Overuse of care, considered aggressive at end of life

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Associate Professor
Department of Internal Medicine
Objectives

1. Recognize variation in end of life care across the United States.
2. Describe the examples and trends of care considered aggressive during end of life.
3. Examine the factors associated with inappropriate EOL care.
4. Discuss Ethical dilemma related to EOL care.
Art of dying 2011
Meet Mac

9/14/2011

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Facts

• 6% of Medicare beneficiary who die each year consume 30% of Medicare expenditures

• Medicare paid $55 billions in physician and hospital fees for patients in last 2 months of life in 2009

• Estimated 30% is for overuse

CBS news “60 minutes” 8/7/2010
Statement of
Peter R. Orszag
Director
The Overuse of Health Care

Overuse occurs when a service is provided even though its risk of harm exceeds its likely benefit—that is, when it is not warranted on medical grounds.

July 17, 2008
How can care at the best medical center in the world cost twice as much as care at the best medical center in the World?

Peter R. Orszag
Dartmouth Atlas
Variation in End of life care

- 77 hospitals appeared in 2001 *US News and World Report* “best hospitals” for heart, pulmonary, cancer and geriatrics
- Medicare patients
- Most of the care in the last 2 years of their lives were at the “best hospital”
- Outcome Measure: Use of healthcare resources in the last 6-months of life

Distribution of rates and statistical measures of variation for end of life care among 77 cohorts assigned to hospitals with national reputations for high quality.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Care during last six months of life</th>
<th>Terminal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days in hospital</td>
<td>14.5</td>
<td>26.9</td>
</tr>
<tr>
<td>Days in ICU</td>
<td>3.72</td>
<td>39.6</td>
</tr>
<tr>
<td>Physician visits</td>
<td>34.1</td>
<td>23.1</td>
</tr>
<tr>
<td>% seeing 2+ physicians</td>
<td>37.3</td>
<td></td>
</tr>
<tr>
<td>% admitted to hospital</td>
<td>26.9</td>
<td></td>
</tr>
<tr>
<td>% of deaths in hospital</td>
<td>1.46</td>
<td></td>
</tr>
<tr>
<td>% of deaths with ICU stay</td>
<td>1.22</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Mean (1.38)</th>
<th>Interquartile ratio (1.72)</th>
<th>Extremal ratio (5.85)</th>
<th>Coefficient of variation (0.23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days in hospital</td>
<td>2.89</td>
<td>5.85</td>
<td>4.33</td>
<td>0.23</td>
</tr>
<tr>
<td>Days in ICU</td>
<td>1.47</td>
<td>1.55</td>
<td>4.33</td>
<td>0.28</td>
</tr>
<tr>
<td>Physician visits</td>
<td>3.46</td>
<td>3.46</td>
<td>3.46</td>
<td>0.28</td>
</tr>
<tr>
<td>% seeing 2+ physicians</td>
<td>4.05</td>
<td>3.50</td>
<td>4.38</td>
<td>0.17</td>
</tr>
<tr>
<td>% admitted to hospital</td>
<td>1.46</td>
<td>1.22</td>
<td>1.34</td>
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</tr>
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<td>1.22</td>
<td>1.34</td>
<td>1.34</td>
<td>0.28</td>
</tr>
</tbody>
</table>

