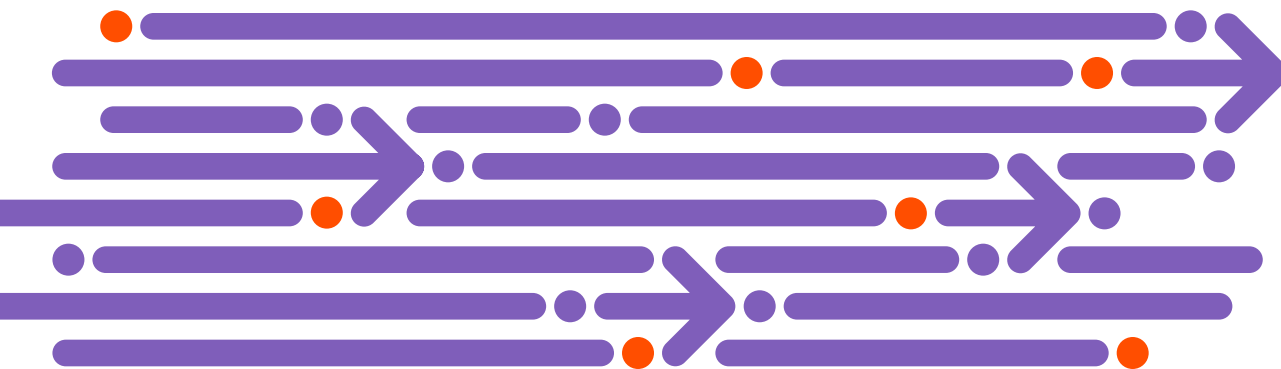


Touch Point

Doing well by doing good: Improving end-of-life care

October 2016



The perplexing challenges associated with death and dying are not new, and thoughtful research on the topic has been done from a wide range of perspectives. Despite that, however, the U.S. health care delivery system continues to struggle with end-of-life care. Wide variation in the care of terminally ill patients at the end of life, arising from inconsistent adherence to evidence-based standards, detracts from the quality of patients' lives while disproportionately consuming scarce resources.

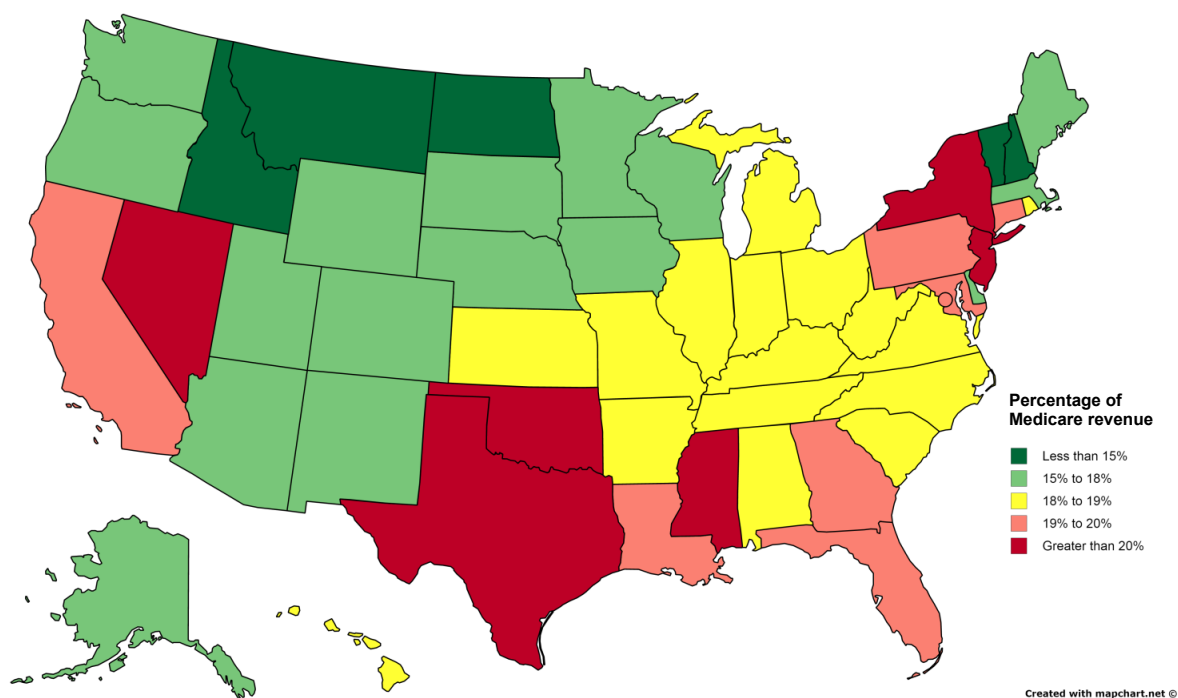
With rising health care costs threatening to bankrupt the U.S. if not addressed, end-of-life care has come under increasing focus. For Medicare, the roughly 6 percent of patients who die each year account for approximately 27 to 30 percent of total program costs.¹ The majority of end-of-life care spending among Medicare decedents—58 percent

