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**Care for Dying Medicare Patients at Elite Cancer Centers
Differs Little from Community Hospitals**

***National study shows care varies widely between similar hospitals,
terminally ill cancer patients receive aggressive care***

Lebanon, N.H. (April 9, 2012) – The nation’s most elite cancer care centers performed only modestly better than community hospitals at meeting recognized quality standards for treating dying cancer patients, displaying similar patterns of relatively aggressive, high-intensity treatments in the final weeks of these patients’ lives, according to a [new study](#) by Dartmouth researchers published in the April 2012 issue of *Health Affairs*.

The Dartmouth researchers also found that even among hospitals with a specific clinical focus on cancer care, such as those in the National Comprehensive Cancer Network and at designated National Cancer Institute centers, there were significant variations in how they treated patients at the end of life. The analysis found two-fold differences among these institutions in the rates of intensive care unit use in the last month of life, chemotherapy in the last 14 days of life, deaths occurring in the hospital, and the use of hospice care for fewer than three days.

Researchers compared the care experienced by patients at hospitals with distinct characteristics—community hospitals, academic medical centers, for-profit and nonprofit, in addition to those with special cancer care designation—by examining the intensity of health care services delivered to Medicare patients who were terminally ill with cancer. They found that the overall amount of care provided was high—more so than many patients might prefer—but also varied greatly, even among hospitals of similar size, tax status and designation as a cancer center.

The analysis included more than 215,000 Medicare patients with poor-prognosis cancer (meaning that they were likely to die within a year) and the care provided to them at approximately 4,400 hospitals nationwide from 2003 through 2007. For each patient, researchers studied the care received in the six months preceding their death, such as hospitalizations, hospice use, intensive care unit use and the number of physicians providing care.

Remarkably, no specific type of hospital, whether it was a designated cancer center, an academic medical center or community-based hospital, was found to excel at providing care that is consistent with standards endorsed by the National Quality Forum, such as having lower rates each of use of the intensive care unit in the last month of life, use of chemotherapy in the last 14 days of life, deaths occurring in the hospital, and the use of hospice care for fewer than three days.

Following these guidelines matters because it helps determine whether patients with short life expectancies receive relatively high levels of comfort-focused, palliative services and are less likely to die in a hospital or in a hospital's intensive care unit, or whether they are more likely to spend their last days in the hospital, often in intensive care units receiving uncomfortable treatments—such as using a breathing tube connected to a ventilator—that are unlikely to prolong or enhance the quality of life.

“Each hospital needs to examine the care it provides to patients believed to be nearing death, and question its alignment with patient preferences—whether they be for early supportive care or aggressive treatment in the last days of life,” said Nancy E. Morden, MD, MPH, lead author and researcher at the Dartmouth Institute for Health Policy and Clinical Practice.

Researchers observed that hospital characteristics explained little of the observed variation in intensity of end-of-life cancer care and that none reliably predicted a specific pattern of care. [Previous research](#) had found no consistent pattern of care or evidence that treatment patterns follow patient preferences, even among the nation's leading academic medical centers.

“These results indicate the need for a broad reexamination of end-of-life cancer care and whether it meets the needs and wants of patients. We recommend that efforts to improve the quality of end-of-life care extend to every type of hospital, regardless of their designation,” said David C. Goodman, MD, MS, co-principal investigator of the Dartmouth Atlas Project and director of the Center for Health Policy Research at The Dartmouth Institute for Health Policy and Clinical Practice.

The individual hospital data used in the *Health Affairs* article, “End-of-Life Care For Medicare Beneficiaries With Cancer Is Highly Intensive Overall And Varies Widely,” can be found at <http://content.healthaffairs.org/content/31/4/786.abstract>. Additional authors include Chiang-Hua Chang, research instructor at the Dartmouth Institute for Health Policy and Clinical Practice, Joseph O. Jacobson, chief quality officer at the Dana Farber Cancer Institute, Ethan M. Berke, associate professor at Dartmouth Medical School, Julie P.W. Bynum, associate professor at the Dartmouth Institute for Health Policy and Clinical Practice and Kimberly M. Murray, research associate at the Maine Medical Center Research Institute's Center for Outcomes Research and Evaluation.

The Dartmouth Atlas Project is located at the Dartmouth Institute for Health Policy and Clinical Practice and principally funded by the Robert Wood Johnson Foundation. For more information, visit www.dartmouthatlas.org.

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Methodology

Researchers identified a 20 percent sample of fee-for-service Medicare beneficiaries between 2003 and 2007 who had continuous inpatient and outpatient Medicare insurance in the last six months of life. Decedents were included if they had at least one hospital discharge or two clinician visits in the last six months of life with a cancer diagnosis associated with a high risk of near-term death, and if they had at least one hospital admission for cancer care in the last six months of life. Medical care was attributed to the hospital providing the patient with the largest number of hospitalizations for cancer care in the last six months of life. Hospitals were categorized into four types: National Comprehensive Cancer Network members; National Cancer Institute cancer centers; academic medical centers not in the network or designated cancer centers; and community hospitals.

About the Dartmouth Atlas Project

For more than 20 years, the [Dartmouth Atlas Project](#) has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems across America.