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High Hospitalization Rate Near Death, Low Use of Hospice Among Younger Cancer Patients Raise Concerns

Adults younger than 65 years of age with metastatic cancer receive relatively low rates of disease-directed treatments near death, yet approximately one-third die in the hospital and more than 40% receive no hospice care, according to a report published in the *Journal of the National Cancer Institute*.

“This is the first study to examine use of aggressive care and hospice services at the end of life for contemporary patients younger than age 65 years across the U.S.,” write the authors. “We found overall low uses of chemotherapy, intensive care, and emergency room visits at the end of life across the five common cancers examined,” suggesting likely adherence to recommendations of national guidelines for limiting the use of aggressive treatments near the end of life.

“However, there was a relatively high utilization of hospital-based care,” they continue. “These results demonstrate an opportunity for continued improvements in the provision of high-value, patient-centered care at the end of life for younger patients.”

Investigators analyzed commercial insurance claims data across 14 U.S. states for patients aged 18 to 64 years who died between 2007 and 2014 with metastatic lung (n = 12,764), colorectal (n = 5207), breast (n = 5855), pancreatic (n = 3397), or prostate (n = 1508) cancer. Across the five cancers, most (83.1%) patients were aged 50 to 64 years.

KEY FINDINGS

- Within the last 30 days of life, more than half (55.3% to 59.3%) of patients had a hospital admission, with 5.5% being

admitted on either the day of or the day before death.

- About one-third (30.3% to 35.4%) died in the hospital.
- 15.9% to 20.6% received intensive care in the last 30 days of life; just 1.5% to 2.5% visited an emergency department more than once in that time period.
- In the last 14 days of life, 10.1% to 14.1% of patients received chemotherapy.
- 54.4% to 59.6% of patients enrolled in hospice at least 3 days before death; however, only 10.2% were enrolled for more than 90 days.

“Prior studies have shown that early enrollment in hospice helps reduce aggressive care, improves patient quality of life, and improves the quality of end-of-life care; thus, hospice is commonly considered to be high-value, patient-centered care,” write the authors.

“While our numbers are similar to those from the Medicare population, more than 40% of younger patients with incurable cancers at the end of life did not receive hospice care — indicating that there is further room for improvement.”

Source: “Aggressive End-of-Life Care for Metastatic Cancer Patients Younger Than Age 65 Years,” Journal of the National Cancer Institute; September 1, 2017; 109(9). Falchook AD et al; Department of Radiation Oncology; Division of Pharmaceutical Outcomes and Policy; UNC Eshelman School of Pharmacy; Lineberger Comprehensive Cancer Center; Department of Health Policy and Management, Gillings School of Global Public Health; and Cecil G. Sheps Center for Health Services Research, all at the University of North Carolina at Chapel Hill.

National Guidelines Updated to Emphasize Cancer Patients' Needs for Palliative Care and Transition to Hospice

A not-for-profit alliance of 27 leading U.S. cancer centers has issued its latest Clinical Practice Guidelines in Oncology, including guidelines recommending early hospice and palliative care. The National Comprehensive Cancer Network (NCCN) updates its guidelines at least annually, based on a review of the most recent clinical evidence by its interdisciplinary panel of experts in the field.

“These recommendations were revised to provide clearer guidance for oncologists as they care for patients with cancer who are approaching the transition to end-of-life (EOL) care,” write the authors of an article published in the NCCN’s official journal.

“Recommendations for interventions and reassessment based on estimated life expectancy were streamlined and reprioritized to promote hospice referrals and improved EOL care,” continue the authors, whose article discusses highlights of the revised guideline’s goals and changes.

CANCER PATIENTS’ NEED FOR PALLIATIVE CARE

The stance of the NCCN is that improved access to palliative care and hospice may help cancer patients and their families deal with symptoms and challenges.

“Generally speaking, earlier incorporation of palliative care in the cancer care continuum has been associated with improved EOL outcomes,” write the authors. “Palliative care has been shown to reduce symptom burden, improve quality of life (QOL), and increase the odds of dying at home.” In addition, they note, multiple studies have shown that hospice care is associated with QOL benefits including fewer hospitalizations, fewer invasive procedures, and less high-intensity care.

Many cancer patients still receive aggressive treatment near the EOL and do not receive hospice care early enough, which is cause for concern, the authors note. In

2014 the median length of stay for hospice patients was only 17.4 days, and more than one-third of hospice patients were enrolled for seven days or fewer. “Targeted interventions may lead to enhanced use of hospice care and improved EOL experiences for patients and their families,” the authors suggest.

NCCN RECOMMENDATIONS

The NCCN provides an algorithm to help clinicians apply important steps of palliative care at the appropriate time during the disease trajectory. The following are some of the updated palliative care recommendations for clinicians, based on the patient’s prognosis.

