Palliative Care And Oncology: Opportunities and Challenges.

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Objectives

1. Recognizing the problem:
   • Care is not optimal, and we are partly to blame.
   • Value is missing in some of our spending
   • Costs are rising at an unsustainable rate

2. Palliative care alongside oncology offers practical ways to improve health, quality of care, and value
   • What are the benefits of concurrent care?
   • What does PC do alongside ONC?
   • Having difficult conversations.
   • How can we integrate these best practices?
Value: The death rate from cancer is changing but not fast compared to other medical care – and use of the same money.

From Jemal, A. et al. Death Rates for Cancer and Heart Disease for Ages Younger than 85 Years and 85 Years and Older, 1975-2005
There is unwarranted practice variation in chemo at the end of life, up to >12%. Morden N, 2011

There are opportunities to change our practice

Medicare Patients, Unadjusted Cancer Care Measures, By Hospital Characteristics, Morden 2011

<table>
<thead>
<tr>
<th>Measure</th>
<th>All</th>
<th>NCCN cancer centers</th>
<th>Non-NCCN NCI cancer centers</th>
<th>Academic hospitals</th>
<th>Community hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death in hospital (%)</td>
<td>30.2</td>
<td>32.6</td>
<td>32.4</td>
<td>33.8</td>
<td>29.7</td>
</tr>
<tr>
<td>Hospice use, last month of life (%)</td>
<td>53.8</td>
<td>53.4</td>
<td>52.4</td>
<td>50.3</td>
<td>54.2</td>
</tr>
<tr>
<td>Days in hospice, last month of life (per decedent)</td>
<td>8.4</td>
<td>8.6</td>
<td>8.1</td>
<td>7.6</td>
<td>8.5</td>
</tr>
<tr>
<td>Hospice initiated, last 3 days of life (%)</td>
<td>8.5</td>
<td>7.1</td>
<td>7.9</td>
<td>8.3</td>
<td>8.6</td>
</tr>
<tr>
<td>Hospitalized, last month of life (%)</td>
<td>64.9</td>
<td>60.2</td>
<td>61.7</td>
<td>64.4</td>
<td>65.1</td>
</tr>
<tr>
<td>Days in hospital, last month of life (per decedent)</td>
<td>5.3</td>
<td>5.6</td>
<td>5.6</td>
<td>5.9</td>
<td>5.3</td>
</tr>
<tr>
<td>ICU use, last month of life (%)</td>
<td>24.7</td>
<td>23.3</td>
<td>26.3</td>
<td>26</td>
<td>24.6</td>
</tr>
</tbody>
</table>

### Biggest Concerns for Patients with Serious Illness

<table>
<thead>
<tr>
<th>Concern</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors might not provide all of the treatment options or choices available</td>
<td>58%</td>
</tr>
<tr>
<td>Doctors might not talk and share information with each other</td>
<td>55%</td>
</tr>
<tr>
<td>Doctors might not choose the best treatment option for a seriously ill patient’s medical condition</td>
<td>54%</td>
</tr>
<tr>
<td>Patients with serious illness and their families leave a doctor’s office or hospital feeling unsure about what they are supposed to do when they get home</td>
<td>51%</td>
</tr>
<tr>
<td>Doctors do not spend enough time talking with and listening to patients and their families</td>
<td>50%</td>
</tr>
</tbody>
</table>

Source: ACS 2011 Public Opinion Research on Palliative Care
Medical care costs 2-fold more in the US than any other country

OECD Health Data 2011
Cancer care costs are rising exponentially
- $173 billion at 2% growth rate

Insurance premiums are rising and fewer people can afford them

- Insurance premiums *doubled*
- Patient responsibility doubled
- 9% increase *last year*

Medical care cost increases are unsustainable, but some of them are under our control and fixable.

• As much as 30% of care is not evidence-based and does not add value. (Cong Budget Office.)

• About 25% of all Medicare funds are spent in the last year of life, and over 9% (over $50 billion) in the last MONTH of life (Riley and Lubitz, *Health Services Research* 45.2 (2010): 565-76.)

• Much of the pattern of care is under our control including imaging, chemotherapy choices, surveillance after curative care, integration of palliative care, use of hospice, and avoiding chemotherapy and hospitalization near the end of life.
Bending the Cost Curve in Cancer Care

Thomas J. Smith, M.D., and Bruce E. Hillner, M.D.