## Variation in end of life care across Texas hospital 2001-2005

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Hospital Days</th>
<th>ICU days</th>
<th>No. of different physicians seen during the last 6 months of life</th>
<th>% seeing &gt; 10 physicians</th>
<th>%Death occurring in the hospital</th>
<th>% death a/w ICU admission</th>
<th>% decedents enrolled in hospice during last 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTMB</td>
<td>14.9</td>
<td>4.9</td>
<td>8.7</td>
<td>37.7%</td>
<td>34.4%</td>
<td>21.7%</td>
<td>42.7%</td>
</tr>
<tr>
<td>The Methodist</td>
<td>18.3</td>
<td>6.2</td>
<td>11.4</td>
<td>50.9%</td>
<td>41.4%</td>
<td>29.7%</td>
<td>33.5%</td>
</tr>
<tr>
<td>MD Anderson</td>
<td>18.3</td>
<td>4.5</td>
<td>11.4</td>
<td>56.5%</td>
<td>36.3%</td>
<td>21.95</td>
<td>38.0%</td>
</tr>
<tr>
<td>Memorial Hermann-TMC</td>
<td>13.8</td>
<td>8.0</td>
<td>10.0</td>
<td>45.6%</td>
<td>42.7%</td>
<td>36.8%</td>
<td>31.9%</td>
</tr>
<tr>
<td>Clear lake regional</td>
<td>16.5</td>
<td>9.6</td>
<td>10.3</td>
<td>46.1%</td>
<td>32.1%</td>
<td>26.6%</td>
<td>45.1%</td>
</tr>
<tr>
<td>McAllen, TX</td>
<td>17.7</td>
<td>7.1</td>
<td>12.4</td>
<td>59.6%</td>
<td>47.5%</td>
<td>34.7%</td>
<td>12.2%</td>
</tr>
</tbody>
</table>
## Cost of cancer care in 2004

<table>
<thead>
<tr>
<th>Type of cancer</th>
<th>Initial 12 mths</th>
<th>Continuing (annual)</th>
<th>Last year of life (12 mths)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>$35,672</td>
<td>$3926</td>
<td>$51,757</td>
</tr>
<tr>
<td>Breast</td>
<td>$11,728</td>
<td>$1201</td>
<td>$29,199</td>
</tr>
<tr>
<td>Colorectal</td>
<td>$29,609</td>
<td>$2254</td>
<td>$36,483</td>
</tr>
<tr>
<td>Prostate</td>
<td>$10,612</td>
<td>$2134</td>
<td>$33,691</td>
</tr>
<tr>
<td>Pancreatic</td>
<td>$57,819</td>
<td>$4656</td>
<td>$65,576</td>
</tr>
</tbody>
</table>

Cost of cancer care
End of life care- Resurrecting the dead

-1yr  -6 months  -30 days
“Well, your condition is serious but you can take some comfort in the fact that nobody lives forever!”
Indicators of aggressive care during end of life

- ICU use
- In hospital CPR
- Feeding tube placement
- Intensive use of chemotherapy
- ER visits
- Hospitalizations
- Low rates of hospice use
ICU care

• ICU bed – Monitoring equipment
• Mechanical Ventilation
• Vasopressor support
• Cardiopulmonary resuscitation
Use of ICU at the end of life in the United States

- Six states (Florida, Massachusetts, New Jersey, New York, Virginia, and Washington) hospital discharge database 1999
- 552,157 deaths, 38.3% occurred in hospital
- 22.4% occurred after ICU admission
- 1 in 5 Americans die using ICU services

Angus et al. Crit Care Med. 2004
What happens to older adults who survived their ICU stay?
3-year Outcomes of patients who survived ICU stay

Wunsch, H. et al. JAMA 2010;303:849-856
Relationship between aggressive cancer care and hospice use

Trends in ICU and hospice use among advanced lung cancer patients
Unadjusted percentages of ICU use and hospice use in the last 6 months of life among patients with advanced lung cancer by year of death.

Sharma G et al. Chest 2008;133:72-78
The clinical trajectory of patients admitted to an ICU with advanced lung cancer.

- Had ICU Stay N=9,942
  - Died in Hospital N=4,101 (41.3%)
  - Discharged Alive N=5,841 (58.7%)
    - Discharged Home N=3,316 (56.8%)
      - Re-hospitalized N=1,642 (51.0%)
      - Hospice N=1,792 (54.0%)
    - Nursing Home* N=886 (26.7%)
      - Re-hospitalized N=891 (35.2%)
      - Hospice N=1,053 (41.7%)

- Discharged to Nursing Home* N=2,525 (43.2%)

Median survival of those d/c alive-33 days

*Includes any institutional setting

Sharma G et al. Chest 2008;133:72-78
Summary

• Among advanced lung cancer patients, ICU utilization during end of life increased from 17.5% in 1993 to 24.7% in 2002

• 36.8% had a potentially reversible condition.

