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## NEW EMERGENCY DEPARTMENT PROGRAM STREAMLINES END-OF-LIFE TRANSITIONS TO HOSPICE CARE

For patients with a life-threatening condition presenting at an emergency department (ED) near the end of life, researchers found that the implementation of a new ED-to-hospice program increased the odds of timely transition to goal-concordant hospice care, thus circumventing typical delays and avoiding hospital admission and possible in-hospital death, according to a report published in *JAMA Network Open*.

“When patients come to an emergency department near the end

of life, the default is typically to admit them to the hospital, engage them in conversations about goals and end-of-life care and potentially move them into hospice care,” says lead author Christopher Baugh, MD, an emergency physician in the ED at Brigham and Women’s Hospital, Boston.

“However, this lengthy process can take longer than the patient has left to live,” Baugh continues. “This program helps us identify patients who may be eligible for hospice as quickly as possible while they are still in the ED and reduce the time it takes to get them into hospice care.”

Investigators analyzed data collected prospectively during the implementation of a “novel” care transitions program in the ED of a large tertiary care academic hospital in Boston. The program was collaboratively designed by a multidisciplinary task force to identify and transition to hospice those patients presenting to the ED whose goals of care were concordant with hospice care without hospital admission and in a timely manner (within 96 hours).

“Traditionally, the pathway toward inpatient hospital admission is well

resourced, but the pathway toward hospice care is not,” write the authors. “Without a defined clinical pathway similar to other emergency conditions with well-established workflows (such as acute stroke), operationalizing timely hospice care is challenging.”

The control period before the transition program (September 1, 2018, to January 31, 2020) included 270 patients (median age, 74.0 years; female, 49.3%; White race, 67.8%). The intervention period (August 1, 2021, to December 31, 2022) included 388 patients (median age, 73.0 years; female, 53.6%; White race, 72.4%). Patients with cancer represented the largest subgroup (29.6%) followed by patients with neurologic diagnoses (19.3%).

### Elements of the transition program include:

- Screening of potential transition candidates using data from the EHR (electronic health record), then alerting the emergency department care facilitator to eligible patients via email
- Using dedicated rounding to identify candidates early
- Addressing knowledge gaps by

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## ◀ NEW EMERGENCY DEPARTMENT PROGRAM (from page 1)

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educating ED clinicians and specialists biannually about what hospice offers and how it benefits patients and families

- Building relationships with new hospice vendors and reviewing the performance of established vendors to expand the capacity for general inpatient hospice
- Tracking and reporting of both hospice-enrolled and missed eligible patients
- Conducting weekly multidisciplinary case reviews

“Identifying hospice candidates quickly after ED arrival mostly falls on the shoulders of ED clinicians, so our goal with the program is to make this process as simple and efficient as possible,” says Baugh. “With our approach, we’re able to mobilize the hospice transition within one to two days most times, which is much faster than would be possible if the patient was admitted directly into inpatient care.”

### Key findings

- 54.1% in the intervention period vs 22.6% in the control period achieved the primary outcome of transition to goal-concordant hospice without hospital admission within 96 hours of ED presentation.
- The intervention was associated with increased odds of timely hospice transition in the univariable model (odds ratio [OR], 4.04; 95% confidence interval [CI], 2.85 to 5.73) and independently associated with increased odds of timely transition after adjustment in multivariable analysis (aOR, 5.02; 95% CI, 3.17 to 7.94).
- The presence of a Medical Orders for Life-Sustaining Treatment form (MOLST\*) at ED presentation was also independently associated with greater odds of timely hospice transition (aOR, 1.88; 95% CI, 1.18 to 2.99) across all groups. [\*Note: Program names vary by state, but these completed documents are most often called Physician Orders for Life-Sustaining Treatment (POLST) forms.]
- In-hospital mortality was lower in the intervention

cohort than in the control cohort (48.5% vs 64.4%).

