PALLIATIVE CARE IN HEMATOLOGIC MALIGNANCIES

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DISCLOSURES
OBJECTIVES

• To discuss how hematologic malignancies qualitatively differ from solid tumor malignancies with regard to palliative care integration

• To discuss the difficulty with using standard oncologic quality measures in patients with hematologic malignancies

• To discuss the barriers involved with integrating palliative care in patients with hematologic malignancies

• To discuss ways to progress the integration and why it is important
WHAT DO HEMATOLOGIC ONCOLOGISTS THINK?

- In one study, 20 hematologic oncologists from Dana-Farber participated in four focus groups regarding end of life care for leukemia, lymphoma, multiple myeloma, and hematopoietic stem-cell transplantation.

- Focus groups employed a semi-structured format with case vignettes and open-ended questions and were followed by thematic analyses.

QUALITATIVE DIFFERENCES

• Hematologic oncologists have difficulty identifying the end of life phase for patients with hematologic cancers.

• Hematologic malignancies differ from solid tumors because there is a continued potential for cure with advanced disease.

• There is often a ”rapid pace of decline near death” for these patients.
IDENTIFYING WHEN END OF LIFE (EOL) CARE BEGINS…

• “The median survival of older adults with leukemia is not that different from advanced pancreatic cancer or stage IV lung cancer…but we are stuck with this tail and so what do we do with that? We live on the tail, this 5% to 10% tail.”

• “EOL is such a tricky thing in our field; it can change momentarily. I had a patient who had a transplant, he was doing well, but then he relapsed, the disease took off...and he died within a few days. If you had asked me a month earlier if he was in the EOL phase, I would have said no. He just had a transplant! It’s unpredictable.”
Oy Vey!
FACTORS INFLUENCING EOL CARE

• “Age plays such a big role; if you’ve got somebody who is 25 years old, you are going to go down blazing typically for someone like that – they may get multiple transplants, they may get 7 or 8 lines of chemotherapy because they can take it for a while”

• “There are those who may not even be refractory but are unable to tolerate [treatment] because of comorbidities; that would be when I would seriously have those [EOL] discussions.”
Palliative Care ≠ End of Life Care
DOES IT MATTER WHAT YOU CALL IT?

- When compared to *palliative care*, the term *supportive care* was associated with better understanding (7.7 vs. 6.8; \( p=0.021 \)), more favorable impressions (8.4 vs. 7.3; \( p=0.002 \)), and higher future perceived need (8.6 vs. 7.7; \( p=0.017 \)).

DOES IT MATTER WHAT YOU CALL IT?

- Survey of a random sample of 100 medical oncologists and 100 mid-level providers from MD Anderson Cancer Center was conducted in 2009.

- The name “palliative care” compared with supportive care was perceived more frequently by providers as a barrier to referral (23 vs 6% P < .0001), decreasing hope (44 vs 11% P < .0001), and causing distress (33 vs 3% P < .0001) in patients and families.

Does it matter what you call it?
UNDERUTILIZATION OF PALLIATIVE CARE IN HEMATOLOGIC MALIGNANCIES

• One study at MD Anderson reviewed all patients who died from advanced cancer between September 2009 and February 2010.

• Patients with advanced hematologic malignancies had significantly fewer palliative care (PC) referrals (33%) as compared to those with gynecologic (>60%), lung (>40%), and head/neck cancers (>40%).

• Hematologic malignancy patients also had significantly longer intervals between a cancer diagnosis and PC consultation (median 16 months), and the shortest interval between PC consult and death (median, 0.4 months)

Percentage of patients referred to palliative care according to tumor type.
UNDERUTILIZATION OF PALLIATIVE CARE IN HEMATOLOGIC MALIGNANCIES

• Performance on National Quality Forum and ASCO EOL quality measures for 816 consecutive patients with hematologic malignancies vs solid tumors was analyzed.

• In the last 30 days of life, patients with hematologic malignancies have significantly higher rates of emergency room visits, hospitalizations, ICU admissions, and chemotherapy use, compared with patients with advanced solid tumors.

• Hematologic malignancy patients were also more likely to die in the hospital and ICU.

