A new concept in cancer care: The supportive care program

Peg Esper, MSN, RN, CS, AOCN
Janet N. Hampton, BS, RN
John Finn, MD
David C. Smith, MD
Sandra Regiani, BS, MBA
Kenneth J. Pienta, MD

Abstract

This article describes the findings of a pilot program designed to enter advanced prostate cancer patients into the hospice benefit while they are still being actively treated, but in situations where treatment is known to be primarily palliative in nature. The supportive care program *(SCP) combines the medical model's goal to prolong life with the goal of hospice to palliate symptoms and improve quality of life (QOL). The concept of a SCP was developed to create a team approach where advanced prostate cancer patients who are starting investigational chemotherapy are concurrently enrolled into a hospice program. The objectives were to identify whether SCP improved QOL and continuity of care while remaining cost-effective. Data were collected on patient quality of life, performance status, use of health care resources, and costs for the 36 enrolled patients. A comparison was made to a matched set of 23 control patients. Our findings indicate that the SCP contributes to continuity of care while being cost-effective.*

Peg Esper, MSN, RN, CS, AOCN, Nurse Practitioner, Oncology, Department of Internal Medicine, University of Michigan Comprehensive Cancer Center, Ann Arbor, Michigan.

Janet N. Hampton, BS, RN, Clinical Coordinator, Oncology, Department of Internal Medicine, University of Michigan Comprehensive Cancer Center, Ann Arbor, Michigan.

John Finn, MD, Executive Medical Director, Hospice of Michigan, Ann Arbor, Michigan.

David C. Smith, MD, Assistant Professor of Medicine, Hematology/Oncology, Department of Internal Medicine, University of Michigan Comprehensive Cancer Center, Ann Arbor, Michigan.

Sandra Regiani, BS, MBA, Senior Financial Analyst, Financial Operations, University of Michigan Health Systems, Ann Arbor, Michigan.

Kenneth J. Pienta, MD, Professor of Medicine, Hematology/Oncology, Director, Urologic Oncology Program, Department of Internal Medicine, University of Michigan Comprehensive Cancer Center, Ann Arbor, Michigan.

Introduction

Over the years, two separate models have existed to care for patients with advanced malignancies. The first model, or the traditional medical model, has its focus on the prolongation of life by the use of various known and investigational agents. The second model, the hospice model, focuses on the palliation of symptoms in people with terminal illness who are believed to have a life expectancy of six months or less.[1] While these two models of care appear to be at opposing ends of the spectrum, critical commonalties exist between them. This overlap of goals has led to the development of a model of care referred to as the *supportive care program* (SCP), which is the topic of this article.

Prostate cancer is first in male cancer incidence and second only to lung cancer in cancer deaths in US men. Of the estimated 184,500 new cases in 1998, 20 percent of those patients will be diagnosed with metastatic disease. Approximately 39,000 patients with advanced prostate cancer will die from their disease this year.[2] Once a patient has been diagnosed with

metastatic disease, there is no known curative therapy. The standard treatment of disease at this stage is hormonal ablative therapy. This therapy is effective in a large percentage of patients with advanced prostate cancer, but is only a temporary measure. Most patients will have evidence of recurrent disease in approximately 18 months.[3] Following failure of hormonal treatment (hormone refractory prostate cancer), the choice becomes enrollment in a clinical trial, use of treatments with some track record of efficacy, alternative therapies, or supportive care measures.

To date, treatments utilized following hormonal therapy have failed to demonstrate any significant impact on survival. As a result, additional endpoints such as quality of life (QOL) have been examined to help determine whether or not therapy has any benefit in this population.[4] Patients at this stage who elect to undergo treatment with chemotherapeutic agents are subject to a multitude of potential side effects and toxicities, such as myelosuppression, mucositis, nausea and vomiting, and anorexia. In addition, these patients suffer the symptoms frequently associated with their disease process, which can include pain, difficulty with urination, and fatigue.[5] Patients undergoing treatment are generally seen in the outpatient clinic at frequent intervals to monitor their response to treatment as well as evaluation of side effects and toxicities resulting from therapy. Eventually, however, treatments fail and a time comes when no further treatment is feasible. This is frequently the time when hospice referrals are made.

