

## Investing in Better Care for Patients Dying in Nursing Homes

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Dame Cicely Saunders founded St. Christopher's Hospice in London in the 1960s and established the principles of modern hospice care. Remarkably, she was trained as a nurse, social worker, and physician — the professions instrumental in the delivery of high-quality care at the end of life. In 1982, the U.S. Congress expanded Medicare to include coverage for hospice care. Patients with a life expectancy of 6 months or shorter who are willing to forgo curative treatments may choose the Medicare hospice benefit. The per diem payment covers the costs of care by the hospice team (which typically includes nurses, physicians, social workers, chaplains, and home health aides) and palliative medications. The expectation was that the addition of the hospice benefit to Medicare would be cost-neutral or even cost-saving. The hospice benefit was initially used primarily by patients with cancer who were living at home, but in recent years, there have been large increases in hospice use among patients with noncancer terminal conditions, such as heart failure and dementia, and patients living in nursing homes.<sup>1</sup> Spending on hospice services has the potential to replace spending on treatments such as chemotherapy and hospitalizations, and, in fact, many studies have reported that hospice care both saves money and improves quality of care.<sup>2-6</sup>

In this issue of the *Journal*, Gozalo et al.<sup>7</sup> report that the increase in hospice use between 2004 and 2009 among patients in nursing homes resulted in higher Medicare expenditures in the last year of life. This finding may seem surprising at first glance, given previous reports that hospice care is cost-saving.<sup>3-5</sup> However, previous studies did not account for patients' care preferences. The observed spending differences probably reflected both the preferences among hospice enrollees to avoid aggressive treatments and the hospice teams' prevention of unwanted hospital transfers.

Gozalo et al. took advantage of the natural experiment created by the recent increase in hospice use among patients in nursing homes. They combined data from Medicare claims and the Minimum Data Set, which includes information

about do-not-resuscitate and do-not-hospitalize orders as indicators of preferences for aggressive care. Using robust methods, they found that hospice expansion between 2004 and 2009 increased Medicare expenditures by about \$6,800 per decedent, which resulted from \$10,200 of additional spending on hospice and \$3,400 less in spending on hospital and other services. The expansion of hospice care in nursing homes focused on patients who were willing to forgo curative treatments; therefore, the potential savings to offset the cost of hospice care were relatively small. In addition, the new hospice users in 2009 accrued larger hospice bills, owing to longer hospice lengths of stay; this reflects efforts to enroll patients earlier and to enroll more patients with diagnoses such as advanced dementia, for whom the 6-month prognosis is difficult to accurately estimate.<sup>8</sup>

Although the findings of Gozalo et al. are striking for patients in nursing homes, they cannot be generalized to patients receiving hospice care at home. For community-dwelling patients, hospice care may be more likely to prevent hospitalizations prompted by uncontrolled symptoms than it is for patients in nursing homes, who have easier access to medical care. In addition, these findings should not be interpreted as evidence that hospice care cannot be cost-neutral or cost-saving, even in nursing homes. If hospice enrollment results from a general strategy of educating patients and their families about prognoses and the benefits and burdens of treatments, many dying patients will probably shift the focus of their care to comfort and forgo aggressive treatments that are not consistent with their preferences and goals.

Gozalo et al. showed that hospice expansion was associated with modest reductions in the use of aggressive treatments at the end of life, but their study was not able to measure other potential improvements in the quality of care that may result from hospice services. More than 25% of people dying in the United States die in nursing homes.<sup>9</sup> Nursing homes must be able to provide excellent end-of-life care to all patients as an integral part of their mission, and all

nurses, nursing assistants, social workers, and physicians who make up nursing home patients' primary care teams should have the expertise to provide that care. If these front-line providers develop this expertise, the role of specialized palliative care teams in nursing homes, including hospice providers, would probably evolve to become a more consultative role focusing on patients with the most challenging palliative care needs.

