

Section of Palliative Care and Medical Ethics

When Hospice Referrals are Placed to Reduce Acute Care Hospital Mortality Metrics

Gina Piscitello MD MS

Hospice in the United States

- All Medicare-certified hospice must offer 4 levels of care:
 - Routine home care
 - General inpatient care
 - Continuous home care
 - Respite care

Disclosures

- I have no disclosures

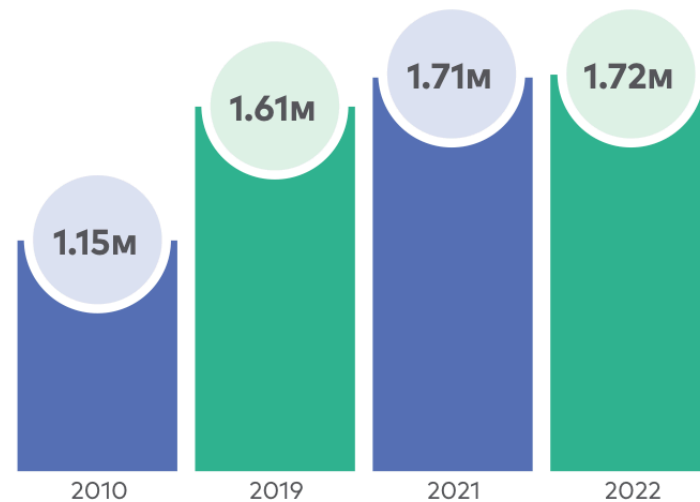
Section 2: Who Receives Hospice Care?

How many Medicare beneficiaries received care?

As seen in Figure 2, 1.72 million Medicare beneficiaries were enrolled in hospice care for one day or more in calendar year (CY) 2022. This is a slight increase from 2021 but approximately equal to 2020. This includes patients who:

- Died while enrolled in hospice
- Were enrolled in hospice in 2021 and continued to receive care in 2022
- Left hospice care alive during 2022 (live discharges)

Figure 2: Number of Medicare hospice users (millions of beneficiaries)



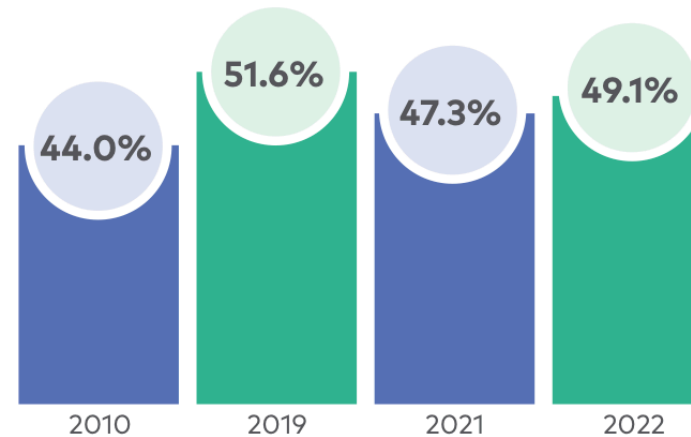
Source: MedPAC July Data Book, 11-8

What proportion of Medicare decedents were served by hospice?

Of all Medicare decedents¹ in CY 2022, 49.1% received one day or more of hospice care and were enrolled in hospice at the time of death. This is the first increase in utilization since 2019. Utah had the highest hospice utilization by Medicare decedents (59.61%) and Puerto Rico had the lowest utilization (21.36%)

1. Decedents refers to Medicare beneficiaries who have died.

Figure 3: Share of Medicare decedents who used hospice (percentage)

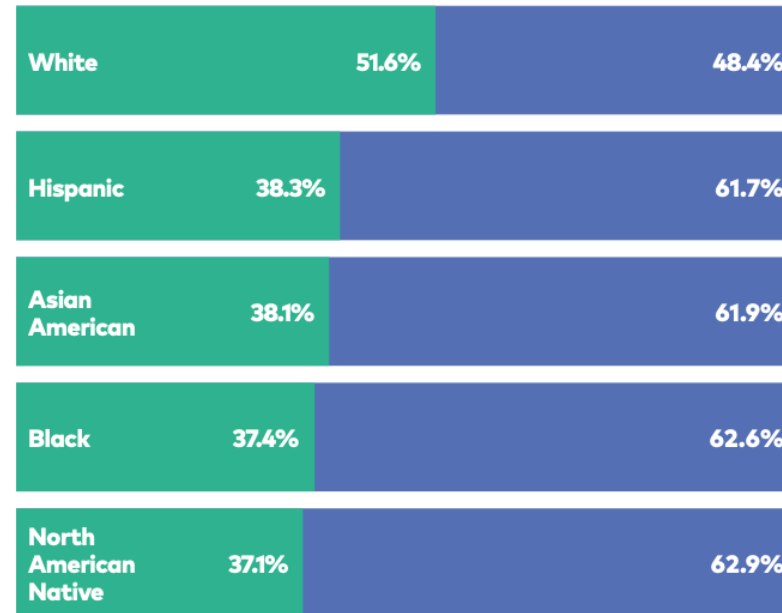


Source: MedPAC March 2024 Report to Congress, Table 9-2

Receipt of Hospice by Race/Ethnicity

Figure 10: Share of Medicare decedents who used hospice, by race

■ Medicare Decedents who utilized hospice
■ Medicare Decedents who did not utilize hospice



Source: MedPAC March 2024 Report to Congress, Table 9-3

CY 2022 saw an increase in hospice utilizations by all race/ethnicity groups with Hispanic beneficiaries seeing the largest increase. No group has returned to pre-COVID-19 utilization.

(NHPCO Facts and Figures 2024 Edition, AllianceForCareAtHome.org)

Trends in Discharge to Hospice After Critical Illness Among US Medical Beneficiaries 2011-2023

- Increased from 5.6% to 6.8% among U.S. Medicare beneficiaries between 2011 and 2023.
- This study also noted increased use of palliative care (7% to 15%) and higher rates of do-not-resuscitate orders (11% to 25%).