Referral to hospice at this point can be very disconcerting for both health care providers and patients and their families. The frequent clinic visits during treatment normally lead to close bonds developing between patients and the clinical staff providing care. Once hospice care is instituted, the clinic visits are infrequent or even absent, creating a sense of abandonment on the part of the patient and family. The clinical staff also feels a sense of loss as this individual, in whom they have personally invested, will no longer be under their immediate care.

From the hospice vantage point, there is also frustration. Hospice staff generally includes nurses, health-aides, social workers, and others who function as a team to support patients and their families in the dying process. While physical symptom management is a priority, much attention is given to the psychosocial and spiritual aspects of the dying process. The median length of stay (LOS) found in most hospices is 36 days.[6] One can imagine the difficulty hospice staff has in trying to establish relationships with patients and families that enable them to address such delicate issues effectively in this brief time frame. Many hospice staff members feel that they end up doing little more than "crisis intervention." Financially, the situation for the hospice is also less than optimal. As has been well documented, the last two weeks of life are the most expensive for the majority of patients.[7] Given that this becomes the major time period in which patients are enrolled in hospice, the cost-effectiveness of care provided by the organization is frequently in question.

Hospice staff members are experts at symptom management and in dealing with psychosocial issues related to terminal illness. The concept of a supportive care model was developed to try and create a "win-win" situation in which the critical skills of hospice staff could be combined with those of the acute care staff in a "team approach" that would allow what we have referred to as a "transitionless" model of care. In this model, patients who are considered to be "hormone refractory" and are starting investigational or salvage treatments are concurrently enrolled into a hospice program. Hospice staff becomes a team with the acute care providers in helping to manage the patients' side effects and symptoms from treatment at home, while they begin to address issues related to terminal illness with the patient and family. The acute care staff has frequent contact with the hospice staff from the beginning, making the eventual move to complete hospice support less distressing for everyone involved. Patients and their caregivers have been able to develop relationships with hospice staff. As a result, they do not view the move to total hospice support as abandonment. A diagrammatic representation of this model is found in Figure 1.

The intent of developing the SCP transitionless model was to provide care for patients with advanced prostate cancer that would eliminate abandonment, enhance QOL and quality care by beginning hospice support earlier in the course of terminal illness, and be cost-effective for the hospice, acute care facility, and third-party payors.

Objectives and purpose

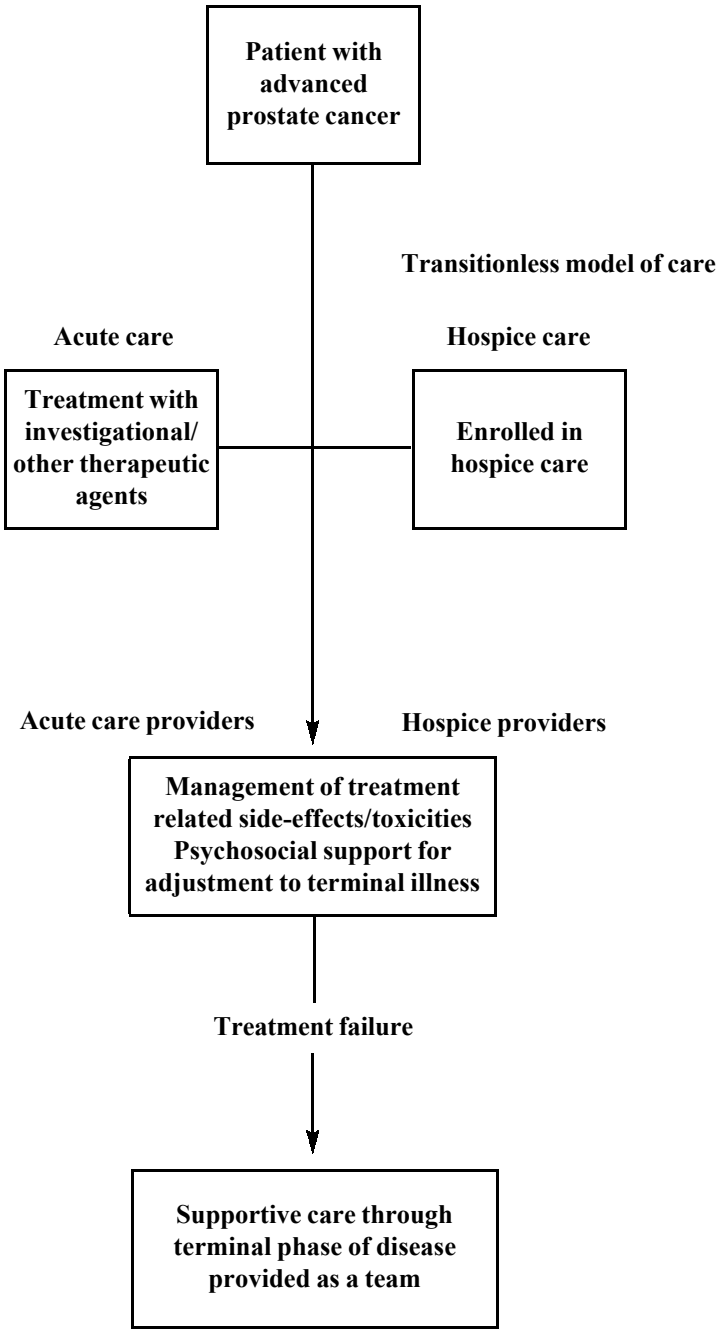
Our objective was to identify if enrollment in a hospice program during active treatment for metastatic hormone refractory prostate cancer would:

