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Hospice Care Reduces Hospital Days across Diagnoses, National Study Finds

Medicare beneficiaries using hospice spent fewer days hospitalized near the end of life, and incurred lower overall medical costs during their last six months of life than did those not enrolled in hospice, according to researchers from the U.S. Department of Health and Human Services and the Johns Hopkins School of Public Health.

"We found that the Medicare hospice benefit is successful in its goal of avoiding hospital care at the end of life, as such care is often futile, invasive, and uncomfortable," write the authors of a report published in the *Journals of Gerontology B*, an official publication of the Gerontological Society of America.

Investigators analyzed data on Medicare hospice beneficiaries who died in 2010 (n = 205,904) and a comparison group of propensity-matched, non-hospice beneficiaries who died the same year (n = 227,159). The impact of hospice use on hospitalizations and expenditures in the last six months was examined for both nursing home residents and non-residents across five major disease groups.

KEY FINDINGS

- Hospice care for more than two weeks prior to death was associated with fewer hospital days (one to five days overall) for all Medicare beneficiaries in the study, with greater decreases in hospital use for longer hospice stays.
- Spending was lower (\$900 to \$5,000 less) for hospice use of 31 to 90 days for all non-nursing home beneficiaries, except for those with Alzheimer's disease.
- Hospice beneficiaries with lung cancer and colorectal cancer had the

greatest reductions in both hospital use and end-of-life spending, compared with non-hospice decedents.

LESS STRESS AND SUFFERING

"While some level of hospital care may always be appropriate for terminally ill individuals, reductions in hospital use can represent reductions in stress and suffering, meet patient and family wishes, and be consistent with clinical, cultural, and ethical guidelines," the authors note.

"[M]ost beneficiaries were in hospice care for less than a month, indicating that they may not have realized the full benefit of hospice care," they add. "Policies that encourage timely initiation of hospice and discourage extremely short stays could increase these successes while maintaining program goals."

Source: "Hospice Use, Hospitalization, and Medicare Spending at the End of Life," Journals of Gerontology B: Psychological Sciences and Social Sciences; Epub ahead of print, December 11, 2015; DOI: 10.1093/geronb/gbv109. Zuckerman RB, Stearns SC, Sheingold SH; Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC; Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore; and Department of Health Policy and Management, The University of North Carolina at Chapel Hill, Chapel Hill.

Hematologists Often Initiate End-of-Life Conversations with Patients ‘Too Late’

More than half of hematologic oncologists in a nationwide survey reported that, in their experience, end-of-life discussions with their patients occurred “too late.” Nearly one-quarter reported waiting until death was imminent to discuss hospice care, with 40% waiting until patients were clearly dying to discuss their preferred place of death, according to a research letter published in *JAMA Internal Medicine*.

“Existing studies suggest a quality gap with respect to end-of-life care for patients with blood cancers, and less timely end-of-life discussions may be partly to blame,” write lead author Oreofe O. Odejide, MD, a medical oncologist at the Dana-Farber Cancer Institute, Boston, and colleagues.

Patients with blood cancers are less likely than those with solid tumors to use hospice services, and when they do enroll, they are likely to do so within three days of death, point out the authors. Further, hematologic cancer patients are more likely to receive chemotherapy, be hospitalized near the end of life, and die in acute care settings.

In the U.S., about 57,000 individuals die annually of hematologic cancers, most of them in the age group that is eligible for Medicare. But this population has the lowest rates of hospice use in oncology, notes Odejide. In an earlier survey, Dana-Farber researchers found that 93% of hematologic oncologists agreed that hospice was beneficial, yet agreeing with the hospice philosophy may not necessarily translate into timely hospice discussions.

Investigators analyzed survey responses gathered in late 2014 and early 2015 from 349 hematologic oncologists (median age, 52 years; male, 75.4%) practicing primarily in community centers (55.4%) or tertiary care centers (42.9%) in the U.S.

FINDINGS

- Overall, 55.9% of respondents reported that end-of-life care discussions with their patients who have hematologic cancers typically occur “too late.”
- 42.5% reported conducting their first conversation about resuscitation status at less optimal times (i.e., during an acute hospitalization or when death is imminent).
- 23.2% of hematologists practicing in community centers and 39.9% of those practicing in tertiary care centers said they typically wait until death is clearly imminent before conducting an initial conversation about hospice care or preferred site of death.
- Hematologists in tertiary care centers were more likely to report late discussions than were those in community centers (64.9% vs 48.7%).
- Tertiary care center hematologists were less likely to initiate hospice and resuscitation status discussions at more optimal times (i.e., at diagnosis, during a period of stability, or at disease progression) than were respondents at community centers.

“These findings suggest the need for physician-targeted interventions for improving the timeliness of end-of-life discussions, especially for patients with hematologic cancers treated in tertiary settings,” write the authors. In addition, although an emphasis on physician and patient factors is necessary for increasing access to hospice enrollment, it must be accompanied by a major shift in policy to address eligibility barriers, suggests Odejide.