(Law and Bosch et. al., Annals of ATS, 2026)

Trends in Discharge to Hospice After Critical Illness Among US Medical Beneficiaries 2011-2023

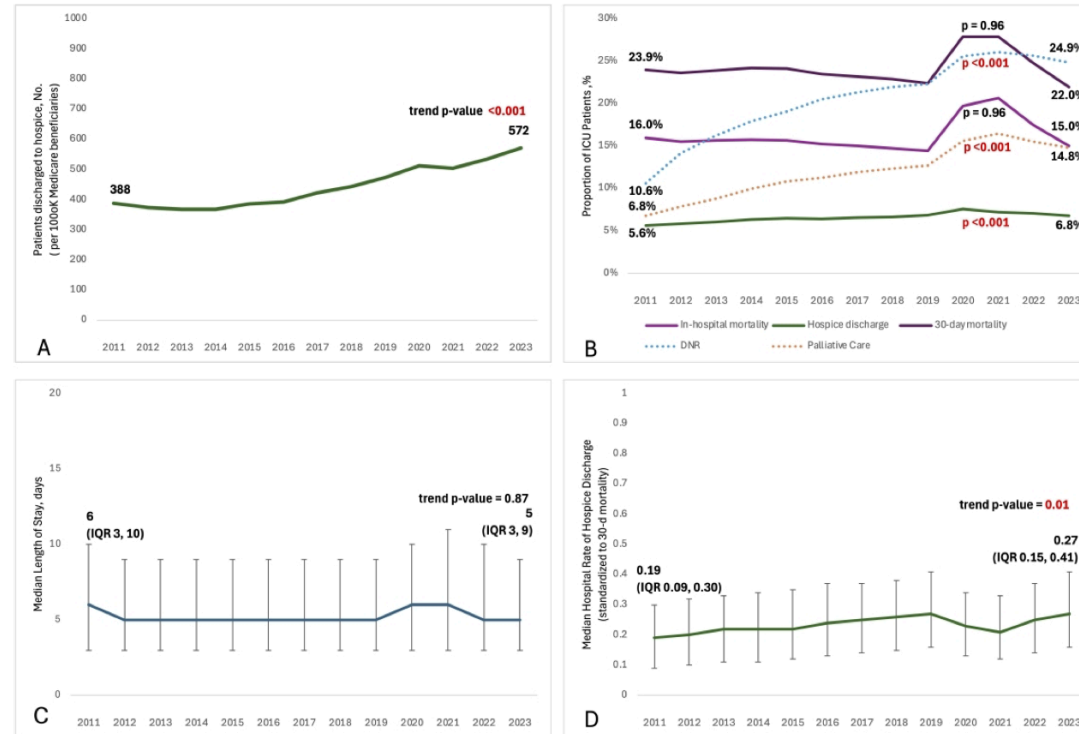


Figure 1. Trends in outcomes of Medicare beneficiaries admitted to an ICU, 2011-2023.

- A. The annual number of hospice discharges per 100,000 Medicare beneficiaries over 65 years of age.
- B. The proportion of ICU patients who died in hospital, were discharged to hospice, died within 30 days, received a DNR order, and received palliative care.
- C. Median hospital length of stay over time.

D. Among ICU patients, the annual national median in hospital rates of hospice discharge standardized to 30-day mortality (i.e., for each hospital, annual hospice discharge divided by annual 30-day mortality rate; national median is then identified).

IQR = interquartile range.

(Law and Bosch et. al., Annals of ATS, 2026)

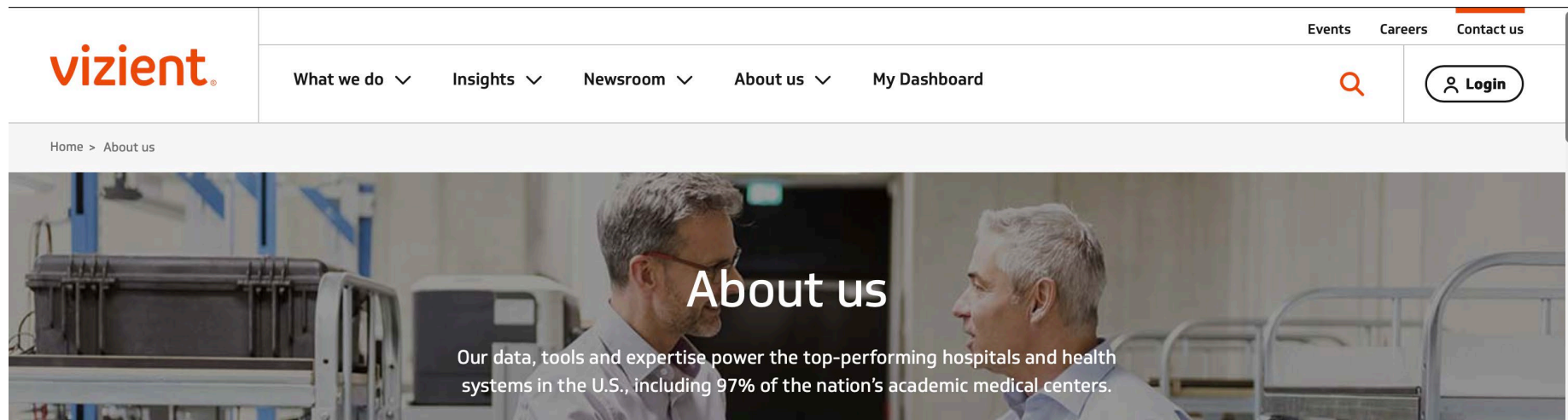
Inpatient Mortality Metrics

- Risk-adjusted inpatient mortality is one way in which the quality of US acute care hospitals is assessed.

(<https://www.vizientinc.com/about-us>)

Vizient Inpatient Mortality

- Vizient's total inpatient mortality index includes all inpatient cases that had a discharge status of "expired"
 - Measured by observed mortality rate divided by expected mortality rate
 - Mortality index of greater than 1 means mortality was higher than expected



(<https://www.vizientinc.com/about-us>; <https://regents.universityofcalifornia.edu/regmeet/oct20/h5attach1.pdf>)

Who is Excluded from the Vizient Inpatient Mortality Index?

