Turning data into information to improve patient care

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.

CONTENTS

Hospice Cost Reports Now Available in InfoMAX!!

Hospice Analytics is committed to constantly upgrading and expanding access to vital business intelligence. As of mid-January, **full freestanding hospice cost reports back to 1999 are live in current InfoMAX accounts and no additional charge!**

Cost Reports will be refreshed every week, so you'll always have the most current data available.

If you are a current client, details on how to access your InfoMAX Cost Reports can be found on your login page. Once your download is generated, you'll find **all 17 freestanding cost report worksheets populated with all cost report detail reported for all the hospices in your selection of counties.**

We'll be adding other InfoMAX report formats based on these cost report fields and cost reports for the hospital-based, SNF-based, and HHA-based hospices soon.

While InfoMAX pricing may change in the future, as promised all this additional information is provided to you free through your current subscription.

If you are not a current InfoMAX subscriber, please contact Dr. Cordt Kassner for details: 719-209-1237, ckassner@hospiceanalytics.com.

Hospices Exceeding Aggregate Cap in 34 States

Based on 2013 Medicare Claims Data, Hospice Analytics has identified hospices exceeding the aggregate cap in 34 states. In some states, only 1 agency is at risk of penalties to Medicare (HI, KS, MN, NY, NC, OR, TN, VA).

The highest number occurs in California, at 83, while the highest percentage is in Nevada at 39%. **Of note, 87% of hospices exceeding the aggregate cap are for-profit:** 67% serving fewer than 65 patients per day and 20% serving more than 65 patients per day.

Medicare will not inform hospices exceeding the cap in 2013 until mid-summer 2015. **Hospice Analytics can tell you today if your hospice has exceeded the cap** and by how much, so you can begin budgeting for the penalty now, and adjust practices to avoid further penalties in coming years.

States with highest numbers of hospices exceeding cap	
California	83
Texas	62
Georgia	49
Mississippi	31
Alabama	23
States with highest percentage* of hospices exceeding cap	
Nevada	39%
Mississippi	29%
South Carolina	28%
Georgia	27%
AL, AZ, CA each at	20%

**Total number of hospices based on unique CMS provider numbers, not including branches, satellites, other locations billing under a single provider ID*

Hospice Use Remains High as Median Length of Service Continues to Decline

Approximately 1.5 to 1.6 million patients — well over half with diagnoses other than cancer — were cared for by U.S. hospices in 2013. These figures are similar to those of the previous year, reports the National Hospice and Palliative Care Organization (NHPCO), in the recently published 2014 edition of its annual publication, "Facts and Figures: Hospice Care in America."

"[T]he number of people with a non-cancer diagnosis continues to track at 63%, reflecting the ability of hospice providers to care for people at life's end who may be coping with dementia, heart disease, lung disease, stroke, or kidney disease," states the NHPCO.

However, more than a third of hospice patients received care for a week or less, half received care for less than 18 days, and the median length of stay in hospice is continuing its downward trend of recent years.

"Of ongoing concern to hospice and palliative care professionals is the fact that 34.5% of patients died or were discharged within seven days of admission," notes the NHPCO. This echoes the concern recently voiced by the Institute of Medicine in its 2014 report on the state of end-of-life care, "Dying in America," which called for greater access to hospice and palliative care for Americans.

The NHPCO report on trends in the growth, delivery, and quality of hospice care in the U.S. was released in October 2014, and is based on data from the organization's annual survey, the National Data Set, and NHPCO membership data. Care was provided in 2013 by more than 5800 hospice programs in all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.

KEY FINDINGS:

- Median length of service was 18.5 days, a decrease from 18.7 days in 2012, 19.1 days in 2011, and 21.2 days in 2009.
- 34.5% of hospice patients died or were discharged within seven days of enrollment, a slightly smaller proportion compared with 35.5% in 2012.
- Nearly half (48.8%) of patients died within 14 days of admission in 2013, a very slight drop from 2012 (49.5%).
- The same proportion of patients remained in hospice for longer than 180 days in both years (11.5%).
- Two-thirds of hospice care (66.6%) was provided in the place the patient called home, whether in a private residence (41.7%), a nursing home (17.9%), or a residential facility (7.0%).
- 91.2% of hospice care was covered by the Medicare Hospice Benefit.
- Cancer remains the most common admitting diagnosis, but it continues to account for less than half (36.5%) of all hospice admissions.

