

# HOSPICE ANALYTICS

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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.

## A Glimpse Into the Future of Hospice...

This year's TEDMED conference included a diverse gathering of over 50,000 people who are passionate about imagining the future of health and medicine. They generated a list of the 20 Greatest Challenges of Health & Medicine:

1. The role of the patient
2. Managing chronic diseases better
3. Obesity (adults)
4. The caregiver crisis
5. Eliminating medical errors
6. Achieving affordable innovation
7. Obesity (children)
8. End-of-life care
9. Preparing for the dementia tsunami
10. Addressing whole-patient care
11. Make prevention popular & profitable
12. Improving medical communication
13. Faster adoption of best practices
14. Addressing the impact of poverty
15. Addressing costs and payment systems
16. Promoting active lifestyles
17. Wellness programs that work
18. Addressing sleep deprivation
19. Coping with stress
20. Personalized medicine

At least 75% of these challenges are applicable to the hospice industry. We are not facing these challenges alone, nor are we alone in trying to solve them. However, we live in a system with limited resources – so our ethics and mission must guide us in prioritizing our goals. As I've thought about the future of hospice throughout this entire year, it occurs to me that four factors deserve close attention:

- |                 |               |
|-----------------|---------------|
| 1. Transparency | 3. Innovation |
| 2. Quality      | 4. Advocacy   |

**1. Transparency:** “Transparency in health care is the new normal”, says Anne Weiss in a Health Affairs blog. In context, she is discussing the upcoming Physician Compare website, and how it will come along side Hospital Compare and more than 250 similar websites. In the hospice industry, the National Hospice Locator ([www.HospiceAnalytics.com](http://www.HospiceAnalytics.com)) is an important resource in providing information and transparency about hospices to the general public. Hospice Analytics is planning more helpful tools for hospices and researchers in the near future.

**2. Quality:** High quality hospice care has always been a priority, and even more so in an age of transparency. “Quality” can be measured in many ways – patient satisfaction surveys, family satisfaction surveys, accreditation, hospice utilization (aka, death service ratio), etc. Certainly CMS and Med-PAC are interested in tracking and increasing the quality of hospice care – and presumably reporting it at some point. All hospices could benefit from benchmarking their hospice compared to other hospices in the area, state, and nationally. The hospice industry is fortunate to have outstanding state and national hospice organizations, and several companies able to assist – including Weatherbee Resources (regulations), Deyta (family surveys), MVI (cost reports), and Hospice Analytics (claims and research).

**3. Innovation:** Atul Gawande wrote a provocative article, “Big Med,” in *The New Yorker* where he contrasts The Cheesecake Factory to health care. He notes the restaurant chain serves millions of people at a rea

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# Patient Treatment Preferences Have Little Influence on Receipt of Chemotherapy, National Study Finds

*Experts from across the U.S. call for greater emphasis on shared decision making between patient and physician*

Most patients with metastatic colorectal cancer who preferred comfort-oriented care stated they believed that chemotherapy would not extend their lives or help them with cancer-related problems. Nevertheless, these patients did receive chemotherapy, suggesting a need for more emphasis on shared decision making between patient and physician, according to the authors of a report published in the journal *Cancer*.

“The majority of patients received chemotherapy even if they expressed negative or marginal preferences or beliefs regarding chemotherapy,” write the authors, led by S. Yousef Zafar, MD, MHS, of the Duke Cancer Institute in Durham, NC. In addition, “patient preferences and beliefs were not associated with the intensity or number of chemotherapy regimens.

“Although chemotherapy for patients with advanced colorectal cancer can modestly extend survival, such treatment is associated with the risk of significant toxicity. This balance between possible benefit versus probable risk necessitates a patient-centered approach to treatment decision making,” observe the authors.

Investigators conducted a prospective cohort study of 702 patients with stage IV colorectal cancer who were enrolled nationwide by the Cancer Care Outcomes Research and Surveillance (CanCORS) Consortium. Patients were adults (aged 21 years or older) enrolled within three months of diagnosis from 2003 to 2006 and followed for 15 months. Data were collected from patient medical records and by telephone interview with patients or surrogates familiar with patients’ cancer care.

## OVERALL FINDINGS

- 91% of patients consulted a medical oncologist.
- Among those treated by an oncologist, 82% of patients received chemotherapy.
- 63% received more than one therapeutic agent as their first line of therapy.

