



## Missed opportunities: Patterns of medical care and hospice utilization among ovarian cancer patients



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### HIGHLIGHTS

- Most received at least one marker of aggressive medical care at the end of life.
- Those going to hospice did so in the time immediately surrounding their death.
- Provider recommendations may impact a patient's decision to enroll in hospice.

### ARTICLE INFO

#### Article history:

Received 19 June 2014

Accepted 27 August 2014

Available online 2 September 2014

#### Keywords:

Ovarian cancer  
End-of-life care  
Advance directives

### ABSTRACT

**Objectives.** To assess aggressive medical care, hospice utilization, and advance care documentation among ovarian cancer patients in the final thirty days of life.

**Methods.** Ovarian, fallopian tube, or primary peritoneal cancer patients registered at our institution during 2007–2011 were identified. Statistical analyses included Wilcoxon–Mann–Whitney, Chi-square analysis, and multivariate analysis.

**Results.** 183 patients met inclusion criteria. Median age at diagnosis was 58. Most were white and had advanced ovarian cancer.

Fifty percent had experienced at least one form of aggressive care during the last 30 days of life. Patients with provider recommendations to enroll in hospice were more likely to do so (OR 27.7,  $p = <0.001$ ), with a median hospice stay of 18 days before death.

Seventy-five percent had an in-hospital DNR order and 33% had an out-of-hospital DNR order. These orders were created a median of 15 and 12 days prior to death, respectively. Twenty-eight percent had a Medical Power of Attorney and 20% had a Living Will. These documents were created a median of 381 and 378 days prior to death, respectively.

**Conclusions.** Many ovarian cancer patients underwent some form of aggressive medical care in the last 30 days of life. The time between hospice enrollment and death was short. Patients created Medical Power of Attorney and Living Will documents far in advance of death. DNR orders were initiated close to death.

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### Introduction

Early discussions regarding the patient's treatment goals and need for palliative supportive care may be perceived as premature by some. However, early palliative care interventions provide advanced cancer patients with improved quality of life (QOL), regardless of whether or not they are receiving anti-cancer treatment [1,2]. As a result, both the American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN) recommend that providers engage in discussions regarding advanced cancer patient's treatment goals, expectations, and need for palliative care interventions early in the disease

process [3,4]. These advance care planning discussions serve two main purposes. First, these discussions give patients time to think about the issues they may have to face in the future. Second they give patients the opportunity to discuss their wishes with their family members and medical care team [5,6]. Often these discussions result in less aggressive care at the end-of-life and increased hospice utilization [7,8].

Unfortunately, many patients do not have early advance care planning discussions with their providers [9,10]. As a result, many patients experience aggressive medical care ranging from chemotherapeutic administration to multiple hospital admissions in the final days of life [7,8]. While there is no universal definition of what constitutes aggressive medical care at the end of life, several researchers use the following metrics identified by the National Quality Forum: chemotherapy administration within the last 14 days of life, more than one emergency room visit in the last 30 days of life, more than one hospital admission in

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the last 30 days of life, more than 14 days spent admitted to the hospital in the last 30 days of life, intensive care unit (ICU) admission in the last 30 days of life, death in the hospital, and hospice admission during the last three days of life [7,8,11,12].

For those patients who will eventually succumb to their disease, hospice care provides an alternative to aggressive medical care at the end of life by allowing the patient to transition from the active treatment of disease to the management of symptoms and identification of expectations surrounding death. In addition to the benefits provided to the individual patient, hospice provides benefits on a global healthcare level. Recent studies demonstrate decreased utilization of hospital resources (i.e. procedures, admissions) and increased medical cost savings among patients enrolled in hospice [13–15]. In order to efficiently utilize the limited health care dollars available, we must evaluate the benefits of aggressive measures taken at the end of life.

Ovarian cancer is often diagnosed at an advanced stage and has the highest mortality rate among gynecologic cancers [16]. Overall survival is poor, with a 5-year survival rate of 40–50% following initial diagnosis [17,18]. Limited studies have evaluated the medical care received by ovarian cancer patients at the end of life [8,19]. The primary objective of this study was to assess patterns of medical care, hospice utilization, and aggressive medical care among ovarian cancer patients at our institution in the last 30 days of life. A secondary objective was to assess the utilization of advance care documentation, such as Medical Power of Attorney documents, Living Wills, or Do Not Resuscitate (DNR) orders, among deceased ovarian cancer patients at our institution.