BARRIERS TO TIMELY HOSPICE CARE FOR PATIENTS WITH HEMATOLOGIC CANCERS INCLUDE:

The characteristics of blood cancers. Unlike most solid malignant neoplasms, many hematologic cancers remain potentially curable when they reach an advanced stage, note the authors. They add that “[t]his lack of a clear distinction between the curative and end-of-life phase of disease for many hematologic cancers may delay the initiation of appropriate end-of-life discussions.”

Physician uncertainty. Physicians may fear affecting patients’ hope or emotional coping capacity by mentioning death, and thus may hesitate to initiate end-of-life care discussions. Also, some physicians may themselves find it difficult to consider “giving up” on patients they might have potentially cured.

The Medicare Hospice Benefit. Since Medicare’s initiation of coverage for hospice care in 1982, eligibility has been restricted to patients who have an estimated life expectancy of six months or less and who are willing to forgo all treatment directed at their underlying disease.

“As science and clinical care have advanced over time, what is appropriate for end-of-life care in 2016 is very different from 1982,” writes Odejide in an editorial published in the *Journal of the American Medical Association*. “These enrollment requirements result in underuse of hospice and instead contribute to excess use of hospital care and intensive care at the end of life.”

The requirement for patients, in particular those with hematologic cancers, to forgo disease-directed therapy creates “an artificial dichotomy between hospice care and disease-directed care that is palliative, and does not account for many treatments or procedures whose purpose is simply to help patients feel better,” writes Odejide.

Source: “Timeliness of End-of-Life Discussions for Blood Cancers: A National Survey of Hematologic Oncologists,” JAMA Internal Medicine; Epub ahead of print, December 21, 2015; DOI: 10.1001/jamainternmed.2015.6599. Odejide OD, Cronin AM, Condrón N, Earle CC, Wolfe J, Abel GA; Division of Population Sciences; Center for Lymphoma; and Center for Leukemia, Department of Medical Oncology; and Department of Psychosocial Oncology and Palliative Care, all at Dana-Farber Cancer Institute, Boston; and Ontario Institute for Cancer Research, Toronto, Canada. “A Policy Prescription for Hospice Care,” Journal of the American Medical Association; January 19, 2016; 15(3):257-258. Odejide OD; Division of Population Sciences, Department of Medical Oncology, Dana-Farber Cancer Institute, Boston.

Palliative Care Initiated in Emergency Department Found to Improve Quality of Life

Patients with advanced cancer referred directly to palliative care consultations from the emergency department (ED) showed improved scores in quality of life (QOL) at 12 weeks, with a trend toward increased survival time at one year, according to a report published in *JAMA Oncology*.

“We found that initiating palliative care in the ED for patients with advanced cancer improved QOL and did not seem to shorten survival,” write the authors. “Given the diversity of the ED population and its often limited access to specialty care, this is an important place to initiate palliative care consultation.”

Visits to the ED are common among patients with advanced cancer, who usually present with physical or emotional symptoms requiring prompt palliation, note the authors. Decisions about preferred intensity of care are often made in this time of crisis. Yet palliative care services typically do not begin until a week into a seriously ill patient’s hospital stay.

“A consultation prompted from the emergency department may be a unique point in which to ensure that care is congruent with patients’ wishes and to interrupt the cascade of intensive, end-of-life care that could be a marker of low-quality care,” the authors observe.

“Better matching of patients’ goals of care to treatments would not only result in better concordance of emergency department disposition with patients’ preferred site of care, but also might decrease ICU admission at the end of life and increase referrals to hospice,” they suggest.

Investigators conducted a single-blind, randomized clinical trial of ED-initiated palliative care consultation versus usual care among 136 patients with advanced cancer who presented to the ED at an urban academic medical center from 2011 to 2014. Patients were randomly assigned to receive either a comprehensive palliative care intervention or usual care. QOL was measured at baseline and 12-week follow-up by the Functional Assessment of Cancer Therapy-General Measures (FACT-G) score, which ranges from 0 to 108.

FINDINGS

- QOL at 12 weeks was significantly higher among the intervention group (median standard deviation [SD] increase, 5.91 points) than among the control group (median SD increase, 1.08 points; $P = .031$).
- Median survival estimate was longer in the intervention group (289 days; 95% confidence interval [CI], 128 to 453 days) than in the control group (132 days; 95% CI, 80 to 302 days), although this did not reach statistical significance ($P = .20$).
- Hospice use was slightly higher in the intervention group than in the usual care group (28% vs 25%), although this difference was also not significant ($P = .85$).

“Patients’ main concerns at the end of life include maintaining control, relieving burdens, and strengthening relationships, which may conflict with ICU admission.”