- A larger percentage of patients with cancer in the intervention group achieved timely hospice transition compared with those in the control group (65.7% vs 34.4%;  $P < 0.001$ ). The intervention was independently associated with timely transition of cancer patients in multivariable analysis (OR, 4.19; 95% CI, 2.04 to 8.60).
- In the subgroup of patients with neurologic disease, a larger percentage in the intervention group compared with the control group achieved timely hospice transition (59.2% vs 32.1%;  $P = 0.004$ ).
- The percentage of patients who were “hospice pathway enrolled,” that is, in the process of transitioning into hospice but who died in observation status prior to enrollment, was lower in the intervention group (9.5%) compared with the control group (29.5%).

“It’s been incredibly moving to witness the care delivered by our multidisciplinary program, and the impact on patients and families,” says senior author Mallika L. Mendu, MD, vice president of clinical operations and care continuum at Brigham and Women’s. “As a result of this program, patients and families are receiving meaningful support at a critical point in their lives, which can have a long-lasting impact on bereaved loved ones.”

The authors suggest further investigation be conducted to examine the generalizability and sustainability of the ED-to-hospice transition program. Meanwhile, they declare that “ongoing efforts to create and sustain education campaigns to influence the perception of hospice as patient- and family-centered are needed,” as are efforts to increase the effectiveness and frequency of serious illness conversations so as to better document goals of care.

Source: “A Hospice Transitions Program for Patients in the Emergency Department,” *JAMA Network Open*; July 1, 2024; 7(7):e2420695; DOI: 10.1001/jamanetworkopen.2024.20695. Baugh CW, Ouchi K, Mendu M, et al; Department of Emergency Medicine, Brigham and Women’s Hospital; Department of Psychosocial Oncology and Palliative Care, Dana Farber Cancer Institute; Division of Renal Medicine, and Office of the Chief Operating Officer, Brigham and Women’s Hospital, all in Boston.

## NEPHROLOGISTS SUPPORT THE HOSPICE CONCEPT, BUT NEED EDUCATION AND TRAINING TO HELP PATIENTS GAIN ACCESS

Despite expressing general support for the concept of hospice care, many interviewed nephrologists indicated misunderstanding and hesitation about the use and benefits of the end-of-life (EOL) service, and few could recall any of their patients with end-stage kidney disease (ESKD) who had been referred to hospice. That is according to a report published in the *Journal of the American Geriatrics Society*.

While Medicare policy regarding concurrent hospice care and disease-directed treatment such as dialysis poses a barrier to timely, high-quality hospice care for ESKD patients and thus needs to be addressed, any policy reform must be accompanied by the education and training of nephrologists, urge the authors.

“Nephrologists need to receive more education in primary palliative care skills including indications for hospice care, initiating conversations about hospice with patients and families, and collaborating with hospice clinicians in the care of these vulnerable patients,” they write.

Older adults with ESKD in the U.S. have “markedly lower” rates of hospice utilization and shorter duration of hospice stay compared with their counterparts with other serious illnesses, for example, those with cancer or congestive heart failure, note the authors. “Among Medicare beneficiaries who have received maintenance dialysis, only 20% ever receive hospice versus almost 50% for the overall Medicare population,” they write. “Furthermore, among these hospice users with ESKD, 40% receive three days or less of hospice, versus 28% in the overall Medicare population.”

Medicare often does not cover the cost of dialysis for ESKD hospice patients, which can force many patients and families to make the hard choice between hospice care and dialysis. However, this lack of coverage alone fails to fully account for the discrepancy between hospice usage for ESKD patients compared with that for other patients at the EOL, note the authors. Hospice use is low among ESKD patients, even among those not receiving dialysis, as well as among patients using Medicare paid for by the Veterans Health Administration, which does cover the cost of concurrent hospice and dialysis, they point out.

The authors find this gap in care access concerning, due to the proven benefits of hospice. “Hospice use is

associated with better symptom management, family caregiver mental health, and patient- and family-reported care experience,” they write. Although the authors note that research is lacking regarding the hospice experiences of patients with ESKD, they cite a 2019 study that found that family-rated quality of EOL care was higher among those whose loved ones with ESKD received hospice care.

