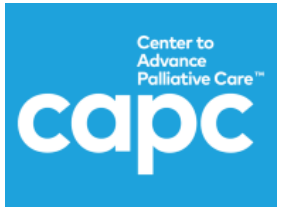
From Early Access to Effective Scaling:

The State of the Science in Innovative Palliative Care for Oncology



July 24, 2024

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State of the Science Speaker

Ramy Sedhom, MD

Medical Director, Oncology and Palliative Care
Penn Medicine Princeton Health

Assistant Professor of Clinical Medicine
University of Pennsylvania

Penn Medicine

From Early Access to Effective Scaling: The State of the Science in Innovative Palliative Care for Oncology

Ramy Sedhom
Clinical Director Medical Oncology & Palliative Medicine at Penn Princeton
Assistant Professor, Hematology & Oncology, Perelman School of Medicine
Associate Director, Program in Geriatric and Supportive Oncology, Penn Center for Cancer Care Innovation (PC3I)

What is Precision Oncology?

“Getting the right cancer treatment to the right patient at the right dose and the right time.”

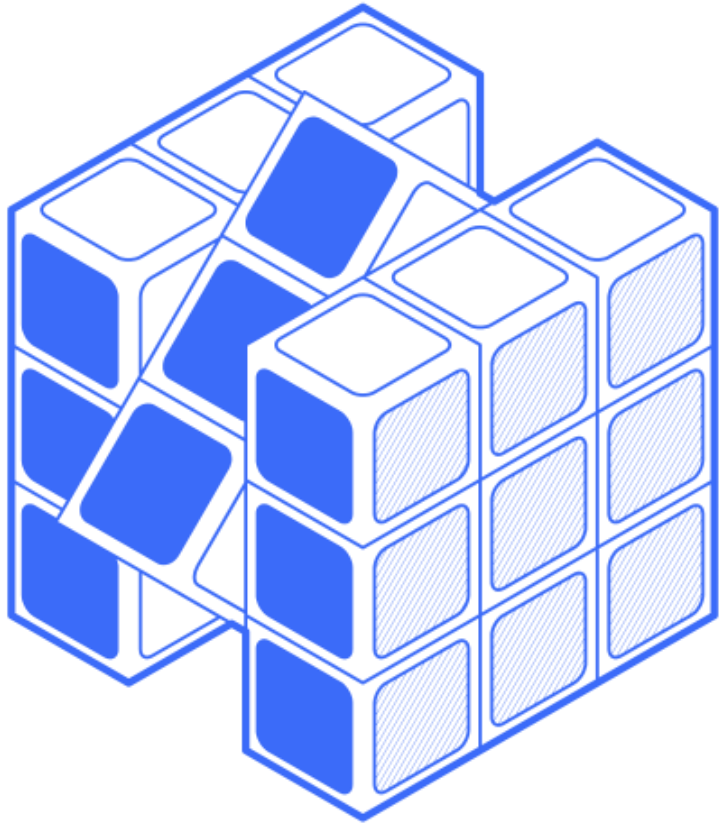
“Precision Palliative Care”

“Getting the right cancer support to the right patient (& caregiver) at the right dose and the right time (and in the right place).”

Sedhom, JCO, 2023

Implementation Barriers for Precision Palliative Care

- Refer appropriately
- Balance supply/demand
- Delivery PC in a practical, patient-centered way
- Recognize evolving need



Take Home Points

- **Abstract 12000; Temel et al: STEPPED PC**
  - Need-based palliative care is non-inferior to time-based

- **Abstract LBA3; Greer et al: REACH PC**
  - Telehealth to scale and improve access to palliative care

ASCO Recommends Early Palliative Care

Palliative Care for Patients With Cancer: ASCO Guideline Update

Justin J. Sanders, MD, MSc[1]; Sarah Temin, MSPH[2]; Arun Ghoshal, MBBS, MD, MRes[3]; Erin R. Alesi, MD[4]; Zipporah Vunoro Ali, MD[5]; Cynthia Chauhan, MSW[6]; James F. Cleary, MD[7]; Andrew S. Epstein, MD[8]; Janice I. Firn, PhD, MSW, HEC-C[9]; Joshua A. Jones, MD, MA[10]; Mark R. Litzow, MD[11]; Debra Lundquist, PhD, RN[12]; Mabel Alejandra Mardones, MD[13]; Ryan David Nipp, MD, MPH[14]; Michael W. Rabow, MD[15]; William E. Rosa, PhD, MBE, APRN[8]; Camilla Zimmermann, MD, PhD, FRCPC[3]; and Betty R. Ferrell, PhD[16]

DOI https://doi.org/10.1200/JCO.24.00542

For *EVERY PATIENT* with Advanced Cancer

- By an interdisciplinary care team
- Concurrent with cancer care
- EARLY 8-12 weeks from diagnosis*
- Caregivers + Phase I

Supply/Demand Mismatch is Real…

1.6 Million Diagnosed

600,000 Die

13,000 Med Oncs

6,000 PC

Active Physician Summary, AAHPM 2017; Kirkwood JCOP 2013

Palliative Care Dose and Dose-Intensity Matter

- In all major RCTs, PC intervention was multidimensional, targeting at least the physical and psychological domains (“Dose”)

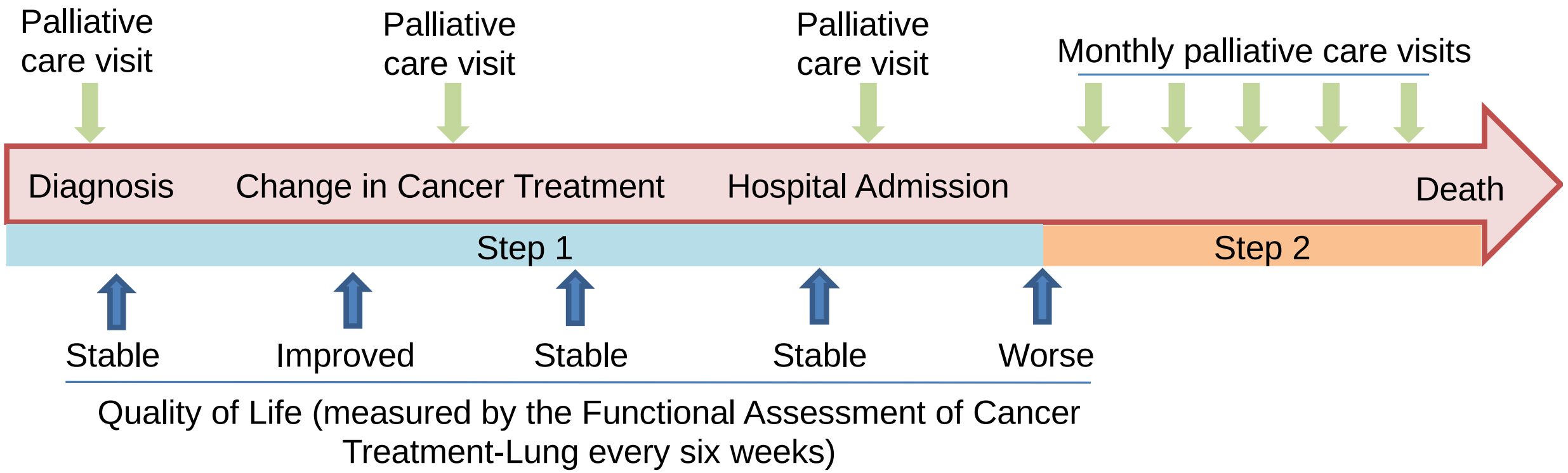
- Patients & families were seen for 1 hour every month, averaging 4 visits over 12 weeks (“Dose intensity”)