The traditional payment and quality-reporting structures of Medicare and Medicaid do not provide the incentives needed for nursing homes to make excellence in end-of-life care a top priority.<sup>10</sup> For example, traditional fee-for-service Medicare provides financial incentives for the transfer of nursing home patients to the hospital, which often results in fragmented care, burdensome transitions, and unwanted aggressive treatments. One study suggested that comprehensive managed-care programs that bundle payment for Medicare (including hospice) and Medicaid services were associated with fewer hospital transfers for nursing home patients dying with advanced dementia.<sup>11</sup> There has been much enthusiasm focused on reducing avoidable hospitalizations of nursing home patients who have advanced illness.<sup>12</sup> Similar enthusiasm should focus on motivating the culture change needed for nursing homes to integrate high-quality palliative care into their routine practice. This will require the development and assessment of new models of care that tie payment to performance measured with the use of appropriate palliative care metrics.<sup>10</sup> Nursing home quality measurement and reporting should expand to include assessments of staff training in palliative care, the quality of end-of-life care delivered, and the experiences of dying patients and their families.<sup>13</sup> The catalyst for improving care and controlling spending at the end of life in the nurs-

ing home population will be the alignment of incentives so that high-quality end-of-life care is measured and rewarded.

Disclosure forms provided by the author are available with the full text of this article at [NEJM.org](http://NEJM.org).

1. Miller SC, Lima J, Gozalo PL, Mor V. The growth of hospice care in U.S. nursing homes. *J Am Geriatr Soc* 2010;58:1481-8.
2. Stevenson DG. Growing pains for the Medicare hospice benefit. *N Engl J Med* 2012;367:1683-5.
3. Meier DE. Increased access to palliative care and hospice services: opportunities to improve value in health care. *Milbank Q* 2011;89:343-80.
4. Obermeyer Z, Makar M, Abujaber S, Dominici F, Block S, Cutler DM. Association between the Medicare hospice benefit and health care utilization and costs for patients with poor-prognosis cancer. *JAMA* 2014;312:1888-96.
5. Kelley AS, Deb P, Du Q, Aldridge Carlson MD, Morrison RS. Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay. *Health Aff (Millwood)* 2013;32:552-61.
6. Gozalo PL, Miller SC. Hospice enrollment and evaluation of its causal effect on hospitalization of dying nursing home patients. *Health Serv Res* 2007;42:587-610.
7. Gozalo P, Plotzke M, Mor V, Miller SC, Teno JM. Changes in Medicare costs with the growth of hospice care in nursing homes. *N Engl J Med* 2015;372:1823-31.
8. Mitchell SL, Miller SC, Teno JM, Kiely DK, Davis RB, Shaffer ML. Prediction of 6-month survival of nursing home residents with advanced dementia using ADEPT vs hospice eligibility guidelines. *JAMA* 2010;304:1929-35.
9. Teno JM, Gozalo PL, Bynum JP, et al. Change in end-of-life care for Medicare beneficiaries: site of death, place of care, and health care transitions in 2000, 2005, and 2009. *JAMA* 2013;309:470-7.
10. Institute of Medicine. *Dying in America: improving quality and honoring individual preferences near the end of life*. Washington, DC: National Academies Press, 2014.
11. Goldfeld KS, Grabowski DC, Caudry DJ, Mitchell SL. Health insurance status and the care of nursing home residents with advanced dementia. *JAMA Intern Med* 2013;173:2047-53.
12. Polniaszek S, Walsh EG, Wiener JM. Hospitalizations of nursing home residents: background and options. Washington, DC: Department of Health and Human Services Office of Disability, Aging and Long-Term Care Policy, June 2011 (<http://aspe.hhs.gov/daltcp/reports/2011/NHResHosp.pdf>).
13. National Quality Forum. NQF endorses palliative and end-of-life care measures ([http://www.qualityforum.org/News\\_And\\_Resources/Press\\_Releases/2012/NQF\\_Endorses\\_Palliative\\_and\\_End-of-Life\\_Care\\_Measures.aspx](http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Palliative_and_End-of-Life_Care_Measures.aspx)).

DOI: 10.1056/NEJMe1502735

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