Investigators analyzed interview responses of 20 nephrologists (mean age, 50 years; mean years in practice, 18 years; White race, 85%) from two tertiary care medical centers (75%) and four community nephrology practices (25%). The focus on nephrologists’ experiences with hospice, as well as their perspectives on hospice, palliative care, and EOL care was conducted as a secondary analysis of a larger study on treatment decision making in older adults with chronic advanced kidney disease. Two main themes contributing to the lack of timely access to high-quality hospice care for ESKD patients emerged.

### Theme I: Nephrologists view dialysis and hospice as mutually exclusive

- A “narrow vision” of when hospice should be considered was shared by participants, none of whom mentioned involving hospice in the context of patients who were receiving dialysis, “regardless of how uncomfortable or close to death the patient might be,” write the authors.
- For example, one participant recalled a patient who was imminently dying, but was not referred to supportive care because the patient wished to continue dialysis. This nephrologist expressed regret that the patient experienced a “two-week end-of-life hospitalization,” saying that if the patient had chosen non-dialytic care, “I would’ve arranged palliative care...even hospice at some point.”
- Discomfort with the concept of hospice was expressed by some nephrologists. A few held strongly negative views of hospice, feeling that the transition to hospice care had been pushed on their patients, or made too suddenly, or that they themselves were not involved in the conversation.
- Medicare policy barriers to concurrent hospice care and receipt of dialysis were mentioned by several

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# RISK FACTORS FOR AGGRESSIVE END-OF-LIFE CANCER CARE IDENTIFIED; ASCO ISSUES 2024 PALLIATIVE CARE GUIDELINE UPDATE

Predictors of receipt of high-intensity care near the end of life (EOL) among patients with four common types of cancer and representing multiple demographic characteristics have been identified in the hope of aiding clinicians to refer those patients who could benefit to hospice and palliative care, according to the authors of a study published in the *Journal of Geriatric Oncology*.

“The risk factors identified in this study can be used to help oncologists identify which patients are at greatest risk of receiving high-intensity EOL care,” write the authors. “In light of the fact that the current and future capacity of specialty palliative care cannot absorb the care of all patients who are at risk for high-intensity EOL care, it is crucial that oncologists target palliative care interventions to those patients who are most at risk of excessive EOL care.”

Investigators analyzed linked data from the population-based cancer registry SEER (Surveillance, Epidemiology, and End Results) and Medicare claims of 59,355 beneficiaries (female, 49.2%; non-White, 21.2%; mean age at diagnosis, 76 years; mean age at death, 77 years) diagnosed with common solid tumors (breast, colorectal, lung, or prostate cancers) who died of the underlying cancer between 2011 and 2015. Overall, 44.8% of study patients received aggressive EOL care.

## Indicators of aggressive EOL cancer care included:

- ≥ 1 admission to the ICU in the last 30 days of life
- ≥ 2 inpatient admissions in the last 30 days of life
- ≥ 2 ED visits in the last 30 days of life
- Receipt of any oral or parenteral chemotherapy in the last 14 days of life

“These indicators have been widely adopted in the literature and endorsed as quality-of-care measures by the American Society of Clinical Oncology (ASCO) and the National Quality Forum (NQF),” point out the authors. They note that although these quality measures were developed a few decades ago, “despite innovations in cancer management, the primary features of high-quality medical care at the end of life have not evolved to include high-intensity interventions, and therefore these benchmarks remain appropriate.”