- **Patients with an estimated prognosis of years, or years to months.** Assess the patient’s and family’s awareness of prognosis and disease course. Engage in regular discussions about prognosis, advance care planning, and the potential for a surrogate decision-maker. Assess the patient’s and family’s values and preferences. Assess the need for specialized palliative care or hospice care. When the patient has a prognosis of 6 to 12 months, consider having a “hospice information” visit to ease the care transition.
- **Patients with an estimated prognosis of months to weeks, or weeks to days.** “Referral to hospice agencies should be a priority,” state the authors. Assess patient/family understanding of the dying process, and educate those who desire to know more. Consider the need for care transitions, while keeping patients’ primary care and oncology teams involved. Be prepared to offer information or referrals for psychosocial assessment, grief counseling, funeral planning, and other support. Keep the goals and needs of patient and family in mind. Ensure the patient does not die alone unless that is their established preference.

The NCCN suggests regular reassessment and clear communication. It

recommends intensifying palliative care interventions if patients and families do not experience benefits, such as reduced distress, decreased caregiver burden, and optimized QOL.

UPDATES TO PALLIATIVE CARE GUIDELINES

The 2017 updates reflect the panel members’ desire to emphasize the need to support patients through care transitions and EOL care. Changes to the guidelines include:

- **An algorithm page previously titled more broadly was renamed** “Preparing Patients and Families for End of Life and Transition to Hospice Care.” This change streamlines suggestions and emphasizes patients’ need for support during the transition to EOL care and hospice services.
- **“Refer to hospice agencies”** is now the first recommendation for patients with shorter prognoses. This change highlights the importance of an early referral to hospice.
- **Patients with a life expectancy of “months to weeks”** were added to the group previously containing only patients with a prognosis of “weeks to days.” This may help cancer patients receive hospice and other EOL care earlier in their disease course.

The NCCN panelists also stressed the need to consistently communicate with patients and families about goals, values, and expectations, which are likely to shift throughout the disease course.

The complete version of the updated NCCN Guidelines for Palliative Care can be found at www.NCCN.org.

Source: “NCCN Guidelines Insights Palliative Care, Version 2.2017: Featured Updates to the NCCN Guidelines,” Journal of the National Comprehensive Cancer Network; August 2017; 15(8):989–997. Dans M, Smith T, Back A, Scavone JL, et al; National Comprehensive Cancer Network, Fort Washington, Pennsylvania.

Physicians Urged to Take Advantage of Available Instructional Tools for Breaking Bad News

“Delivering bad news is one of the most daunting tasks faced by physicians,” assert the authors of a report published in *BUMC Proceedings*, a peer-reviewed quarterly journal of the Baylor University Medical Center. Their article offers clinicians brief reviews of several tested approaches to delivering bad news effectively and argues for structured training to help clinicians handle the communication complexity and emotional intensity of breaking bad news.

“Professionalism and interpersonal communication skills are two of the six core competencies required by the Accreditation Council for Graduate Medical Education for all specialties,” the authors write. “As opposed to continuing the tradition of implicitly learning professionalism by observing how attendings behave in a clinical setting, we believe that explicit, structured learning via formal curricula is necessary.”

To assess the need for an instructional program on conducting difficult conversations, researchers analyzed questionnaire responses of residents and attendings (n = 54) in the surgery department of their academic medical center. Bad news was defined as “any news that drastically and negatively alters the patient’s view of her or his future.”

Nearly all (93%) respondents believed that delivering bad news was a “very important” skill. However, only 43% considered they had sufficient training to deliver bad news, while fully 85% (residents, 59%; attendings, 26%) felt they needed additional training to do so effectively.

Fears of possible repercussions from delivering bad news poorly include:

- Being blamed for the bad news
- Evoking a difficult-to-handle emotional reaction
- Expressing emotion oneself
- Not knowing enough to answer potential questions

Succumbing to these fears may lead clinicians to protect themselves by becoming emotionally disengaged, note the authors. “Additionally, bad news delivered

inadequately or insensitively can impair patients’ and relatives’ long-term adjustments to the consequences of that news.”

The authors recommend that institutions provide (and individual physicians pursue) training in giving bad news using a patient- and family-centered approach, which has been shown to yield high patient satisfaction along with the perception of the physician as available, expressive of hope, and not dominating.

In a patient- and family-centered approach, the physician identifies the patient’s and family’s needs (including cultural values and spiritual beliefs) and conveys the information accordingly, then checks for understanding. The physician can express empathy without exhibiting an excess of emotion or sympathy, which can hinder appropriate information exchange.

Many resources are available in published articles and online for physicians interested in improving their skill in communicating bad news, the authors note. They present the highlights of several protocols that have been in use over the past two decades, as well as offering a summarized approach of their own, based on the factors of setting, structure, message, and mode.

