V.A. campaign to increase hospice care showing results

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A new study in the July issue of *Health Affairs* finds that a U.S Department of Veterans Affairs (V.A.) initiative to improve care at the end of life led to a substantial increase in the use of hospice among U.S. veterans.

The V.A. contracted with lead author Susan Miller, a professor of health services, policy and practice in the Brown University School of Public Health, to study the effect of the department's four-year Comprehensive End-of-Life Care (CELC) initiative, which began in 2009. Not only did the initiative encourage more hospice use among military veterans, Miller found, but also the growth outpaced the rate of increase among demographically comparable members of the public receiving Medicare.

Through the initiative, the V.A. invested in new inpatient hospice units, palliative care staff, palliative care training and mentoring for leaders and staff, a systematic quality monitoring program, and outreach to community providers outside V.A. medical centers through the "We Honor Veterans" campaign.

To conduct the evaluation, Miller and her co-authors at the V.A., including the Geriatrics and Extended Care Data Analysis Center, analyzed the trend in hospice use among more than a million male veterans age 65 and older between 2007 and 2014, and compared the rate of growth with what was happening among hundreds of thousands of demographically similar Medicare beneficiaries not enrolled in V.A .health care.

"Compared to enrolled veterans' hospice use in the years before CELC began, their use of hospice after the initiative increased substantially, and rates of increased use were approximately two percentage points higher than the increases observed for Medicare beneficiaries not enrolled in V.A. health care," Miller said. "Based on population data, we estimated that this increase resulted in an additional 17,046 veterans receiving hospice care in fiscal years 2010 to 2014."

The V.A. began work to establish a system-wide hospice and palliative care program in 2002, Miller said.

"Palliative care, in the form of palliative care consults and visits and hospice care, has been found to improve care at the end of life and to result in care more aligned with patient and family preferences," she said. "Thus, palliative care results in less aggressive (and undesired) care such as emergency room visits and hospitalizations near the end of life. The V.A.'s efforts to improve veterans' end-of-life care arose from the recognition that improvement was needed and the belief that greater access to palliative care and hospice could help to achieve this improvement."

Over the decade, the V.A. saw clear growth in hospice use. In 2008, for example, 30 percent of inpatient deaths in V.A. medical centers were in hospice beds, Miller wrote, but by 2011 that proportion had climbed to 44 percent.

A careful comparison

But during the same timeframe, hospice use had been growing among the general population, too. Miller and her colleagues therefore structured the study specifically to determine whether the CELC initiative drove growth beyond any trend in the general Medicare population. That wasn't a simple task given that older veterans are eligible for Medicare as well as V.A. benefits.

"Some veterans receive care in their last year of life reimbursed by the V.A. or Medicare or both," Miller said. "So our evaluation compared differences in changes in hospice use for groups of veterans with differing combinations of health care use."

The study reports that nonveterans (with only

Medicare) increased hospice use by 5.6 percent between the pre-initiative period (fiscal year 2007 and 2008) and the post-initiative period (fiscal years 2010 to 2014). Meanwhile the growth was 7.6 percent among V.A.-only veterans, 6.9 percent among dually enrolled veterans who used V.A. care, 7.6 percent among veterans who blended the V.A. and Medicare and 7.9 percent among dually enrolled veterans who used Medicare.

"Additionally, we did a sub-analysis including only veterans and nonveterans with any hospitalization in the last year of life because we believed that if indeed the CELC initiative drove the observed two percentage point population-level differences, we would see even greater effects for veterans with exposure to V.A. medical centers since most of the CELC investments occurred in these settings," Miller said. "The validity of our findings was supported as we found that veterans who used only V.A. health care and had V.A. hospital exposure, compared to similar Medicare beneficiaries, had a greater increase in hospice use of four percentage points."

More improvement needed

Despite their relatively large increases in hospice use, the small V.A.-only population of veterans not enrolled in Medicare (about 1 percent of the study population) remained the least likely users of hospice care by a gap of about 10 percentage points throughout the study period. Miller said the data may in part reflect a socioeconomic disparity but may also result from the study's inability to determine if hospice was received through another payer such as Medicaid.

"Research has shown that African Americans and lower-income individuals use hospice less and since this [V.A.-only] group of veterans tend to have lower incomes and are more often African American, this is likely part of the reason for lower use," she said. "However, there are likely other factors at play that need to be identified. The V.A. is continuing to evaluate the reasons for this observation of underutilization so interventions for improvement can be enacted, as needed."

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