

Issues in Oncology: 2021 ASCO Annual Meeting Highlights for the Advanced Practitioner



Josh Epworth, ARNP, of University of Washington Medical Center, considers the findings of three important abstracts from the 2021 ASCO Annual Meeting and reflects on how advanced practitioners can improve access and care for their patients with cancer. Meeting coverage is provided by *The ASCO Post*.

Abstract 103

Results of a Restrictive Opioid Prescription Protocol for Patients With Cancer Undergoing Surgery

By Jo Cavallo

Visit <https://meetinglibrary.asco.org/record/196633/abstract> to read the full abstract and view author disclosures.

Seeing an opportunity to safely reduce the number of opioid doses prescribed to patients with cancer, researchers proposed a new pain management guideline for all patients undergoing surgery at Roswell Park Comprehensive Cancer Center. The results from the first 6 months of that effort, reported by Ricciuti et al during the 2021 ASCO Annual Meeting (Abstract 103), show that this opioid-restricting protocol resulted in a 45%

decrease in the amount of opioids prescribed, without any significant effect on patient recovery or satisfaction.

“The rates of opioid prescription in the United States for routine surgeries are significantly higher than in many European and Asian countries,” noted first author of the study, Jason Ricciuti, MD, a gynecologic oncology fellow at Roswell Park. “This is particularly problematic, because persistent opioid use has been observed in 6% to 8% of people who were not taking opioids until they underwent surgery.”

“Our goal,” he added, “was to demonstrate that prescribing 3 or fewer days of opioid supply is feasible in most postsurgical patients without compromising recovery or patient satisfaction, and that this approach will decrease chronic opioid use.”

Details of the Protocol

The restrictive opioid prescription protocol was implemented from February 2019 through July 2019 for all Roswell Park patients undergoing a surgery for which opioids would be routinely prescribed at discharge—more than 2,000 patients in all. For comparison, the researchers used data from surgeries performed by the same services from August 2018 through January 2019.

Unless patients had a maximally invasive procedure or required multiple doses of opioids during their hospitalization, they did not routinely receive opioids at discharge. Each surgical service across the center developed a particular protocol

to tailor the pain management approach based on their clinical experience.

To facilitate the transition, the researchers implemented several interventions, including identifying surgeons from each surgical service to serve as a champion of the protocol for their department and informational sessions on the initiative with colleagues from nursing, pharmacy, and center administration. Information technology team members were enlisted to update the default outpatient prescription for surgical patients in the electronic medical record (EMR) system.

Results

Protocol compliance, tracked by pharmacists on a daily basis, was higher than 95%. No difference in postsurgical pain intensity between cohorts was observed. The data showed that patients in the restricted-opioid cohort had fewer refill requests compared to those in the comparison group. Ad-

ditionally, there was no significant difference in patient-reported satisfaction with postoperative pain control or in the impact of pain on daily activities between the two groups.

Use of opioids decreased significantly, and chronic use of opioids also went down dramatically—from 6.5% before the protocol was initiated, to less than 3%.

“By putting this evidence-driven approach into effect across our center, we reduced the amount of opioids prescribed to our patients by 45%, without compromising our patients’ experience or recovery at all,” said senior study author Emese Zsiros, MD, PhD, FACOG, Associate Professor of Oncology in the Department of Gynecologic Oncology at Roswell Park. “Our experience provides clear evidence that reducing the number of opioids routinely prescribed after surgery is safe, feasible, and effective, and can be an important tool in the fight against the ongoing opioid epidemic.”

The Advanced Practitioner Perspective

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Currently, there is significant awareness of the hazards of a laissez-faire approach to opioid use. This awareness followed a period of significant increase in the number of prescriptions of this type of medication beginning in the 1990s and increasing again a decade ago. Since there has been a public reckoning with the utilization of these habit-forming medications, efforts have been made to decrease the number of opioids prescribed by all variety of providers. Because advanced practitioners in oncology are involved with the management of cancer-related side effects, one of which is pain, this is a subject that is very relevant to our practice.