- Hospitalized adults admitted and discharged under observation status
- Hospitalized adults admitted under general inpatient hospice

(<https://regents.universityofcalifornia.edu/regmeet/oct20/h5attach1.pdf>)

General Inpatient Hospice (GIP)

- GIP is one of four levels of hospice care intended for short-term inpatient management of uncontrolled symptoms that cannot be effectively managed in another setting.
- Patients may potentially be discharged from the hospital and enrolled in GIP in the same hospital location, even the same bed, and excluded from the hospital's inpatient mortality measures.

(Piscitello, JPSM, 2026)

What Care Is Provided with GIP in Acute Care Hospital Settings?

- Varies by hospital and hospice agency



(<https://www.hchbuniversity.com/bereavement-hos>)

Pros of Hospital Initiatives to Increase Transitions to GIP

- When appropriately implemented, GIP has the potential to improve the quality of end-of-life care for the over one-third of US deaths which occur in acute care hospitals, many of these in intensive care unit settings.
- Excluding hospice discharges from inpatient mortality calculations may allow patients to transition to comfort-focused end-of-life care without penalizing hospital quality measures.

Cons of Hospital Initiatives to Increase Transitions to GIP

- It may influence the use of GIP for patients that may derive uncertain clinical benefit from it, such as patients transitioned to GIP hours prior to death.
- It may contribute to patients and families feeling pressured to transition to GIP
- Patients may be required to pay a co-pay for these services

Encouragement for GLP Transitions



NBC NEWS

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EXCLUSIVE

HCA HOSPITALS INVESTIGATION

'You're not God': Doctors and patient families say HCA hospitals push hospice care

Transfers to hospice care from HCA's facilities grew faster than the national average, while HCA's "in hospital" deaths were lower than average, data shows.

(<https://www.nbcnews.com/health/health-care/doctors-say-hca-hospitals-push-patients-hospice-care-rcna81599>)

Financial Incentives Associated with Increased GIP Transitions

- HCA's in-hospital mortality rate was one of 10 metrics used since 2021 to calculate the incentive pay received by top company executives.

(<https://www.nbcnews.com/health/health-care/doctors-say-hca-hospitals-push-patients-hospice-care-rcna81599>)

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When Hospice Referrals are Placed to Improve Acute Care Hospital Mortality Metrics

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(Piscitello, JPSM, 2026)

Study Participants

- We emailed all 4889 members of AAHPM in July 2025.
- We received 332 responses from participants representing 182 unique health systems encompassing 1091 hospitals across all US states.
- Health systems were in the Northeast (20%), South (24%), Midwest (15%) and West (32%)
- 25% had a university affiliation.

(Piscitello, JPSM, 2026)

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(Piscitello, JPSM, 2026)

77% (n=141/182) of Health Systems Track Acute Care Hospital Inpatient Mortality Metrics

(Piscitello, JPSM, 2026)

62% (n=113/182) of Health Systems Attempted to Increase Patient GIP Discharges to Improve Inpatient Mortality Metrics

(Piscitello, JPSM, 2026)

Hospital Initiatives to Increase GIP Transitions

Table 1
Hospital Initiatives to Increase Transitions to General Inpatient Hospice (GIP) Level of Care

Hospital Initiative	Number of Health Systems (N= 186)
Encouragement from hospital leaders to place hospice referrals for GIP	86
Automatic hospice agency referrals for hospitalized patients at the end of life	17
Peer comparison of hospice transition rates across clinicians	10
Dedicated clinical position to facilitate transitions to GIP	2
Admit patients receiving life-sustaining treatment such as extracorporeal membrane oxygenation or mechanical ventilation to GIP prior to withdrawal of life-sustaining treatment	2
Clinician incentive packages tied to mortality and hospital length of stay metrics	1
One-on-one discussions between hospital leadership and clinicians to discuss why hospice transitions did not occur for hospice-eligible patients	1
Clinician notifications about open hospice beds when the hospital census is over capacity	1

(Piscitello, JPSM, 2026)

Limits on GIP Transitions

- One reported health system did not target patients with a life expectancy of 24 hours or less for transition to hospice GIP because of concerns about the logistical burdens to enrollment for patients and families with limited potential for patient benefit in this short time frame.

(Piscitello, JPSM, 2026)

Limits on GIP Transitions

- Unable to contract with a hospice agency to provide GIP with the acute care hospital

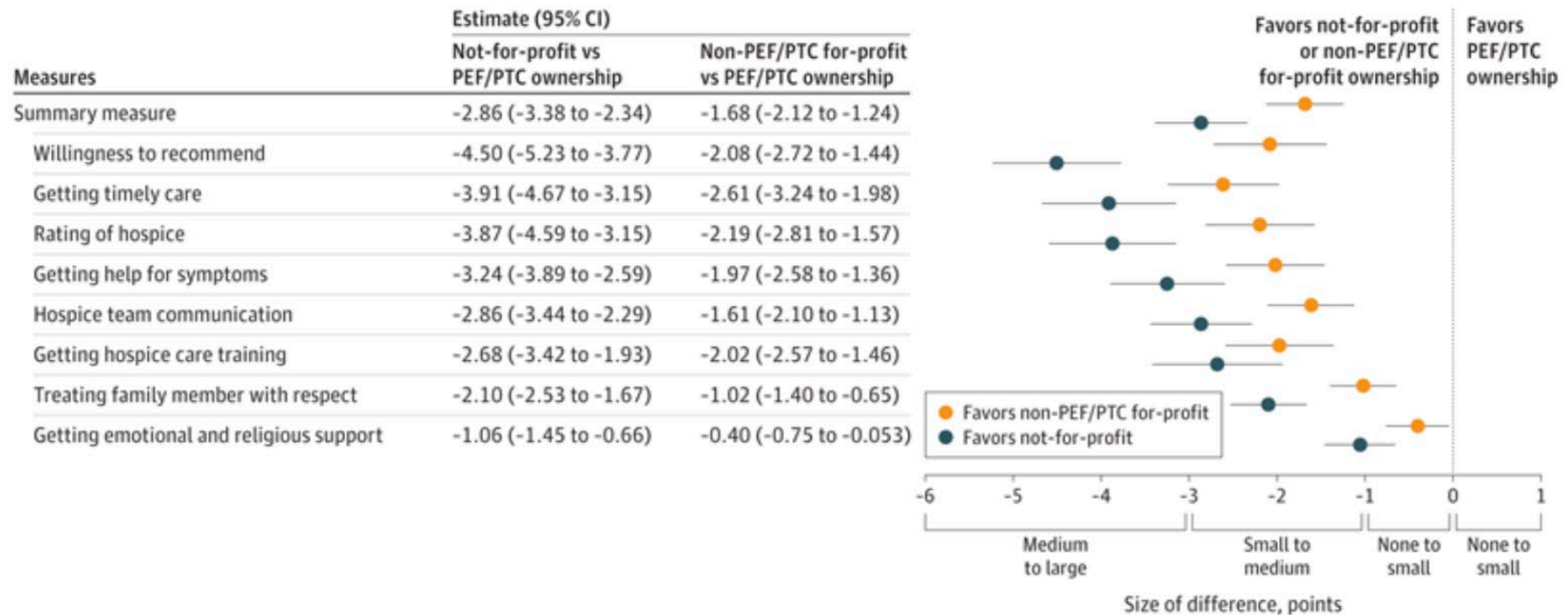
(Piscitello, JPSM, 2026)