Sedhom, Oncologist 2020

Case # 1: Palliative Care Dose-Intensity

- **Your medical oncology group is hiring a multidisciplinary palliative care (PC) team**
- **There is a major supply-demand mismatch between patients who may benefit and available clinician slots**
- **Your rotating fellow reminds you: "In the seminal trials, patients were seen every 4 weeks by PC?!"**
- **How do you tailor care delivery to balance efficacy with sustainability?**

Stepped Care Model of Early Palliative Care (Temel)



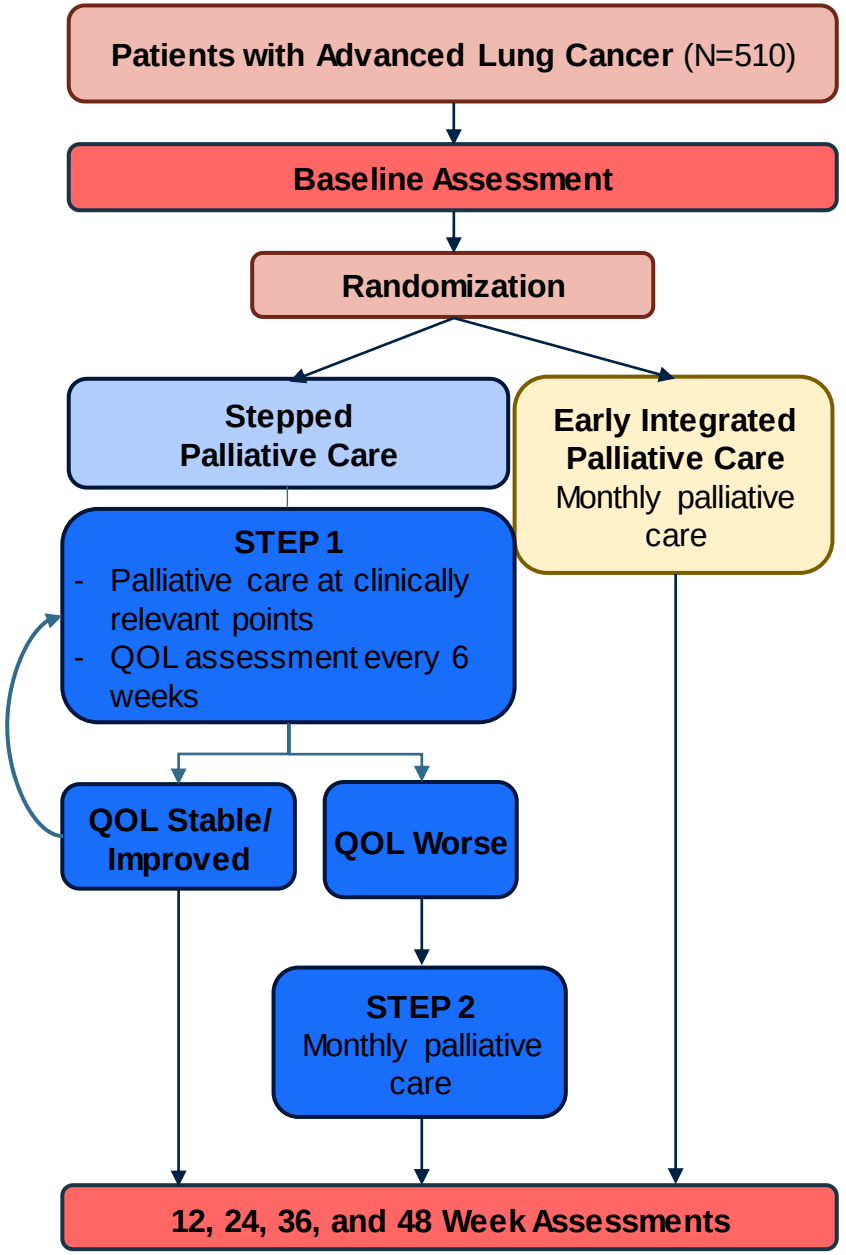
Temel, JAMA, 2024

Key Methods

- Prospective, non-inferiority trial with incurable LUNG cancer
- 3 academic sites (MGH, Duke, Penn)
- ECOG of 0 to 2
- CRC screened patients*, scheduled the PC visit
- QOL survey every 6 weeks for 18 months after enrollment
- Primary outcome: FACT-L QOL measure at 6 months

Study Procedures

- Research assistants reviewed health records to identify eligible patients.
- After clinician approval, research assistant approached and consented patients.
- Patients were randomized 1:1 to study group.
- Research assistants collected patient-reported outcomes throughout the study.
- Enrollment period 2/12/18 – 12/15/22.