Annual direct costs for cancer care are projected to rise — from $104 billion in 2006\(^1\) to over $173 billion in 2020 and beyond.\(^2\) This increase has been driven by a dramatic rise in both the cost of therapy\(^3\) and the extent of care.\(^4\) In the United States, the sales of anticancer drugs are now second only to those of drugs for heart disease, and 70% of these sales come from products introduced in the past 10 years. Most new molecules are priced at $5,000 per month or more,\(^5\) with some marketed for $25,000 or more,\(^6\) and the market for targeted therapies is expanding. It is easy to see why this is so.\(^7\) But we should also recognize that much of the expensive care does not benefit patients.\(^8\) For example, there is no benefit to surveillance testing with serum tumor markers or imaging for most cancers, including those of the pancreas, ovary,\(^9\) or lung,\(^10\) yet these tests are commonly used in many settings. In breast cancer, randomized studies showed that scheduled (not symptom-guided) imaging does not detect curable recurrences or alter survival. Twenty years ago, the estimated cost of wasted medical resources in the United States for patients with breast cancer was $1 bil-
Table 1: Five changes in oncologist behavior that will bend the cancer cost curve

1. Target surveillance procedures to those where there is proof or high likelihood of benefit.
2. For most solid tumors limit 2\(^{nd}\) line and for all 3\(^{rd}\) line for metastatic treatments to sequential mono-therapies.
3. For patients with cancer that has progressed on treatment limit future active therapy to patients with good performance status.
4. Dose reduction can replace white-cell stimulating factors in metastatic solid cancers.
5. For patients not responding to three consecutive regimens further cancer directed therapy should be limited to clinical trials.

Table 2: Five Attitudes that require acknowledgement and change

1. Acknowledge that we drive the costs of care by what we do and don’t do.
2. Both doctors and patients need more realistic expectations.
3. Realign compensation and rebalance cognitive services.
5. Accept the need for cost-effectiveness analysis and some limits on care.

Ground Rules

1. Everything is on the table for discussion.
2. Accept data where it exists.
3. Clinical trials are exempt.
4. Curative/adjuvant care is exempt.
5. Recognize that this is going to be painful.
   • Supportive care and chemo “cost” is a main source of oncology income.
   • Hospitalizations for cancer patients are one of the main sources of hospital income.
   • Pharmaceutical companies must profit from drugs.
   • Doctors and patients do not like to have difficult discussions.
   • Not everyone can get everything they want.
Why palliative care?

• It is good and sometimes better clinical care.
• It may allow people to live longer, not the opposite.
• Hospitals are full, often of dying people who don’t really want to be there.
• We need some rational ways to improve care at a cost we can afford.
• *PC offers the trifecta of better quality of life, and better quality of care, at less cost.*
• *There are ways to give better and more information.*
The American Society of Clinical Oncology now recommends concurrent palliative care early in the course of illness for any patient with metastatic cancer and/or high symptom burden.
Objectives

1. Recognizing the problem:
   2. Palliative care alongside oncology offers practical ways to improve health, quality of care, and value
      • What are the benefits of concurrent care?
      • What does PC do alongside ONC?
      • Having difficult conversations.
      • How can we integrate these best practices?
Cancer patient symptoms are improved by PC consultation or transfer

Memorial Symptom Assessment Scale, Condensed; 30 pts with at least 2 consult days and symptoms > 0. Khatcheressian J, et al. Oncology September 2005
ESAS scale 0-10; Elsayem A, et al. JCO 2004
Palliative care in addition to usual oncology care allowed lung cancer patients to live almost 3 months longer than those who got usual oncology care.


- Longer and better survival
  - Better understanding of prognosis
  - And goals of care
  - Less IV chemo in last 60 days
  - Less aggressive end of life care
  - More and longer use of hospice
Palliative care in addition to usual oncology care allowed lung cancer patients to have much better quality of life (FACT) and less anxiety and depression.

People who use hospice for even one day live longer.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Added survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>+ 81 days, $P = 0.0540$</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>+ 39 days, $P &lt; 0.0001$</td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td>+ 21 days, $P = 0.0102$</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>+ 33 days, $P = 0.0792$</td>
</tr>
<tr>
<td>Breast</td>
<td>+ 12 days, $P = 0.6136$</td>
</tr>
<tr>
<td>Prostate</td>
<td>+ 4 days, $P = 0.8266$</td>
</tr>
</tbody>
</table>

Final Days

Unlikely Way to Cut Hospital Costs:
Comfort the Dying

$7000 less in last 5 days of life if PC involved.
With equal survival.
And better symptom control.