Other Types of Hospital Initiatives Across the US

- Transition to GIP in-hospital without having a hospice team member provide patient care (hospitalist is primary for patient)
- Patients transition to hospice rather than comfort measures only status, and only receive comfort measures only status if patient/surrogate decline hospice
- Hospice representative present in hospital 24 hours a day
- Observation status pending GOC

Variation in Hospice Quality

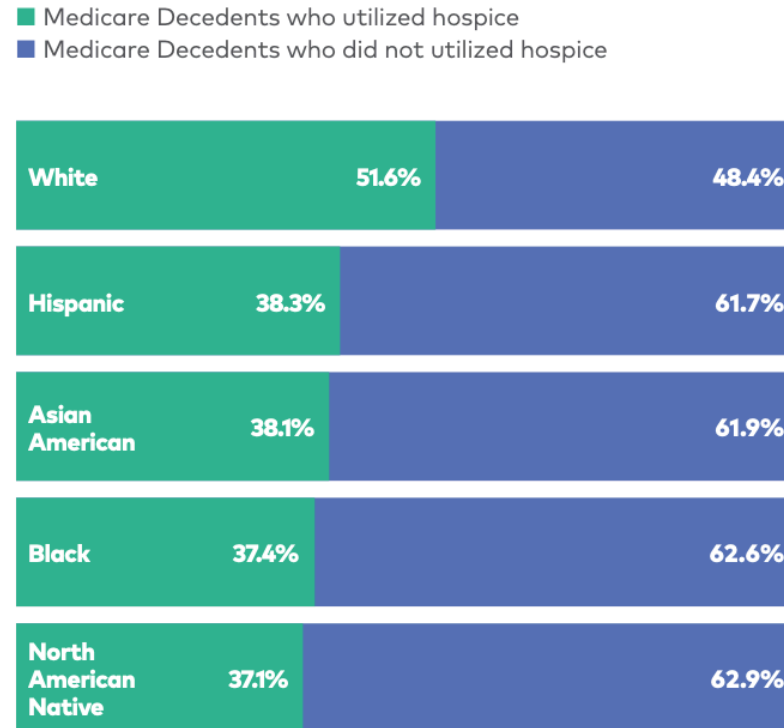
Figure. Adjusted Differences in Caregiver-Reported Hospice Quality Between PEF/PTC Hospice Ownership and Other Ownership Categories



(Soltoff, JAMA, 2024)

Potential to Improve or Exacerbate Sociodemographic Disparities

Figure 10: Share of Medicare decedents who used hospice, by race



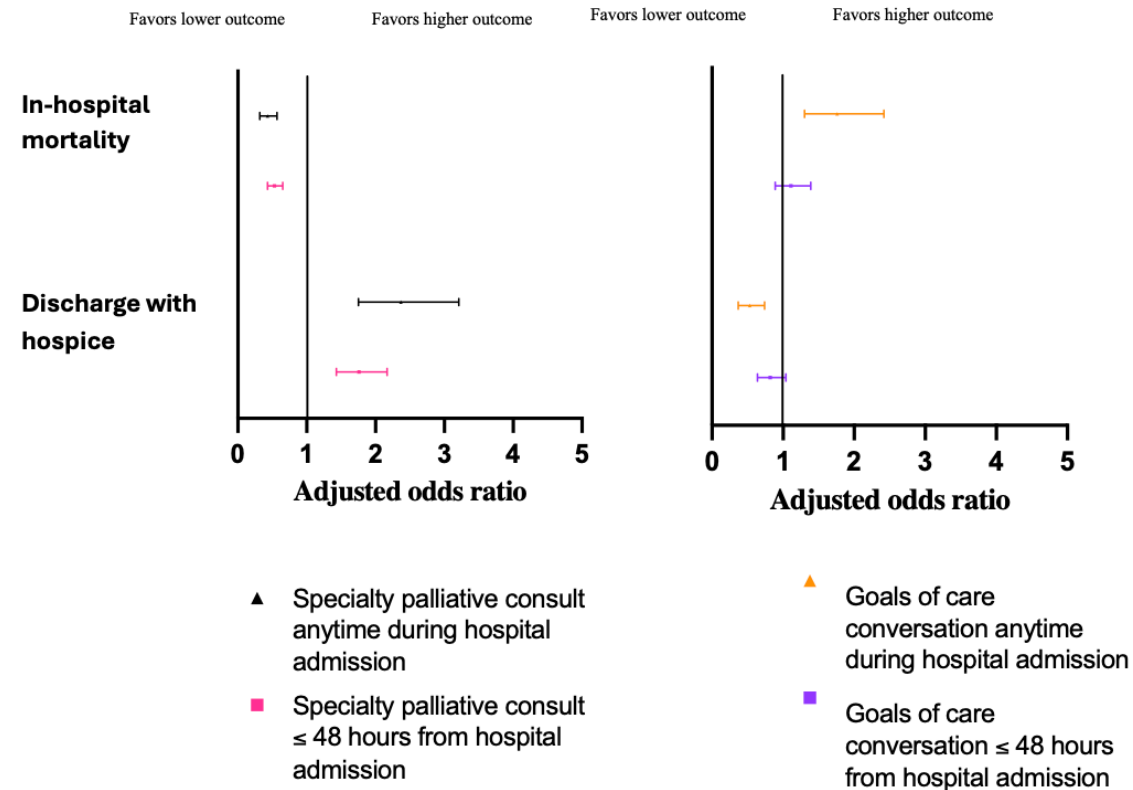
Source: MedPAC March 2024 Report to Congress, Table 9-3

