

Turning data into information to improve patient care

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Hospice Analytics is an information-sharing research organization whose mission is to improve hospice utilization and access to quality end-of-life care through analysis of Medicare and other national datasets. Please contact Hospice Analytics with any questions or ways we may assist you.

Calculating Live Discharge— If It's So Easy, How Come It's So Hard?

Regulators are looking closely at rates of live discharge from hospice programs these days. Rates that are too low—say, less than 5 percent—indicate a hospice program may be restricting access too tightly. Rates that are too high—above 20 percent—can be a red flag for fraud. Knowing where you stand in live discharges is essential to monitor quality and compliance. But calculating the percentage of live discharges is both easy and hard: Easy, because you're dividing a numerator by a denominator and that's your percentage. Hard, because the numerator and denominator are often undefined and different folks use different definitions.

Here are a few examples:

1. MedPAC calculates the percentage of live discharges by first limiting all Medicare beneficiaries only to those who died, then determining if the remaining beneficiaries received hospice or died in hospice. **So their numerator is the number of deceased beneficiaries who were admitted to your hospice but died outside of your hospice, and their denominator is all deceased beneficiaries admitted to your hospice.** MedPAC looks at hospice use across all years of Medicare service.

2. Hospice Analytics calculates the percentage of live discharges in the same way as MedPAC does, except we run the calculation based on calendar year—

because that's how Medicare provides the file, and it's a smooth comparison of multiple years.

3. **Others simply divide total "beneficiary discharge status = alive" by total beneficiaries served.** This is easy, but not very specific. For example, using this method, one beneficiary with 5 admissions to the same hospice who died during the last admission would be counted as 4 live discharges and 1 deceased discharge. Using the methods above, this beneficiary would count as one deceased discharge.

It's important to know how the data is run and what the purpose of the calculation is. MedPAC is looking at national industry trends, so their calculation makes sense given their purpose. It's possible to run the percentage of live discharges by a particular beneficiary, or hospice provider, or county, or state, etc. Running the data different ways answers different questions—so you want to be clear about what question you're asking and clear about how the data is run to answer your specific question.

Bottom line: If you're comparing your percentage of live discharges to someone else's calculation—just be sure you know what numerator and what denominator is being used. Differences are not usually in the calculation, but how the numerator and denominator are defined.

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Hospital Clinicians Identify Patient and Family Factors as Chief Barriers to Goals of Care Discussions

Physicians see greater role for nurses and other health care professionals

Hospital-based clinicians consider that family-related and patient-related issues pose the greatest obstacles to discussing goals of care (GOC) decisions with seriously ill patients and their families, more so than any clinician or system factors, Canadian researchers have found. Difficulty accepting a poor prognosis or understanding treatment options, family disagreement about GOC, and lack of decision making capacity were cited as the most important barriers.

Further, physicians are in favor of the inclusion of other members of the health care team in conducting certain aspects of end-of-life care discussions, according to a report on the findings of the large national study, which was published in the *Journal of the American Medical Association*.

“All study participants viewed staff physicians and residents as the most acceptable professional groups to engage in communication and decision making about goals of care,” write the authors. However, “they also believed that a range of clinician groups could play a role in several other key activities, including initiating goals of care discussions and acting as a decision coach.”

Because two aspects of end-of-life care found to be of crucial importance to seriously ill hospitalized patients are communication and decision making about GOC, the researchers hope their findings aid efforts to improve end-of-life care by tailoring interventions to address existing barriers, in this case from the perspective of clinicians.

Investigators analyzed survey responses of 1256 clinicians who were on a medical teaching unit in one of 13 hospitals across seven Canadian provinces from September 2012 to March 2013. Participants were staff physicians (n = 260), internal medicine residents (n = 484), and nurses (n = 512). Respondents rated the

importance of each barrier to GOC discussions on a 7-point scale, with 1 being “extremely unimportant” and 7 indicating “extremely important.”

All three clinician groups consistently identified family- and patient-related factors as being the greatest barriers (“somewhat” to “very” important) to conducting GOC discussions.