The abstract outlined a useful approach to addressing acute/postsurgical pain. The results indicate that the number of opioids prescribed post surgery can be reduced with a concentrated approach utilizing team champions, pharmacists, medical records personnel, and prescribers.

Like all good studies, it also generates some questions:

- This work appears to focus on surgery-related pain. Can this approach be applied to cancer-related pain?
- Can some part of this approach be applied to chronic pain? What are some of the barriers (both personal and institutional) that may hamper a change in approach?
- This abstract focused exclusively on solid tumors. What can be done with these ideas in the setting of liquid tumors?

Appropriate pain management is one of the hallmarks in quality cancer care. With the increased involvement of advanced practitioners in the management of cancer-related side effects, including pain, comes increased scrutiny over our approach to this issue. It behooves us as providers to implement approaches that allow us to achieve the goal of balancing adequate pain control with patient safety. In addition, the team-based tactic to implementing change in facility culture and practice is applicable beyond acute pain management and may well be considered for cancer-related pain management and a host of other issues.

Disclosure: Mr. Epworth has no conflicts of interest to disclose.

Abstract 1503**Remote Monitoring Program Reduced Hospitalization Among Patients With Cancer Infected With COVID-19**

By The ASCO Post Staff

Visit <https://meetinglibrary.asco.org/record/196712/abstract> to read the full abstract and view author disclosures.

A study by researchers at Mayo Clinic Cancer Center found that patients with cancer diagnosed with COVID-19 who received care at home via remote patient monitoring were significantly less likely to require hospitalization for their illness, compared to patients with cancer infected with the virus who did not participate in the program. Results of the study were presented by Pritchett et al during the 2021 ASCO Annual Meeting (Abstract 1503).

Program Methods

“For our study, we evaluated 224 Mayo Clinic patients with cancer who were found to have COVID-19 through standardized screening prior to receiving cancer treatment, or due to symptoms or close exposure,” said Tufia Haddad, MD, a Mayo Clinic medical oncologist and the study’s senior author. Researchers followed the patients from March 18 to July 31, 2020.

Dr. Haddad said that at the outset of the COVID-19 pandemic, the Mayo Clinic rapidly developed and implemented a remote patient monitoring program to support patients who were diagnosed with COVID-19 and at risk for severe illness.

The program featured the use of in-home technology to monitor oxygen levels, vital signs, and symptoms of COVID-19 infection, and a centralized virtual care team of nurses and physicians to manage patients. Dr. Haddad said the program had served more than 8,000 patients in rural and urban locations across 41 states by November 2020.

Researchers found that among patients who did not require urgent hospitalization at the time of their COVID-19 diagnosis, those whose care was managed by the remote patient monitoring program were significantly less likely to require hospitalization for their illness, compared with those who were not managed by the program.

“After balancing the two groups of patients who were or were not managed by the remote monitoring program for factors known to impact COVID-19 outcomes—such as old age, male sex, and obesity—there was a 78% reduction in the risk of hospitalization (a 2.8% risk for patients on the remote monitoring program, compared to 13% for patients not on the program) attributed to the remote monitoring program,” said Dr. Haddad.

In addition, Dr. Haddad said that when patients who had been managed through the remote monitoring program were hospitalized, they experienced fewer hospitalizations of more than a week, intensive care unit admissions, and deaths.

“It is possible that our results were due to early detection of adverse symptoms and vital sign trends that enabled earlier care interventions to alter the trajectory of disease,” she pointed out.

Dr. Haddad is encouraged by the results, but cautioned that further research will be necessary to confirm them.

The Advanced Practitioner Perspective

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As of July 30, Louisiana was experiencing the most significant COVID-19 outbreak of July. This is fueled by a highly infectious Delta variant and a below-the-national-average full vaccination rate (per the CDC, 36.8%). The grim recitation of infections, deaths, and overflowing hospitals has become tragically familiar. At this point, we are still not in the clear from the pandemic, and it is not guaranteed that, when this is published,

we will be in a significantly improved position. Early in the pandemic, one of the initial goals of cancer centers was to reduce the risk of exposing patients to infection. New methods were developed to mitigate this. Many of us have used various forms of telehealth to “see” our patients while minimizing the risk of exposure. The program developed by the Mayo Clinic is, to some extent, an extension of telehealth.