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(NHPCO Facts and Figures 2024 Edition, AllianceForCareAtHome.org)

Factors Associated with Increased Hospital Transitions to Hospice

Figure 1. Adjusted Odds Ratio of 1) In-hospital Mortality and 2) Discharge with Hospice for Patients with Comfort Measures Only Orders



(Piscitello, JPSM, 2026)

UPMC Goals of Care Note Template

GOALS OF CARE		
Correct Date/Time		
Clinicians attending goals of care discussion:		
☐ Attending physician ☐ PCP ☐ APP ☐ Resident ☐ Bedside Nurse ☐ Social Worker ☐ Fellow ☐ Subspecialty Physician ☐ Intensivist-Critical Care ☐ Other: ☐ Palliative Care Service		
Which family members attended the meeting? Check all that apply.		
☐ Patient ☐ Friend ☐ Spouse/Partner ☐ Other: ☐ Parent(s) ☐ Child ☐ Sibling		
Surrogate Information		
Surrogate Name: Alice Smith		
Surrogate relationship: Friend		
Surrogate best phone contact information: C412 511 1212		
Prognosis:		
Prognosis information shared:		
☐ Discussed ☐ Previously discussed ☐ Not discussed		
Prognosis information discussed:		
If prognosis depends on management approach, describe Best case/Worst case 		
If prognosis not discussed, why? 		
Survival:		
☐ Hours to days ☐ Days to weeks ☐ Weeks to months ☐ Years ☐ Uncertain		
Function:		
☐ Likely to return to previous function ☐ Likely to return to previous function with adaptations ☐ High likelihood of dependency ☐ Uncertain		
Patient/Surrogate response to prognostic information?		
☐ Agrees with information ☐ Does not agree with information		
Values:		
Given this news, what is important to the patient?		
☐ Discussed ☐ Not discussed		
Patient Hopes		
☐ Live as long as possible ☐ Be comfortable ☐ Be mentally aware ☐ Be independent ☐ Be at home ☐ Be a support for family ☐ Cultural/Spiritual beliefs ☐ Values information shared by patient/surrogate ☐ Other:		
Patient Concerns		
☐ Pain ☐ Other physical suffering ☐ Inability to care for others ☐ Loss of control ☐ Finances ☐ Being a burden ☐ Cultural/Spiritual belief ☐ Inability to meaningfully		
Values information shared by patient/surrogate:		
If values not discussed, why?		
Decisions Made:		
Patient Decisions made		
☐ Continue current care plan ☐ Change in care plan		
Change in care plan included:		
If Change in Code Status or Comfort Measures Only are selected, complete CPR Status Order. ☐ Pursue all life-prolonging treatments ☐ Time-limited trial ☐ Change code status and continue other treatments ☐ Comfort Measures Only		
Date to check in on success of the trial:		
no time frame		
Goals discussed that would show the trial successful:		

Qualitative Study - How Acute Care Hospitals Navigate General Inpatient Hospice Transitions

- Semi-structured interviews with 15 hospice and palliative medicine clinicians across the United States

Variation in specifications of hospital initiatives to promote transitions to inpatient hospice

Screening end-of-life patients for hospice

“So there are definitely times when social work may be sort of notified about a potential hospice evaluation, and they might even make a referral to the different agencies that are contracted to the virtual hospice. But they won't actually meet with the family until they've made that definitive decision that they're interested in it. So I, you know. To my knowledge, there are not random hospice agencies just showing up and being like, hey, do you want hospice? Without having a clinician, you know, have that conversation. I hope that's not happening.”

Variation in specifications of hospital initiatives to promote transitions to inpatient hospice

Automatic consults for hospice

“So when we consult hospice automatically, we sever whatever that grieving process might look like, because there's no relationship with the hospice, there's not a provider seeing them, and it becomes institutional then, and the medications are then hypothetically changed based on what a nurse is reporting, not because a provider is evaluating. So in general, that's what we're seeing with this new shift with automatic [hospice] consults.”

Variation in specifications of hospital initiatives to promote transitions to inpatient hospice

Dedicated clinical position to aid in hospice transitions

[Serving as] clinical liaison for the patients admitted at this hospital to the hospice organization...once the inpatient hospice consult is initiated, the, uh, APP liaison, I'd here work with the hospice and medical director who's off-site as well as a hospice nurse and social worker that are on-site, and we go evaluate the patient, those on-site together, review the medical record, um, assess our own prognosis, physical exam, and then we contact the hospice medical director, share our thoughts, concerns, if there are any, and then if eligible for inpatient hospice per our criteria, of hours to days of life expectancy, we offer the patient-slash-surrogate, the option of enrolling in inpatient hospice, and if they choose to enroll, then we help the primary teams facilitate a discharge with a readmission under hospice care."

Variation in specifications of hospital initiatives to promote transitions to inpatient hospice

Hospital administrator encouragement

“Yes [there any encouragement from hospital leaders to place hospice referrals] in the sense that they're looking at this dashboard, so it's comparing us to other systems and so trying to get in the top decile of hospice utilization and palliative care utilization.”

