

Challenges to Contain Costs and Standardize End-of-Life Care

Many of the forthcoming changes to healthcare regulations and reimbursement are based on the premise of improving quality and coordination of healthcare services while facilitating reduction in the cost of care. Given the aging of the baby boomer population and resulting increase in Medicare beneficiaries, one area of care that is receiving more scrutiny in the healthcare market include hospice and end-of-life care. A study recently released by the Dartmouth Atlas Project reviewed trends in more than 2 million Medicare beneficiaries, and has shown that at least in this area of healthcare, though challenges still exist, providers are exhibiting some improvements in appropriate care.¹

From 2007 to 2010, chronically ill Medicare patients suffered fewer deaths in the hospital (reduction by 4.5%); spent fewer days in the hospital (by 9.5%); and, reduced the number of physician visits (by 1.8%). Although chronically ill patients are spending more days in hospice care (a 15% increase) as opposed to ICU care, the report also found that the cost of care for these patients in the last two years of life increased from \$60,694 to almost \$70,000 during the same time frame; this increase in cost significantly outstrips the rise in the consumer price index over the same period of time (15.2%, compared to only 5.3%).² In addition, although the study recognized various providers' successes in improvements to end-of-life care, the report observed no change in the widespread variation of care among providers and the relatively slow growth and lack of standardization across entities.³ This variation in care observed in the 2013 report echoes findings of prior studies published by the Dartmouth Atlas Report, released in 2008 and 2010.⁴

However disappointing the results of the recent Dartmouth report may be in the context of healthcare reform, another recent study found that in a sample of Medicare beneficiaries in 2000 compared to 2005 and 2009, although fewer died in a hospital setting, they experienced higher ICU use and late referrals to hospice, i.e., transfer occurred 3 or fewer days before death.⁵ As the number of adults eligible for Medicare will likely double by 2030, it is expected that healthcare spending will also increase, by about 25% during that time frame. Given the vast financial implications of the changing demographics of the U.S population, and that most people prefer that end-of-life care be rendered at

home with family, and pain-free, the subject of end-of-life care has become a topic of increasing public health significance.⁶

Currently, healthcare reform legislation is focusing on implementing measures to hold hospitals accountable for mortality within 30 days of admission for patients with selected chronic diseases, which some believe may pressure providers to consider a hospice option earlier in the patient's stay than has historically been the case, and which may lead to premature transition of patients to hospice care.⁷ Some have suggested potential solutions to the costly and currently inefficient practice of hospice and palliative care, including altering the decision for hospice care from being time dependent (i.e., having 6 months or less to live) to a patient population recognized to need specialized care (e.g., pain control). Other suggestions to improve end-of-life care include tying palliative care programs and communication training about end-of-life to hospital accreditation and physician and provider reimbursement, respectively.⁸ These concerns are addressed based on the literature and continuing efforts of reform legislation, however it is apparent that providers still struggle to optimize appropriate end-of-life care decisions, prompting continuing efforts to standardize and align provider utility of appropriate end-of-life care for patients in the future.

¹ "Tracking Improvement in the Care of Chronically Ill Patients: A Dartmouth Atlas Brief on Medicare Beneficiaries Near the End of Life", by Goodman et al., The Dartmouth Institute for Health Policy & Clinical Practice, June 12, 2013

² *Ibid.*, Goodman et al., June 12, 2013, p. 1-2

³ *Ibid.*, Goodman et al., June 12, 2013, p. 2-3

⁴ "Quality of End-of-Life Cancer Care for Medicare Beneficiaries: Regional and Hospital-Specific Analyses", by Goodman et al., The Dartmouth Institute for Health Policy & Clinical Practice, November 16, 2010, p. 3; "Tracking the Care of Patients with Severe Chronic Illness", by Wennberg et al., The Dartmouth Institute for Health Policy and Clinical Practice, 2008, p. 22-23

⁵ "Change in End-of-Life Care for Medicare Beneficiaries: Site of Death, Place of Care, and Health Care Transitions in 2000, 2005 and 2009", by Teno et al., *Journal of the American Medical Association* (2013), Vol. 309, No. 5, p. 472

⁶ "Healthy Aging: Improving and Extending Quality of Life Among Older Americans", the National Center for Chronic Disease Prevention and Health Promotion, 2009, p. 2

⁷ "The Morality of Using Mortality as a Financial Incentive: Unintended Consequences and Implications for Acute Hospital Care", by Joel Kupfer, *Journal of the American Medical Association* (June 5, 2013), Vol. 309, No. 21, p. 2213-2214

⁸ "Better, if Not Cheaper, Care", by Ezekiel J. Emanuel, *The New York Times*, January 3, 2013, <http://opinionator.blogs.nytimes.com/2013/01/03/better-if-not-cheaper-care/> (Accessed July 15, 2013)



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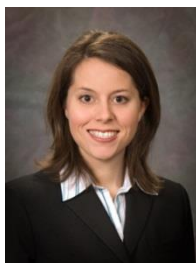
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