- improve quality of life for these patients;
- provide improved management of side effects and toxicities associated with treatment;
- provide cost-effective versus cost-prohibitive care;
- improve continuity of care between the acute care facility and home hospice staff.

Literature review

The need for improved end-of-life (EOL) care has become recognized as a critical social issue over the past five

Figure 1. The supportive care model



to 10 years. A significant awareness of inadequacies in EOL care was made in the report of the *SUPPORT project* (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment). A total of 9,015 adult patients in five US teaching hospitals were involved in this study. Reported shortcomings in EOL care included deficits in communication between physicians and patients, where only 47 percent of physicians were aware of their patients preference to avoid CPR. An alarming 38 percent of the patients who died had documented stays of at least 10 days in intensive care units, where they underwent multi-invasive procedures. Even more disturbing were reports that pain levels were moderate to severe at least half the time in 50 percent of conscious patients.[8]

While the need for improved EOL care is evident, there continue to be questions as to how best to deliver this care. Much has been published related to the need for improved education and training in EOL care for health care providers.[9,10] Both medicine and nursing have identified a lack of education in their initial training in this area.[11]

However, few programmatic methods for improving EOL care are reported in the literature. A report by Ferrell *et al.*, discusses the development of a training program to help nurses take an active role in pain management for hospital patients. This program is intended to improve pain management via the interventions received, as needed, by the "prn" nurses.[12] Another program designed by the Oregon Health Sciences University is called, the *comfort care team*. This interdisciplinary team provides consultative services primarily for hospitalized, seriously ill patients with comfort care needs. The services include pain management as well as psychological, spiritual, and symptom management support. The consultative team is available Monday through Friday, 8:00 am to 5:00 pm. Patients

are not required to be terminal for referrals to be made.[13]

Another concept, termed "Medicaring," has been proposed, which suggests that EOL care is best facilitated in a managed care *capitated* setting. The benefit of such a system is felt to be the provision of access to the desired elements of palliative care within the managed care structure.[14] Admittedly, an identified concern with this type of program is the fear that participating physicians would face ethical dilemmas as they make decisions about how much care is too much and what services or procedures are too high in cost and not beneficial from an incentive perspective.

Another issue addressed in the literature concerns the cost of both hospice and EOL care. Multiple studies have attempted to identify costs of care accurately at the end of life. It has been suggested that hospice can save between 25 percent and 40 percent of costs during the last month of life.[15] However, this figure drops to between 0 and 10 percent, if the last 12 months of life are considered.

Bloom and Amenta compared the costs of hospice care for study patients to the comparable cost if the same patients had had the alternative of hospital and nursing home care. The authors reported an estimated savings of almost four million dollars.[7] There is still considerable debate on what the real savings potential would be, if any, when patients were enrolled into the hospice benefit sooner rather than later. Several studies attribute this problem to the fact that median lengths of stay in many hospice programs are extremely short. In a study of 6,451 hospice patients by Christarkis and Escarce, the median LOS was found to be 36 days with over 15 percent of patients dying within seven days of enrollment. Multiple potential causes of this limited LOS have been theorized with a frequent reference to the fear physicians have in inaccurately estimating the Medicare-prescribed "six months or less" prognosis for patients.[6]

The topic of this article, then, provides a new dimension to the current literature and adds to the body of knowledge in EOL care by its multidimensional evaluation of providing early hospice care to patients still receiving therapeutic treatment for an incurable malignancy. An evaluation of physical, psychosocial, and financial elements of care utilizing matched controls is discussed to help determine the feasibility of pursuing such a program on a larger scale.