The abstract states that the symptoms and physiologic data were assessed in a central location by nurses and physicians. Although

not mentioned, it is likely that advanced practitioners (APs) were involved in this process as they are in clinic. As stated in the data, the use of remote monitoring had a positive impact on the number of admissions of the study group. This, in turn, had the potential to improve a hospital's ability to provide care for those people who did require admission.

Telemedicine has been a valuable asset in maintaining patient care during the pandemic. Organizations as varied as the AANP, the AAPA, and the AMA have in some way embraced telemedicine and acknowledge that it will continue to be part of medical practices in the future. The

use of these technologies extends our reach as providers and improves our ability to be in contact with patients. It can be an important aid for APs in meeting our mandate to provide care in places where access to quality treatment has been lacking. Telemedicine, including remote patient monitoring, can allow APs to increase access to patients who may have difficulty getting to clinic. In addition, if remote access and monitoring are used by studies, it may allow them to have a broader selection of patients and be more inclusive.

Disclosure: Mr. Epworth has no conflicts of interest to disclose.

Abstract 6512

Study Finds Income Eligibility Limits for Medicaid May Be Associated With Worse Long-Term Survival Among Newly Diagnosed Patients With Cancer

By Jo Cavallo

Visit <https://meetinglibrary.asco.org/record/196693/abstract> to read the full abstract and view author disclosures.

Reshma Jagsi, MD, DPhil, of the University of Michigan, and Narjust Duma, MD, of the University of Wisconsin Carbone Cancer Center, discuss the state of diversity in the hematology-oncology workforce, mechanisms that lead to inequities, promising interventions, and where the field should go next (Abstract 11000).

A study investigating the association between state Medicaid income eligibility limits and long-term survival among newly diagnosed patients with cancer has found that patients living in states with lower Medicaid income eligibility limits had worse long-term survival compared with patients living in states with higher income eligibility limits. The findings by Zhao et al were presented during a presscast in advance of the 2021 ASCO Annual Meeting (Abstract 6512).

Study Methodology

The researchers used data from the National Cancer Database to identify 1,425,657 adults aged 18

to 64 who were newly diagnosed with 17 common cancers between 2010 and 2013. They categorized states' Medicaid income eligibility limits as $\leq 50\%$, 51% to 137%, and $\geq 138\%$ of the federal poverty level. Survival time was measured from the date of diagnosis through December 31, 2017, for up to 8 years of follow-up.

Multivariable Cox proportional hazard models with age as time scale were used to assess associations of eligibility limits and stage-specific survival, controlling for age group, sex, race/ethnicity, metropolitan statistical area, number of comorbidities, year of diagnosis, facility type, and the random effect of state of residence.

Results

The researchers found among newly diagnosed patients with cancer aged 18 to 64, 22.0%, 43.5%, and 34.5% resided in states with Medicaid income eligibility limits $\leq 50\%$, 51% to 137%, and $\geq 138\%$ of the federal poverty level, respectively. Compared with patients living in states with Medicaid income eligibility limits $\geq 138\%$ of the federal poverty level, patients living in states with Medicaid income eligibility limits $\leq 50\%$ and 51% to 137% of the federal poverty level were more likely to have worse survival for most cancers, both early- and late-stage.

The highest hazard ratios were observed among patients living in states with eligibility limits $\leq 50\%$ of the federal poverty level (P trend $< .05$). For example, for women with early-stage breast cancer, the hazard ratios were 1.31 (95% confidence interval [CI] = 1.18–1.46) and 1.17 (95%

CI = 1.06–1.30) for patients living in states with Medicaid income eligibility limits $\leq 50\%$ and 51% to 137% compared to those living in states with Medicaid income eligibility limits $\geq 138\%$ of the federal poverty level.