• Total health care cost $40,929 in ICU users and $27,160 in non-ICU users (P<0.001)

• During the same period hospice enrollment has increased from 28.8% to 49.9%

• After adjusting for patient characteristics, there was 6.6% annual increase in ICU use

• 6.5% had both ICU and hospice use.

• Median time in hospice was 15 days
Why is there overuse?

• Patient and family preferences?
• Physician preferences?
• Religion?
• Lack of trust in healthcare system
• Inability to predict death with certainty
• Health care delivery
Factors a/w EOL Care

Societal issues
- Local philosophies
- Legal/ethical concerns

Patient Characteristics
- Age
- Ethnicity
- Education
- Religious / cultural beliefs
- End of life preferences (Advance Directives)
- Quality of life
- Trust in medical system
- Relationship with physician

Medical Care Provider
- Training
- Religious / cultural beliefs
- Conflict of interest
- Ability to Predict death
- Communication skills
- Practice setting

Insurance status

Outpatient continuity of care

Outpatient to inpatient Transition care continuity

Family / Surrogate
- Prior experience
- Beliefs
- Trust in medical system
- Knowledge/attitude

Resource
- Availability of ICU beds
- Availability of hospice services

Disease characteristics
- Acute vs. chronic
- Probability for cure
- Comorbidity
Religion coping and use of life sustaining therapies at the end of life

• Median time to death-122 days
• Intensive life prolonging care
  – Mechanical ventilation
  – CPR in last week of life
RCOPE: Religious Coping Methods

**Religious Methods of Coping to Find Meaning**

1. Benevolent Religious Reappraisal – redefining the stressor through religion as benevolent and potentially beneficial.
2. Punishing God Reappraisal – redefining the stressor as a punishment from God for the individual’s sins.
4. Reappraisal of God’s Powers – redefining God’s power to influence the stressful situation.

**Religious Methods of Coping to Gain Control**

1. Collaborative religious Coping – seeking control through a partnership with God in problem solving.
2. Active Religious Surrender – an active giving up of control to God in coping.
3. Passive Religious Deferral – passive waiting for God to control the situation.
4. Pleading for Direct Intercession – seeking control indirectly by pleading to God for a miracle or divine intercession.
5. Self-Directing Religious Coping – seeking control directly through individual initiative rather than help from God.

*J Clin Psych 2000*
Religious Methods of Coping to Gain Comfort and Closeness to God
1. Seeking Spiritual Support – searching for comfort and reassurance through God’s love and care.
2. Religious Focus – engaging in religious activities to shift focus from the stressor.
4. Spiritual Connection – experiencing a sense of connectedness with forces that transcend the individual.
5. Spiritual Discontent – expressing confusion and dissatisfaction with God’s relationship to the individual in the stressful situation.
6. Marking Religious Boundaries – clearly demarcating acceptable from unacceptable religious behavior and remaining within religious boundaries.

Religious Methods of Coping to Gain Intimacy with Others and Closeness to God
1. Seeking Support from Clergy or Member – searching for comfort and reassurance through the love and care of congregation members and clergy.
2. Religious Helping – attempting to provide spiritual support and comfort to others.
3. Interpersonal Religious Discontent – expressing confusion and dissatisfaction with the relationship of clergy or members to the individual in the stressful situation.