Methods and procedure

During the period from September 1995 through August 1997, a total of 36 men with hormone refractory prostate cancer were enrolled into the hospice SCP. The concept of the program was introduced to patients in the outpatient clinic during a regularly scheduled visit by the oncologist or oncology nurse practitioner, generally at the time patients were going to be starting a new treatment for their cancer. A convenience sample was obtained as patients were presented with the concept of the program and automatically enrolled if they agreed. Those patients who agreed to participate were introduced to the SCP coordinator who was jointly employed by the Comprehensive Cancer Center where patients were receiving care as well as the hospice participating in this program. The coordinator would spend additional time with patients reviewing the program and arrange a time for a home visit with the hospice staff to do a "formal" admission to the hospice program. From this point, patients were jointly cared for by the cancer center and hospice staff.

The SCP coordinator played a vital role in the program by handling all communication to hospice staff regarding clinic visits (medication changes, schedule for lab draws, tests, treatment changes, and treatment response, etc.). The SCP coordinator also reported nursing assessments made to the acute care providers at the cancer center. The hospice home-care nurses would directly contact the physician or nurse practitioner for order changes or acute problems, but relied on the SCP coordinator for transfer of routine information regarding patient and family issues to the Cancer Center staff.

Hospice staff assessed the needed frequency for home visits. This was generally more frequent in the very beginning, decreased in frequency during stable phases of treatment and increased when patients were experiencing symptom management difficulties or in the final stages of their illness. All of the various services that hospice has to offer were available to the SCP patients.

Patients were seen for regularly scheduled visits by their oncologist in keeping with protocol or standard care requirements. Charges for treatment, clinic visits, medications, professional fees, diagnostic studies, etc., were billed to hospice as long as they were related to the patients diagnosis of prostate cancer.

If patients were experiencing problems, attempts were made to have them evaluated first by the hospice staff at home. The hospice nurses would go to the home, assess the problem, and report back to the oncology team at the cancer center to avoid unnecessary trips to the clinic or emergency room. Patients who required hospitalization for acute treatment, symptom control, or respite were admitted to the cancer center's inpatient hospice beds.

In an effort to demonstrate what difference, if any, a program of this nature makes, a control group was established. The control group for this project consisted of 23 patients who were concurrently identified as having hormone refractory prostate cancer during this same time interval and undergoing similar treatment. Some of the control group

Table 1. Demographics				
	Conventional care (n = 23)		Palliative care (n = 36)	
Characteristics	Number	%	Number	%
Age, in years				
< 57	2	8.7	4	11.1
57 - 64	6	26.1	4	11.1
65 - 71	11	47.8	6	16.7
> 71	4	17.4	22	61.1
Mean age (years)	67		72	
Race				
White	22	96	29	80.5
Black	1	4	7	19.5
Deaths	2	9	9	25
Range LOS (days)	90 - 180		90 - 180	
Mean LOS (days)	166		162	
Chemotherapy				
IV	17	74	10	27.9
PO (oral)	6	26	25	69.4
none	0		1	2.7
OP (out patient) diagnostic procedures	19	82.6	13	36
Performance status				
0 (90 - 100)*	16	69.6	14	38.9
1 (70 - 80)*	7	30.4	16	34.4
2 (60)*	0	0	6	16.7
* Karnofsky scale				

were patients who had not been interested in the program when presented it. The majority of patients in the control group, however, lived outside the geographic range of services for the hospice participating in this project. The average age for SCP patients was 72, while the control group's average age was 67. The study followed patients for approximately six months (180 days) with an average of 162 days for the SCP patients, as compared to 166 days for control patients. In terms of response to treatment, 30 percent of SCP patients had a therapeutic response to therapy (decrease in amount of disease), while 22 percent of the control patients demonstrated a positive response to treatment. Table 1 summarizes demographic data for the two groups.

For both the enrolled (SCP) and control groups, information was collected on the financial costs of care, clinic visits, emergency room visits, unscheduled visits, hospital admissions, treatment received, laboratory work, PSA (prostate specific antigen) values, length of stay in program, performance status, pain scores, and QOL measurement. The financial staff of the cancer center and hospice worked together to track the costs associated with care. Data were initially kept in Excel spreadsheet files and, at the time of review, were exported to SPSS 7.5 files for statistical analysis.