## Quality of EOL Care in the Last 30 Days of Life

<table>
<thead>
<tr>
<th>Patient characteristics</th>
<th>Solid tumors (n=703)</th>
<th>Heme malignancies (n=113)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any ER Visit</td>
<td>43%</td>
<td>54%</td>
<td>0.03</td>
</tr>
<tr>
<td>Any Hospital Admission</td>
<td>47%</td>
<td>81%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospital Death</td>
<td>16%</td>
<td>47%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ICU Death</td>
<td>4%</td>
<td>33%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Chemotherapy Use</td>
<td>14%</td>
<td>43%</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
QUALITY OF EOL CARE IN LAST 14 DAYS OF LIFE

<table>
<thead>
<tr>
<th></th>
<th>Solid (n=703)</th>
<th>Heme (n=113)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy Use</td>
<td>6%</td>
<td>21%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Targeted therapy use</td>
<td>5%</td>
<td>17%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Chemotherapy and targeted agent use</td>
<td>10%</td>
<td>28%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Any palliative care consultation</td>
<td>47%</td>
<td>33%</td>
<td>0.006</td>
</tr>
</tbody>
</table>
ARE STANDARD ONCOLOGIC MEASURES OF QUALITY USEFUL IN PATIENTS WITH HEMATOLOGIC MALIGNANCES?

- Avoid use of ICU in the last 30 days of life

- Avoid chemotherapy in last 14 days of life

- Increase hospice use while reducing proportion of patients enrolled in hospice for fewer than 3 days
ARE STANDARD ONCOLOGIC MEASURES OF QUALITY USEFUL IN PATIENTS WITH HEMATOLOGIC MALIGNANCIES?

• Most surveyed hematologic oncologists from Dana Farber Cancer Institute felt that current quality measures for EOL care were unacceptable for patients with hematologic malignancies (32.5% mean acceptability).

• New hematology-specific measures such as no platelet transfusions (50%) or blood transfusions (65%) within the final week of life were more accepted than standard measures [such as no death in an acute care facility (15%) and not more than one emergency department visit in the last month of life (20%)].

Odejide et al. JOP 2014;10:e396-e403
RACIAL DISPARITIES

• Ethnic minorities use palliative care services at significantly lower rates than whites

• Among Medicare beneficiaries who died in 2010, 45.8% of whites used hospice compared to 34% of African Americans, 37% of Hispanics, 28.1% of Asian Americans, and 30.6% of Native North Americans.

• Studies consistently document lower rates of hospice use for minority older adults than for whites across diagnoses, geographic areas, and settings of care, including nursing homes

Table 2. Adequacy of Opioid Supplies at 347 Pharmacies, According to the Racial and Ethnic Composition of the Neighborhood.

<table>
<thead>
<tr>
<th>Racial and Ethnic Composition of Neighborhood</th>
<th>Total Pharmacies</th>
<th>Pharmacies with Adequate Opioids</th>
<th>P Value for Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-39%</td>
<td>110</td>
<td>25</td>
<td>&lt;0.001</td>
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<tr>
<td>40-69%</td>
<td>72</td>
<td>56</td>
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</tr>
<tr>
<td>70-79%</td>
<td>72</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>&gt;=80%</td>
<td>93</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10%</td>
<td>173</td>
<td>61</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>10-19%</td>
<td>53</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>20-39%</td>
<td>57</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>&gt;=40%</td>
<td>64</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
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<td></td>
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</tr>
<tr>
<td>&lt;10%</td>
<td>89</td>
<td>56</td>
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<tr>
<td>10-19%</td>
<td>108</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>20-39%</td>
<td>70</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>&gt;=40%</td>
<td>80</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;10%</td>
<td>241</td>
<td>54</td>
<td>0.01</td>
</tr>
<tr>
<td>10-19%</td>
<td>74</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>20-39%</td>
<td>16</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>&gt;=40%</td>
<td>16</td>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>

TAKE HOME POINTS

• Hematologic malignancies are unique
• Developing hematologic malignancy-specific quality measures is important
• Changing people’s perception of palliative/supportive care is critical
• Early integration involves adequately preparing patients and their families for what ‘could’ happen in the course of their illness.
• Systemic changes to address why racial and ethnic disparities in supportive care services exist must be addressed
REFERENCES

ACKNOWLEDGMENTS

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Questions?