according to a recent Kaiser Family Foundation study²—is associated with hospital utilization (inpatient and outpatient), making it an attractive target for cost savings.

What would the impact on a typical hospital be if Medicare was successful in reducing end-of-life hospital use?

For the typical hospital, 20 percent of Medicare revenue is attributable to care delivered during the last six months of patients' lives, with modest inter-regional variation (Figure 1). Assuming that Medicare accounts for one-third of a hospital's net patient revenue, a reduction of 10 to 20 percent in utilization among end-of-life patients would trim top-line revenue by 0.7 to 1.3 percent. A cut of that magnitude would be material but not catastrophic for most hospitals. For those that are operating at or near capacity, such a change would actually allow them to redeploy newly free capacity for other purposes, particularly higher-intensity cases.

Figure 1. Percentage of hospital Medicare revenue from end-of-life care

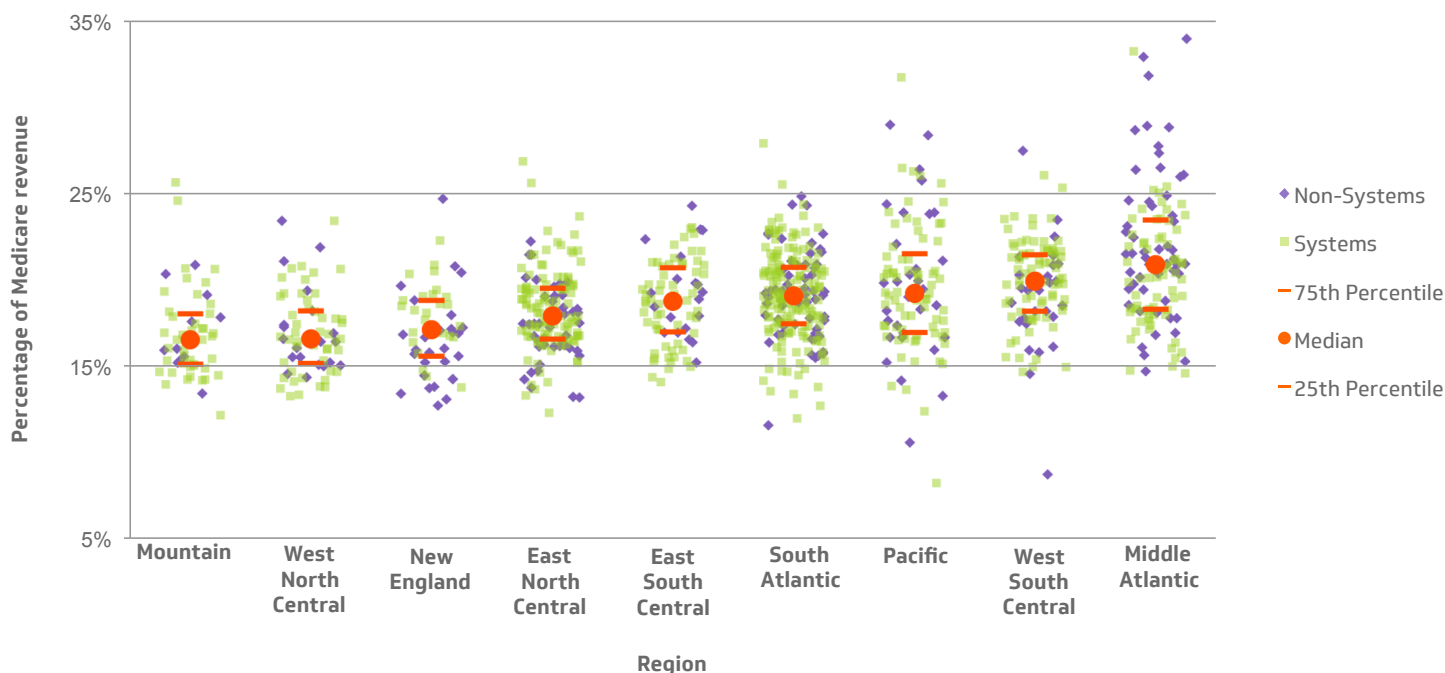


Source: Vizient analysis of 2011-2014 Medicare claims data.

While inter-regional variation is moderate, there is considerable intra-regional variation in the percentage of hospital Medicare revenue generated from care delivered to patients in the last six months of life (Figure 2).