## Predictors of greater odds for high-intensity EOL care

- Increased comorbidity burden (odds ratio [OR], 1.29; 95% confidence interval [CI], 1.28 to 1.30)
- Black race (OR, 1.14; 95% CI, 1.07 to 1.23) or other minority race/ethnicity (OR, 1.20; 95% CI, 1.10 to 1.30) compared with those identifying as White
- Stage III disease (OR, 1.11; 95% CI, 1.05 to 1.18)
- Female sex (OR, 1.05; 95% CI, 1.01 to 1.09)
- Residence in a county with > 1 million people compared with those living in a county with < 250,000 people (OR, 1.23; 95% CI, 1.16 to 1.31)
- Living in a census tract with > 20% poverty (OR, 1.12; 95% CI, 1.04 to 1.19)
- Having state-subsidized Medicare premiums (OR, 1.18; 95% CI, 1.12 to 1.24)

## The risk of high-intensity EOL care was lower among those who:

- Had poor performance status (OR, 0.26; 95% CI, 0.25 to 0.28)
- Were older than mean age at diagnosis (OR, 0.98; 95% CI, 0.98 to 0.99)
- Lived in the Midwest (OR, 0.69; 95% CI, 0.65 to 0.75), South (OR, 0.70; 95% CI, 0.65 to 0.74), or West (OR, 0.81; 95% CI, 0.77 to 0.86) compared with the Northeast U.S.
- Lived in mostly rural areas (OR, 0.92; 95% CI, 0.86 to 1.00) compared with those in all-urban areas

“Results were largely consistent across cancer types,” write the authors. Further, “among patients who died within six months of diagnosis, those diagnosed with cancer at an advanced stage were less likely than those diagnosed with early-stage disease to receive high-intensity EOL care.”

Admission to ICU and/or hospital was the most common type of high-intensity EOL care identified, with receipt of

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## ◀ RISK FACTORS FOR AGGRESSIVE EOL CANCER CARE (from page 4)

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chemotherapy being the least common type, “with little variation across cancers,” note the authors. They suggest these findings could be explained by the study’s exclusion of “patients with hematologic malignancies, who experience higher rates of high-intensity EOL care relative to patients with solid tumors.”

Further explanation of the low rate of EOL chemotherapy the researchers found could be the continuing declining trend in chemotherapy administration within 14 days of death, they note.

### **ASCO issues updated palliative care guideline**

In May 2024, ASCO published an updated guideline for palliative care (PC) for cancer patients, which not only reinforces previous recommendations for early integration of PC into oncology practices, but also addresses the importance of providing PC to patients often excluded from this supportive care: Those with hematologic malignancies and those in early-phase clinical trials.

Oncologists who may be hesitant to refer patients with hematologic malignancies due to worry that PC would interfere with potentially life-saving treatment should know that the ASCO update cites three new publications since the previous guideline (2016) that demonstrate the benefits of PC for hematologic patients, notes update lead author Justin Sanders, MD, MSc, of McGill University in Montreal and co-chair of the guideline expert panel.

The guideline acknowledges the important role oncology clinicians have in delivering what it refers to as “generalist” or “primary” PC. Aspects of primary PC provided by oncology clinicians include:

- Assessment and management of symptoms and physical needs as well as of psychosocial and spiritual concerns
- Attention to cultural aspects of care, including ethical issues
- Coordination of supportive care services and referrals to specialty PC or hospice

The guideline strongly recommends that oncology clinicians refer patients with advanced solid tumors and hematologic malignancies early in the disease course — and alongside active treatment — to specialized interdisciplinary PC teams that provide outpatient and

inpatient care. In addition, “patients and/or caregivers should also be able to request palliative care at any stage, with any prognosis, based on their needs.”

Specialty PC teams enhance oncology clinicians’ primary PC by providing: An extra layer of support for patients with advanced disease and those at the EOL; consultation for the management of complex physical, psychosocial, or spiritual concerns; and communication with patients/families about goals of care and EOL care decisions.

“This guideline is a call to action for everyone to think about how they are integrating PC for all patients with cancer,” says senior author Betty Ferrell, PhD, of City of Hope and co-chair with Sanders of the expert panel. “There are great advances in cancer care, but none of these will be fully effective unless we fully integrate palliative care.”