Medical care costs have become a recent focus of research, especially during the last year of life. Some 27 percent of annual Medicare expenditures are for services delivered within this time frame.[16] Accordingly, one

objective of this pilot study was to evaluate the impact of intervention on the cost from a societal perspective. All except one of the patients in the intervention group were enrolled into the Medicare Hospice Benefit. The control group consisted of 17 (74 percent) with standard Medicare coverage, 5 (22 percent) with Blue Cross/ Blue Shield (BC/BS), and 1 (4 percent) with other insurer coverage. For this selection of patients, Medicare expenditures were used as a proxy for cost. Medical expenditures in both the intervention (Hospice Benefit) and control (standard Medicare) were calculated as standard Medicare reimbursement. We did not look at the expenditures of Hospice of Michigan, the hospice providing the home-care services.

Costs for the outpatient facility's services were determined by using a cost-to-charge ratio based upon facility charges.[17] Medicare fee-screen reimbursement for billed codes (CPT-4) (current procedural terminology) was used as a proxy for professional costs and Medicare reimbursement by DRG (diagnosis related group) was the basis for hospitalization costs. Facility costs include intravenous chemotherapy and, in order to capture oral chemotherapy, costs were derived from the index of wholesale drug prices.[18] Patients were tracked prospectively for laboratory tests, procedures, hospitalizations, chemotherapy, clinic visits, transfusions, radiation therapy, emergency room visits, and response to chemotherapy.

The selection of a time frame for cost comparisons in previous end-of-life studies have limitations. Comparisons can be over too short of a time span for adequately evaluating cost differences. In studies comparing hospice versus conventional care reviewed by Emanuel, costs over longer time periods resulted in smaller savings.[15] The design of this pilot study compares costs over six months, starting at the initiation of chemotherapy. The analysis of outcome and process measurements, including cost, depends on data collection that is consistent in both groups. Therefore, we enrolled patients into the hospice program with metastatic prostate cancer at a fixed time period when patients start to receive chemotherapy and ended at 180 days, death, or completion of the study.

Charts were reviewed prospectively to obtain data on visit history, admissions, PSA values, etc. Patients were asked to provide a pain score using a linear analog scale of 1 to 10 at each visit. Karnofsky performance-status evaluation was recorded at each visit as well. Quality-of-life assessment was made utilizing the Functional Assessment of Cancer Therapy Prostate (FACT-P).

The Functional Assessment of Cancer Therapy—General (FACT-G) is a 34-item, generic, quality-of-life measurement tool, which was developed by Cella and colleagues. The instrument measures four cornerstone dimensions of quality of life: physical well-being (PWB), social/family well-being (SWB), emotional well-being (EWB), and functional well-being (FWB). FACT-G also includes a brief (two-item) assessment of the individual's relationship with his or her doctor (RWD). The prostate-specific subscale was added to the FACT-G in 1993 to include questions specific to the quality of life in men with prostate cancer, resulting in what is now referred to as the FACT-P. The reliability and validity of the FACT-G and FACT-P, used in this study, are well established.[19,20] The instrument is written at a sixth-grade reading level and is available in eight languages. All of the data reported were collected using the English form. The FACT-P takes approximately eight to 10 minutes to complete. Version 3 of the FACT-P was utilized for all patients participating in this study. Version 4 is now available for use. It differs from Version 3 in that the "Relationship With Doctor" subscale has been deleted. This two-question subscale was associated with a ceiling effect and produced little variability in the data. Also, global quality-of-life questions at the end of each subscale that were never used in the scoring of the instrument have been deleted. Item numbering has also been changed to universal alphanumeric codes. The prostate-specific subscale has remained unchanged.

Results

Data on a total of 36 SCP and 23 control patients were used to evaluate the desired outcomes of this study. The two groups were quite similar in relation to mean age and mean length of stay. In the supportive care program, 80.5 percent of participants were Caucasian with 19.5 percent African American, as compared to the control group, where 96 percent of the participants were Caucasian with only four percent African American (Table 1). During the analysis period, 25 percent of the patients in the supportive care program died, while only 8.7 percent of the control group died.