APPROACH TO DELIVERING BAD NEWS

- Arrange for a location that is private, comfortable, and quiet, with ample time and no interruptions.
- Offer the patient the choice/option of a family member or friend to accompany them, if desired.
- Be prepared to deliver the message.
- Find out what the patient already knows.
- Convey some form of hope.
- Allow for emotional expression and questions.
- Summarize the discussion.

“The message should be delivered with empathy and respect and in language that is understandable to the patient, free from medical jargon and technical terminology,” write the authors.

PROTOCOLS PUBLISHED IN THE LITERATURE OR AVAILABLE ONLINE

1. How to Break Bad News: A Guide for Health Care Professionals (Buckman R; Johns Hopkins University Press, Baltimore, 1992) is a landmark book on the topic, and includes the following criteria:

- Deliver bad news in person.
- Find out how much the patient knows.
- Share the information.
- Ensure that the message is understood.
- Plan a contract.
- Follow through.

2. ABCDE plan (“Beyond Breaking Bad News: How to Help Patients Who Suffer;” Rabow MW and McPhee SJ. *West J Med* 1999; 171[4]).

- Make Advance preparation.
- Build a therapeutic environment and relationship.
- Communicate well.
- Deal with patient/family reactions.
- Encourage and validate Emotions; Evaluate the news.

3. “SPIKES — A Six-Step Protocol for Delivering Bad News,” (Baile et al. *Oncologist* 2000; 5[4]).

- Set up the interview.
- Assess the patient’s Perception.
- Obtain the patient’s Invitation.
- Give Knowledge and information to the patient.
- Address the patient’s Emotions with empathetic responses.
- Create a Strategy, then Summarize.

4. VitalTalk (www.vitaltalk.org) is an online resource for clinicians, which includes communication tools, tips, and protocols such as SPIKES, along with articles and videos describing and illustrating each step in conducting difficult conversations with seriously ill patients.

Source: “Delivering Bad News to Patients,” Baylor University Medical Center Proceedings; January 2016; 29(1):101–102. Monden KR, Gentry L, Cox TR; Department of Surgery, Baylor University Medical Center at Dallas, Texas.

Clinicians Encouraged to Use Patients' Bucket Lists to Enhance Goals-of-Care Discussions

Advance care planning discussions often focus largely on the clinical aspect of end-of-life treatment choices and can fail to capture what matters most to patients: how they want to live. The finding that most U.S. adults surveyed (91.2%) report having a bucket list suggests that the wishes expressed therein can be used to spark goals-of-care conversations focused on patient values, according to a report published in the *Journal of Palliative Medicine*.

"We propose the use of the bucket list to help patients identify what matters most to them," write the authors. "Knowing a patient's bucket list can aid clinicians in relating each treatment option to its potential impact (if any) on the patient's life and life goals to promote informed decision making."

While clinicians are traditionally trained to manage disease within the medical context, patients may lack the medical knowledge to understand the impact of proposed treatments on their lives and plans, the authors point out.

The widely used term "bucket list" denotes an itemization of experiences people want to have or goals they wish to accomplish before they die (i.e., "kick the bucket") and as such can be used as a framework to discuss choices leading to preference-sensitive care, suggest the authors.

Investigators analyzed responses of 3056 adults from all 50 U.S. states who participated from 2015 to 2016 in an online survey. 91.2% of respondents (mean age, 50.0 years; non-Hispanic whites, 37.8%) had a bucket list and were asked to share up to five of their items, from which six common themes were identified.

KEY BUCKET LIST THEMES INCLUDED A DESIRE TO:

- Travel (78.5%)
- Accomplish a personal goal (78.3%)
- Achieve specific life milestones (51%)
- Spend quality time with friends and family (16.7%)

Clinicians are urged by the authors to inquire routinely about the contents of their patients' bucket lists, as items on these lists are likely to change over time, as will patients' goals of care.

Source: "Common Items on a Bucket List," Journal of Palliative Medicine; Epub ahead of print, February 8, 2018; DOI: 10.1089/jpm.2017.0512. Periyakoil VS, Neri E, Kraemer H; Division of Primary Care and Population Health, Center of Population Health Sciences, Stanford University School of Medicine, Stanford; VA Palo Alto Health Care System, Palo Alto, both in California.

Where care and medical care come together...

Mother's Touch stands for quality and caring service in all aspects of hospice care. We employ tenured leadership and management, with many years of experience in home care nursing, home health, hospice and other forms of care for seniors.

Our dedicated interdisciplinary hospice teams provide end-of-life medical, emotional and spiritual care. Our team members have focused their careers to use their extensive knowledge, professional experience, and most importantly, a mission-driven commitment to support our patients and their loved ones.

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