Self-Report Measures

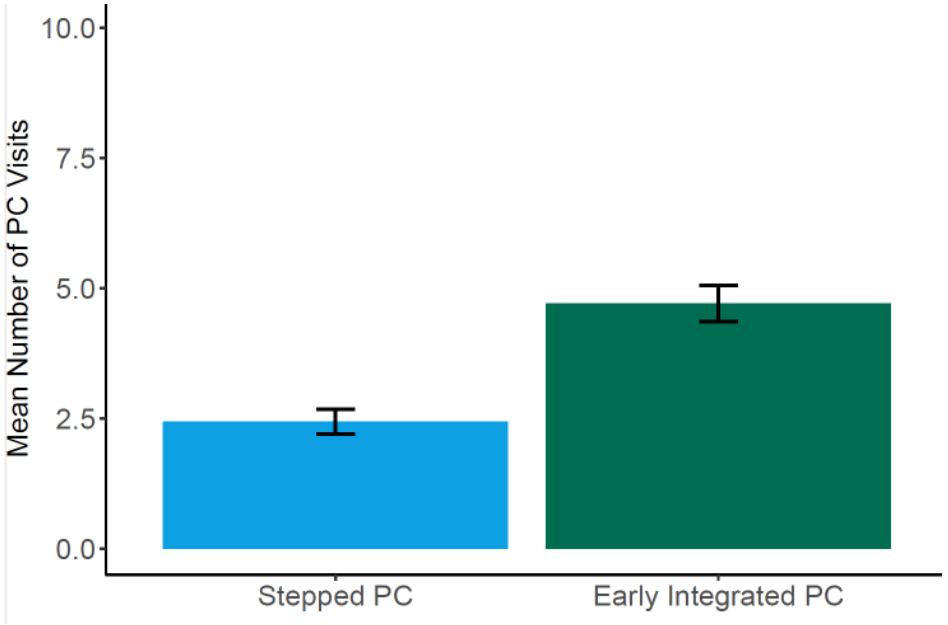
Construct	Tool	Study Outcome
Quality of Life	Functional Assessment of Cancer Therapy – Lung (FACT-L)	Primary
End-of-Life (EOL) Communication	Prognosis and Treatment Perceptions Questionnaire	Secondary
Depression	Patient Health Questionnaire-9 (PHQ-9)	Exploratory
Coping	Brief Cope (Modified)	Exploratory

Participant Characteristics

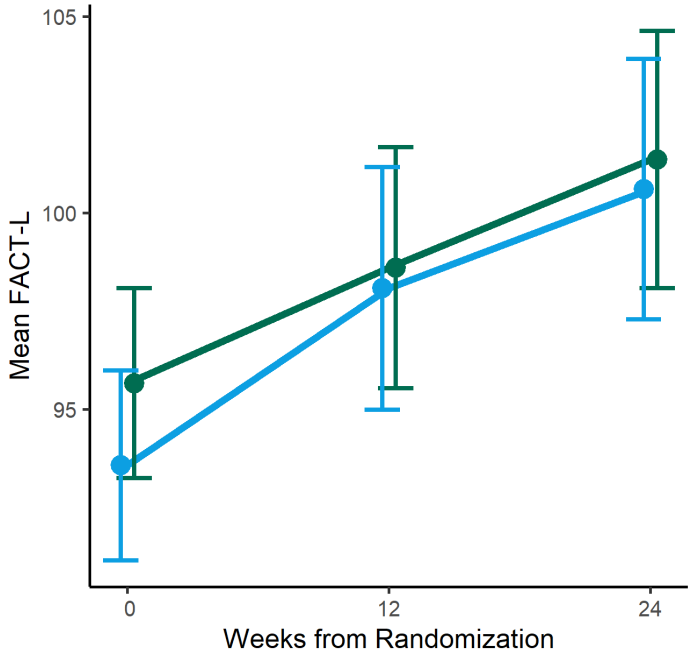
Characteristic	Early Integrated PC (N=257)	Stepped PC (N=250)
Age, Mean Years (SD)	66.1 (11.1)	66.8 (9.2)
Woman	130 (51%)	130 (52%)
American Indian or Alaskan Native	2 (<1%)	2 (<1%)
Asian	11 (4%)	3 (1%)
Black or African American	28 (11%)	29 (12%)
Native Hawaiian or Pacific Islander	0 (0%)	0 (0%)
White	212 (83%)	215 (86%)
Hispanic or Latino/x	5 (2%)	3 (1%)
ECOG PS 0	64 (25%)	61 (24%)
ECOG PS 1	153 (60%)	153 (61%)
ECOC PS 2	40 (16%)	36 (14%)

STEP-PC: Stepping it up

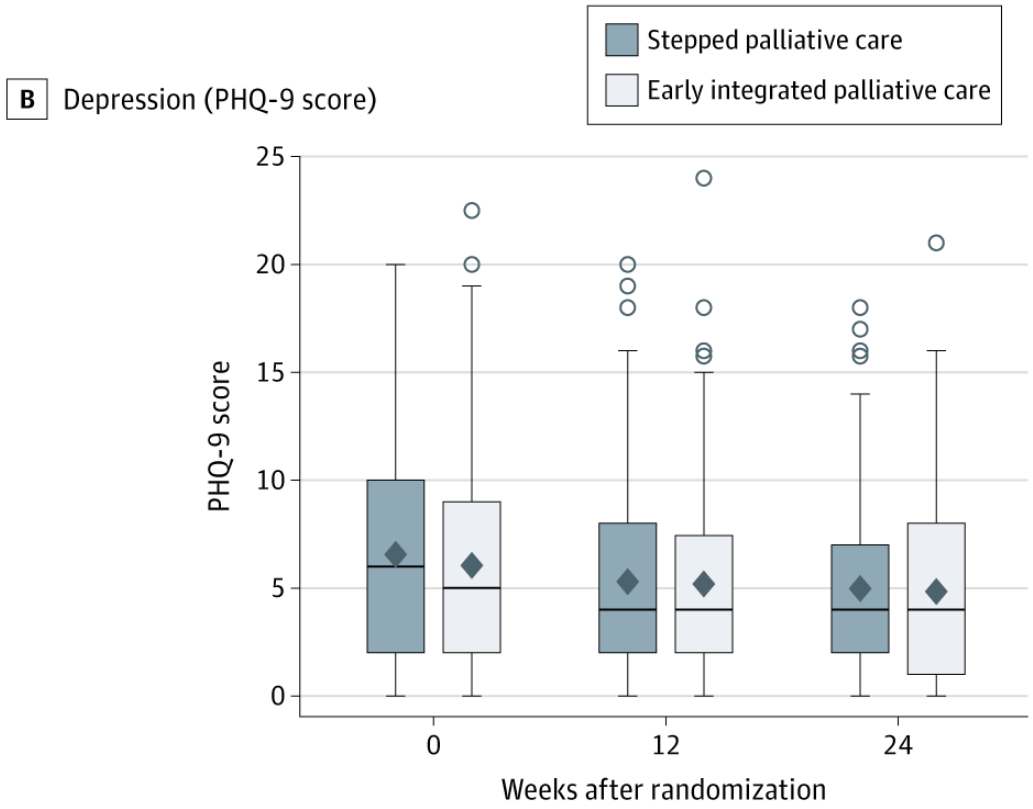
Fewer PC visits by Week 24 (and 48)