The two groups varied in baseline performance status as well. Sixty-nine percent of the control patients had a performance status of 90 to 100, while only 39 percent of the SCP patients were in this range. Overall, the performance of the SCP patients at baseline was significantly less than that of the control group (chi square=7.14, $p < .03$).

Resource utilization was also evaluated. Numbers overall were small and, as a result, no statistical analysis was feasible. Table 2 shows the various services utilized by the two groups. Though no substantive statements can be made regarding these figures, note that the overall number of visits per SCP participant was less than that of the control group (5.9 versus 6.9). Considering the lower performance status of the SCP group as a

Table 2. Cost analysis				
Itemized costs	Conventional care (n = 23)		Supportive care (n = 36)	
	Total cost per patient	Average cost per patient	Total cost per patient	Average cost per patient
OP (out patient) facility cost	48,304	2,100	52,858	1,461
IV chemotherapy*	120,531	7,090	72,861	7,286
OP (out patient) chemotherapy†	3,738	623	15,894	611
IP (in patient) DRG	22,496	979	88,802	2,467
Professional cost	25,137	1,093	34,476	958
Total cost	220,170	9,573	264,612	7,350
Average cost per day per patient		58.70		43.50
* IV chemotherapy for controls (n = 17) and for SCP (n = 10); † PO chemotherapy for controls (n = 6) and for SCP (n = 26)				

whole, one would have expected those patients to require more frequent visits for problem intervention.

The cost comparison of the intervention versus the control group shows an overall savings of $2,736 over six months. This figure is calculated from the average cost per day of $43.50. However, in comparing the medical treatment of the two groups, the treatment modalities employed must be considered. Control patients had higher performance status and received IV chemotherapy (74 percent, control, versus 28 percent, SCP) at a higher percentage. Oral chemotherapy is less toxic and does not demand the number of diagnostic tests to monitor patients as compared with IV chemotherapy. Both the chemotherapy and diagnostic tests could contribute to an increase in cost. Hospice home care cost was not included in this analysis and will be assessed in future projects. Cost analysis is presented in Table 2.

Finally, quality-of-life evaluation used comparisons between a baseline FACT-P score and two subsequent readings at one month post-initiation of treatment and the third score between three and six months post-initiation of treatment. Of the 59 patients on which data were collected, only 37 had complete QOL data for analysis. Some data were not available due to incomplete surveys, surveys being lost, or spouses completing them instead of the patient. Of those that could be evaluated for QOL measurement, 24 were enrolled in the SCP and 13 were control patients.

No statistically significant changes were noted in either the general FACT, the prostate-specific subscale, or total FACT-P scores at any of the three points in time. Of note, however, is that our experience in past studies with prostate cancer patients on clinical trials with this instrument has been that scores have generally decreased at the first month for the majority of patients.[21] This has been attributed to the onset of side effects and toxicities associated with treatment. This was true for the control group in relation to the FACT score at time point 1. However, the SCP patients actually saw an increase in all three scores at the one-month time point. We believe that the support patients received from hospice staff may have had a positive effect on them, which prevented this drop from occurring, but the numbers are too small to demonstrate significant differences. The route of chemotherapy administration was significantly different between groups with fewer patients in the SCP group receiving IV chemotherapy ($p < .04$). Despite this, note that there still were no significant differences in QOL scores, tending to suggest that therapies did not significantly alter QOL, regardless of whether they were administered intravenously or not. Table 4 summarizes mean QOL scores for both groups.

Limitations of analysis

An obvious limitation of this study was the sampling technique utilized. As a convenience sample, we lacked the strength in reporting findings that a randomized sample would provide.

Table 3. Health care services				
	Conventional care		Palliative care	
Health services	N	Total	N	Total
Ambulatory care visits	23	158	36	214
Unscheduled visits	6	8	5	5
ER visits	4	5	3	3
Hospital days	6	35	9	67
Transfusions	3	6	7	14
Radiation therapy	3	3	1	1
Home health aide visits		N/A	36	305
LPN visits		N/A	36	381
RN visits		N/A	36	507
Social worker visits		N/A	36	231

The study and control groups were matched reasonably well with the exception of the route of administration of therapy and initial performance status. There may have been a bias to enroll patients in the program who would not be treated as aggressively, or patients with a lower performance status were more likely to be willing to participate in this type of program. Our goal in the future is to enroll patients earlier during the more aggressive treatment phase and follow the transition to palliative and supportive medical intervention up to the time of death and including the bereavement phase. Data collected through these transitions will be needed to evaluate cost-effectiveness. The pilot study's cost analysis supports the hypothesis that the intervention group will not cost more than those receiving conventional medical care.

