Cancer Treatment Centers of America:
Changing the Conversation:
Utilizing Palliative & Survivorship Care
in the Clinic

Amanda Hutchinson, MD
ACOFP FULL DISCLOSURE FOR CME ACTIVITIES

Please check where applicable and sign below. Provide additional pages as necessary. Name of CME Activity: 2017 AOA/ACOFP Osteopathic Medical Conference & Exposition (OMED)

Dates and Location of CME Activity: October 7-11, 2017 – Pennsylvania Convention Center and Marriott, Philadelphia, Pennsylvania
Topic: CTOCA: Changing the Conversation: Utilizing Palliative & Survivorship in the Clinic
Tuesday, October 10, 2017 1:30-2:30pm

Name of Speaker/Moderator: Amanda Hutchinson, MD

DISCLOSURE OF FINANCIAL RELATIONSHIPS WITHIN 12 MONTHS OF DATE OF THIS FORM

A. Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services.

B. I have, or an immediate family member has, a financial relationship or interest with a proprietary entity producing health care goods or services. Please check the relationship(s) that applies:

- Research Grants
- Stock/Bond Holdings (excluding mutual funds)
- Speakers’ "Bureaus"
- Employment
- Ownership
- Partnership
- Consultant for Fee
- Others, please list:

Please indicate the name(s) of the organization(s) with which you have a financial relationship or interest, and the specific clinical area(s) that correspond to the relationship(s). If more than four relationships, please list on a separate piece of paper:

<table>
<thead>
<tr>
<th>Organization With Which Relationship Exists</th>
<th>Clinical Area Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cancer Treatment Centers of America</td>
<td>1. Employed Physician</td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

*If you checked “Speakers’ Bureaus” in item B, please continue:

- Did you participate in company-provided speaker training related to your proposed topic? Yes: No:
- Did you travel to participate in this training? Yes: No:
- Did the company provide you with slides of the presentation in which you were trained as a speaker? Yes: No:
- Did the company pay the travel/lodging/other expenses? Yes: No:
- Did you receive an honorarium or consulting fee for participating in this training? Yes: No:
- Have you received any other type of compensation from the company? Please specify: Yes: No:
- When serving as faculty for ACOFP, will you use slides provided by a proprietary entity for your presentation and/or lecture handout materials? Yes: No:
- Will your topic involve information or data obtained from commercial speaker training? Yes: No:

DISCLOSURE OF UNLABELED/INVESTIGATIONAL USES OF PRODUCTS

A. The content of my material(s)/presentation(s) in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

B. The content of my material(s)/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated below:

I have read the ACOFP policy on full disclosure. If I have indicated a financial relationship or interest, I understand that this information will be reviewed to determine whether a conflict of interest may exist, and I may be asked to provide additional information. I understand that failure or refusal to disclose, false disclosure, or inability to resolve conflicts will require the ACOFP to identify a replacement.

Signature: Amanda Hutchinson, MD
Date: 9/25/17

Please fax this form to 847-852-5116, or e-mail to joank@acofp.org as soon as possible. Deadline: Monday, September 25, 2017
Changing the Conversation: Utilizing Palliative & Survivorship Care in the Clinic

Amanda Hutchinson MD
Family Medicine, Continuity of Care Clinic
Cancer Treatment Centers of America

Disclosures

• None
Learning Objectives

• Define the cancer survivor.
• Describe the family provider’s role in cancer survivorship, palliative care and throughout the cancer care continuum.
• Summarize practical strategies for approaching care for the “disease control” patient population.
• Discuss palliative care and its value in chronic disease management.

Cancer Care Continuum

Active Therapy: Curative

Survivorship Plan & Surveillance:
• Cancer-Free Survival
• Recurrence or 2nd cancer
• Chronic "Advanced" disease

Death

Non-cancer causes
Who is a Survivor?

• The National Coalition for Cancer Survivorship (NCCS) pioneered the definition of survivor as being any person diagnosed with cancer, from the time of initial diagnosis until his or her death. This expansive definition of "survivor" includes people who are dying from untreatable cancer.

• NCCS later expanded the definition of survivor even further to include family, friends and voluntary caregivers who are affected by the diagnosis in any way.
Who is a Survivor?

- The CoC supports the Institute of Medicine, National Coalition for Cancer Survivorship, and the NCI Office of Cancer Survivorship in the idea that:

  “an individual is considered a cancer survivor from the time of cancer diagnosis through the balance of his or her life.”