Non-inferior QoL at Week 24

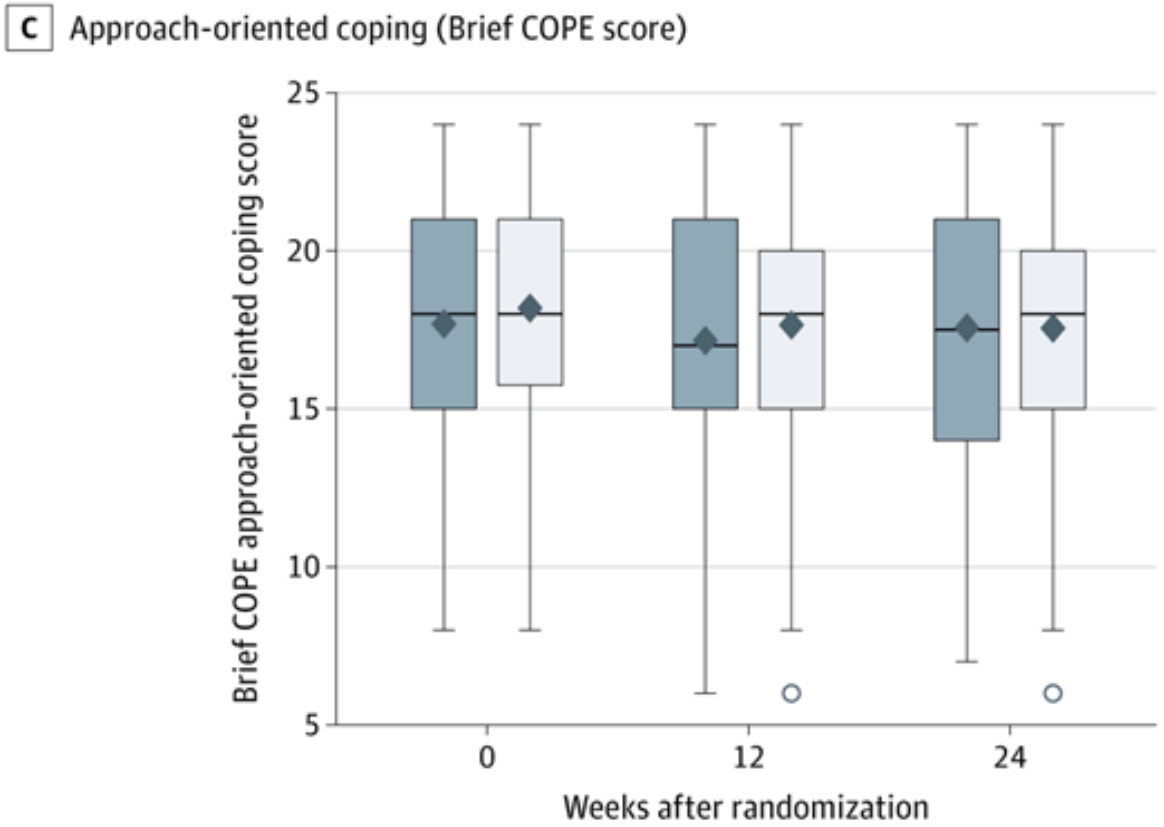


- Consistent EoL discussions
- Similar receipt of hospice
- *Shorter hospice utilization*



No. of patients

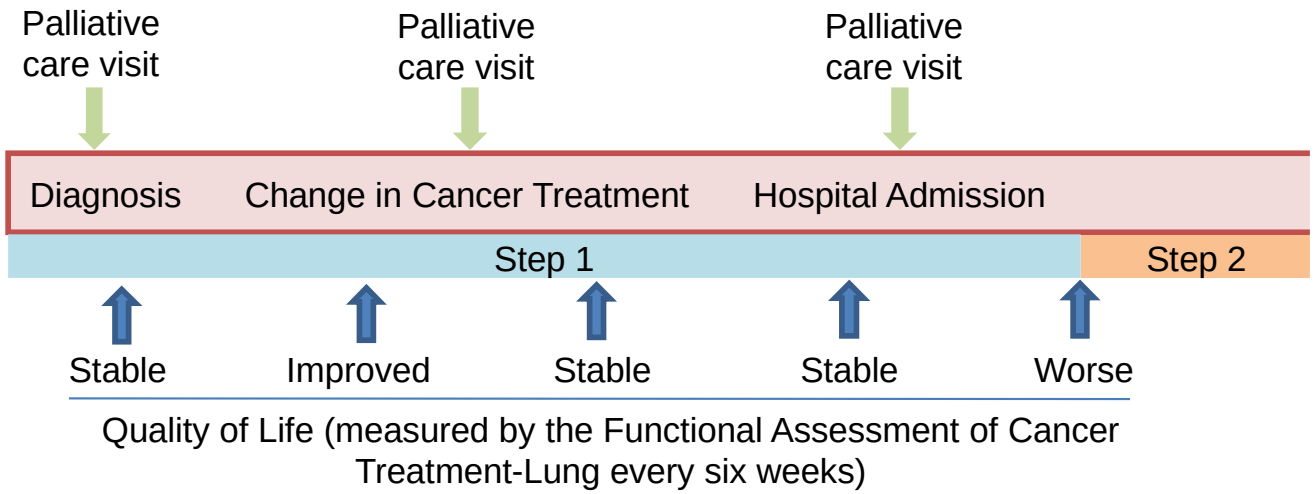
Stepped palliative care	240	171	141
Early integrated palliative care	246	175	144

