

# Evidence-Based ONCOLOGY™

APRIL 2020  
VOL. 26 • NO. 4

## ALSO IN THIS ISSUE



SP106

**DYING WITHOUT FEAR.** Kashyap Patel, MD, oncologist with Carolina Blood and Cancer Care Associates and associate editor of Evidence-Based Oncology™, has published an account of his efforts to engage patients on the topic that was never covered in medical school: facing death. A review, [SP106](#).



### CARE CONNECTIONS.

A session of the Institute for Value-Based Medicine in Tampa, Florida, with Florida Cancer Specialists covered how payers,

oncologists, and leaders in primary care can cooperate for the benefit of patients, [SP109](#).



### ACCC MEETS.

One of the last conferences to take place before in-person medical meetings were canceled, the Association of Community Cancer Centers gathered March 4 to 6, 2020, in Washington, DC. For full coverage, see [SP111-SP113](#).



### OUR EXPERTS.

AJMC<sup>®</sup> catches up with leading physicians and

advocates to discuss palliative care and the transition to the Oncology Care First model, [SP122-SP123](#).

## DIGITAL TECHNOLOGY

### The Need for a Serious Illness Digital Ecosystem (SIDE) to Improve Outcomes for Patients Receiving Palliative and Hospice Care

*Jonathan Nicolla, MBA; Hayden B. Bosworth, PhD; Sharron L. Docherty, PhD, PNP-BC; Kathryn I. Pollak, PhD; Jeremy Powell, MEd; Nichole Sellers, BA; Bryce B. Reeve, PhD; Greg Samsa, PhD; Linda Sutton, MD; and Arif H. Kamal, MD, MBA, MHS*

#### Introduction

Palliative and hospice care services produce well-known benefits for patients living with serious illness and for their families. Benefits include improved quality of life and reduced symptom burden, spiritual and emotional distress, and caregiver distress.<sup>1</sup> Additionally, when integrated into usual care, palliative and hospice services result in savings to patients, caregivers, payers, and health systems, particularly from reducing avoidable hospital admissions and emergency department visits.<sup>1</sup>



Pillars of Model

## FRONTIERS IN CARE

### Why Palliative Care Is the Answer to the Serious Illness Question in Payment Reform

*Maggie R. Salinger MD, MPP; Nathan A. Boucher, DrPH, PA, MS, MPA; Thomas W. LeBlanc, MD, MA; Kevin C. Oeffinger, MD; Kathryn Pollak, PhD; Jesse D. Troy, PhD; and Arif H. Kamal MD, MBA, MHS*

**FOLLOWING ENACTMENT OF** the Patient Protection and Affordable Care Act, the Center for Medicare & Medicaid Innovation (CMMI) was established to design and analyze payment models that would replace a fee-for-service reimbursement structure. To that end, CMMI launched reimbursement programs that use risk-adjusted budgets alongside quality-driven rewards to promote value and innovation at the care delivery level. These came to be known as alternative payment models (APMs).

CONTINUED ON SP127 »

## REIMBURSEMENT

### Lack of Clarity on Medicare Advantage Palliative, Other Cancer Care Benefits Limits Consumer Uptake

*Ted Knutson and Mary Caffrey*

**STARTING IN 2019**, Medicare Advantage (MA) plans were allowed to change with the times and offer new social benefits to support patients with serious illness or chronic conditions, such as home-based palliative care.<sup>1</sup>

But the lack of clarity about these benefits has limited uptake by consumers, experts say. In December, CMS proposed funding the hospice benefit differently, which would allow MA plans to “carve in” to this benefit. Although some say this could help seniors in the long run, in the near term it has created uncertainty about how the government will fund care for the seriously ill.<sup>2</sup>

CONTINUED ON SP124 »

CONTINUED ON SP130 »

# Why Palliative Care Is the Answer to the Serious Illness Question in Payment Reform

Maggie R. Salinger MD, MPP; Nathan A. Boucher, DrPH, PA, MS, MPA; Thomas W. LeBlanc, MD, MA; Kevin C. Oeffinger, MD; Kathryn I. Pollak, PhD; Jesse D. Troy, PhD; and Arif H. Kamal MD, MBA, MHS

## CONTINUED FROM COVER

APMs establish budget targets on the basis of either patient populations or care episodes, which creates an incentive for provider networks to cut total spending. APMs also use an array of quality metrics related to: (1) optimizing patient outcomes (eg, rates of hospitalization and mortality or attainment of disease-specific treatment goals), (2) improving health service delivery (eg, accessibility of services or adherence to gold standard therapies), and (3) increasing patient-centeredness (eg, utilization of advance directives or measures of patient satisfaction).<sup>1</sup>

