American Academy
of Value Based Care

Utilization Reduction in Serious Illness: A Clinical & VBC Guide to Palliative and Hospice Care

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Utilization Reduction in Serious Illness: A Clinical & VBC Guide to Palliative and Hospice Care

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Introduction

The AAVBC supports clinical models emphasizing care that prevents avoidable hospitalizations while supporting quality of life for individuals with serious illness. For many patients with advanced disease, repeated emergency department visits, hospitalizations, and intensive interventions often reflect uncontrolled symptoms, limited care coordination, or a lack of documented care preferences rather than improved clinical outcomes.

Palliative and hospice care addresses these gaps by proactively managing symptoms, supporting patients and caregivers, and aligning treatment decisions with documented goals of care. When integrated earlier in the disease course, these services improve patient and caregiver experience while often reducing reliance on hospital-based care.[1-3]

1. CLINICAL SNAPSHOT

Palliative care is specialized, interdisciplinary care for patients with serious illness. Defined by the World Health Organization as an approach that **improves quality of life** through the prevention and relief of suffering, it addresses symptoms, psychosocial distress, and the burdens of advanced disease while supporting both patients and their families.[1] Palliative care may be provided at **any stage of illness — it is not limited to the end of life** and does not require discontinuation of disease-directed treatment.[2]

Hospice care is a specific form of palliative care **reserved for patients with a terminal illness and a life expectancy of six months or less**, when the clinical **focus shifts away from curative intent toward comfort-focused, supportive care.**[4] Under the Medicare Hospice Benefit, patients elect hospice in exchange for forgoing curative treatment related to the terminal diagnosis, while gaining access to comprehensive interdisciplinary services, most often delivered in the home or community setting.[4]

Advance care planning (ACP) is a continuous, patient-centered process of aligning medical decision-making with a patient's values, goals, and preferences — not a one-time form or a task reserved for the final days of life.[5,6] The documentation of advance directives is a critical component of effective palliative and hospice care delivery. Advance directives clarify patient goals, guide treatment intensity, and reduce unwanted high-acuity care near the end of life.

Why This Belongs in a VBC Framework

AAVBC emphasizes that the goal in VBC is not to reduce utilization in isolation, but to support care that is appropriate, timely, and aligned with each individual's goals, lived experience, and clinical trajectory. This reflects a core principle—delivering the right care, at the right time, in the right setting. For individuals and families, this includes understanding the differences between palliative care and hospice, and recognizing how the choice of setting—home, inpatient hospice, or facility-based care—can meaningfully shape comfort, support, and overall experience. Early integration of palliative care allows these decisions to be made thoughtfully, rather than during moments of crisis, while

addressing common drivers of avoidable acute care use such as uncontrolled symptoms, uncertainty in care preferences, caregiver strain, and fragmented transitions.[2,3]

In practice, patterns such as fewer emergency department visits, reduced hospitalizations, and less reliance on high-intensity interventions near the end of life often reflect care that is more closely aligned with what matters to the person receiving it. These changes emerge through proactive symptom management, clear communication, and shared decision-making—ensuring that the chosen site of care and level of support match the individual's needs—rather than through limiting access to services.[3,7]

Prevalence and Utilization Impact

Hospice and palliative care represents a substantial component of end-of-life care in the Medicare population.

Metric	Key Finding	Value Interpretation
Hospice enrollment among Medicare decedents	~52.8% of Medicare beneficiaries who died in FY 2024 received hospice care[3]	Hospice is now a common component of end-of-life care in Medicare, but nearly half of eligible patients still do not receive it
Annual Medicare hospice users	~1.84 million beneficiaries enrolled in FY 2024 — largest single-year increase since 2021[3]	Hospice utilization continues to grow as clinicians increasingly recognize the role of comfort-focused care in serious illness
Median hospice length of stay	~17 days[3]	Indicates late referral patterns, with many patients entering hospice only in the final weeks of life despite earlier clinical eligibility
Routine Home Care (RHC)	98.8% of hospice days occur in the home setting[3]	Hospice care is primarily delivered in the home or community, allowing many patients to avoid hospitalization during advanced illness
Medicare spending in last year of life	~3.1% lower spending among hospice users compared with similar non-hospice patients[7]	Lower spending reflects reduced hospital and ICU utilization, not reduced access to care
Break-even point for hospice enrollment	Total Medicare spending becomes lower for hospice users beginning at day 11 of enrollment[7]	Earlier hospice referral allows symptom management and care planning to stabilize patients outside hospital settings
Longer hospice stays (>6 months)	~11% reduction in Medicare spending vs non-hospice benchmarks; up to 25% reduction in CKD/ESRD populations[7]	Earlier hospice involvement improves symptom control and reduces repeated hospitalizations
Acute care use during hospice enrollment	~$2.0 billion in non-hospice Medicare spending occurred during hospice election in FY 2024[3]	Suggests care coordination challenges and delayed hospice transitions in some patients

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