## DECEDENT CHARACTERISTICS

- 90% of patients who expressed a preference for comfort-oriented care were given chemotherapy.
- 90% of those who felt chemotherapy would not extend their lives received chemotherapy.
- 89% of patients who thought chemotherapy was unlikely to help them with cancer-related problems were nevertheless given chemotherapy.
- Virtually all patients who reported a preference for extend-

*“Physicians may believe it is easier to offer chemotherapy to the patient with advanced cancer rather than engaging in challenging end-of-life discussions.”*

— Zafar et al, *Cancer*

ing life or who believed chemotherapy would extend their lives or help them with cancer-related problems did receive chemotherapy (99%, 99%, and 100%, respectively).

No association was found with the intensity or number of chemotherapy regimens received by patients and their expressed preferences, beliefs, concerns about treatment, actual and preferred roles in decision making, or the quality of communication with their physicians.

Patients with less likelihood of visiting an oncologist included those who were aged 65 to 75 years, those aged 75 years or older, and those whose surveys were completed by a surrogate because they were too sick to respond. Patients with less likelihood of receiving chemotherapy included those aged 75 years or older with moderate or severe comorbidity, and those too sick to complete their own survey.

“Taken together, these data suggest that concerns regarding the potential underuse of chemotherapy in patients with metastatic colorectal cancer largely may be put to rest,” comment the authors.

“Patient preferences should be emphasized particularly in the setting of advanced cancer, in which the treatment is palliative,” the authors state. “These findings shed new light on the patient experience and decision making in the use of palliative chemotherapy, and can shift the focus of health services research in advanced cancer from investigating underuse of treatment to the inclusion of patient preferences in decision making.”

*Source: “Chemotherapy Use and Patient Treatment Preferences in Advanced Colorectal Cancer,” Cancer; Epub ahead of print, September 12, 2012; Zafar SY, Malin JL, Grambow SC, Abbott DH, Kolimaga JT, Zulig LL, Weeks JC, Ayanian JZ, Kahn KL, Ganz PA, Catalano PJ, West DW, Provenzale D, for the Cancer Care Outcomes Research & Surveillance (CanCORS) Consortium; Duke Cancer Institute, Durham, North Carolina; Center for Health Services Research in Primary Care, Durham Veterans Affairs Medical Center, Durham; Greater Los Angeles Veterans Affairs Healthcare System, Los Angeles; Division of Hematology and Medical Oncology, Department of Medicine, David Geffen School of Medicine, University of California, Los Angeles; Department of Biostatistics and Bioinformatics, Duke University Medical Center, Durham; Dana-Farber Cancer Institute, Boston; and Division of Gastroenterology, Department of Medicine, Duke University Medical Center, Durham.*

# Elderly Patients Found to Use Medicare Skilled Nursing Facility Benefit Rather Than Hospice at End of Life

Nearly one-third of Medicare beneficiaries used the Medicare skilled nursing facility (SNF) benefit in the last six months of life, with one in 11 elders dying while enrolled in the SNF benefit, according to a report published in the *Archives of Internal Medicine*.

“Our finding that Medicare decedents commonly used SNF care at the end of life suggests a need to better understand who is using the SNF benefit and whether they are receiving care that matches their goals,” write lead author Katherine Aragon, MD, of the Department of Medicine at the University of California, San Francisco, and colleagues.

Researchers analyzed data from the Health and Retirement Study, a nationally representative, longitudinal survey of older adults, linked to Medicare claims on individuals who died from 1994 to 2007 (n = 5163; mean age, 82.8 years). They examined the prevalence of the use of the SNF benefit in the last six months of life by decedents whose residence prior to the last six months was either in a nursing home or in the community.

## KEY FINDINGS

- 30.5% of Medicare beneficiaries used the SNF benefit in the last six months of life.
- 9.2% of elders died while enrolled in the SNF benefit, most during the first 30 days of admission following hospitalization.
- 42.5% of the 1081 community-dwelling decedents who used the SNF benefit died in a nursing home; 53.5% of these died while enrolled in the SNF benefit, while only 19.3% died under the hospice benefit.
- In contrast, only 5.3% of community dwellers who had not used the SNF benefit in the last six months of life died in a nursing home, and 44.5% of these died with hospice care.

The finding that more than half of these community dwellers who died in a nursing home were enrolled in SNF at the time of death “suggests that patients are being discharged from hospitals to nursing homes under the Medicare SNF benefit for end-of-life care,” point out the authors. Under Medicare, patients can be enrolled in both the SNF and hospice benefits concurrently, but not for the same diagnosis. In this study, only 0.5% of decedents were enrolled in both programs simultaneously.

## REHABILITATION VS END-OF-LIFE TRAJECTORY

The two strongest predictors of SNF benefit use were the expectation of the patient’s death by their next of kin (adjusted relative risk [ARR], 1.46; 95% confidence interval [CI], 1.30 to 1.63) and the use of home health services among community

dwellers before the last six months of life (ARR, 1.24; 95% CI, 1.09 to 1.40).

