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Hospice Positively Impacts Medicare Hospitalisations and Spending

A study published in the 12 November issue of *JAMA* reports that hospice care for Medicare patients who are terminally ill with cancer is associated with fewer intensive care unit (ICU) admissions, lower rates of hospitalisation and invasive procedures, and significant reductions in medical expenditures during a patient's final year of life.

Hospice and Palliative Care

Medicare's hospice program covers care delivery that is oriented toward pain management and a patient's comfort at the end of life — preferences which often conflict with the intensive but sometimes futile interventions associated with terminal illness. Hospice care can include medication, and may be delivered at home or in a hospital setting. Medicare's program is the largest palliative care intervention in the US, but there is uncertainty about how to promote hospice services given its unknown impact on healthcare utilisation and related costs.

A study designed to explore the issue was led by Ziad Obermeyer, MD, MPhil, of Brigham and Women's Hospital and Harvard Medical School (Boston, MA, USA). Obermeyer and colleagues analysed data from Medicare patients who were diagnosed with cancer types considered to have poor prognosis for survival, such as those that affect the brain, the pancreas and cancer which had already metastasised. They composed two groups for comparison, based on whether patients were enrolled in hospice care before death. Of 86,851 patients diagnosed with a poor-prognosis cancer, 60 percent (51,924) were enrolled in hospice before death. After careful matching, each group comprised 18,165 patients.

Hospice Associated With Fewer Procedures, Lower Expenses

Healthcare utilisation and costs were compared across the hospice and non-hospice Medicare beneficiaries. The research revealed significantly higher healthcare utilisation for the non-hospice group, primarily for

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conditions which were not directly related to cancer. Four measures were higher for patients who were not enrolled in hospice compared to hospice recipients: hospitalisation (65 percent / 42 percent); ICU admissions (36 percent / 15 percent); invasive medical procedures (51 percent / 27 percent); and death in a hospital or nursing facility (74 percent / 14 percent).

Not surprisingly, expenditures were higher for patients who were not enrolled in hospice before death. Costs associated with care delivery during the last year of life averaged $71,517 for non-hospice patients, compared to $62,819 for hospice beneficiaries.

The authors wrote, “Our findings highlight the potential importance of frank discussions between physicians and patients about the realities of care at the end of life, an issue of particular importance as the Medicare administration weighs decisions around reimbursing physicians for advance care planning.”

Balancing Quality and Costs

As editorial published alongside the report commented on the topic of end-of-life care. Joan M. Teno, MD, MS, and Pedro L. Gonzalo, PhD, both affiliated with Brown University School of Public Health, pointed out the necessity of focussing on quality when making improvements to the methods of delivering healthcare to terminally ill Medicare patients.

“As financial incentives change in the U.S. health care system, valid measures of care quality are increasingly important for ensuring transparency and accountability. Obermeyer and colleagues assessed hospitalization rates, intensive care admissions, and invasive procedures, but additional measures must have evidence of their ability to discriminate the quality of care and must be responsive to change, easy to understand, and actionable. This will involve investing public dollars in the ‘quality’ of quality measures and their dissemination. If quality of care is not front and center, the momentum to improve end-of-life care in the United States could face a serious setback,” they wrote.

The study was supported by grants from three agencies: the National Institutes of Health, the National Cancer Institute and the Agency for Healthcare Research and Quality.

Source: JAMA

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