Anyone with a cancer diagnosis at any stage is a survivor.
2016 Cancer Statistics Report: “Death Rate Down 23% in 21 Years”

• “The continuous decline in cancer death rates over 2 decades has resulted in an overall drop of 25%, resulting in 2.1 million fewer cancer deaths during this time period.”

Cancer Statistics, 2017

1,199,200 Cancer Deaths Averted
512,100 Cancer Deaths Averted
Cancer Survivors in the United States

Estimated Number of Cancer Survivors in the US

- Projections

- Millions
- Year

Natural History of Serious Illness

Health vs. Time

dx: Diagnosis
death
Cancer as Chronic Disease

- With advancements in cancer treatments, more patients are treated with “curative intent.”
- As the number of cancer survivors increases, oncologists become a limited resource.
- Patients will return to their primary care offices for ongoing preventive services.

Cancer Care Continuum
Role of PCP in Cancer Care

• “Primary care providers...play a critical role in the prevention, diagnosis, treatment, and follow-up care for cancer patients and survivors. Further, they provide coordination of care for patients and access to support services for family members and caregivers.”
  - The Cancer Care Workforce, ACS CAN Policy Team 2011

• In particular, PCPs play a role in the management of:
  – Comorbidities
  – Symptoms and/or side effects
  – Long-term survivorship support

Cancer Care Continuum Teaching Case
Jane Davis: Surviving Cancer for 21 Years
JD Case: Initial Diagnosis

• **1996, August**: 42 yo AAF diagnosed with Stage I DCIS Breast cancer in the Left Breast
  – Treated with lumpectomy and XRT
  – Declined the option for hormonal therapy at that time
  – Continued to follow with her Oncologist for routine screening and follow up.

• Treatment with curative intent

![Diagram of JD Case: Initial Diagnosis, 1996]
Four Components of Survivorship Care

1. Prevention and detection of new cancers and recurrent cancer
2. Surveillance for recurrence or new primaries
3. Interventions for long-term and late effects from cancer and its therapies
4. Coordination between specialists and primary care providers to ensure that all of the survivor’s needs are met

Survivorship Care Plan

• By January 1, 2019 – Oncologists will provide survivorship care plans to all eligible patients per COC accreditation guidelines.
• Key survivorship component
• Road map for post-treatment care
• Tool for care coordination and communication

Treatment Summary + Follow-up Plan = Survivorship Care Plan
Survivorship Care Plan

- **Treatment summary** includes relevant information about the patient’s treatment history, including drugs and doses and side effects.
  - Medical providers and their contact information
  - Diagnosis and appropriate staging
  - Surgery/Chemotherapy/Radiation dates
  - Possible side effects of treatment
  - Side effects the patient has already experienced
  - Reason(s) treatment was stopped
  - Diagnostic information

Survivorship Care Plan

- The **follow-up plan** lays out a schedule of what tests or monitoring is needed, when and who is responsible for those activities. It should also include health behavior recommendations and recommended screenings.

  - The **survivorship care plan** should be created by the patient’s treating team and shared with other specialists, primary care providers and the patient.
  - “Discharge Summary.”
Cardiac Risk of Cancer Survivors

• After 2nd malignancies, cardiovascular disease is the leading cause of long-term morbidity and death among cancer survivors
• Radiation
• Cardiotoxic cancer therapy:
  – Anthracyclines, Trastuzumab, Sunitinib, Sorafenib
  – Because all patients receiving these drugs are at risk for the development of heart failure, they should be considered to have stage A heart failure (no structural disorder, but at risk) at baseline.

JD Case: Recurrence

• 2000, now 46 years old – Recurrence: Left Breast
  – Bilateral Mastectomy
  – Wide excisions, + margins
  – Chose no adjuvant therapy
  – Continued to follow with her oncologist for breast surveillance with no symptoms
  – JD develops reactive anxiety and depression
PCP Consideration: Communication

- Keep the conversation flowing both ways
- Oncologists may not know the latest in general medicine, changes in the standard of care for treatment of other chronic conditions including new medications, side effects, and interactions.
- Keep an eye out for the specialist to specialist referral process and the notes from those visits.
PCP Consideration: Medication List

- Keep an eye on the medication list, consider reconciling the medications yourself
- If patient is actively treating cancer, consider listing chemotherapy agents as historical medications on patient’s medication list in the EHR for Clinical Decision Support
- Patient understanding/education about medications

PCP Consideration: Common Medications

- Anti-emetics
- Anxiolytics
- Steroid courses before/after treatment
- Oral chemotherapeutics
  - Get to know side effects of their main chemotherapy treatment
JD Case: Continue Preventive Screening

- **2004-2014**, JD now in her 50s:
  - Diagnosed with diabetes, hypercholesterolemia, and chronic anemia.
  - Her PCP sent her for her colonoscopy at age 52.
  - She now has chronic low back pain.