Care, Not Cure

Average cost for terminally ill patients in palliative and nonpalliative programs during their final five days at one hospital

<table>
<thead>
<tr>
<th>Service</th>
<th>NON-PCU</th>
<th>PCU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs and chemotherapy</td>
<td>$2,267</td>
<td>$511</td>
</tr>
<tr>
<td>Lab</td>
<td>1,134</td>
<td>56</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>615</td>
<td>29</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>1,821</td>
<td>731</td>
</tr>
<tr>
<td>Room &amp; nursing</td>
<td>4,330</td>
<td>3,708</td>
</tr>
<tr>
<td>Other</td>
<td>2,152</td>
<td>278</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$12,319</strong></td>
<td><strong>$5,313</strong></td>
</tr>
</tbody>
</table>

Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002.

Source: Virginia Commonwealth University medical center.
Kaiser Permanente System *randomized* clinical trials of IDPCTs
- equal survival
- better communication and quality of care
- **Net savings of $5-7000/person, now standard in all KP markets.**
Palliative care in addition to usual oncology care allowed lung cancer patients to live almost 3 months longer than those who got usual oncology care.


- Longer and better survival
  - Better understanding of prognosis
  - Less IV chemo in last 60 days
  - Less aggressive end of life care
  - More and longer use of hospice
  - $2000 per person savings to insurers and society
Every study to date shows significant savings – in addition to better care.
What is the source of the cost savings?

• Avoided hospitalizations.
• Avoided ICU days.
• Less chemotherapy, imaging, and complications at the end of life.
• If palliative care consults, the chances of appropriate discharge to hospice rises from 1% to 30%.
• Hospice saves about $2300 per person in the last month of life
Palliative care is possible, practical, reimbursable, and should pay for itself, mostly.

Table 3. Median Time for Components of Initial Outpatient Palliative Care Clinic Visit (Temel et al, JPM 2011)

<table>
<thead>
<tr>
<th>PC consultation</th>
<th>Median time (range) minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total time</td>
<td>55</td>
</tr>
<tr>
<td>Illness understanding</td>
<td>10</td>
</tr>
<tr>
<td>Symptom management</td>
<td>20</td>
</tr>
<tr>
<td>Decision making</td>
<td>0</td>
</tr>
<tr>
<td>Coping</td>
<td>15</td>
</tr>
<tr>
<td>Planning and referrals</td>
<td>0</td>
</tr>
</tbody>
</table>

Number of visits 3-4 TOTAL in 3 months

Reimbursement DEPENDS
- Who does the service (MD, NP, MSW)
- How we bill – extended service codes, time, counseling
- Standardized forms
- Efficiency
So, how do we do this?

1. Recognize that we don’t do this.
2. Learn key concepts about communication.
1. Recognize that we don’t do this.

- 60% of us prefer not to have “hard conversations” (DNR, AMDs, hospice) until “there are no more treatment options left”. Keating NL, et al. Cancer. 2010
- Half of all lung cancer patients have had NO discussion with any of their doctors about hospice 2 months before they die. Huskamp HA, et al. Arch Intern Med. 2009
2. Some key concepts, and key misconceptions.

1. People DO want this information.
2. It won’t make people depressed.
3. It won’t take away their hope.
4. It won’t make them die sooner.
5. We CAN give realistic forecasts for survival.
6. It is always culturally appropriate to ask “How much do you want to know about your illness?”

The main reason we don’t do this is US.

1. There are good and simple ways for us to learn how to do this. (EPEC, EPEC-O, ELNEC, Oncotalk.)
2. There may be ways to learn how to integrate and survive this. Krasner et al, JAMA 2009 - mindfulness.

2. Always do a symptom assessment – and have standard algorithms to treat the problems.

What can I do? Recommendations for responding to issues identified by patient-reported outcomes assessments used in clinical practice.
2. Always do a symptom assessment – and have standard algorithms to treat the problems.

<table>
<thead>
<tr>
<th>MSAS-C: 0=none, 1=a little bit, 2=somewhat, 3=quite a lot, 4=very much, 7=refused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported by:        Patient   Caregiver   RN   MD</td>
</tr>
<tr>
<td>Unable to respond:  Yes    No</td>
</tr>
<tr>
<td>Delirious:           Yes    No</td>
</tr>
</tbody>
</table>

[Note: Use haloperidol or Seroquel (Quetiapine), NOT BENZODIAZEPINE.]