The changing financial frontier has pushed our medical system to expand its reach to achieve healthcare's Triple Aim as proposed by the Institute for Healthcare Improvement.<sup>2</sup> For provider networks, this translates to offering better and broader services but at a lower cost, an objective that is especially challenging when managing seriously ill patients. Seriously ill patients have an elevated risk of mortality, impairments in functional status, and/or medical conditions with burdensome symptoms. This patient population is growing in number and accounts for a vastly disproportionate amount of healthcare spending.<sup>3</sup>

Health administrators and clinicians alike recognize that meeting the extensive medical and social needs of the seriously ill may no longer be the revenue boon it once was in the fee-for-service era. The transition to pay-for-performance, and especially the inclusion of downsided risk in APM reimbursement schemes, means practices will now face serious threats to long-term sustainability if they cannot meet quality metrics.

In response to the constellation of APM incentives, provider networks have strengthened their capacity to systematically identify and monitor their sickest cohorts. Some have even begun to predict adverse outcomes at the individual level, knowing in advance that a patient may be at high risk for hospitalization or death.<sup>4</sup> However, even with the technological advances in the use of big data and predictive modeling, there is still uncertainty about how to best respond. In a survey of a large, representative sample of accountable care organizations (ACOs), Bleser et al discovered that 94% employ measures to define their seriously ill populations, but that only 8% to 21% of ACOs have either "partially" or "widely" implemented clinical programs targeting these groups.<sup>5</sup>

At this stage of system-wide reform, the question is not *whether* provider networks should augment our medical and social infrastructure for the seriously ill, but *how*. Looking ahead, it is clear that building the ideal future will require greater integration of palliative care principles. Insights from specialty palliative care would enable systems to better manage those patients who place the greatest demands on the system. Palliative care has a growing body of evidence demonstrating its contribution to our industry's Triple Aim by lowering 30-day readmission rates, by reducing the total costs of care at end of life, and by increasing patient well-being and satisfaction.<sup>6-12</sup>

More than a specialty, palliative care represents a philosophical approach to treatment that focuses on reducing suffering and increasing quality of life. Palliative care delivery comes in 3 levels: primary, champion, and specialty.<sup>13</sup> Primary palliative care is the common, fundamental palliative care delivered by every clinician to every patient with serious illness. It comprises basic symptom management and goal setting by which primary and specialty

clinicians (eg, cardiologists, oncologists) are experienced and comfortable. Champion palliative care is provided by clinicians with additional training who serve as advocates for expanded palliative care services in their hospital units, clinics, and other local settings. Specialty palliative care is supported by clinicians who have undergone formal fellowship or other training that establishes an advanced expertise in the field.

A common misconception about specialty palliative care is that it is beneficial only when integrated into the care of the terminally ill. Although there is indeed a subset of palliative care that assists patients and families in the immediate phases before death, the scope of this discipline extends far beyond end-of-life care, such as hospice care. After all, a therapeutic emphasis on patient comfort and family support is relevant at all phases of disease, including as early as diagnosis.

**For seriously ill populations, all medical encounters from the time of diagnoses onward should be regarded as potential opportunities to intervene in a palliative manner. The incentive to do so at earlier stages and in broader contexts is especially compelling when managing cohorts whose diseases have well-characterized patterns of progression.**

Palliative care's patient-centered approach tends to incorporate skillsets of multiple clinicians, such as physicians, advanced practitioners (eg, nurse practitioners, physician assistants), nurses, social workers, physical and occupational therapists, and chaplains. These team members offer care in a variety of settings, like hospitals, community clinics, or homes. The types of services encapsulated in a palliative approach are aimed at educating patients and families about disease trajectories, minimizing symptom burden, leading goals of care discussions, addressing conflict and mistrust, identifying surrogate decision makers, connecting families to community resources, and linking patients with home-based support. When delivered in a nonhospice context, these palliative measures take place alongside disease-targeted therapies, such as hemodialysis for advanced kidney disease, chemotherapy for cancer, or inotropes for heart failure.