BARRIERS TO DISCUSSING GOC DECISIONS

- Family members’ difficulty in accepting a poor prognosis (mean score, 5.8 [\pm standard deviation, 1.2])
- Patients’ difficulty in accepting a poor prognosis (5.6 [1.3])
- Family members’ or patients’ difficulty in understanding the limitations and/or complications of life-sustaining treatments (5.8 [1.2] for both groups)
- Lack of agreement among family members about GOC (5.8 [1.2])
- Incapacity of patients to make GOC decisions (5.6 [1.2])

Only two clinician factors were rated as being “somewhat” important barriers: prognostic uncertainty (5.1 [1.2]) and lack of time (5.1 [1.5]), with nurses rating these factors higher than did staff physicians or residents. “Clinicians perceived their own skills and system factors as relatively less important barriers,” note the authors. Desire to maintain hope (4.2 [1.5]) and fear of litigation (3.5 [1.8]), were viewed as the least important barriers.

Staff physicians indicated the most willingness to engage in communication and decision making about GOC, with residents only slightly less willing. However, a higher percentage of residents reported having formal training in GOC discussions than did staff physicians (34.9% vs 28.5%). Nurses, who had the lowest group percentage of formal training in end-of-life care discussions (9.6%)

were neutral about feeling supported in the role of communicating about GOC, but willing to initiate discussions and act as GOC coaches.

STUDY IMPLICATIONS

“Our study has implications for the future development of interventions aimed at improving communication about goals of care among clinicians, patients, and families,” state the authors. “Promising interventions include more and better communication skills training for clinicians, conversation guides for discussion of prognosis, decision aids to support advance care planning, and greater involvement of the interprofessional health care team in this important process of care.”

CLINICIAN TRAINING AND TOOLS

The finding that family/patient difficulty in accepting prognosis was seen as a key barrier to GOC discussions may be a reflection of the high levels of anxiety and denial often experienced in the hospital setting by seriously ill patients and their families, note the authors. Navigating discussions involving strong feelings requires effective communication skills.

The authors recommend more clinician training in communication skills and improved tools to aid them in supporting patients/families through the decision-making process by enhancing clinicians’ ability to build rapport, listen with empathy, and discuss prognosis.

PATIENT DECISION AIDS

Decision aids should be developed to improve patient and family preparedness to discuss GOC, suggest the authors. Such aids would assist patients with advance care planning and increase their knowledge about life-sustaining treatments prior to an acute event and hospitalization.

“It is crucial, however, that such tools

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Clinician Resources: Having ‘The Conversation’ Can Help Improve Quality of Life for Dying Patients

“Much of the medical care that is delivered at the end of life to patients in the advanced stages of a disease would largely be rejected if patients and families had a better sense of what it involved,” writes Angelo E. Volandes, MD, MPH, in his book arguing that all patients, families, and physicians should be talking about death.

Volandes, a staff physician at Massachusetts General Hospital in Boston, believes that the fallout from the giant advances made in medical technology in recent decades has led to an “assault of medical interventions at the very end of life,” most of which are unwanted and could be avoided if patients talked to their families and physicians about how they want to die.

In his book, entitled *The Conversation: A Revolutionary Plan for End-of-Life Care*, Volandes urges all parties to establish “a new standard of care” for those facing the end of life, and provides lists of questions as guides for starting the dialogue.

“Patients can drive change by having greater knowledge of their options, while doctors can drive change by communicating and advocating for those choices,” Volandes writes. “Doctors have good reason to be the catalysts of change; every doctor knows that in the end, we all find ourselves on the patient’s side of the stethoscope.

“When patients have honest exchanges and have the tools necessary to understand their choices at the end of life, then

Questions All Physicians Should Ask Their Patients

- What kinds of things are important to you in your life?
- If you were not able to do the activities you enjoy, are there any medical treatments that would be too much?
- What fears do you have about medical care or getting sick?
- Do you have any spiritual, religious, philosophical, or cultural beliefs that guide you when you make medical decisions?
- If you had to choose between living longer or having a higher quality of life, which would you pick?
- How important is it for you to be at home when you die?

— Adapted from A.E. Volandes
The Conversation: A Revolutionary Plan for End-of-Life Care

they — not the health care system — remain in charge of decisions about how they want to live,” states Volandes, who is also an assistant professor of medicine at Harvard Medical School.

The book is published by Bloomsbury USA, 2015; ISBN-13: 978-1620408544 (Hardcover); 240 pp.