Primary non-cancer admitting diagnoses in 2013 included:

- Dementia (15.2%)
- Heart disease (13.4%)
- Lung disease (9.9%)
- Stroke or coma (5.2%)

Nursing homes showed the greatest increase as location of death for hospice patients, rising from 17.2% in 2012 to 17.9% in 2013. As Americans live longer, an increasing number die of chronic, progressive diseases requiring more prolonged care, most often in nursing homes, explains the report. Previous research has shown that as Medicare-certified hospice programs in nursing homes rose, so did the percentage of nursing home decedents receiving hospice care, from 14% in 1999 to 33.1% in 2006.

Meanwhile, percentage of deaths in a hospice inpatient facility fell from 27.4% to 26.4%. In addition to providing hospice care in the patient's place of residence, about one in three hospice agencies operate a dedicated inpatient unit. Some of these facilities provide a mix of general inpatient and residential care. Short-term inpatient care is also made available when the caregiver needs respite, or when a patient's pain or symptoms become too difficult to manage at home. Overall in 2013, however, routine home care accounted for 94.1% of patient care days.

Patients of non-Caucasian race continued to account for less than one-fifth of hospice users in 2013, with a slight increase in the proportion of enrollees, from 18.5% in 2011 to 19.1% in 2013. Hospice "provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes," notes the NHPCO. Support is also provided to the patient's loved ones.

"There's a common misconception that hospice care is giving up," says J. Donald Schumacher, PsyD, NHPCO president and CEO. "Nothing could be farther from the truth. Hospice provides high quality medical care and services from an interdisciplinary team of professionals and trained volunteers that maximizes quality of life and makes the wishes of the patient a priority." *[See sidebar, which lists members of a typical hospice care team.]*

"While many dying Americans are opting for hospice care at the end of their lives, far too many receive care for a week or less," adds Schumacher. "We need to reach patients earlier in the course of their illness to ensure they receive the full benefits that hospice and palliative care can offer."

For more details, visit ***www.nhpco.org.***

The Hospice Interdisciplinary Team

- The patient's personal physician
- The hospice physician or medical director
- Nurses
- Hospice aides
- Social workers
- Bereavement counselors
- Clergy or other spiritual counselors
- Trained volunteers
- Speech, physical, and occupational therapists, if needed

Both Regional and Patient Factors Influence Receipt of Intensive Procedures at Life's End

Individual characteristics and regional medical practice patterns have been identified as important determinants of intensive procedure use in the last six months of life, with black race and living in a high-intensity treatment region more than doubling the odds of undergoing an intensive procedure near the end of life, according to a report published in the *Journal of the American Geriatrics Society.*

"The most important finding from this study is that regional health care intensity has a strong independent effect on the medical care that individuals receive at the end of life, even after controlling for individual medical, social, and functional characteristics," write the authors. "The effect of nonclinical factors highlights the need to better align treatments with individual preferences."

Investigators analyzed Medicare claims linked to data for 3,069 individuals aged 66 years or older (mean age, 83.2 years) enrolled in the Health and Retirement Study (HRS), a nationally representative longitudinal cohort study of older adults. Subjects were those decedents for whom a proxy had completed an interview between 2000 and 2008.

HRS data was linked to participants' hospital referral region and to the Dartmouth Atlas of Health Care database information on each region's supply of medical resources (number of hospital beds, physicians, and specialists) and the Hospital Care Intensity (HCI) Index, a measure of local practice pattern intensity (days spent in hospital and intensity of physician services received while hospitalized).

The most common chronic medical conditions among the subjects were ischemic heart disease (35.6%), congestive heart failure (31.2%), diabetes mellitus (29.4%), and chronic obstructive pulmonary disease (28.3%).

OVERALL:

- 17.8% of patients underwent at least one intensive procedure in the last six months of life.
- 5.2% underwent two or more procedures.
- Of those who underwent at least one intensive procedure, 79% had such a procedure in the final month of life.

The frequency of each procedure among those who underwent at least one intensive procedure was as follows: intubation and mechanical ventilation (67.6%); gastrostomy tube insertion (25.5%); enteral or parenteral nutrition (23.1%); cardiopulmonary resuscitation (11.2%); and tracheostomy (8.1%).

One factor that increased the odds was when patients were living in a region with higher HCI (AOR, 2.16; 95% CI, 1.48 to 3.13). Thus, point out the authors, an older person living in Miami, FL (HCI Index, 1.78) would have more than double the probability of undergoing an intensive procedure at the end of life than if he or she were living in Rochester, MN (HCI Index, 0.64).

Black race also more than doubled the odds of receiving an intensive procedure in the last six months of life (AOR, 2.02; 95% CI, 1.52 to 2.69). This was a strong independent association, note the authors, and not a proxy for other determinants of care intensity, such as urban residence. Hispanic ethnicity, while not statistically significant in the primary analysis, was associated with three-times higher odds of undergoing gastrostomy tube placement.