### **ASCO guideline: Essential components of PC**

- Rapport and relationship building with patient and family caregivers
- Symptom, distress, and functional status management (e.g., pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation)
- Exploration of understanding and education about illness and prognosis
- Clarification of treatment goals
- Assessment and support of coping and spiritual needs
- Assistance with medical decision making
- Coordination with other care providers
- Provision of referrals to other care providers as needed

Sources: “Predictors of High-Intensity Care at the End of Life Among Older Adults with Solid Tumors: A Population-Based Study,” *Journal of Geriatric Oncology*; June 2024; 15(5):101774; DOI: 10.1016/j.jgo.2024.101774. Baird CE, Wulff-Burchfield E, Panagiotou OA, et al; Center for Gerontology and Healthcare Research, Department of Health Services Policy and Practice, Brown University School of Public Health, Providence, Rhode Island; Medical Oncology Division and Palliative Medicine Division, Department of Internal Medicine, University of Kansas School of Medicine, University of Kansas Cancer Center, Kansas City. “Palliative Care for Patients with Cancer: ASCO Guideline Update,” *Journal of Clinical Oncology*; July 1, 2024; 42(19):2336–2357; DOI: 10.1200/JCO.2400542. Sanders JJ, Temin S, Ferrell BR, et al; McGill University, Montreal; American Society of Clinical Oncology (ASCO), Alexandria, Virginia; City of Hope National Medical Center, Duarte, California.

# ▶ ADDRESSING RACISM IN END-OF-LIFE CARE: 'HOSPICE AND PALLIATIVE CARE SHOULD BE MADE ACCESSIBLE FOR ALL...'

The persistent racial and ethnic disparities in healthcare, which professional organizations have officially recognized and made formal attempts to address in recent years, continue to be of concern for the quality of care delivered to minority patients approaching the end of life (EOL), impacting their care in specific areas, as identified in a literature review and published in a report in *Annals of Palliative Medicine*.

Although the researchers found in their review of studies published from 2000 to 2023 that the disparities in EOL care experienced by minority patients are “complex and multifaceted,” they report evidence of contributing factors at the patient, provider, and institution levels and identify the domains of EOL care most impacted by the disparities, as well as offering suggestions for providers to reduce inequitable care.

“[D]isparities in communication, palliative and hospice care utilization, and symptom management must be eradicated,” write the authors. “Hospice and palliative care should be made accessible for all patients and families experiencing severe illness regardless of their racial or ethnic background.”

## Key domains of EOL care impacted by healthcare disparities:

- **Palliative care access and utilization.** “While the majority of studies have found racial and/or ethnic disparities in the use of palliative care and hospice at EOL, many studies have also found variation across hospitals in palliative care and hospice use,” the authors write.
- **Pain and symptom management.** Black patients are known to be “less likely to have their pain evaluated by physicians, to receive or have access to pain medications, and are more likely to have their pain underestimated by physicians,” report the authors.
- **Completion of advance care directives.** Black and Hispanic patients are less likely than their White counterparts to name a healthcare representative, engage in conversation with their clinicians about their goals, values, and EOL preferences, and to have an advance care planning (ACP) document.

“It is important to note that although there are racial and ethnic differences in ACP documentation,

there is a low prevalence of ACP documentation across all patients,” write the authors. “Increased ACP documentation and increasing the frequency of goals-of-care conversations held between patients, surrogates, and clinicians should be pursued in clinical practice across all specialties and with all patients regardless of race, ethnicity, age, or gender.”

- **Hospice utilization.** “[O]verwhelming evidence shows that Black patients have an appreciably lower rate of obtaining hospice services at EOL compared to White patients, and Black patients are more likely to die in the hospital,” write the authors.

With its family-centered care and offer of spiritual support, hospice care “can be culturally tailored to the needs of minority patients, making it a useful resource to improve the quality of EOL care.”

## Factors contributing to racial/ethnic disparities in EOL care include:

- Health literacy
- Access to care
- Mistrust of the healthcare system
- Social determinants of health (SDH)
- Medical racism
- Cultural and religious values and customs of patients/families
- Communication between providers and patients

## The importance of physician-patient communication

“It has been shown that Black patients consistently report experiencing poorer quality communication and receipt of information, in addition to having lower levels of patient participation and shared decision making compared to Whites,” write the authors.