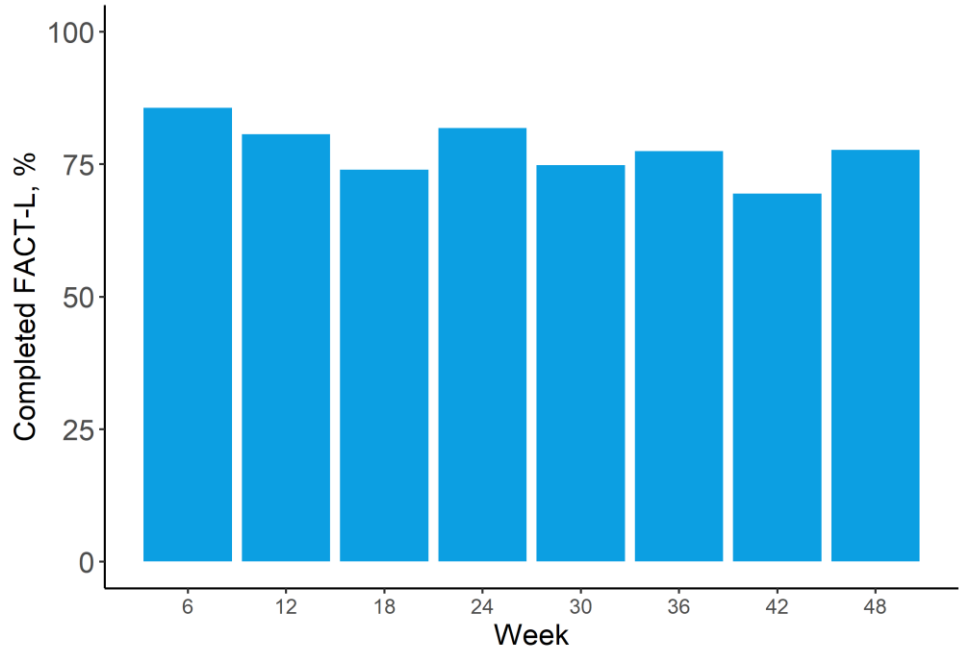


No. of patients

Stepped palliative care	216	159	128
Early integrated palliative care	220	153	127

Completion of FACT-L and Proportion that Stepped Up

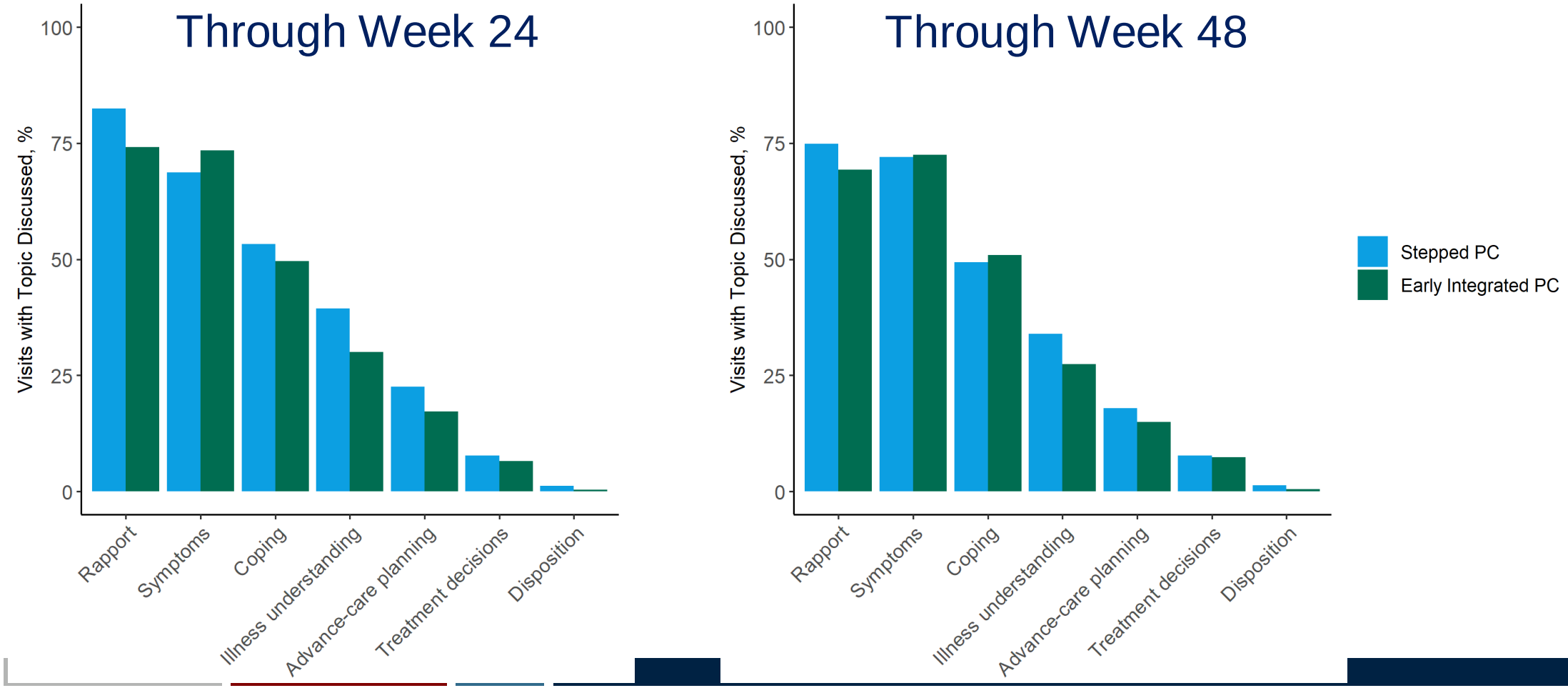




66 (26.4%) of Step 1 patients stepped up to Step 2 by week 24

91 (36.4%) of Step 1 patients stepped up to Step 2 by week 48

Fidelity of Intervention Delivery



STEP-PC: One Step Towards Precision PC

Strengths

- No “strawman” comparison in the control arm
- Appropriately powered for non-inferiority (very small margin)
- Smaller, more “sustainable” dose

Limitations

- Generalizability
  - Lung cancer
  - Well-staffed academic sites w/expert teams
- Scalability
  - Monitoring of patients and PRO

Significance

- Lays groundwork for **timely, need-based** PC
- Establishes a framework for future studies and care delivery models of patient-driven **“precision”** PC *(AI?)*

Case #2:

Your health system has bought out every oncology practice across the state. You have oncologists available at the regional sites, which are over 200 miles away.

You have invested well in a PRO program and symptom management team. You have PC clinicians, but it is challenging to convince them to live in the rural regional sites. You decide to leverage a model leveraging telemedicine visits.

Do patients who opt for PC via telehealth receive inferior care to those who are able to access in person?

