What the Oncologist Wants the Hospitalist to Know

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Disclosure of Relationships

I have no real or apparent conflict of interest with the material in this presentation. I have no financial relationships to disclose.
Learning Objectives

- Understand the benefits and burdens of consultative oncology.
- Identify important issues that are addressable with inpatient oncologist consultation.
- Recognize limitations of consultative oncology and understand how those limitations can be addressed.
“What’s An Oncologist?”

- Internal medicine subspecialist? Maybe not!
  - Surgical
  - Urologic
  - Gynecologic
  - Orthopedic
  - Radiation
  - Adult/Pediatric
  - Endocrinologist
  - Dermatologist
What’s Your Situation?

- Teaching/academic hospital or community hospital?
- Are oncology services segregated (different doc inpatient vs outpatient) or non-segregated (patient sees same doc whether in or out)?
### Location of Service

<table>
<thead>
<tr>
<th></th>
<th>The Hospital</th>
<th>The Clinic</th>
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<tbody>
<tr>
<td><strong>Ambience</strong></td>
<td>Busy, hectic</td>
<td>Quiet, intimate</td>
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<tr>
<td><strong>Distractions</strong></td>
<td>Pagers, cell phones, televisions, semi-private rooms</td>
<td>Minimal</td>
</tr>
<tr>
<td><strong>Time Management</strong></td>
<td>Variable</td>
<td>Controlled (historically)</td>
</tr>
<tr>
<td><strong>Completeness of information</strong></td>
<td>Variable (pathology reports, pending labs, etc.)</td>
<td>Complete</td>
</tr>
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What Is The Problem?

- Directly related to cancer
  - Neutropenic fever, paraneoplastic syndromes, others
- General medical problems
  - Pneumonia, uncontrolled diabetes, COPD exacerbations, stroke, acute MI, others
What Is The Problem?

- Our inpatient consult service
- 750 bed tertiary referral center
- NCI designated Comprehensive Cancer Center
- Approximately 1800 inpatient consults/year
What Is The Problem?

- Our inpatient consult service
  - Percent consults directly related to oncology problem 21%
  - Percent consults directly related to non-oncology problem 79%
What Is The Problem?

- Non-oncology problems evaluated by oncology consult team…
  - Medical: pneumonia, missing labs, constipation, hypothyroidism, ICU admission with stable oncology findings, “FYI” (consult required!)
  - Social: clinic visit expedites, conversations with family members, outpatient needs (commode, wheelchair, etc)
What Your Oncology Team Can Do

- Manage oncologic problems
  - Paraneoplastic syndromes, neutropenic fever, others
  - Administer/oversee chemotherapy for patients who require inpatient treatment
  - Facilitate discussion on goals of care, treatment options, and prognosis in patients with disease progression
What Your Oncology Team Cannot Do

- Manage general medical problems
- If cancer is stable, patient can be managed along established guidelines
What Your Oncology Team Cannot Do

- Over-rule the decision of the managing oncologist
  - Ethically challenging
  - Professional etiquette
  - Guidelines have helped (NCCN, others)
  - Osteopathic Oath: “I will work with my colleagues in a spirit of progressive cooperation…”
What Your Oncology Team Cannot Do

- Anticipate the results of the final pathology report
- In most studies, discordance rate between FS diagnosis and final diagnosis is 2-10%
- In every case where discordance exists and a formalized discussion of prognosis and treatment options has been held, the oncologist loses trust with the patient!
Why It’s Hard to Give Chemo in the Hospital

- CMS Billing Codes
  - J Code: used for injectables (chemotherapy) in most settings
  - C Code: part of CMS’s Prospective Payment System (PPS) and covers outpatient chemotherapy
  - CMS now prefers for outpatient chemotherapy services to be billed with a C code and inpatient services to be billed with a J code
Why It’s Hard to Give Chemo in the Hospital

- Reimbursement for $100 infusion (cost of acquisition)
  - C code (outpatient): average $85
  - J code (inpatient): average $45
- A $40 disparity for one drug costing $100!
There’s Sometimes a Disconnect…

- Many patients admitted toward end of disease course
- Most often 2º advancing cancer
- Treatment may be viewed as “doing something” to assuage guilt, address family concerns
What Do Oncologists Say about Chemotherapy at the Very End of Life? Results from a Semiqualitative Survey

(Behl D, Jatoi A; Jour. Pall. Med. 2010; 13(7): 831-835)

61 (422 mailed) oncologists in midwest surveyed on attitudes around chemotherapy near the end of life

In response to JCO article noting that 20% of oncology patients received chemotherapy in the last two weeks of life

The Disconnect

What Do Oncologists Say about Chemotherapy at the Very End of Life—Nine Major Themes Emerged

1. These decisions are strongly patient-driven

2. Newer agents are driving the decision to continue with cancer treatment

3. Financial incentives on the part of the medical community explain these high rates

4. Healthcare reform is necessary

5. Even a small chance of patient benefit justifies this practice
The Disconnect

What Do Oncologists Say about Chemotherapy at the Very End of Life—Nine Major Themes Emerged

6. This practice is detrimental to patients because it precludes the initiation of hospice services

7. Others may be prescribing in this manner, but “not us”

8. These issues are complicated, revolve around society values, and the oncologist alone cannot claim responsibility for such high rates of chemotherapy administration

9. There exist barriers to end-of-life discussions
The Disconnect

http://www.choosingwisely.org/societies/american-society-of-clinical-oncology/

American Society of Clinical Oncology

Five Things Physicians and Patients Should Question

Don’t use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.

1. Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
2. Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.
3. Implementation of this approach should be accompanied with appropriate palliative and supportive care.
Tips and Tricks to Effective Consultation

- "What would help you out before you come for the consult?"
- Frequent question asked by inpatient teams
- Cordial, collegial, friendly...driven by sincere desire
  to help...a good thing!!!
Tips and Tricks to Effective Consultation

- Good clinical history
- Avoid the “shotgun” approach
- Get great biopsies
- Be prepared for anxiety when informing patients that “the cancer doctor will be by”
- Pick up the telephone
- Curbsides are good, too
What We’ve Covered

- Understand the benefits and burdens of consultative oncology
  - Benefits: lots we can do to help
  - Burdens: expensive, non-oncologic problems not as well managed by oncologist
What We’ve Covered

- Identify important issues that are addressable with inpatient oncologist consultation
- Cancer-related problems: treatment, toxicities, progressive disease, goals of care, end-of-life discussions
What We’ve Covered

- Recognize limitations of consultative oncology and understand how those limitations can be addressed
  - Need information
  - The push to treat
  - Cost of inpatient treatment
“You’ve got a friend in me!”