Hospice News

Holly Vossel, July 30, 2024

Recent research has found disparities in hospice discharge rates and outcomes among Black and Latino patient populations.

Black and Hispanic patients are more likely to have shorter stays and be discharged from hospice into a hospital setting compared to others, according to a recent study published in the Journal of the American Medical Association (JAMA) Network Open. These patients also face a higher likelihood of having burdensome care transitions compared to white populations, the study found.

The findings illustrate how access to quality end-of-life care is impacted by health inequities among underserved populations, said study author Elizabeth Luth, assistant professor at Rutgers University's family medicine and community health department. Co-authors included researchers from Care Dimensions, VNS Health, Weill Cornell Medicine and Emory University.

"Black and Hispanic individuals who are discharged alive are also at greater risk for poor outcomes once they leave hospice," Luth told Hospice News in an email. "Specifically, Black individuals are more likely to have a 'revolving door' experience: They are discharged alive, hospitalized and then readmitted to hospice."

The study examined the trajectories of more than 115,000 Medicare fee-for-service decedents between 2014 and 2019. Roughly 15% of patients leave hospice before death due to unplanned hospitalizations or to seek curative treatment, among other reasons, the study found. About 1-in-7 of these patients were either hospitalized or readmitted to hospice within two days of a discharge.

Patients with the highest rates of rehospitalization or death after a discharge identified as Black or Hispanic and had a hospice length of stay totalling seven days or less.

“Some folks, such as persons from racial and ethnic minoritized groups, or those who are discharged after a short hospice stay, are more vulnerable to experiencing poorer outcomes such as hospital death or hospitalization and readmission after live discharge,” Luth said.

Nearly half (42%) of hospice patients who are discharged alive die within six months, the study found. These live discharges can result in fragmented health care, the researchers indicated.

Data such as these can help hospices to better strategize their care delivery approaches in ways that help breakdown barriers to access and quality among underserved populations, according to Luth.

“We were interested in learning more about what happens to individuals who are discharged alive from hospice because live discharge is something that matters to policy makers, payers, hospice agencies, hospice nurses, social workers and families,” Luth said. “Our study provides insight into what happens once patients leave hospice. With this information, hospices have an opportunity to think about how they approach care for patient groups who are vulnerable to poorer post-discharge outcomes.”

Patients who received general inpatient (GIP) or respite care had lower odds of hospitalization and hospice readmission. Inpatient hospice services represented 6.2% of hospice spending, largely due to restrictive eligibility criteria and limited availability, the study found.

The findings suggest that GIP and respite services may reduce burdensome transitions and more effectively support patients with more complex care needs, the researchers indicated.

Widespread introduction of systemic discharge planning could help facilitate improved care transitions for Black and Hispanic populations, the researchers stated.

“Live discharge matters a lot to the U.S. Centers for Medicare & Medicaid Services (CMS),” Luth said. “[Hospices] want to provide high quality care for dying individuals and their families and still meet regulatory guidelines. It is important for hospice providers to understand that the potential negative impacts of live discharge are not evenly distributed across the hospice patient population.”

Greater attention and provider collaboration is needed to better address the unmet needs among underserved populations, according to Luth.

Adjusting hospice reimbursement structures in ways that disincentivize discharge could also reduce high-cost health care utilization and readmission rates.

“Improving patient care and experiences after hospice discharge will need collaborations and care coordination between hospices and many other providers and organizations, including integrated health systems who are responsible for population health, such as [Accountable Care Organizations (ACOs)], may play an important role,“ Luth said.