LOWERING THE RISK

Factors significantly associated with lower odds of an intensive procedure included:

- Cancer diagnosis (adjusted odds ratio [AOR], 0.60; 95% confidence interval [CI], 0.43 to 0.85)
- Aged 85 to 94 years vs 65 to 74 years (AOR, 0.67; 95% CI, 0.51 to 0.90)
- Residence in a nursing home (AOR, 0.70; 95% CI, 0.50 to 0.97)
- Alzheimer's disease (AOR, 0.71; 95% CI, 0.54 to 0.94)
- Having an advance directive (AOR, 0.71; 95% CI, 0.57 to 0.89)

The presence of an advance directive (AD) reduced the odds of undergoing an intensive procedure by 30%, but when procedures were considered independently, having an AD was associated with lower odds of receiving only two procedures: intubation and cardiopulmonary resuscitation.

"This highlights the need to move beyond advance directives with 'do not resuscitate' and 'do not intubate' checkboxes to broader discussion and documentation of individuals' goals of care and values that could guide treatment decisions in a wider array of clinical scenarios," suggest the authors.

The study is the first to simultaneously examine the effect of individual characteristics and regional factors on the likelihood of undergoing one or more intensive procedures at the end of life, note the authors. "By recognizing these factors, clinicians can work more effectively to ensure that the treatment provided to individuals with serious illness is consistent with their individual preferences.

"Most importantly, by confirming that regional factors exert a real and independent influence on the care that individuals receive at the end of life, this study emphasizes the need to investigate the causes of disparate practice patterns and develop models of care that prioritize individuals' values and goals."

Source: "Factors Influencing the Use of Intensive Procedures at the End of Life," Journal of the American Geriatrics Society; *November 2014; 62(11):2088-2094. Tschirhart EC, Du Q, Kelley AS; Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, New York City; and Geriatric Research, Education, and Clinical Center, James J. Peters Veterans Affairs Medical Center, Bronx, New York.*

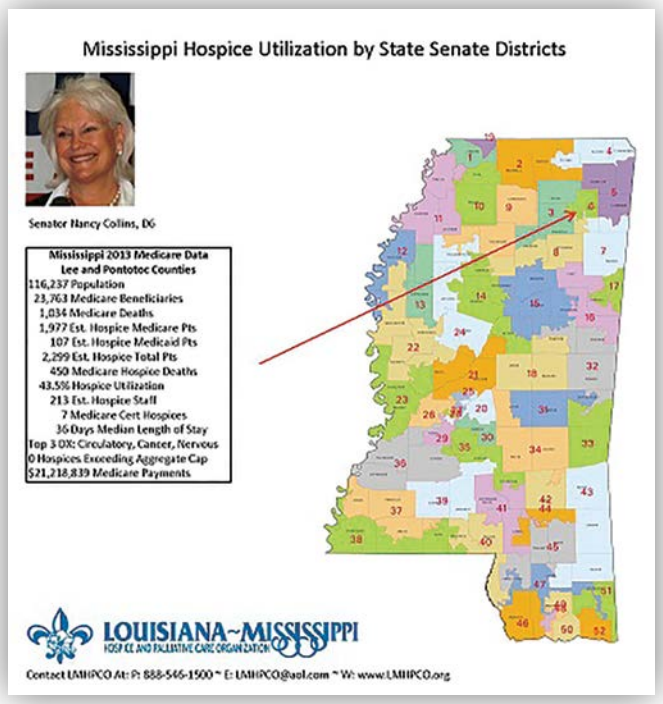
Hospice Analytics Can Boost Your State and National Advocacy

As hospice comes under increasing pressure, keeping law and policy makers informed of our issues is critical. In our work with legislators nationally and in our clients' states, we encounter one of two scenarios: lawmakers and policy aides who have had personal experience with hospice, usually excellent but sometimes negative, or those who know almost nothing about hospice or our challenges.

Hospice Analytics can help you provide essential facts about hospice care in your district or state to inform and support your policy objectives. We can:

- Create a district or state map showing key hospice facts
- Detail utilization statistics by age, race, gender, or diagnosis
- Compare state or district statistics with national trends and benchmarks
- Identify and quantify extent of "outlier" practices that may warrant regulatory scrutiny
- Backup policy recommendations with data and results from clinical and social research
- Create reports and visuals to accompany your presentations and proposals

Contact Dr. Cordt Kassner, ckassner@hospiceanalytics.com; 719-209-1237 for details how we can help advance your causes.



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.

For additional information, please contact:

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