J Clin Psych 2000
Religious Methods of Coping to Achieve a Life Transformation

1. Seeking Religious Direction – looking to religion for assistance in finding a new direction for living when the old one may no longer be viable.
2. Religious Conversion – looking to religion for a radical change in life.
3. Religious Forgiving – looking to religion for help in shifting from anger, hurt, and fear associated with an offense to peace.
Inclusion criteria

• diagnosis of an advanced cancer with metastases,
• disease progression following first-line chemotherapy,
• age of at least 20 years,
• presence of an informal caregiver (eg, spouse),
• adequate stamina to complete the 45-minute interview, and
• ability to speak English or Spanish
# Level of Positive Religious Coping and End-of-Life Care

<table>
<thead>
<tr>
<th></th>
<th>Level of positive religious coping</th>
<th></th>
<th>Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Mechanical ventilation</td>
<td>11.3%</td>
<td>3.6%</td>
<td>2.81 (1.03-7.69)</td>
</tr>
<tr>
<td>CPR</td>
<td>7.4%</td>
<td>1.8%</td>
<td>3.05 (0.79 – 11.78)</td>
</tr>
<tr>
<td>Either</td>
<td>13.6%</td>
<td>4.2%</td>
<td>2.90 (1.14 – 7.35)</td>
</tr>
<tr>
<td>Death in ICU</td>
<td>10.7%</td>
<td>4.2%</td>
<td>1.80 (0.68 – 4.73)</td>
</tr>
<tr>
<td>Hospice enrollment</td>
<td>71.3%</td>
<td>73.5%</td>
<td>0.97 (0.58 – 1.65)</td>
</tr>
</tbody>
</table>

Phelps et al. JAMA 2009.
Does faith makes it harder to have a good death?
SECOND OPINION

BY ROB ROGERS

IF YOU'RE COUNTING ON A MIRACLE FROM GOD... WHY ALL THE LIFE SUPPORT?

MY GOD NEEDS ALL THE HELP HE CAN GET!
Prognostic Disclosure to patients with cancer near EOL

- 326 patients with cancer
- Enrolled from 5 hospices in Chicago, IL
- Physician formulated and communicated survival estimates to patients
  - Would not communicate survival estimate 22.7%
  - Communicate formulated survival estimate 37%
  - Communicate different estimate than formulated 40.3%

Relationship between formulated and communicated survival.

The diagonal line represents frank disclosure. Patients above the diagonal line would receive knowingly overestimated survival information, and patients below the diagonal line would receive knowingly underestimated survival information.

Relationship between communicated, formulated, and actual survival.

Median actual survival - 26 days
formulated survival - 75 days
communicated survival - 90 days.

The median isn’t the message

Survival time

Stephen Jay Gould
Evolutionary biologist at Harvard
Physician beliefs and EOL care

Physicians' Religious Beliefs Influence End-of-Life Decisions

8857 UK medical practitioners were mailed an anonymous questionnaire to assess their end-of-life decisions for patients.

3733 (42.1%) responded, and 2923 reported on the care of a patient who had died.

The most religious physicians were less likely to have discussed end-of-life care decisions with their patients and less likely to administer narcotics/sedatives than other physicians.

Seale et al J Med Ethics. 2010
"I admire your persistence, doctor. But face it. You've lost this patient."
At the end of life denial comes at a price
Physicians discussion with patients on EOL care

- "Have you and your doctor discussed any particular wishes you have about the care you would want to receive if you were dying?"

- 627 patients with advanced cancer
- Multisite coping with cancer study
- 188 (31.2%) had EOL care discussion at baseline

Table 4. Medical Care, Location and Quality of Death, and Survival Time by the Presence or Absence of End-of-Life (EOL) Care Discussion Among the Deceased Propensity Score-Matched Cohort

