

# **EXECUTIVE SUMMARY**

## **Financial Implications of Promoting Excellence in End-of-Life Care A Summary of Conference Proceedings**

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**Presented by  
PROMOTING EXCELLENCE IN END-OF-LIFE CARE  
A National Program Office of  
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## **A Call for Reform of Medicare End-of-Life Policies**

National experts in end-of-life care, convened in Washington, D.C., on September 9, 2002, called unanimously for a major overhaul of Medicare's payment structure for dying Americans.

Three major messages emerged at the conference, which was sponsored by The Robert Wood Johnson Foundation (RWJF).

First, it was pointed out that Medicare—the nation's largest payer of care for the elderly—spends an immense amount of money on expensive, painful and futile life-prolonging care, while spending little for pain relief, quality of remaining life, and emotional support for patients and their families.

Second, new evidence from some small-scale model programs suggests that Medicare can deliver much better care for dying Americans while not raising program costs.

Third, experts agreed that the federal government should launch large-scale demonstration programs within Medicare to determine whether findings from the smaller-scale studies hold up when applied to the general population.

The conference was held in part to discuss findings from RWJF's five-year initiative, *Promoting Excellence in End-of-Life Care*, which funded 22 health care programs offering palliative care at an earlier stage in a patient's illness than is now allowed under Medicare regulations. (Palliative care is care designed to relieve physical, emotional and spiritual suffering in order to improve the patient's quality of life.)

A review of the 22 programs showed that the earlier introduction of palliative care, together with life-extending care, resulted in less frequent hospital stays and the reduced use of high-tech care, thus bringing down costs.

### **Disparities**

John Wennberg, M.D., director of the Center for the Evaluative Clinical Sciences at the Dartmouth Medical School and a national expert in health care usage and spending patterns, presented evidence to illustrate that when it comes to Medicare spending on end-of-life care, more is not necessarily better. There is tremendous regional variation and general overuse of services for patients in the last year of life—hospitalizations, stays in intensive care units and physician visits—with no measurable effect on patient outcomes.

For example, he showed that between 1995 and 1996, in Miami, Florida, and in the borough of Manhattan, in New York City, more than 30 percent of Medicare patients saw 10 or more physicians during their last six months of life, while in Missoula, Montana, in Iowa City, Iowa, and in Portland, Oregon, the rate was lower than 7 percent.

In the same year, in Miami, nearly 50 percent of Medicare enrollees in their last six months of life spent time in intensive care units (ICUs), while in Minneapolis, Missoula

and Portland, the rate was lower than 23 percent. In any event, Wennberg said, the number of ICU visits had no impact on life expectancy. “On an age/sex/race and illness-adjusted basis,” he said, “total spending would be reduced by 33 percent in the Medicare program if the benchmarks for the efficient areas (e.g., Minneapolis, Missoula and Portland) were the national norm.”

### **What Is Good Care?**

According to Ira Byock, M.D., director of *Promoting Excellence*, good care for people who are dying, or for those with advancing serious illnesses who are not yet terminal, should emphasize “comfort and quality of life.” Good care, he said, informs patients about how their illnesses are most likely to progress. Patients must be told the extent to which various life-saving treatments might help them and how such treatments will make them feel, so that they can decide, in the context of their own values and preferences, if they want to pursue them. Good care also teaches patients how to manage their illnesses to avoid unnecessary hospitalizations, and it provides emotional and social support to patients and their families as the illness advances. These elements form the essence of palliative care, Byock said.

### **Fixing the System**

Byock said that the promotion of life-prolonging care without consideration of the patient’s comfort and quality of life derives from two aspects of the health care system. First, physicians have been trained to save lives. The ways in which they practice and the systems in which they work both support this exclusive focus. For instance, few physicians have been taught how to have an emotionally difficult and time-consuming discussion with a patient about care alternatives. In the pressure of a busy practice, it is often easier to admit a patient to the ICU for treatment than it is have such a discussion.

Second, payment incentives within Medicare, as well as in most private health plans, support the focus on acute, life-saving care. Public and private insurers alike have set physician reimbursements for lengthy consultations so low that they are actually significant financial disincentives. (Doctors must constantly meet productivity goals in order to support their employee and office-overhead costs.)

