontrolled nausea, vomiting, pain or SOB
Conclusion

EOL care is complex, time consuming and deserves our best effort.

We deserve adequate compensation.
Conclusion

• Incorporate payment for patient management
  • Indexed to cost control from decreased utilization of toxic, expensive therapies

• Excellent patient management leads to:
  • Increased patient and family satisfaction
  • Decreased hospital admissions
  • Increased QOL for patients
Questions?
Works Cited

3. NEJM 2010;363:733-742
6. Adelson, K. et al, ASCO Quality Care Symposium Abstract 37, Nov 2013