Another limitation of the study was the small number of patients for evaluation, particularly in regard to QOL data. The numbers did not provide adequate power to generalize findings. As this was a pilot study, however, to analyze data as soon as possible was important to be certain that there were no significant negative effects as a result of this program from the perspective of either patient care or cost.

Other limitations included the inability to track pain management adequately in the control group patients, making comparison to the enrolled group impossible. This would have been valuable information to report. The other major weakness in this study was the lack of evaluation of caregiver response to enrollment in the SCP. While the verbal feedback was very positive, we did not have systems in place to measure caregiver burden in the two groups. Along that same perspective, the effect of the program on hospice staff and acute care staff was obtained in an anecdotal fashion only, and therefore not accurately reportable. The study also had the limitation of being confined to prostate cancer patients, making generalization to patients with other malignancies more difficult. The narrow focus was important, though, in this initial pilot study.

Discussion and implications for practice

As primary caregivers involved with the care of advanced prostate cancer patients, we found the supportive care program concept to be very positive. Our ability to provide increased continuity of care for patients was evident to us, despite the inability of the data to reflect this adequately. To have knowledgeable staff in the

Table 4. Quality of life scores					
QOL measurement timepoint*	**N**	**Minimum**	**Maximum**	**Mean**	**Standard deviation**
SCP					
FACT baseline	24	56	111	82	15.57
FACT time 1	24	62	112	84	14.65
FACT time 2	22	47	112	79	18.2
PROSTATE baseline	24	11	42	29	7.49
PROSTATE time 1	24	14	40	30	8.19
PROSTATE time 2	22	13	43	29	7.11
TOTAL FACT baseline	24	67	146	111	21.28
TOTAL FACT time 1	24	76	152	114	20.83
TOTAL FACT time 2	22	60	155	107	22.65
Control					
FACT baseline	13	57	97	81	11.96
FACT time 1	13	61	101	80	11.76
FACT time 2	13	61	104	82	13.61
PROSTATE baseline	13	16	37	28	6.8
PROSTATE time 1	13	11	39	29	7.26
PROSTATE time 2	13	10	42	29	7.75
TOTAL FACT baseline	13	73	134	108	17.78
TOTAL FACT time 1	13	72	134	109	16.61
TOTAL FACT time 2	13	81	146	111	19.19

* FACT - Functional Assessment of Cancer Therapy - General Measure
PROSTATE - Prostate specific subscale
TOTAL - Combined FACT and PROSTATE scores

home has been extremely helpful to assist in managing the side effects of treatment once patients begin therapy and then to be able to work with the same staff in supporting the patient and family during the final days of life. For those of us involved, a sense of "team" developed along with increased trust in each other's abilities to provide quality patient care.

We expected to see a more significant difference in QOL scores for those patients enrolled in the SCP. Perhaps, the measurement tool was not capable of capturing the changes that we perceived to be taking place. The use of a symptom distress scale, for instance, might have been a useful adjunct to the FACT-P instrument.

Of major concern was the fear that this program would prove to be financially burdensome to one or more of the parties involved. While the SCP actually appeared to be a more cost-effective means of delivering care at this stage, the significant differences in route of administration of therapy and lack of randomization of the sample must be considered in the overall evaluation. Still, the increased length of stay for hospice patients seemed to alleviate some of the "major hit" that hospice programs take when patients are admitted to the hospice benefit during the final "crisis of death."

The concept of a SCP has proven to be worth pursuing further in our initial pilot study. Plans are underway to expand the program to include several disease sites, including one non-cancer terminal illness, and to conduct the next trial as a randomized multi-institutional study. These plans also include more in-depth cost analysis, more comprehensive QOL measurement (including a caregiver burden survey), and general satisfaction surveys at timed intervals.

The need for more patient-focused end-of-life care is real. The SCP program is one way of helping to increase the resources available to patients and families who are entering this stage of illness without causing a negative economic effect on society. The ability to move patients from the therapeutic treatment stage to pure palliation of symptoms in a "transitionless" fashion is certainly a concept that requires further investigation. Our initial findings, however, provide support for expanding and further exploring the potential benefits of this type of program for patients, families, and health care providers alike.

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