<table>
<thead>
<tr>
<th></th>
<th>Pain</th>
<th>Tiredness</th>
<th>Nausea</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Drowsiness</th>
<th>Anorexia</th>
<th>Constipation</th>
<th>Dyspnea</th>
<th>Secretions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
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<td>3</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>Dexameth</td>
<td>Ginseng</td>
<td></td>
<td>Anti-D's</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Methyl-naltrexone</td>
</tr>
<tr>
<td></td>
<td>Ginseng</td>
<td></td>
<td></td>
<td>Methylphen Ketamine – single dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Ginger 0.5-1.0 g/day. Ryan et al. Support Care Cancer. 2012
2. Always do a religious/spiritual assessment – and get some help.

<table>
<thead>
<tr>
<th>Item</th>
<th>Question for health care practitioner to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Do you consider yourself to be spiritual or religious?</td>
</tr>
<tr>
<td>I</td>
<td>Do you consider yourself to be a person of faith? Where do you find your strength? How important is this to you?</td>
</tr>
<tr>
<td>C</td>
<td>Are you a member of a faith community?</td>
</tr>
<tr>
<td>A</td>
<td>How would you like your health care team to address these issues?</td>
</tr>
</tbody>
</table>

Is religion or spirituality important to you? Would you like to see a chaplain?

**FICA Spiritual History Tool**
www.gwumc.edu/gwish/clinical/fica.cfm

Generates referral to Pastoral Care
2. Always do a prognosis assessment.

<table>
<thead>
<tr>
<th>%</th>
<th>Ambulation</th>
<th>Activity Level Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Level of Consciousness</th>
<th>Estimated Median Survival in Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Full</td>
<td>Normal <strong>No Disease</strong></td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
<td>(a) 100</td>
</tr>
<tr>
<td>90</td>
<td>Full</td>
<td>Normal <strong>Some Disease</strong></td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
<td>(b) N/A</td>
</tr>
<tr>
<td>80</td>
<td>Full</td>
<td>Normal with Effort <strong>Some Disease</strong></td>
<td>Full</td>
<td>Normal or Reduced</td>
<td>Full</td>
<td>(c) N/A</td>
</tr>
<tr>
<td>70</td>
<td>Reduced</td>
<td>Can't do normal job or work <strong>Some Disease</strong></td>
<td>Full</td>
<td>As above</td>
<td>Full</td>
<td>145</td>
</tr>
<tr>
<td>60</td>
<td>Reduced</td>
<td>Can't do hobbies or housework <strong>Significant Disease</strong></td>
<td>Occasional Assistance Needed</td>
<td>As above</td>
<td>Full or Confusion</td>
<td>29 4</td>
</tr>
<tr>
<td>50</td>
<td>Mainly sit/lie</td>
<td>Can't do any work <strong>Extensive Disease</strong></td>
<td>Considerable Assistance Needed</td>
<td>As above</td>
<td>Full or Confusion</td>
<td>30 11</td>
</tr>
<tr>
<td>40</td>
<td>Mainly in Bed</td>
<td>As above</td>
<td>Mainly Assistance</td>
<td>As above</td>
<td>Full or Drowsy or Confusion</td>
<td>18 8</td>
</tr>
<tr>
<td>30</td>
<td>Bed Bound</td>
<td>As above</td>
<td>Total Care</td>
<td>Reduced</td>
<td>As above</td>
<td>8 5</td>
</tr>
<tr>
<td>20</td>
<td>Bed Bound</td>
<td>As above</td>
<td>As above</td>
<td>Minimal</td>
<td>As above</td>
<td>4 2</td>
</tr>
<tr>
<td>10</td>
<td>Bed Bound</td>
<td>As above</td>
<td>As above</td>
<td>Mouth Care Only</td>
<td>Drowsy or Coma</td>
<td>1 1</td>
</tr>
<tr>
<td>0</td>
<td>Death</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*# 125 The Palliative Performance Scale (PPS) - EPERC - Medical ... [Link](www.eperc.mcw.edu)*
Have a referral script. Write it down at diagnosis, revisit at each transition, have that hospice information visit 3-6 months before death.

- Palliative care is about improving quality of life, providing an extra layer of support, and having a team focus on your care.
- Hospice is about improving quality of life, providing an extra layer of support, and having a team focus on your care. Hospice is not a place you go (usually) but specially trained nurses who can come to your house to fix pain and other symptoms, keep you up and going. We will still be involved in your care.