It is likely that individuals referred to SNF care are those who are seen as having a potential for recovery. However, note the authors, it is also possible for physicians to overlook that a decline during hospitalization may reflect a health condition that will continue to deteriorate despite rehabilitation.

“In fact, the needs that necessitate SNF use are the same indicators of an end-of-life trajectory seen in frail elders,” they point out. “Honest and frank discussions about goals of care not only in the hospital, but once they are admitted to a SNF may allow an earlier introduction to palliative care.”

Those who used the SNF benefit had greater disability and required more home health and nursing home care than those who did not use the benefit. Patients transferring to SNF often have high care needs and can be medically complex.

“Incorporating a palliative care focus into SNF-level care may allow earlier recognition of when hospice referral is appropriate,” suggest the authors. “While rehabilitation is an important aspect of elder care, other issues near the end of life (e.g., symptom management or discussions about goals of care) may not be addressed when a patient is enrolled in the SNF benefit.”

## FINANCIAL INCENTIVES FOR USE OF THE SKILLED NURSING FACILITY BENEFIT

Nursing homes receive higher reimbursement for patients enrolled in the SNF benefit compared with long-term care reimbursement through Medicaid, giving these facilities a financial incentive to hospitalize patients who will then be enrolled in the SNF benefit upon discharge, the authors observe.

Elderly patients living in the community may be hospitalized when their symptoms and functional decline can no longer be managed at home, then admitted to a nursing home under the SNF benefit rather than hospice. Unlike SNF, the hospice benefit does not cover room and board, which must be paid for either out of pocket or through Medicaid.

“Families often face an uncomfortable choice: either they pay for room and board out of pocket to have access to hospice services, or they continue under the Medicare SNF benefit, relying on nursing home services for palliative and end-of-life services,” note the authors.

*Source: “Use of the Medicare Posthospitalization Skilled Nursing Benefit in the Last Six Months of Life,” Archives of Internal Medicine; Epub ahead of print, October 1, 2012; DOI: 10.1001/archinternmed.212.4451. Aragon K, Covinsky K, Miao Y, Boscardin WJ, Flint L, Smith AK; Divisions of Palliative Care and Geriatrics, Department of Medicine, and Division of Biostatistics, Department of Epidemiology and Biostatistics, University of California, and San Francisco Veterans Affairs Medical Center, San Francisco.*

## A Glimpse Into the Future of Hospice... (continued)

sonable cost with consistent level of quality. They are computerized and use prediction modeling with a goal of wasting no more than 2.5% of food. It is interesting to consider how much hospice and health care might learn from other industries. The importance of benchmarking and trending information, implementing consistent methods, and synthesizing health policy and innovation in other industries has never been more important for hospices than now.

**4. Advocacy:** NHPCO established the Hospice Action Network, the Louisiana ~ Mississippi Hospice and Palliative Care Organization established the Alliance for the Advancement of

End-of-Life Care, and the Midwest Alliance in Ohio is preparing to debut a political action committee – see the trend? With the increasing prevalence of end-of-life issues, hospice and palliative care organizations must be at the political table, too. We must regularly engage in conversations with state and national political and policy leaders – having our data-driven talking points in hand, modeling the impact of reimbursement and regulatory proposals before entering the meeting, and being a unique resource of information regarding our community and those we serve. If we aren't at the table representing hospice and palliative care, who will?

### Closing Updates

- **Please welcome Jeff Towns**, Director of Market Development, to Hospice Analytics! Jeff brings a wealth of health-care leadership experience, including serving as the CEO of the Michigan Hospice & Palliative Care Organization. He can be reached at phone 517-290-0853 and email JTowns@HospiceAnalytics.com.
- **Special thanks to National Hospice Locator Sponsors:** Sangre de Cristo Hospice & Palliative Care in Pueblo, CO; VNA Hospice Care in Woburn, MA; Family LifeCare in Berne, IN; and HCI Care Services in West Des Moines,

IA. Also, special thanks to NHL Advertisers: Hospice & Palliative Care of Northeast Illinois in Barrington, IL; and Delta Care Rx.

- **New 2011 Medicare Data:** The new Medicare data files have been ordered and shipment is expected in early December. Reports using the new data will be available shortly thereafter.
- **New Funeral Home Reports:** These reports have been requested by several funeral homes to encourage hospice / funeral home relationships – a valuable addition for hospices.

**Hospice Analytics thanks you for your trust and business through 2012, and we look forward to serving you and continuing to promote increased access to and utilization of high quality hospice care in 2013!**

## *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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