“Lower Medicaid income eligibility limits were associated with worse long-term survival within stage, with variation below the Medicaid eligibility threshold as part of the Affordable Care Act. States that have not expanded Medicaid income eligibility limits should expand them to help improve survival among [patients with] cancer,” concluded the study authors.

Ensuring Equal Cancer Care for All Patients

“[This] study clearly shows by the evidence that state expansion of Medicaid income eligibility lim-

its is associated with better long-term survival in newly diagnosed patients,” commented ASCO President Lori J. Pierce, MD, FASTRO, FASCO, during a media presscast highlighting this study abstract.

“This is particularly relevant, since there are such variable limits among states regarding Medicaid expansion with the Affordable Care Act. I think these data can be used to encourage those states that have chosen not to expand Medicaid coverage to strongly reconsider, since people who are uninsured are very likely to forgo screening, so you miss the detection of early lesions when cure can be far more likely. Those who are uninsured are unlikely to receive cancer care and for those who are able to start cancer treatments, they are unlikely to complete their cancer care. Equity of care is very, very critical.”

The Advanced Practitioner Perspective

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Before addressing the advanced practitioner perspective on this abstract, this piece will begin with a very brief review of Medicaid and how access varies by state. If you already have a good understanding of Medicaid, please skip the following section.

Overview of Medicaid

All state Medicaid programs are not created equal. Medicaid is a health insurance program that is funded through a combination of federal and state dollars. It was originally developed in 1965 to provide health care for Americans who were unable to work. States don't have to participate, but they all do. Each state must meet the guidelines of the Centers for Medicare and Medicaid Services to qualify for federal funding, but they have significant leeway to implement restrictions as they see fit once they have met the federal requirements. In each state, access to the resources varies based on a host of factors, including income, age, number of household members, pregnancy, and presence of reduced abilities.

With the passage of the Affordable Care Act (ACA), an attempt was made to make Medicaid requirements consistent between states. The benchmark for access to Medicaid through the ACA was 133% above the federal poverty level (FPL). Of note, the FPL varies

by size of family. For example, under the ACA, an individual earning less than \$17,130 would have access to Medicaid via the ACA's initial calculations. (The FPL for an individual earning an adjusted taxable income is approximately \$12,880. $FPL \times 1.33$.) This provision of the ACA was overturned by the Supreme Court, and the percentage above the poverty line providing access to Medicaid was left to individual states. For example, an individual in Alabama, which did not expand Medicaid to cover low-income adults outside certain parameters, is not eligible for Medicaid insurance if they make 0% over FPL—a low Medicaid income eligibility limit. In contrast, Arizona expanded access to Medicaid, for those who don't qualify for other programs, to people making less than 138% of FPL—a high Medicaid income eligibility limit.

Advanced Practitioner Roles

This abstract presented at the ASCO Annual Meeting reports that more generous availability of Medicaid insurance translates into improved survival for cancer patients. What part do advanced practitioners play in improving these outcomes? One of the answers comes down to the difference between availability and access. In states that have an FPL criteria of 138% , there is greater availability to insurance and care. A patient with insurance, in general, may have cancer care earlier in the disease process than patients without cover-

age. The abstract states that this translates into better outcomes. However, access is different from availability. Expanded Medicaid improves the ability of patients to have insurance (availability). But having insurance does not guarantee access to high-quality cancer care in both urban and rural settings.

With cancer, a timely diagnosis and initiation of treatment is a critical factor to improve outcomes. It is clear, from this study, that availability of insurance is a part of improving out-

comes. Another critical aspect is improving access to quality medical care. Advanced practitioners operating in traditionally underserved settings and extending the reach of cancer centers can improve outcomes by expanding this access. Beyond our clinical practices, advanced practitioners can serve their patients by advocating for a higher income eligibility limit in states that do not already have one.

Disclosure: Mr. Epworth has no conflicts of interest to disclose.