Organizations with a higher percentage of revenue from end-of-life care will be more vulnerable if hospital utilization at the end of life declines nationally.

Figure 2. Percentage of hospital Medicare revenue from care in the last six months of life, by region

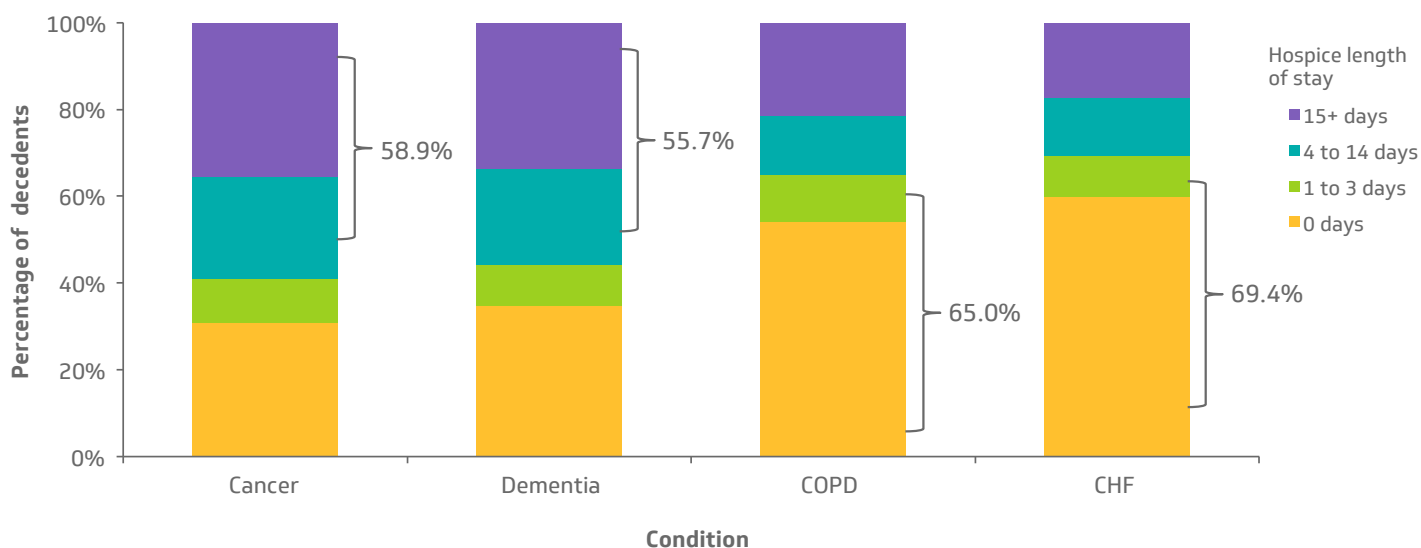


Source: Vizient analysis of 2011-2014 Medicare claims data.

Broader access to and earlier enrollment in hospice is widely regarded as a preferred alternative to patients dying in hospitals. Terminally ill patients routinely express the desire to die at home rather than in the hospital.^{3,4} Despite the advantages of hospice from both a cost-of-care and quality-of-life perspective, its utilization varies greatly by condition (Figure 3). More than 55 percent of Medicare patients who die from cancer and dementia have four or more days in hospice, with the largest

share—35 percent of patients—having 15 or more days of hospice at the end of life. Among Medicare patients who die of chronic obstructive pulmonary disease (COPD) and chronic heart failure (CHF), on the other hand, 65 to 70 percent have 3 days or less in hospice, with the largest share—55 to 60 percent—receiving no hospice care. An almost identical 70 percent of COPD and CHF patients are hospitalized in the last 30 days of life.