Abstract LBA3: Comparative Effectiveness Trial of Early Palliative Care Delivered via Telehealth versus In Person among Patients with Advanced Lung Cancer (Greer; REACH PC)

- PC delivery via video telehealth equivalent to in-person on quality-of-life in patients with advanced lung cancer

- Patients and caregivers in both study groups reported similarly high levels of satisfaction with care

Study Aims and Design

Primary Aim:

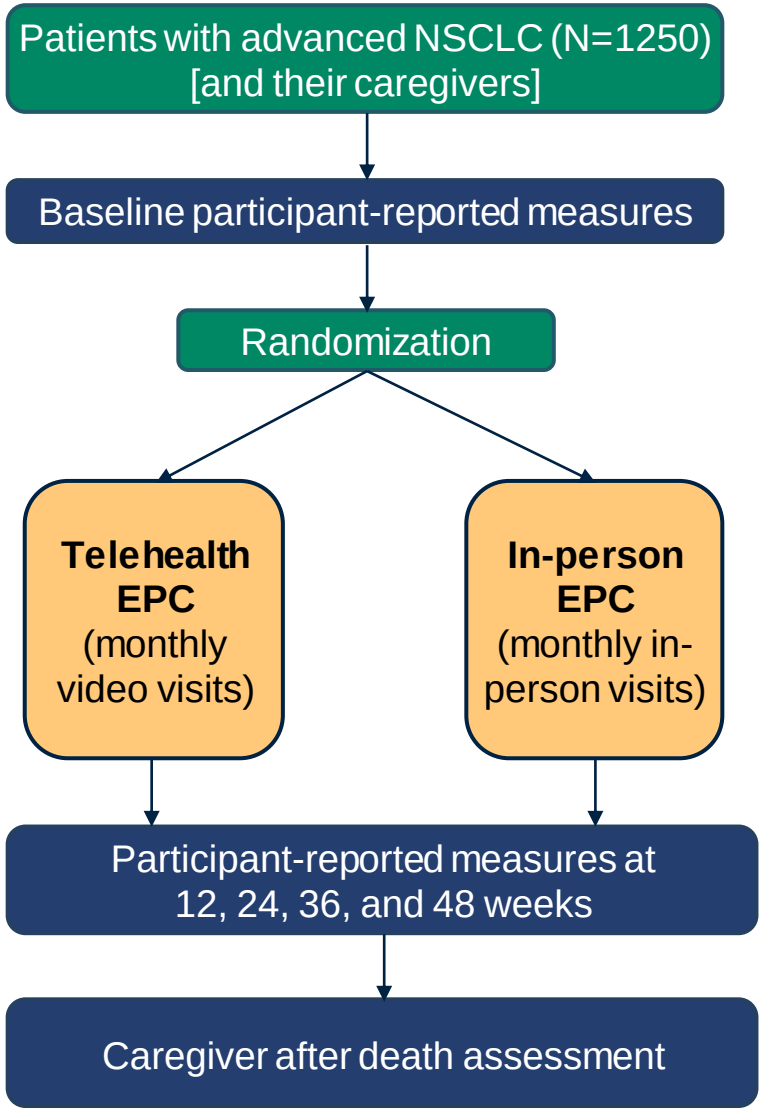
- Equivalence of the effect of delivering EPC via telehealth using secure video versus in-person visits on patient-reported quality of life

Secondary Aims:

- Patient and caregiver satisfaction with care
- Caregiver attendance at EPC visits

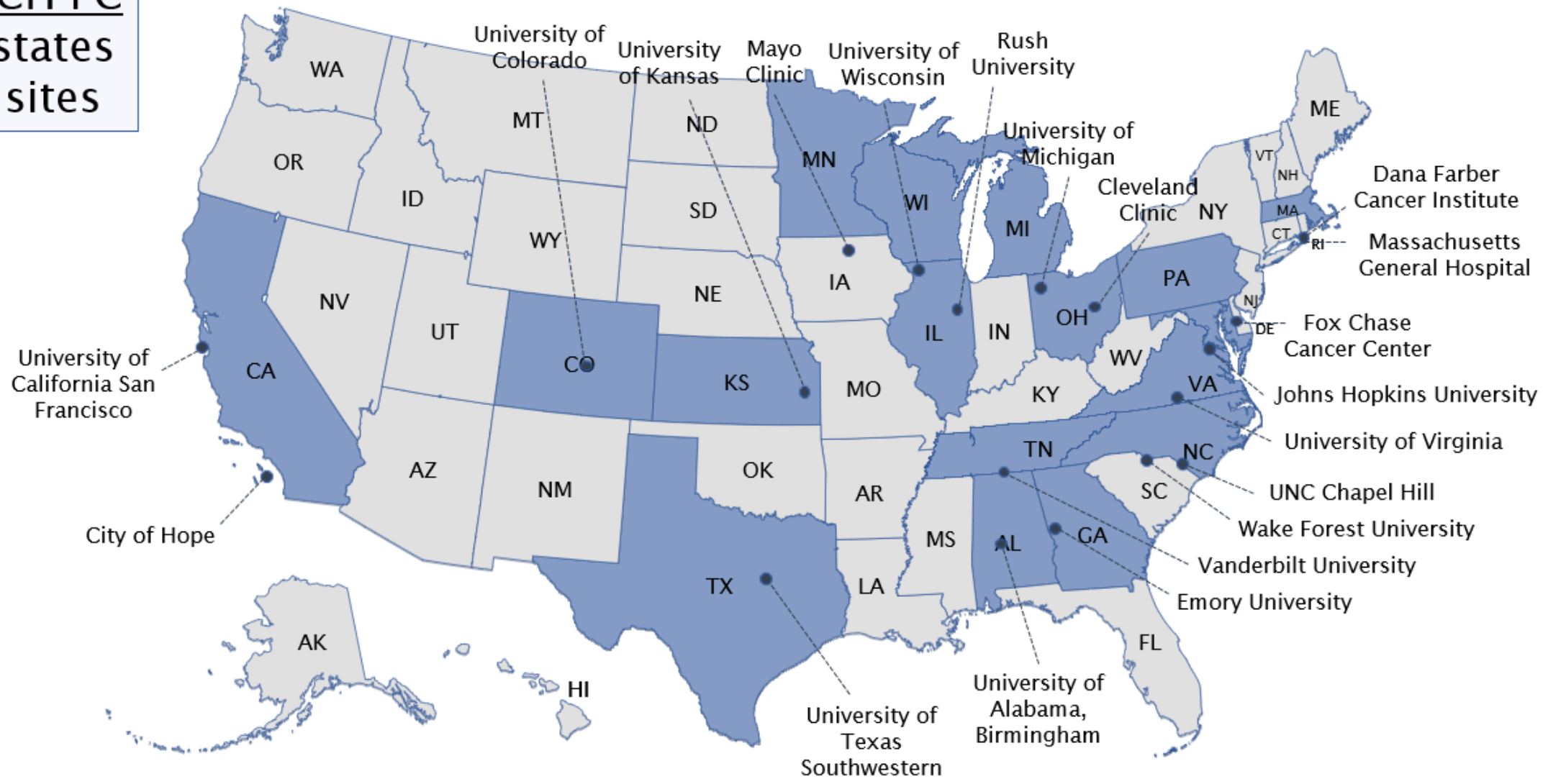
Exploratory Aims:

- Patient-reported mood symptoms and perceptions of prognosis/goals of treatment
- Caregiver-reported quality of life, mood symptoms, and perceptions of prognosis/goals of treatment