<table>
<thead>
<tr>
<th>Variable</th>
<th>Yes (n=75)</th>
<th>No (n=70)</th>
<th>Adjusted Odds Ratio (95% Confidence Interval)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care received during the last week of life, No. (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive care unit stay</td>
<td>2 (2.7)</td>
<td>10 (14.3)</td>
<td>0.01 (0.02-0.60)</td>
<td>.01</td>
</tr>
<tr>
<td>Ventilator use</td>
<td>1 (1.3)</td>
<td>10 (14.3)</td>
<td>0.030 (0.009-0.300)</td>
<td>.005</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>1 (1.3)</td>
<td>6 (8.6)</td>
<td>0.10 (0.02-1.30)</td>
<td>.09</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>4 (5.3)</td>
<td>7 (10.0)</td>
<td>0.6 (0.1-1.6)</td>
<td>.30</td>
</tr>
<tr>
<td>Inpatient hospice used</td>
<td>8 (10.7)</td>
<td>5 (7.1)</td>
<td>1.8 (0.5-6.5)</td>
<td>.34</td>
</tr>
<tr>
<td>Inpatient hospice stay ≥1 wk</td>
<td>4 (5.3)</td>
<td>2 (2.9)</td>
<td>3.7 (0.4-38.2)</td>
<td>.27</td>
</tr>
<tr>
<td>Outpatient hospice used</td>
<td>58 (77.3)</td>
<td>40 (57.1)</td>
<td>3.2 (1.5-6.9)</td>
<td>.004</td>
</tr>
<tr>
<td>Outpatient hospice stay ≥1 wk</td>
<td>52 (69.3)</td>
<td>34 (48.6)</td>
<td>2.5 (1.2-5.0)</td>
<td>.01</td>
</tr>
<tr>
<td>Place of death, No. (%)&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive care unit</td>
<td>2 (2.9)</td>
<td>9 (13.2)</td>
<td>0.10 (0.03-0.70)</td>
<td>.02</td>
</tr>
<tr>
<td>Hospital</td>
<td>15 (21.7)</td>
<td>15 (22.5)</td>
<td>0.7 (0.3-1.6)</td>
<td>.45</td>
</tr>
<tr>
<td>Inpatient hospice</td>
<td>5 (7.2)</td>
<td>3 (4.4)</td>
<td>1.9 (0.4-8.8)</td>
<td>.44</td>
</tr>
<tr>
<td>Home</td>
<td>47 (66.1)</td>
<td>36 (55.9)</td>
<td>1.3 (0.6-2.6)</td>
<td>.49</td>
</tr>
<tr>
<td>Quality of life at death, mean (SD)&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological distress</td>
<td>3.7 (3.0)</td>
<td>3.2 (3.3)</td>
<td>0.5 (0.6)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>.37</td>
</tr>
<tr>
<td>Physical distress</td>
<td>3.6 (3.2)</td>
<td>4.5 (3.7)</td>
<td>-1.2 (0.8)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>.04</td>
</tr>
<tr>
<td>Quality of death</td>
<td>6.3 (2.7)</td>
<td>5.7 (3.3)</td>
<td>0.5 (0.5)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>.39</td>
</tr>
<tr>
<td>Survival time, median [quartiles]</td>
<td>88 [54-218]</td>
<td>85 [30-253]</td>
<td>0.8 (0.6-1.1)&lt;sup&gt;e&lt;/sup&gt;</td>
<td>.22</td>
</tr>
</tbody>
</table>

<sup>a</sup>The odds ratio is conditional on quintiles of predicted propensity scores and is adjusted for confounders of sociodemographic characteristics, health status measures, recruitment sites, terminal illness acknowledgment, treatment preferences, and survival time if they remain significant in the multivariate model.

<sup>b</sup>Percentages are based on 69 patients for yes and 68 patients for no because of missing data.

<sup>c</sup>Higher score based on 69 patients for yes and 68 patients for no because of missing data.

<sup>d</sup>B (SE).

<sup>e</sup>Hazard ratio (95% confidence interval).

Cost of care in patients with and without EOL discussions
Association between cost and quality of death in the final week of life (adjusted $P = .006$)

Summary

• Patients with advanced cancer who reported having EOL conversations with physicians had significantly lower health care costs in their final week of life.