Figure 3. Hospice length of stay, by condition

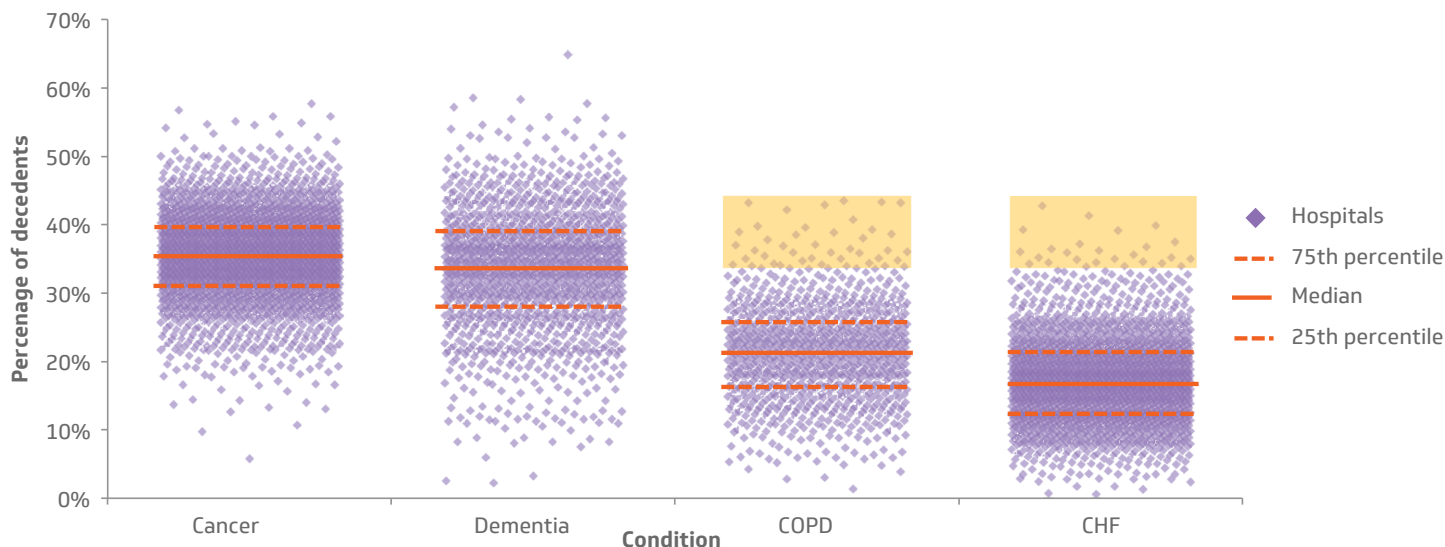


Source: Vizient analysis of 2011-2014 Medicare claims data.

Given that the hospice movement had its origins among terminally ill cancer patients, and that there has recently been a heightened focus on increasing access to hospice among patients with advanced dementia, it is not surprising that patients with those two conditions have the greatest use and duration of hospice care. The practices of some organizations, however, demonstrate that hospice

use in cases of COPD and CHF can approach or even exceed that observed in cancer and dementia (Figure 4). For a small but not insignificant number of hospitals, the percentage of COPD and CHF decedents with 15 or more days of hospice is equal to or greater than the median percentage observed across hospitals for patients dying of cancer and dementia.