Technology provided: Patients received a study-issued tablet computer if needed

REACH PC
17 states
20 sites



Primary and Secondary Outcome Measures

Construct	Participant	Tool	Scoring	Timing
Quality of Life	Patient	Functional Assessment of Cancer Therapy – Lung (FACT-L)	Range: 0-136, higher scores indicate better quality of life	Every 12 weeks
Satisfaction with Care	Patient & Caregiver	Satisfaction and Care Delivery Questionnaire	Range: 0-52, higher scores indicate greater satisfaction	Every 12 weeks
Participation in EPC visits	Caregiver	Palliative care clinician visit summary form	Yes/No caregiver attended visit	Every EPC visit

Exploratory Outcomes

Construct	Participant	Tool	Scoring	Timing
Mood Symptoms	Patient & Caregiver	Hospital Anxiety & Depression Scale (HADS)	Range: 0-21 on each subscale, higher scores indicate greater symptoms	Every 12 weeks
Perceptions of Prognosis	Patient & Caregiver	Prognosis & Treatment Perceptions Questionnaire	Dichotomous (Yes/No): • Cancer curable • Goal of tx to cure cancer	Every 12 weeks
Quality of Life	Caregiver	Caregiver Oncology Quality of Life Questionnaire (CARGOQOL)	Range: 0-100, higher scores indicate better quality of life	Every 12 weeks

Patient Socio-demographic Characteristics

Characteristic	Video Visit EPC (N=633)	In-Person EPC (N=617)
Age, Mean Years (SD)	65.45 (10.93)	65.51 (10.64)
Woman	356 (56.2)	318 (51.7)
Man	277 (43.8)	297 (48.3)
Missing	0	2
American Indian/Alaskan Native	4 (0.6)	4 (0.7)
Asian	32 (5.1)	32 (5.2)
African American or Black	57 (9.0)	72 (11.8)
Native Hawaiian or Pacific Islander	2 (0.3)	4 (0.7)
White	524 (83.2)	502 (82.2)
Other	21 (3.3)	10 (1.6)
Missing	3	6
Hispanic or Latino/x	29 (4.6)	30 (5.0)
Not Hispanic or Latino/x	596 (95.4)	575 (95.0)
Missing	8	12
Married/Partnered	420 (66.7)	409 (66.8)
Single/Divorced/Widowed/Other	210 (33.3)	203 (32.2)
Missing	3	5

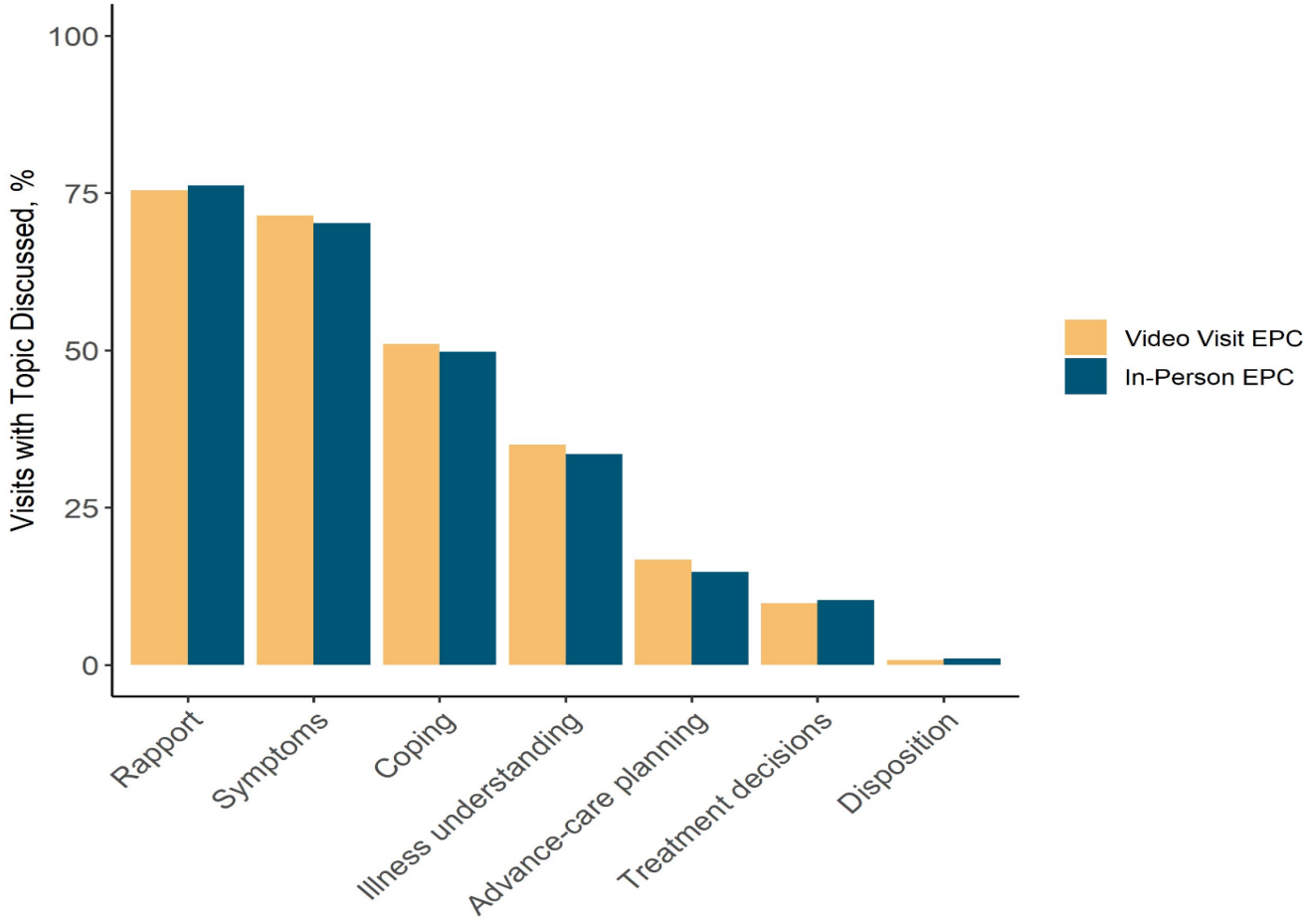
Disease Characteristics

Characteristic	Video Visit EPC (N=633)	In-Person EPC (N=617)
ECOG PS 0	158 (25.0)	143 (23.2)
ECOG PS 1	345 (54.5)	342 (55.4)
ECOG PS 2	111 (17.5)	113 (18.3)
ECOG PS 3	19 (3.0)	19 (3.1)
ALK	28 (4.4)	26 (4.2)
EGFR	113 (17.9)	102 (16.5)
ROS	6 (0.9)	0 (0)
RET	11 (1.7)	7 (1.1)
Other or no mutation	475 (75.0)	482 (78.1)
Platinum-based chemotherapy	257 (40.6)	277 (44.9)
Radiation	138 (21.8)	123 (19.9)
Oral targeted therapy	126 (19.9)	114 (18.5)
Immunotherapy alone	93 (14.7)	72 (11.7)
Single agent IV chemotherapy	7 (1.1)	8 (1.3)
Concurrent chemo and radiation	4 (0.6)	5 (0.8)
No treatment	8 (1.3)	18 (2.9)