An even greater payment problem is that Medicare and most private health plans require patients to give up life-saving care in order to qualify for hospice care, which offers the array of palliative care services that Byock cited as essential. This policy has come to be known in clinical circles as *the terrible choice*.

According to Byock, the terrible choice puts the patient into a Catch-22 situation. The emotional and spiritual support that may help a person to let go of death-prolonging care is denied until the patient decides to forgo life. This policy has created a model of care that focuses on comfort and quality of life only *after* aggressive, life-saving treatments have been discontinued.

In the early 1980s, the Medicare hospice benefit was constructed with the choice between curative or palliative care because Congress demanded cost-neutrality. It was assumed

that if Medicare reimbursed for palliative care services alongside disease-modifying treatments, program costs would rise. But according to Byock, preliminary research suggests otherwise. Findings from five programs that offer palliative care while patients are still pursuing cure (two of them *Promoting Excellence* grantees) showed cost savings from shorter hospital stays and lower use of expensive, life-prolonging care. Results from three of these programs are described below:

### **Promising Preliminary Research Findings**

**1. The Hospice of Michigan and the University of Michigan Comprehensive Cancer Center** started a program that provides hospice care to patients who are receiving life-saving cancer treatments. When compared with patients receiving only cancer treatments, patients receiving both had fewer emergency room visits (0.8 vs. 1.07), fewer hospital admissions (1.65 vs. 1.83), and shorter hospital stays (7.7 vs. 9.9 days).

Average hospitalization costs for patients receiving only cancer care were \$13,126 per patient, compared with \$8,974 for those receiving both cancer care and hospice care. Average total costs for patients receiving only cancer treatments were \$19,790 per patient, compared with \$12,682 for those receiving both forms of care.

**2. The Kaiser Hospice and Home Health program** in Downey, California, provides home hospice care along with curative and restorative care to patients with congestive heart failure, respiratory disease and cancer, who probably have up to a year to live. A team of physicians, social workers, nurses and aides makes home visits to patients to develop treatment goals and provide care. The team also offers the family emotional and social support, as well as respite care. The program's goal is to prevent any unnecessary hospitalizations and ultimately allow patients to die at home, if possible.

Based on a two-year comparative study involving 300 patients who died, patients who were in the program reported higher satisfaction with the care they received. More than 87 percent of the program patients died at home, compared with less than 57 percent of the control group patients. The average daily cost for a patient in the palliative care program was \$62 compared with \$133 for a patient receiving usual care. Total per-patient costs for those in the program were 45 percent lower than for those receiving usual care (\$7,990 vs. \$14,570).

**3. The Lillian and Benjamin Hertzberg Palliative Care Institute at Mt. Sinai Medical Center** in New York provides a team of nurses and physicians who consult with hospital providers on how to manage pain and other symptoms, and how to talk to patients and family members about making sound decisions regarding life-sustaining care. The program was able to improve symptoms for all patients who were experiencing severe, moderate or mild levels of pain, nausea and breathing problems. Estimates of cost impact were based on the 519 Medicare patients who died at Mt. Sinai in 2001 with and without the help of the palliative care program. The patients receiving palliative care spent 360 fewer days in Mt. Sinai than did Medicare patients who were not on the program. The cost savings from palliative care were \$757,555 for those patients who

stayed longer than 14 days in the hospital and \$455,936 for those who stayed more than 28 days.

### **A Call for Large-Scale Demonstrations**

Academic researchers, program providers and advocates for the elderly all urged the government to test, on a wide-scale basis, models that offer combinations of life-prolonging and palliative care that have been shown, on a small scale, to improve quality of care and save money. Medicare could employ a number of different models in various regions of the country, offering all Medicare enrollees in each region access to that particular model. Such demonstration programs would provide the broad data needed to redesign the ways in which Medicare pays for end-of-life care.

“The time to act is now,” Byock said. “We have the potential for providing not only ethically sound and medically competent care, but also care that offers so much more in terms of comfort and quality of life.”

*A transcript and other conference materials from “Financial Implications of Promoting Excellence in End-of-Life Care” are available online at [www.kaisernetwork.org/healthcast/rwjf/09sep02](http://www.kaisernetwork.org/healthcast/rwjf/09sep02) . For more information about Promoting Excellence programs, contact the National Program Office at [www.endoflifecare.org](http://www.endoflifecare.org) .*