Figure 4. Percentage of decedents with ≥ 15 days of hospice care, by condition



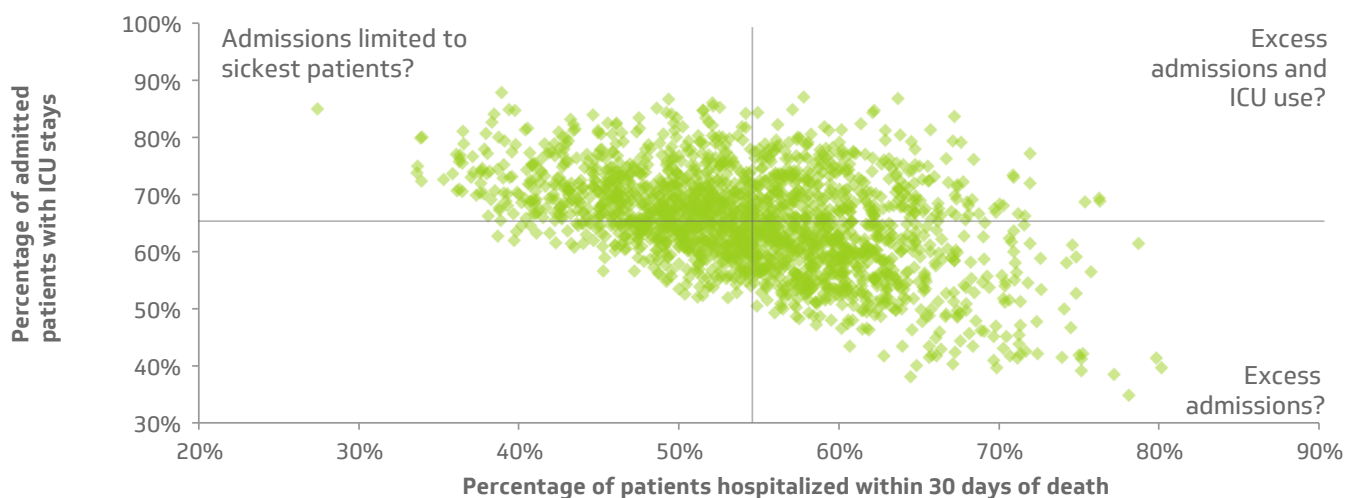
Source: Vizient analysis of 2011-2014 Medicare claims data.

Broadening hospice utilization may require new tools for determining eligibility and ensuring adherence to established guidelines, as well as new models of care. In many organizations, palliative care is structured as a centralized function and operates with a common approach, often born of its initial design for patients with terminal cancer, applied across all clinical services. Recently, some health systems have begun embedding dedicated palliative care at the service-line level, which allows palliative care specialists to develop deep, disease-

specific expertise and tailor their consultations accordingly. The impact of such novel arrangements on hospice utilization warrants further study.

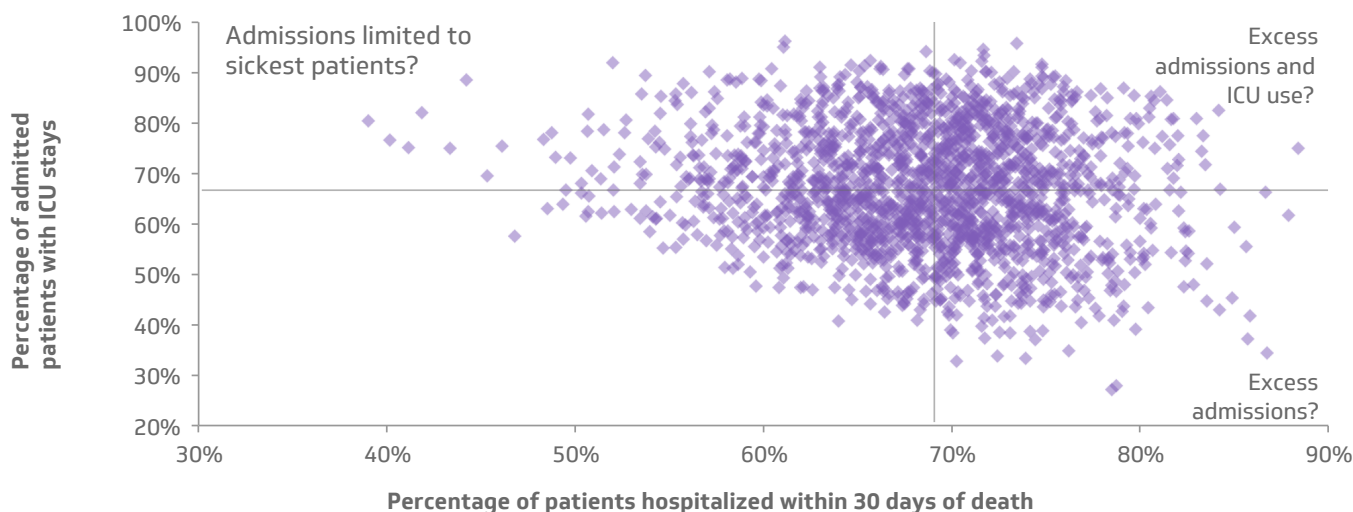
Increasing hospice uptake and duration reduces hospitalizations at the end of life. Figures 5 and 6 illustrate hospitalization rates in the last 30 days of life and intensive care unit (ICU) use among hospitalized patients for those with cancer and CHF, respectively. The data are plotted into quadrants based on the medians for each measure (represented by the horizontal and vertical lines).