JD Case: Second Recurrence

- **11/2014**: JD 60 YO presented to oncologist with weakness, poor balance, multiple falls, anorexia and weight loss.
  - New Lung mass on CT and sent for PET scan
  - R cerebellar mass, L4 lytic lesion, R hilar mass
  - Pt admitted for w/u and tx
  - Craniotomy: Excision and Cyber knife radiation
  - Sent for lung biopsy/bronchoscopy
  - Started on docetaxel (5 mos tx), began anastrozole hormone tx
JD Case: Second Recurrence

- Diabetes worsened by steroids for brain treatment. Now on insulin.
- Anxiety
- Developed PE 5/2015. Now on Lovenox
- Hospitalized with C. Diff 6/2015
- Life disruptions for treatment and hospitalizations

JD Case: Second Recurrence, 2000-2014

- Active Therapy:
  - Curative
  - Disease Control

- Survivorship Plan & Surveillance:
  - 2000 Cancer-Free Survival
  - Recurrence or 2nd cancer
  - 2014 Chronic "Advanced" disease
  - Treatment failure

- Craniotomy: Excised Cyber knife
JD Case: Palliative Oncology Care

- JD is now stage IV disease, and treatments are aimed at disease control and symptom palliation.
- Now has to establish and adapt to a new “normal.”
- Anxiety over what the next set of surveillance scans will show.

ASCO Guidelines:
Integrating Palliative Care into Standard Oncology Care

Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services.
Components of Palliative Care

- Rapport and relationship building with patient and caregivers
- Symptom/distress/functional status management
- Exploration of patient-caregiver understanding of illness/prognosis
- Clarification of treatment goals
- Assessment and support of coping needs, provision of dignity therapy
- Assistance with medical decision making
- Coordination with other care providers
- Provision of referrals to other care providers as indicated
- For newly diagnosed patients with advanced cancer*, the Expert Panel suggests early palliative care involvement within 8 weeks of diagnosis.

* Those with distant metastases, late-stage disease, cancer that is life-limiting and/or with prognosis 6-24 mos.

Prognosis: Palliative Care

- Often patients given a serious diagnosis want to know, “how long do I have to live?”
- Acceptance of the finality of life is the final developmental milestone for patients, caregivers and physicians
- Prognostication is fluid
  - It is a process, not an event
  - May evolve over the course of the disease
  - Prognostic accuracy for a given prognostic factor/tool varies by the definition of accuracy, the patient population, and the time frame of prediction
  - The exact timing of death cannot be predicted with certainty

Benefit of Prognosis

- Helps patients and surrogates make advance directive decisions
- Allows for other preparations
- Shifts focus towards symptom management and helps avoid burdensome or possibly harmful treatments
- Often a palliative care consult can be initiated early in the disease trajectory to facilitate with prognostication and outlining goals of care

Patients Want Prognosis

- Majority of patients and families want information regarding the illness
- Patients report that they want to have time to express their wishes, appoint healthcare proxies, to put their financial affairs in order and to make their funeral preparations
- Prognostic information itself has not been found to contribute towards depression in patients with advanced cancer
How Accurate Are We?

- Study asked 343 physicians to estimate the survival for 468 patients at the time of hospice referral
- A total of 20% of predictions were accurate, 63% were overly optimistic, and 17% were overly pessimistic
- Female patients, certain medical subspecialties, lack of clinical experience, and a *longer duration of the doctor–patient relationship* were associated with less accurate predictions

Why Consult?