For seriously ill populations, all medical encounters from the time of diagnoses onward should be regarded as potential opportunities to intervene in a palliative manner. The incentive to do so at earlier stages and in broader contexts is especially compelling when managing cohorts whose diseases have well-characterized patterns of progression. Examples include heart failure, lung disease, kidney disease, dementia, and advanced cancers, each of which has a pattern whereby hospital admissions may be harbingers for further or more rapid decline. As such, these hospital admissions also tend to mark the beginnings of "new baselines," »



**SALINGER**

Maggie R. Salinger, MD, MPP; Resident Physician at Duke University Hospital



**BOUCHER**

Nathan A. Boucher, DrPH, PA, MS, MPA; Assistant Research Professor in the Sanford School of Public Policy, Duke University



**LEBLANC**

Thomas W. LeBlanc, MD, MA; Associate Professor of Medicine, Duke University School of Medicine



**OEFFINGER**  
Kevin C. Oeffinger, MD;  
Professor of Medicine,  
Duke University School  
of Medicine



**POLLAK**  
Kathryn I. Pollak, PhD;  
Professor in Population  
Health Sciences,  
Duke University School  
of Medicine



**TROY**  
Jesse D. Troy, PhD;  
Assistant Professor of  
Pediatrics, Duke University  
School of Medicine



**KAMAL**  
Arif H. Kamal, MD,  
MBA, MHS; Associate  
Professor of Medicine,  
Business Administration,  
and Population Health  
Sciences, Duke Cancer  
Institute, Duke Fuqua  
School of Business

since it is uncommon for seriously ill patients to return to the level of functioning they had prior to hospitalization.

The value of early palliative methods has been demonstrated by multiple APM-inspired outreach programs targeting seriously ill cohorts. For example, Vidant Health is an ACO serving a rural population that is socioeconomically disadvantaged. Catering to their sickest patients, Vidant Health has launched technology-assisted home monitoring systems, care alignment strategies, and community partnerships, typically with faith-based organizations. Together, these initiatives have generated shared savings through Medicare and have led to lower readmission rates, which declined from 10% to 20% to 1.5% to 5%.<sup>5</sup> Another exemplar ACO, Facey Medical Group has designed a community-based program that includes a 24/7 call center, a palliative-trained physician, nurse practitioners, care managers, social workers, and chaplain services. They reported high levels of patient satisfaction, 68% fewer hospitalizations, and 55% fewer emergency department visits.<sup>5</sup>

When seriously ill patients do experience a hospitalization, they are at greater risk of requiring intensive care. Evaluations of structured palliative programming in this setting help to demonstrate the profound impact of aligning care goals, an impact that could extend to other contexts of care as well. Kyeremanteng et al's systematic review of formal palliative care consultations in intensive care units (ICUs) showed a reduction in ICU length of stay (LOS) compared with those who did not receive the consultations.<sup>14</sup> A separate systematic review and meta-analysis by Bibas et al examined a specific palliative intervention designating surrogate decision makers and found that doing so reduced ICU LOS among patients who die in the ICU.<sup>15</sup> In both of these analyses, there was no impact on overall mortality, just differences in the choices and circumstances surrounding death.

To understand the impact at a more granular level, consider the results of Ma et al's randomized, controlled trial of formal specialist consultations, which showed a substantial increase in code status changes and in transfers to hospice, along with reductions in ventilator days, number of tracheostomies performed, and rates of postdischarge emergency department visits or readmissions.<sup>16</sup> Taken together, these study results suggest that palliative consultations uncover patient- or surrogate-driven desires to limit aggressive therapies— desires that otherwise may go unrealized. Indeed, it is largely through this improved communication regarding expectations, prognosis, preferences, and resources that palliative medicine programs have been able to reliably boost levels of patient and family satisfaction.

In these studies, the documented benefits of specialty palliative care compared with standard of care (ie, some version of primary palliative care) stem from multiple factors, many of which are structural in nature. Although there may have been some discrepancies in the depth and breadth of knowledge about possible tools in the palliative care toolbox, the observed differences in care patterns that accompanied specialist consultations were likely mediated by more than just clinicians' board certifications. What specialist consultants can also bring to the table is their dedicated time and attention, commodities that are in short supply for primary teams with high patient volume and complexity.

As provider networks strive to expand their palliative services, they will have to determine the circumstances in which primary palliative care will suffice and those in which champion and specialist services would be more efficient and efficacious. With our nation's growing number of seriously ill patients and with the increasing use of predictive analytics, we may begin to lean more on dedicated palliative teams to navigate the ever-important goals of care conversations and the ethics of sharing or withholding life expectancy estimates with the individuals we strive to serve. But whether it is through enlisting primary providers, building the champion workforce, or hiring more specialist consultants, there

is no question that palliative programming will need to remain at the heart of our healthcare system's quality transformation. ♦

**AUTHOR INFORMATION**

MRS is a primary care resident, Duke University School of Medicine; NAB is a research scientist with appointments at the Duke University School of Medicine, Duke's Sanford School of Public Policy and the Durham VA Healthcare System; TWL is a cell therapy and hematologic malignancies specialist and palliative medicine specialist, Duke University School of Medicine and Duke Cancer Institute; KCO, with the Duke University School of Medicine and the Duke Cancer Institute, is the founding director of the DCI Center for Onco-Primary Care and the director of the DCI Supportive Care and Survivorship Center; KIP is with Duke University School of Medicine and the Duke Department of Population Health; JDT is with Duke University School of Medicine; and AHK is with the Duke Cancer Institute and the Duke Fuqua School of Business.