Intervention Delivery & Fidelity

Answered Important Questions:

1. **Does telehealth allow similar conversation (dose) of PC delivery?**
   Yes

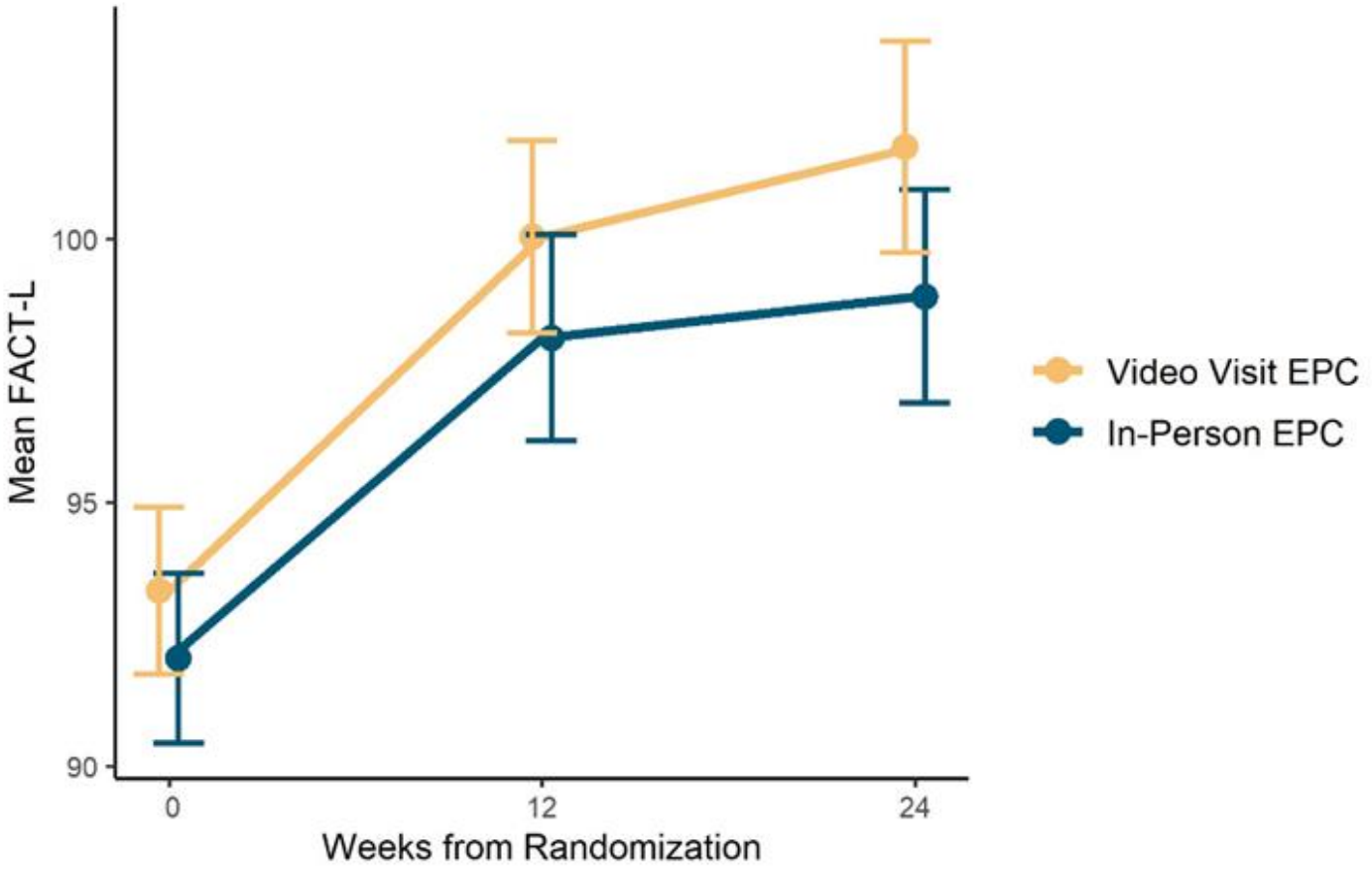


Primary Outcome: Patient Quality of Life

2. Does telehealth compromise QOL outcomes from PC intervention? ***No***

3. Does telehealth compromise quality of care received?

No difference in:
patient and caregiver mood
prognostic perceptions,
caregiver quality of life or satisfaction.



Secondary Outcomes at Week 24

Outcome Measure	Video Visit EPC Estimated Mean/Proportion	In-Person EPC Estimated Mean/Proportion	Difference 95% (CI)	P
Satisfaction with Care				
Patient report, mean	41.34	41.00	0.34 (-0.99, 1.68)	>0.99
Caregiver report, mean	37.18	36.79	0.39 (-1.53, 2.31)	>0.99
Caregiver Attendance at PC Visits				
proportion	0.37	0.50	-0.13 (-0.18, -0.09)	<0.001

REACH-PC: Practical Points

Every participant was initially seen ***early***

(within 12 weeks)

Initial PC encounters were

in person

Video visits

(not telephone)

REACH PC: Remaining Questions

- When should video visits be the preferred modality for delivering EPC?
- When is an in-person visit clinically indicated?
- What other supports are necessary to deliver equitably EPC with telehealth?
- How can we optimize the experiences of patients, caregivers, and clinicians using these care modalities?
- How do intervention effects vary based on:
  - Socio-demographic variables?
  - Technological experience?
  - Presence of a caregiver?

Take Home Points

- **Abstract 12000; Temel et al: STEPPED PC**
  - Need-based palliative care is non-inferior to time-based

- **Abstract LBA3; Greer et al: REACH PC**
  - Telehealth to scale and improve access to palliative care

"To cure sometimes, to relieve often, and to comfort always is all that may reasonably be expected of medicine."

Hippocrates

Panelists

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Medical Director, Palliative Care
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Associate Professor
Oregon Health and Science University
Knight Cancer Institute

Thank You!

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