Figure 5. Hospitalization rates and ICU use in last 30 days of life: cancer



Source: Vizient analysis of 2011-2014 Medicare claims data.

Figure 6. Hospitalization rates and ICU use in last 30 days of life: CHF



Source: Vizient analysis of 2011-2014 Medicare claims data.

For Medicare patients dying of cancer, the median rate of ICU use among admitted patients is higher than the overall admission rate in the last 30 days of life. This pattern indicates that some hospitals are selectively reducing the admissions of higher-acuity patients (upper left quadrant), while other hospitals have a high rate of lower-acuity admissions (lower right quadrant). In CHF, the median rates are exactly the same, suggesting that hospitals overall do not appear to be differentiating between patients based on severity of illness. Hospitals left of the vertical median are less likely to hospitalize any CHF patient at life's end than hospitals to the right of the median.

Finally, the median rate of ICU use among patients hospitalized in the last 30 days of life is virtually identical for both cancer and CHF patients. The equivalent ICU use rates may indicate that there is a subset of dying patients who, if they are admitted, are bound to end up in the ICU. Such patients may be candidates for and may prefer hospice care, but if they are admitted to the hospital instead they are likely to end up in the ICU—the worst possible outcome for a patient who wanted to die at home. For patients with CHF there is a larger number of inpatient admissions in the last 30 days of life that do not involve an ICU stay. Why are there more low-acuity admissions of terminally ill patients with CHF? Because they are less likely to be in hospice than cancer patients.

Few areas of health care delivery afford the opportunity to do well by doing good that exists for end-of-life care. Improving end-of-life care can contribute to the economic sustainability of the U.S. health care system by better matching scarce resources with the attainment of an optimal balance between longevity, functionality and the enjoyment of life. While clear opportunities for improvement can be identified, there are at least two major obstacles to the widespread achievement of such an optimal balance in end-of-life care:

- The capacity of the current health care delivery system is inadequate to meet the needs of patients who express a desire for less invasive, more comfort-oriented end-of-life care. Compounding this inadequacy are structural and behavioral shortcomings within the provider community and ineffective financing mechanisms that combine to obstruct a clear path to the balance between longevity, functionality and enjoyment of life for terminally ill patients.

- A significant portion of the U.S. population lacks a foundational understanding of the clinical and psychosocial implications of end-of-life care, and current communication between health care providers and patients often fails to equip patients and their families to make truly informed decisions regarding their preferences for an end-of-life treatment plan.

The enormity of the challenge and the complex web of inter-related issues associated with any attempt to address it, put us at risk of systemic paralysis unless we can change the tone of discussions on the topic from shrill to measured. We must focus attention on a manageable number of realistic steps that have the potential to lead to modest progress in the intermediate term, but which form the foundation for generational change in the long run. By improving the care of the terminally ill, we can bring more of the joy of living to the end of life, and in the process take a major step toward delivering an economically sustainable health care system to our children.

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- 1 Emanuel EJ. Better, if not cheaper, care for the dying. New York Times. January 3, 2013. <http://opinionator.blogs.nytimes.com/2013/01/03/better-if-not-cheaper-care>. Accessed October 6, 2016.
 - 2 Cubanski J, Neuman T, Griffin S, Damico A. Medicare spending at the end of life: a snapshot of beneficiaries who died in 2014 and the cost of their care. Kaiser Family Foundation website. <http://kff.org/medicare/issue-brief/medicare-spending-at-the-end-of-life/>. Published July 14, 2016. Accessed October 6, 2016.
 - 3 Cloud J. A kinder, gentler death. Time. September 18, 2000:60-66.
 - 4 Where do Americans die? Stanford School of Medicine Palliative Care website. <https://palliative.stanford.edu/home-hospice-home-care-of-the-dying-patient/where-do-americans-die>. Accessed October 6, 2016.



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