- Establish best practices, just like for curative R-CHOP.
- Identify people with average survival less than 6 months.
- Not hard, and has not changed. Saltpeter et al. JPM 2012)
  - Performance status 2 and declining.
  - Anorexia, hypercalcemia, any effusion.
  - Metastatic cancer progressed on one line of treatment.
ASCO “Choosing Wisely” gives us some practical helps:
1. ECOG PS 2 or higher “Did this person walk into the clinic?”
2. 2\textsuperscript{nd} or 3\textsuperscript{rd} line chemo for MOST cancers: breast, colon, lung, prostate, pancreas, etc.
3. Set guidelines like the U.S. Oncology pathways that preserve survival, reduce cost by 35% in lung cancer by evidence-based choices, better communication.

3. Change our standards of care to incorporate national guidelines and best practices about palliative care.

- Insist on hospice referral with 3-6 months to live (not 2 weeks)
- Audit referrals with < 14 days, give feedback to physician
- Communication: Appoint someone in the office to discuss ADs, DPMA, hospice in first 3 visits – and document.
- Limit to 3 rounds of chemo and good PS – follow our own guidelines. Give feedback by doctor.

Every guideline should have a set point to add PC, and stop chemo based on evidence.
QOPI works to reduce overuse: Oncologists who receive feedback give less chemo at the end of life.
Blayney D, et al. JCO 2009

% solid tumor pts getting chemo last 14 days of life

QOPI Instituted; doctors made aware of problem

Spring 06  Fall 06  Spring 07  QOPI Target Goal

[Bar chart showing percentage of solid tumor patients receiving chemotherapy in different periods]
Pegfilgrastim use can be cut by 75% in low risk situations with peer to peer review. Reduces PMPM by ~75¢

The probability of receiving chemotherapy in last 14 days of life was reduced after Medicare Payment Reform.

Colla C H et al. JOP 2012;8:e6s-e13s
4. Use Expanded Access Programs that allow hospice/palliative care alongside usual care.

_Aetna’s Compassionate Care Program maintained survival but doubled hospice use._ (Spettell CM, et al. J Palliat Med. 2009 Sep;12(9):827-32.)

**Hospice use increased**

- Enrollees doubled from 31% to 72%, p<0.0001
- Hospice days increased 15.9 to 28.6, p<.0001

IP days reduced
- Medicare 15,217 down to 2309 per thousand members
  - @ $2500/day

- ICU days reduced
- Medicare CM Group; 9840 down to 1189 per thousand members
  - @ $3500/day

- Overall, at least 22% savings in 40 days of life.
5. Identify hospice eligible patients earlier
- better care with that extra layer of support
- fewer readmissions
- less cost per readmission
We can recognize hospice-eligible patients, prevent readmissions, honor choices, and save money.

U of Iowa Hospitals. 688 in-hospital deaths. 209 decedents had preceding admission; NHPCO, National Hospice and Palliative Care Organization worksheets.

- 60% eligible for hospice on PENULTIMATE admission
- Only 14% had any discussion of hospice, despite being eligible; 14 of 17 enrolled, all from ONE service

Table 1. Comparison of Cost and Length of Stay Between Patients Enrolled and Not Enrolled in Hospice During a Terminal Hospital Admission

<table>
<thead>
<tr>
<th>Enrolled in hospice before last admission n = 7</th>
<th>Not enrolled in hospice, all diagnoses, n = 202</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>$4963</td>
</tr>
<tr>
<td>Median</td>
<td>$3690</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>$3250</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>4.47</td>
</tr>
<tr>
<td>Palliative Care Consultation</td>
<td>IF PC involved, LOS equal but $$ ↓↓ $41,859</td>
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Barriers

1. Finding good PC personnel. Shortage of 10,000 NPs and MDs. So, we have to learn to do this ourselves.
2. Shifting funds from current to projected uses, and current to projected incomes.
3. Helping people to be efficient.
4. Setting realistic but necessary goals for productivity.
5. One EPR that all can use.
6. Coordinated care takes effort....
Conclusions

1. Palliative care alongside oncology care is now the accepted best practice.
2. All the evidence suggests equal or better quality of life, fewer symptoms, equal or better survival, and less cost, with no harms.
3. It is possible to create such programs and have them be expert, sustainable, and even break even.
Selected references


19. L Scott Wilner MD and Robert Arnold MD # 125 The Palliative Performance Scale (PPS) http://www.eperc.mcw.edu/EPERC/FastFactsIndex/ff_125.htm