Outcomes of physician-patient communication vary by race, with EOL discussions between physicians and their Black patients shown to be less likely to result in goal-concordant care than are discussions with White patients.

“Providers must work on multiple fronts to address this inequity and injustice, the first of which is recognition

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## ◀ NEPHROLOGISTS SUPPORT THE HOSPICE CONCEPT (from page 3)

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participants, but they lacked confidence in their understanding of the issues involved.

- Hesitancy in referring to hospice from nephrology is often strongly associated with the prognostic certainty of the imminence of death after dialysis discontinuation, note the authors. “Because discontinuing dialysis almost uniformly portends imminent death,” they write, some nephrologists’ concerns about discontinuing dialysis when recommending EOL care poses “a barrier to hospice care unique to this population.” Further, “...the immediacy of death after dialysis discontinuation takes an emotional toll on nephrologists, a theme underscored by our current findings.”

### **Theme II: Nephrologists are uncertain who should manage hospice care for ESKD patients**

- Respondents reported feeling unprepared to engage in hospice discussions, referral, and care.
- Nephrologists indicated that they would most likely cede care of any ESKD patients who transitioned to hospice and defer to primary care physicians for co-management with hospice teams. Reasons cited included “self-perceived inadequacy to participate in the care of hospice patients...rooted in feeling unfamiliar with EOL care in general,” as well as time constraints and understaffing.
- Participants expressed concern about hospice agencies’ ability to properly care for ESKD patients.

Nephrologists worried that hospice is ill-equipped to provide quality care for those with ESKD and lacks experience with nephrology patients. “There was the lack of understanding on the part of hospice for the care of a hospice renal patient versus a cancer patient. Similar in some ways, but very different in others,” said one participant.

- Nephrologists voiced a desire for more interdisciplinary collaborative care between themselves and hospice clinicians “as a potential path forward to improve care.” One respondent suggested that if some hospice providers feel equally as unqualified as nephrologists in providing end-of-life ESKD care, the best quality care might result from both teams talking together to manage patients’ care.

The authors note that among the limitations of this study are its relatively small size and the predominantly White, non-Latinx sample due to the medical institutions from which the participants were recruited. Clinician views can vary significantly by geographical area, they note, and recommend that further research also include the perspectives of hospice providers, primary care physicians, and patients and their families.

Source: “Nephrologists’ Perspectives and Experiences with Hospice Among Older Adults with End-Stage Kidney Disease,” *Journal of the American Geriatrics Society*; July 2024; 72(7):2060–2069; DOI: 10.1111/jgs.18936. Wachterman MW, Sinha A, Bokhour B; Section of General Internal Medicine, Veterans Affairs Boston Health Care System, Boston; Department of Psychosocial Oncology and Palliative Care, Dana Farber Cancer Institute, Boston; Harvard Medical School, Boston; University of Massachusetts Chan Medical School, Worcester.

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and conversation regarding disparities in EOL care,” the authors urge. “[R]esearch suggests training physicians in cultural competence may improve physician-patient communication and collaboration, increase patient satisfaction, and facilitate adherence, thereby improving clinical outcomes and reducing health disparities.”

The authors note it will be important for healthcare professionals to focus on becoming racially and ethnically diverse by familiarizing themselves with minority cultures and learning how to support the values and preferences of all patients.

“[T]his comprehensive review offers a deeper understanding of why and where differences exist in EOL care,” conclude the authors. “This will encourage providers to introspect, question personal and system-level factors contributing to healthcare disparities, intervene, and engage in their moral and ethical obligation to help mitigate them.”

Source: Disparities in End-of-Life Care for Racial Minorities: A Narrative Review,” *Annals of Palliative Medicine*; March 2024; 13(2):309–321; DOI: 10.21037/apm-23-459. Jawed A and Comer AR; Division of Nephrology, Department of Medicine, University of Michigan, Ann Arbor; American Medical Association, Chicago; School of Health and Human Sciences and School of Medicine, Indiana University, Bloomington.



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