Variation in specifications of hospital initiatives to promote transitions to inpatient hospice

Transition to hospice before withdrawing life-sustaining treatment

“So if somebody's on the vent or on ECMO or vasopressors or some other thing that we think we're going to withdraw that and they might die very quickly, then that's when virtual hospice makes the most sense...Early in the process, many times people were sort of having a, you know, they would go through and they would actually do a comfort care transition and withdraw life support and then come back later and try to sort of sell hospice or sell virtual hospice. But that is not very effective because in honesty, the net benefit that patients receive afterward is not that great. There have been issues with, you know, nursing staff feeling like this, the procedure for virtual hospice transition was too onerous and not worth doing if the prognosis was only a matter of minutes or hours or whatever.”

Variation in specifications of hospital initiatives to promote transitions to inpatient hospice

Clinician financial incentive

“[Clinician incentive packages are tied to] “hospital length of stay as a system...but not any specific provider, but for our entire system.”

Variation in specifications of hospital initiatives to promote transitions to inpatient hospice

Incentive to improve mortality data

We really use language of, you know, when we transition to end of life, we look, you know, to see if you're a candidate for a hospice program, see if that would be helpful for you guys. Whereas other institutions locally just say, well, this time we call in hospice, they'll meet with you and they're in charge of that transition. So they're not like given the choice, if you will. Whereas at our institution, we do try to give that choice, even though the institutional policy very much pushes it. It's pretty substantial. Like the social workers are like audited on what percent of their patients who die actually got GIP consultant or not....Once somebody, like once a family is decided to transition to hospice, the social work and case manager interpretation of that is that the patient is ready for discharge because they're transitioning to hospice. And because of that, like once a patient is considered ready for discharge, they have an expectation for the patient to get out the door as fast as possible

Improves Patient and Family-centered Care

“So overall, I think it's a positive thing. It's, you know, In the back of my mind, I always worry that, you know, are we doing something because it's purely about the numbers and trying to make things look good? At the same time, I understand that that is the environment in which all hospitals exist and sort of length of stay and metrics is simply a fact of life. And so finding a way to work within that system seems to me to be a positive way to do it. And as a result, if we can show that this is improving those numbers, then that is, that hopefully would translate into our ability to have more staff who can provide more care, better palliative care for these patients. So overall, I think it's a good thing as long as it's applied intelligently and as long as we are always at the bottom line, having a real conversation about what matters most to families. If we're doing it and we're not listening and we're just trying to hospice people randomly, that's not the right way.” “

Worsens Patient and Family-centered Care

“[Hospice transitions at my institution are] not patient driven, not patient centered...You know, if this is leadership and metrics...driven, that's what I had said and we're missing this whole level of care, then that's in my eyes not right and families are dissatisfied. But I don't think we're measuring that either. You know, was your loved one cared for at end of life? Do you feel that they were comfortable? Do you feel like your cultural needs were met? So as far as I know, there's not that type of assessment with this initiative. as whether or not this is the right fit for patients... I'm waiting to hear sort of how this unfolds and watching because we're also in a position where we can't complain. If we're if we're bringing up concerns, then we're going against what the metrics are telling us to do and there's not an understanding or, you know, probably there's not anybody looking at the gaps of care that have now occurred. It's strictly missed the metrics on whether or not that patient died under the umbrella of hospice. And that's not patient care. That's metrics driven.”

Hospice Choice

- Some participants shared their hospital placed restrictions on hospice agency choice
- One participant shared concern that their hospital only contracts with their own hospital owned hospital agency rather than encouraging hospice agency choice.
- Other participants shared that their hospitals did not restrict hospice choice

Where Do We Go From Here?

- **Improve education about hospice**
- **Promote earlier communication about hospice**
- **Decrease time to transition to GIP**
- **Improve the quality of GIP**
- **Remove automatic GIP consults for end-of-life patients**
- **Include hospice medical director in other discussions**
- **Promote patient and family-centered care**
- **Dedicate a specialty unit in the hospital for GIP**

Address Potential Harms Involving These Initiatives

- E.g. if concern about limited potential for patient benefit for patients with imminent risk of death, target initiative upstream
- Instead of hospice GLP exclusions from mortality metrics, consider use of comfort measures only order

Clinical/Policy Statement on This Practice

- Written by:
 - Individual clinicians
 - Healthcare performance improvement company
 - Medical societies

Education about this practice:

- For
 - Other clinicians
 - Patients
 - Families

If Vizient Changes How They Measure Inpatient Mortality

- May decrease institutional support to encourage hospice transitions



Thank You!

Open Discussion

Documented GOCC are an Evidence-Based Practice

- Effectiveness studies have identified that **documented GOCC** are associated with improved patient and family satisfaction and improved quality of communication

(Detering KM, BMJ, 2010)
(White DB, NEJM, 2018)

Differences/Disparities in GOCC

Cost-related outcomes

Allocation of GOCC using AI

Documentation of GOCC

Decision-making in GOCC

Am I studying a difference or disparity?

Is the **population** underserved, disadvantaged, or marginalized?

yes

no

— difference

Is this difference rooted in **social factors*** hypothesized to affect this population more than another?

yes

no

— difference

Is this difference **unfair, avoidable, inequitable, unacceptable, and/or unjust?**

yes

no

— difference

disparity

FIGURE 2 | The difference or disparity decision framework. Social factors include access, costs, quality, outcomes, availability and affordability of care, resources, and services, process of care, structures, treatment, racism, bias, or discrimination, and social, political, and economic determinants of health.



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Differences in Cost-related Outcomes

Original Article

Cost-related Outcomes Associated With Documented Goals of Care Conversations



Gina M Piscitello, MD, MS, Robert M Arnold, MD, and Jane Schell, MD, MHS

Division of General Internal Medicine, Section of Palliative Care and Medical Ethics (G.M.P., J.S.), University of Pittsburgh, Pittsburgh, Pennsylvania, USA; Palliative Research Center, University of Pittsburgh (G.M.P., J.S.), Pittsburgh, Pennsylvania, USA; Department of Geriatrics and Palliative Care (R.M.A.), Icahn School of Medicine at Mount Sinai, New York, New York, USA

How are GOCC are Associated with Cost-related Outcomes?