Goals of Care Discussions (from Page 2)

not be considered as a replacement for meaningful communication among clinicians, patients, and families,” caution the authors. “Rather, use of decision support tools can precede, facilitate, and support subsequent goals of care discussions that clinicians need to have with their patients and their families.”

EXPANDED ROLES FOR OTHER CLINICIAN GROUPS

Future interventions to improve end-of-life care could support the involvement of many other health care professionals in certain aspects of GOC discussions, such as initiating discussions and acting as GOC coaches. “[T]here is growing interest in improving the quality of health care and shared decision making through greater interprofessional collaboration within multidisciplinary

health care teams,” the authors observe.

EDUCATION IS THE FIRST STEP

“These findings suggest a way to improve goals of care discussions that is in line with the recent Institute of Medicine report ‘Dying in America’ and the work of many others: empower and even task nurses and other non-physician health care professionals to explore goals of care with patients and families,” writes James N. Kirkpatrick, MD, assistant professor of medicine at the Hospital of the University of Pennsylvania in Philadelphia, in his commentary accompanying the report.

From as early as the SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment) findings, first reported 20 years ago in the U.S., research has consistently shown that seriously ill patients, even if they have

completed an advance directive, rarely communicate their end-of-life preferences to physicians, Kirkpatrick notes.

Because nurses usually spend more time with patients, they are more likely than physicians to have an idea of a patient’s goals and values, and thus would be well placed to initiate discussions, act as decision coaches, and administer decision aids. Physicians would then exchange information and assist patients and families in making final decisions. “A clear first step, however, must be education,” Kirkpatrick states.

Source: “Barriers to GOC Discussions with Seriously Ill Hospitalized Patients and Their Families: A Multicenter Survey of Clinicians,” *Journal of the American Medical Association*; April 1, 2015; 175(4):549-556. You JJ et al, *McMaster University, Hamilton, Ontario*. “GOC Discussion: How Hard It Can Be,” *ibid.*, pp. 557-558. Kirkpatrick JN; *Cardiovascular Division, Department of Medicine, University of Pennsylvania, Philadelphia*.

Hospice Analytics “Basecamp 2015”— Denver, Colorado, July 31, 2015

Hospice Analytics is the premier provider of essential data on hospice utilization and activity for strategic and financial planning. Our interactive web-based tool, InfoMAX, provides up to 25 separate pre-formatted and calculated reports on hospice, hospital, and skilled nursing facilities of the subscriber’s choice.

The Hospice Analytics Basecamp will provide current and prospective InfoMAX subscribers with the opportunity for a **day-long, hands-on intensive exploration into available utilization and financial hospice data:**

- What data is presented and how
- Why it is important
- What the numbers say about quality of care, business stability, regulatory compliance and risk, and opportunities
- How to use the data to improve financial and strategic planning, marketing and development, advocacy, and clinical services

After an overview of InfoMAX features, **attendees will work directly with the data to respond to case studies** offered by the workshop leaders and to problems or questions attendees bring from their own programs.

Learn from the Hospice Analytics team and from your peers about the power of data to improve care and sustain success. Register by completing the form online at www.hospiceanalytics.com/basecamp2015. Earlybird registration at \$375* is available until June 1 (after that, the price goes up!). Don’t delay, space is limited!

*NOTE: Registration fee INCLUDES hotel stay over night of July 30, breakfast and lunch on the conference day, complimentary evening reception on July 30 and 31st, transportation to and from hotel. The conference will be held at the Woolley’s Classic Suites, an upscale all-suites hotel and conference center minutes from Denver International Airport. Make a vacation of it! Attendees may reserve additional nights before or after the event at a specially discounted price; contact Columbia Jenkins, 720-599-3750, ex. 70203 to make reservations.



NEVER underestimate the POWER of data...

Hospice Analytics is an information-sharing organization whose mission is to improve hospice utilization and access to quality end-of-life care through analysis of Medicare and other national datasets.

More than 50% of the State Hospice Organizations participate in Hospice Analytics’ Market Reports Project. These State Hospice Organizations represent over 60% of the hospices serving over 70% of the hospice patients in the country.

Substantial revenue is shared with participating non-profit State Hospice Organizations.

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