— Grudzen et al, *JAMA Oncology*

“Median survival was almost five months longer in the intervention group,” note the authors, adding that the lack of statistical significance was due to the “highly variable length of survival in our cohort.” They suggest that future trials may want to limit enrollment to patients who are at a similar stage in their disease. Notable in this study, however, is the improvement found in QOL across the large ethnic and socioeconomic diversity of its cohort and variability in cancer type.

“While of obvious importance to patients, these findings are also tremendously important to hospitals and policymakers who are concerned with initiating palliative care earlier in the disease course,” write the authors.

“More and better inception points for palliative care are necessary because, in most cases, patients with advanced cancer are referred within 1.5 months of death and after a median of 20 encounters with other medical teams,” writes Eduardo Bruera, MD, chair of the Department of Palliative Care and Rehabilitation Medicine, Division of Cancer Medicine, The University of Texas MD Anderson Cancer Center, Houston, in an editorial accompanying the report.

“This study has demonstrated that an ED visit by a patient with advanced cancer can provide a unique opportunity for improved access to palliative care and quality of life,” he writes. “Emergency department physicians can become important members of the palliative care team by implementing successful early symptom control measures as well as early referral.”

Bruera suggests that the study findings should prompt expanded research to define and test criteria for ED-initiated referral to palliative care referral, as well as efforts to understand the attitudes of ED physicians, outpatient care teams, and patients toward automatic palliative care referrals. “In view of the findings of this study, this research is much needed and justified,” he notes.

*Source: “Emergency-Department-Initiated Palliative Care in Advanced Cancer Patients: A Randomized Clinical Trial,” JAMA Oncology; Epub ahead of print, January 14, 2016; DOI: 10.1001/jamaoncol.2015.5252. Grudzen CR, et al; New York University School of Medicine, New York City; The Icahn School of Medicine at Mount Sinai, New York City; Rutgers-Robert Wood Johnson Medical School, New Brunswick, New Jersey; James J. Peters VA Medical Center, Bronx, New York. “The Emergency Department Point of Palliative Care Access for Patients with Advanced Cancer,” *ibid.*, DOI: 10.1001/jamaoncol.2015.5321. Bruera E; The University of Texas MD Anderson Cancer Center, Houston.*



WHEN TO REFER TO HOSPICE

Call us if your patient exhibits the following indicators:

- Physical / functional decline
- Weight Loss >10% in last 6 months
- Multiple comorbidities

When life expectancy can be measured in weeks or months, hospice is usually the best option. For patients with **dementia**, look for the following indicators:

- FAST Score stage 7
- Urinary and fecal incontinence (intermittent or constant)
- No consistently meaningful verbal communication
- Requires assistance with ADLs
- History of aspiration pneumonia or UTI, sepsis or decubiti within the past 12 months

Call us any time, any day.

Geoffrey Coleman, MD
Medical Director
Montgomery Hospice



Physician Body Language Varies by Race of Dying Patient

Physicians exhibit fewer supportive nonverbal cues at the bedside of terminally ill, hospitalized black patients than they do for white patients in the same condition, a behavior that may influence patients' treatment choices at the end of life, according to a report published in the *Journal of Pain and Symptom Management*.

"Poor nonverbal communication — something the physician may not even be aware he or she is doing — could explain why many black patients perceive discrimination in the health care setting," says senior author Amber E. Barnato, MD, MPH, MS, associate professor of clinical and translational medicine at the University of Pittsburgh School of Medicine.

"Although we found that physicians said the same things to their black and white patients, communication is not just the spoken word," explains Barnato. "It also involves nonverbal cues such as eye contact, body positioning, and touch."

Investigators analyzed physician behavior during 64 videorecorded simulations of encounters with both white and black actors portraying patients with advanced metastatic cancer and similar prognoses and treatment preferences. Physician participants (n = 33) were not told what the trial was testing.

Physicians' scores were 7% lower for nonverbal interactions with black patients than with white patients. While speaking to black patients, they were more likely to stand near the door or to hold a binder in front of them. In contrast, physicians interacting with white patients often stood by the bedside and touched the patient in a reassuring or sympathetic manner.

"Ours is the first study of such interactions in a time-pressured end-of-life situation," write the authors. "To help black patients and their families feel welcome and encouraged to be partners in medical decision making, it is critical that doctors be aware of their verbal and nonverbal communication."

They recommend that future research explore these interactions in actual clinical environments and assess their impact on decision making and quality of care for black patients.

Source: "Differences in Physicians' Verbal and Nonverbal Communication with Black and White Patients at the End of Life," *Journal of Pain and Symptom Management*; January 2016; 51(1): 1-8. Elliott AM, Alexander SC, Mescher CA, Mohan D, Barnato AE; Department of Medicine, Department of Critical Care Medicine, and Center for Research on Health Care, University of Pittsburgh School of Medicine, Pittsburgh; and College of Health and Human Science, Purdue University, West Lafayette, Indiana.