Palliative, hospice care lacking among dying cancer patients, Stanford researcher finds

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Medical societies, including the American Society of Clinical Oncology, recommend that patients with advanced cancer receive palliative care soon after diagnosis and receive hospice care for at least the last three days of their life. Yet major gaps persist between these recommendations and real-life practice, a new study shows.

Risha Gidwani, DrPH, a health economist at Veterans Affairs Palo Alto Health Economics Resource Center and a consulting assistant professor of medicine at the Stanford University School of Medicine, and her colleagues examined care received by all veterans over the age of 65 with cancer who died in 2012, a total of 11,896 individuals.

The researchers found that 71 percent of veterans received hospice care, but only 52 percent received palliative care. They also found that exposure to hospice care differed significantly between patients treated by the U.S. Department of Veterans Affairs and those enrolled in Medicare. In addition, many patients who received palliative care received it late in their disease's progression rather than immediately following diagnosis, as recommended by ASCO.

Gidwani is the lead author of the study, which will be published online May 27 in the *Journal of Palliative Medicine*. The senior author is Vincent Mor, PhD, a professor of health services, policy and practice at Brown University.

Differences between hospice, palliative care

Hospice and palliative care are often confused, but they are two distinct services, Gidwani explained. Palliative care is intended to alleviate symptoms and improve quality of life, and is appropriate for all patients with serious illness, not just those who are at the end of life. Conversely, hospice care is end-of-life care, which can also provide social support for family members. Physicians can recommend hospice care only if they believe the patient has fewer than 180 days to live.

"The main lesson learned is we need to improve exposure to palliative care, both in terms of how many patients receive it and when they receive it," Gidwani said. The team's analysis of palliative care focused on care provided by the VA because palliative care is not coded consistently in Medicare. However, the researchers could examine hospice care in both environments. When they compared the timing and provision of hospice care between patients treated by the VA and those who received care paid for by Medicare, they discovered differences that could not be explained by cancer types. For example, patients receiving VA care were less likely to receive hospice care for the minimum recommended three days compared with those in Medicare or in other contracted care paid for by VA. VA patients first received hospice care a median of 14 days before death, compared with patients in VA-contracted care who entered hospice a median of 28 days before death.

"Ideally, there shouldn't be any difference in timing of this care," Gidwani said. "Patients should receive a service based on their clinical need, not due to health-care system factors."

Hospice care policies differ

Interestingly, Medicare and the VA have different policies on the use of hospice care; VA cancer patients can continue receiving curative treatment while in hospice care, but Medicare patients must stop any chemotherapy or radiation before beginning hospice. However, nearly 70 percent of VA patients stopped curative treatment before entering hospice, even though they didn't need to, Gidwani said. She and colleagues are planning future research to understand why.

The team also found differences in the use of hospice and palliative care between cancer types and ages. Patients with brain cancer were more likely to receive palliative care than those with kidney cancer, for example. In addition, patients older than 85 were less likely to receive palliative care than patients between the ages of 65 and 69. But patients older than 80 were more likely to receive hospice care than younger patients. Those with brain cancer, melanoma or pancreatic cancer were more likely to receive hospice than patients with prostate or lung cancer.

"Our work indicates palliative care needs to be better integrated into standard oncological care and that there is wide variation in receipt of hospice care. The VA is strongly supportive of palliative care and hospice, so it's possible that other non-VA environments are performing even worse with respect to appropriate receipt of hospice and palliative care for cancer patients," Gidwani said.

The research did uncover some positive findings, said VJ Periyakoil, MD, clinical associate professor of medicine at Stanford and director of the Stanford Palliative Care Education and Training Program, who was not involved with the study.

"The authors found that 85.6 percent of veterans had some exposure to hospice care or palliative care in the approximately 180 days before death. This is a much higher percentage than what we see in the community," Periyakoil said. The higher number is likely due to the size

of the VA and its commitment to improving the care for seriously ill veterans, she said.

However, the study highlights opportunities to improve access to care for patients older than 85, who are likely to have several medical ailments, Periyakoil said. In addition, the study's findings on palliative care are worrisome.

"We know that early palliative care increases both longevity and quality of life. It is really puzzling as to why patients are referred so late despite compelling data to do otherwise," she said. "Some doctors may say that they are unsure about the prognosis and that is why they refer patients late. However, that argument does not hold water as earlier referrals are better, and at worst we would be guilty of referring a patient a little earlier in the trajectory."

Provided by Stanford University Medical Center

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