## Materials and methods

This retrospective study was approved by The University of Texas MD Anderson Cancer Center's Institutional Review Board (IRB). Deceased patients, ages 18 years or older with a diagnosis of ovarian, fallopian tube, or primary peritoneal cancer who were registered at The University of Texas MD Anderson Cancer Center in Houston, Texas during 2007–2011 were identified through our institution's Tumor Registry. Patients who did not receive their primary cancer care at The University of Texas MD Anderson Cancer Center, received the majority of their cancer care in the final month of life at an outside institution, or did not have a documented location of death were excluded from the study.

Demographic data and end-of-life care outcomes were collected from the electronic medical record of patients satisfying these inclusion criteria. Data collected included: age, race, cancer type, education level, cancer stage, date of diagnosis, date of death, location of death, provider recommendations regarding hospice care (a documented conversation in the medical record where a medical care provider suggested that the patient transition to hospice care), presence of advance directive document (DNR, Medical Power of Attorney, and Living Will), and date of advance directive document signing (when applicable).

Of note, our institution has a palliative care unit where patients may be transferred to when they decide to pursue hospice care during a hospital admission. Patients often go to our palliative care unit prior to moving to either home hospice or another inpatient hospice unit outside our institution. Deaths occurring in the palliative care unit were counted as hospital deaths in the results because the patients were listed as dying at our institution.

Information regarding aggressive medical care during the last 30 days of life was collected. For the purposes of our study, we adopted the metrics outlined by the National Quality Forum (chemotherapy administration within the last 14 days of life, more than one emergency room visit in the last 30 days of life, more than one hospital admission in the last 30 days of life, more than 14 days spent admitted to the hospital in the last 30 days of life, intensive care unit (ICU) admission in the last 30 days of life, death in a hospital, and hospice admission during the last three days of life) as indicators of aggressive medical care [7,8,11,12].

Additionally, we collected information regarding palliative care consultation, including whether or not the first palliative care consult occurred in the in-patient or the out-patient setting and the time between palliative care consult and death. For the purposes of our study, late palliative care consultation was defined as a consultation taking place in the final 30 days of life.

Descriptive statistics were used to characterize the study population. Differences between groups were evaluated using Wilcoxon–Mann–Whitney, Chi-square, and multivariate analysis. IBM SPSS Statistics (v. 21) was used for the statistical analyses.

## Results

One-thousand sixty-eight records were identified in the initial query of The University of Texas MD Anderson Cancer Center's Tumor Registry. Of these, 480 patients received only treatment recommendations at our institution and then received the remainder of their cancer care at an outside hospital. Eight-hundred and eighty-five patients received cancer care primarily at an outside institution during the last month of life or were lost to follow-up prior to death. One-hundred and eighty-three patients met all of the inclusion criteria for this study and had information regarding both their cancer care during the last month of life and place of death. The median age of eligible patients at diagnosis was 58 years. Most patients were white with advanced stage ovarian cancer. Table 1 lists pertinent demographics.

### Aggressive care received in the last 30 days of life

Twelve patients (7%) received chemotherapy or a clinical trial drug in the last 14 days of life. Thirty-four (19%) had more than one ER visit in the last 30 days of life. Of these 34 patients, the mean number of ER visits was two visits (SD 0.55 visits, range 2–4 visits). Thirty-one (17%)

**Table 1**

Patient demographics.

Median age at diagnosis: 58 years (SD: 11.4, range: 22–87 years old).

Median age at death: 60 years (SD 11.3, range 25–90 years old).

Characteristic	N (%)
<i>Race/ethnicity</i>	
White	124 (67.8)
Black	24 (13.1)
Hispanic	24 (13.1)
Asian	10 (5.5)
Other	1 (0.5)
<i>Cancer type</i>	
Ovarian	177 (96.7)
Fallopian tube	5 (2.7)
Primary peritoneal	1 (0.5)
<i>Stage of cancer</i>	
I	4 (2.2)
II	8 (4.4)
III	79 (43.2)
IV	36 (19.7)
Unstaged/neoadjuvant	42 (23.0)
Not documented	14 (7.7)
<i>Marital status</i>	
Single	29 (15.8)
Married	114 (62.3)
Divorced	21 (11.5)
Widowed	19 (10.4)
<i>Education</i>	
Less than college	99 (54.1)
College and beyond	61 (33.3)
Unknown	23 (12.6)
<i>Insurance</i>	
Private	110 (60.1)
Medicare	58 (31.7)
Medicaid/self-pay/indigent	15 (8.2)

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