**REFERENCES**

1. APMs overview. Quality Payment Program/HHS website. [qpp.cms.gov/apms/overview](http://qpp.cms.gov/apms/overview). Accessed January 2020.
2. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27(3):759-769. doi: 10.1377/hlthaff.27.3.759.
3. Japinga M, Alexander M, Casarett D, Bleser WK, McClellan MB, Saunders RS. Slowly getting serious: the new CMS primary care models and implications for serious illness care. *Health Affairs Blog*. <https://www.healthaffairs.org/doi/10.1377/hblog20190730.120245/full/>. Published July 31, 2010. Accessed January 2020.
4. Courtright KR, Chivers C, Becker M, et al. Electronic health record mortality prediction model for targeted palliative care among hospitalized medical patients: a pilot quasi-experimental study. *J Gen Intern Med*. 2019;34(9):1841-1847. doi: 10.1007/s11606-019-05169-2.
5. Bleser WK, Saunders S, Winfield L, et al. ACO serious illness care: survey and case studies depict current challenges and future opportunities. *Health Aff (Millwood)*. 2019;38(6):1011-1020. doi: 10.1377/hlthaff.2019.00013.
6. Walling AM, Tisnado D, Ettner SL, et al. Palliative care specialist consultation is associated with supportive care quality in advanced cancer. *J Pain Symptom Manage*. 2016;52(4):507-514. doi: 10.1016/j.jpainsymman.2016.04.005.
7. Smith S, Brick A, O'Hara S, Nomand C. Evidence on the cost and cost-effectiveness of palliative care: A literature review. *Palliat Med*. 2014;28(2):130-150. doi: 10.1177/0269216313493466.
8. May P, Normand C, Cassel JB, et al. Economics of palliative care for hospitalized adults with serious illness: a meta-analysis. *JAMA Intern Med*. 2018;178(6):820-829. doi: 10.1001/jamainternmed.2018.0750.
9. Milazzo S, Hansen E, Carozza D, Case AA. How effective is palliative care in improving patient outcomes? *Curr Treat Options Oncol*. 2020;5(2):12. doi: 10.1007/s11864-020-0702-x.
10. Zimmermann C, Swami N, Krzyzanowska M, et al. Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial. *Lancet*. 2014;383(9930):1721-1730. doi: 10.1016/S0140-6736(13)62416-2.
11. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010;363(8):733-742. doi: 10.1056/NEJMoa1000678.
12. Kavalieratos D, Corbelli J, Zhang D, et al. Association between palliative care and patient and caregiver outcomes: a systematic review and meta-analysis. *JAMA*. 2016;316(20):2104-2114. doi: 10.1001/jama.2016.16840.
13. Kamal AH, Bowman B, Ritchie CS. Identifying palliative care champions to promote high-quality care to those with serious illness. *J Am Geriatr Soc*. 2019;67(S2):S461-S467. doi: 10.1111/jgs.15799.
14. Kyeremanteng K, Gangon LP, Thavorn K, Heyland D, D'Egidio G. The impact of palliative care consultation in the ICU on length of stay: a systematic review and cost evaluation. *J Intensive Care Med*. 2018;33(6):346-353. doi: 10.1177/0885066616664329.
15. Bibas L, Peretz-Larochelle M, Adhikari NK, et al. Association of surrogate decision-making interventions for critically ill adults with patient, family, and resource use outcomes: a systematic review and meta-analysis. *JAMA Netw Open*. 2019;3(2):e197229. doi: 10.1001/jamanetworkopen.2019.7229.
16. Ma J, Chi S, Buettner M, et al. Early palliative care consultation in the medical ICU: a cluster randomized crossover trial. *Crit Care Med*. 2019;47(12):1707-1715. doi: 10.1097/CCM.0000000000004016.



Looking Back on the 10th Anniversary of the ACA with Rep. Frank Pallone, D-NJ  
Read more at: [www.ajmc.com/link/4567](http://www.ajmc.com/link/4567)