- Prognostication as a fluid process falls within the skillset of a Palliative Care Provider familiar with the disease process.
- Successful palliative care requires time
  - Education
  - Reassessment of disease and goals of care
  - Assessment of symptoms and other stressors affecting QOL
- At least an hour or more with patient and family monthly.
- Palliative Care is expanding into Telemedicine, which may be of benefit for patients who live far from their treatment centers.
Role of PCP in Palliative Care

• Consider referral from your practice if not done already.
• Consider therapeutic goals of each medication you prescribe in context of lifespan.
  – Statins:
    • Evidence suggests that stopping statins is safe and prudent in patients taking them for ASCVD prevention and an estimated prognosis of less than two years. The data is less clear for patients with a prognosis of 1-2 years who are taking statins for secondary prevention.
    • Conversations can be emotional. This topic is best situated within the bigger prognosis talk.
• Consider relevance of disease screening in context of lifespan.

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

2010 NEJM

• Showed improved survivorship for patients enrolled early in palliative care programs.
• Median survival calculated from time of enrollment to time of death:
  – Whole group: 9.8 mos (n=151)
  – Early palliative care: 11.6 months (n=77)
  – Standard care: 8.9 mos (n=74)
• Palliative patients had better quality of life scores and fewer depressive symptoms. Despite the fact that fewer patients in the early palliative group received aggressive end-of-life-care, median survival was longer in that group.
JD Case: Living with Advanced Cancer

- 10/2015 surveillance:
  - CT demonstrates stable disease
  - Continue “palliative” hormonal therapy
- 12/2015 scans – stable disease
  - Continued on hormonal therapy and surveillance
- 6/2016 – 62 years old: Disease progression in R lung with obstruction
  - Bronchoscopy (therapeutic aspiration), radiation therapy complete 7/2016
  - Continue hormonal therapy

JD Case: Advanced Disease & Progression

6/2017 – 63 years old, 21 years from original diagnosis, 2+ years from brain mets.
- Disease progression in the right hilum with airway obstruction as well as worsening subcutaneous metastases in the right upper quadrant. Not candidate for recurrent chest XRT
- Now requiring O2
- Fulvestrant (Estrogen antagonist) and Palbociclib (CDK inhibitor)
JD Case: Advanced Disease & Progression

- Pt has good family support present at appointments, helping her manage her symptoms.
- Pt has frequent contact with providers.
- Has had open and honest conversations with her oncologist.
- Understands that future progression will need a change in therapy and that will depend on getting tissue, which will likely require biopsy.
- Current quality of life is acceptable, pain well controlled.
- Together, pt and oncologist have opted to continue current plan and avoid invasive procedures.

JD Case: 2015-2016

Diagram showing the progression of disease from diagnosis and staging, through curative and disease control treatments, to recurrence, progression, and end-of-life care. Key events include:
- 2015: Hormonal therapy Taxotere
- 2016: Progression
- Chronic "Advanced" disease
- Treatment failure
- Hospice
- Death
Transitioning to Hospice

- Hospice is indicated when life expectancy less than or equal to 6 months
- Disease modifying treatments are no longer deemed beneficial
- Burdens of treatment outweigh benefit
- Referral to Hospice is especially important if the goals of care are identified as comfort, staying at home, staying in control.

Hospice Conversation

- Set aside time.
- Can be difficult if patient has not had benefit of palliative services or has poor understanding of disease process.
- First, make sure providers are all on the same page regarding consensus on prognosis and treatment options and if conversation is appropriate.
- Second, Ask: find out what the patient’s understanding of their disease and prognosis. Use open-ended questions. Take time to answer and clarify gaps in understanding of their disease/prognosis.
Hospice Conversation

- Next, Ask about what patient knows about hospice or has had any experience with a hospice.
- You can determine if there are misconceptions and clarify for patient.
- Ask if you can share information about hospice. Some patients may say no, but provide ongoing availability and follow up. Introduce hospice as a tool to achieve care goals: staying home for example.
- Take time to respond with empathy to your patient’s emotional response.

Patients may ask you first about hospice

- Some patients will bring it up with you, the PCP, because they are afraid their oncologist will think they’re “quitting.”
- If you’re not sure the prognosis, still take the opportunity to explain what hospice is and how it benefits patients. Some patients are relieved to find there are other options that still count as “care.”
In Conclusion

• The PCP is an important player in cancer care and survivorship.
• Communication between team members is critical
• Keep conversation open with oncologists/specialists
• Survivorship Plans are becoming standard of care. **ASK!**
• Encourage your patients to be self-advocates.
• Having access to a Palliative Care Team can help your patients immensely.
• Patients appreciate open, honest conversations

JD Case: 2017 Status Update

• **8/2017** scans – shrinkage of abdominal mass
• Brain disease has never progressed from 2014
• Major symptoms continue to be respiratory.
Thank you