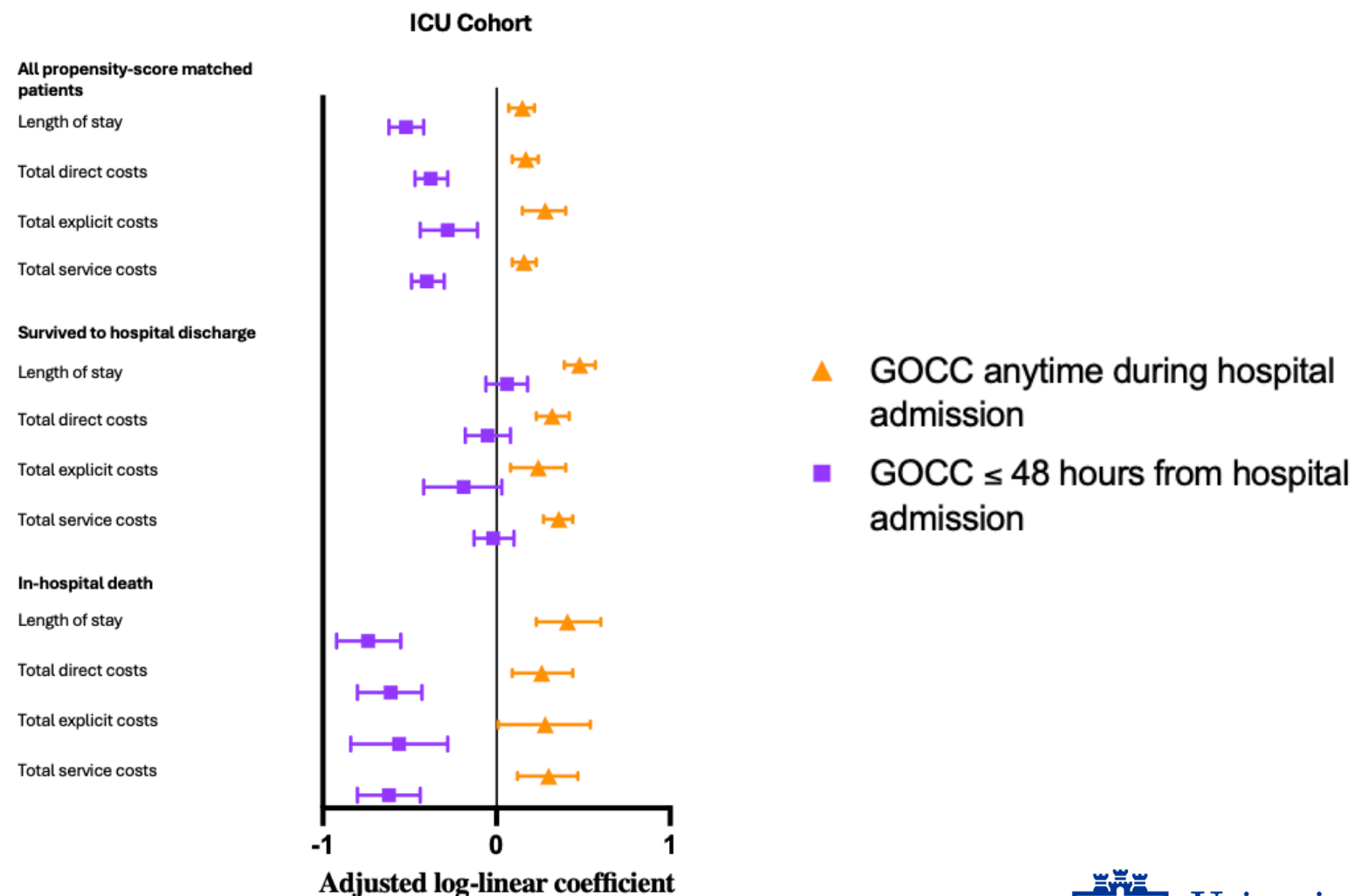
- We created a propensity-score matched cohort from all hospitalized adult patients admitted to 4 UPMC hospitals with >2000 patient beds between 2022-2024 (N= 267,375)
- The propensity-score matched cohort included 24,600 patients

Documented GOCC are Associated with Increased Length of Stay and Hospital Costs



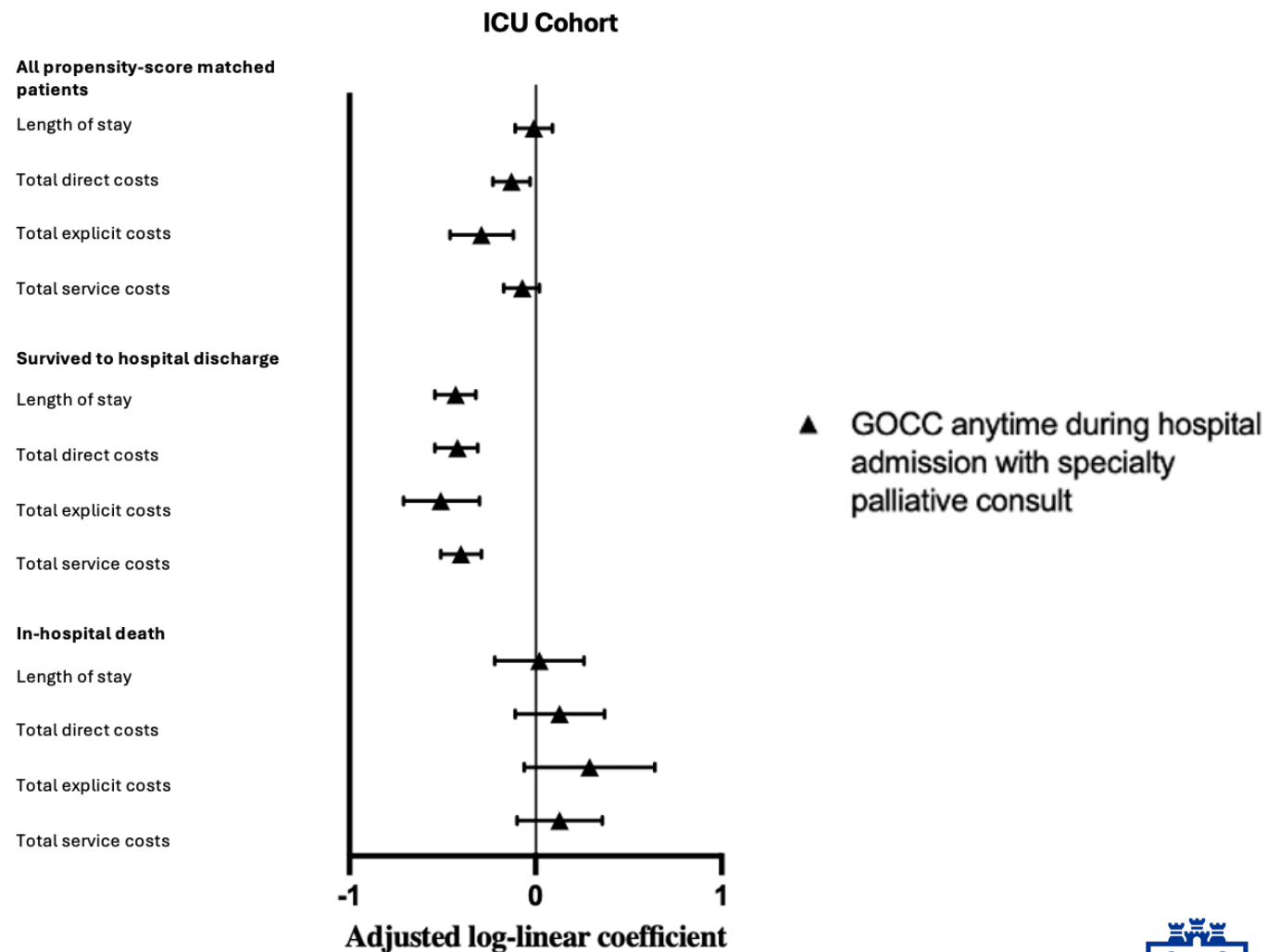
(Piscitello, GM, JPSM, 2026)