• Higher costs were associated with worse quality of death.
PCP visit and health care utilization during end of life

- Retrospective study of Medicare beneficiaries, age ≥ 66 years and died in 2001.
- Medicare data for 18 months prior to death
- 38% had no PCP visit in a preceding year.
- 22%, 19%, 10% and 11% had 1-2, 3-5, 6-8, >9 visits respectively.
## Outcomes

<table>
<thead>
<tr>
<th></th>
<th>No PCP visit</th>
<th>≥ 9 visits in a year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days</td>
<td>15.3</td>
<td>13.4</td>
</tr>
<tr>
<td>Cost</td>
<td>$24,400</td>
<td>$23,400</td>
</tr>
<tr>
<td>Died in Hospital</td>
<td>44%</td>
<td>40%</td>
</tr>
<tr>
<td>Preventable hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>1.0</td>
<td>0.82</td>
</tr>
<tr>
<td>CHF</td>
<td>1.0</td>
<td>0.81</td>
</tr>
</tbody>
</table>

PCP visit in the preceding year is a/w less costly end of life care

Outpatient to inpatient continuity of care and EOL ICU in advanced lung cancer patients

• Outpatient to inpatient provider continuity decreased from 60.3% in 1992 to 52.3% in 2002

• Older age, black race, low socioeconomic status, and treatment at a teaching hospital are a/w decreased continuity

• Patients with outpatient to inpatient continuity had a 19.8% reduced odd of ICU use during terminal hospitalization.

Sharma et al Arch Intern Med. 2009
Early palliative care for patients with metastatic Non-small cell lung cancer

<table>
<thead>
<tr>
<th></th>
<th>Palliative care</th>
<th>Standard care</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive sx</td>
<td>16%</td>
<td>38%</td>
<td>0.01</td>
</tr>
<tr>
<td>Median survival</td>
<td>11.6 months</td>
<td>8.9 months</td>
<td>0.05</td>
</tr>
<tr>
<td>Aggressive EOI</td>
<td>33%</td>
<td>54%</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Tennel et al. NEJM 2010
Advanced
Directive Works!!
Advance directive and decision making before death

Schematic Representation of the Study Population.

# Outcomes according to Advance Directives

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Living Will N=444</th>
<th>No Living Will N=552</th>
<th>Adjusted OR (95% CI)</th>
<th>DPA N=589</th>
<th>No DPA N=407</th>
<th>Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death in hospital</td>
<td>38.8%</td>
<td>50.4%</td>
<td>0.71 (0.47-1.07)</td>
<td>38.2%</td>
<td>55.8%</td>
<td>0.72 (0.55-0.93)</td>
</tr>
<tr>
<td>All care possible</td>
<td>8.1%</td>
<td>27.7%</td>
<td>0.33 (0.19–0.56)</td>
<td>13.4%</td>
<td>27.0%</td>
<td>0.54 (0.34-0.86)</td>
</tr>
<tr>
<td>Limited care</td>
<td>80.6%</td>
<td>66%</td>
<td>1.79 (1.28-2.50)</td>
<td>75.4%</td>
<td>68.1%</td>
<td>1.18 (0.75 -1.85)</td>
</tr>
<tr>
<td>Comfort care</td>
<td>96.8%</td>
<td>91.3%</td>
<td>2.59 (1.06-6.31)</td>
<td>95.9%</td>
<td>90.6%</td>
<td>2.01 (0.89-4.52)</td>
</tr>
</tbody>
</table>

DPA: Durable power of Attorney for health care

**NEJM 2010**
Summary

• Aggressive care during EOL is common
• There is large variation in EOL practices across the United States
• Patient and physician religious beliefs do a play a role in EOL care
• Current models are inaccurate in predicting survival
• Continuity of care and EOL care planning can prevent unnecessary ER visits and ICU use.
• Early use of palliative care can curtail EOL care cost
• How will paying for AD discussion effect EOL care needs to be seen?
Ars Moriendi: the art of dying - Circa 1450
QUESTIONS OR COMMENTS?