Early Documented GOCC are Associated with Cost-Saving Outcomes



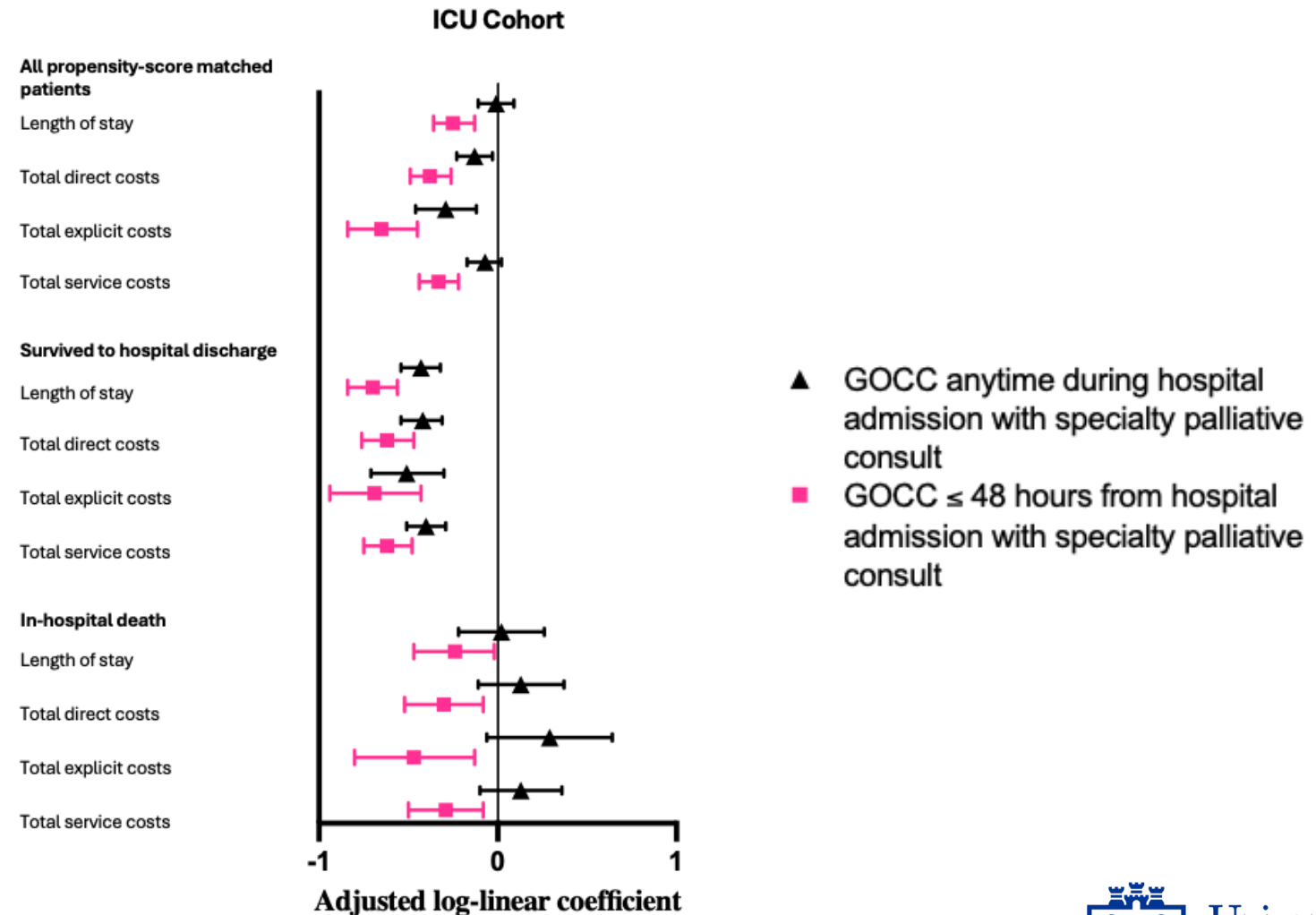
(Piscitello, GM, JPSM, 2026)

Documented GOCC with Specialty Palliative Consults are Associated with Cost-Saving Outcomes



(Piscitello, GM, JPSM, 2026)

Early Documented GOCC with Specialty Palliative Consults are Associated with Cost-Saving Outcomes



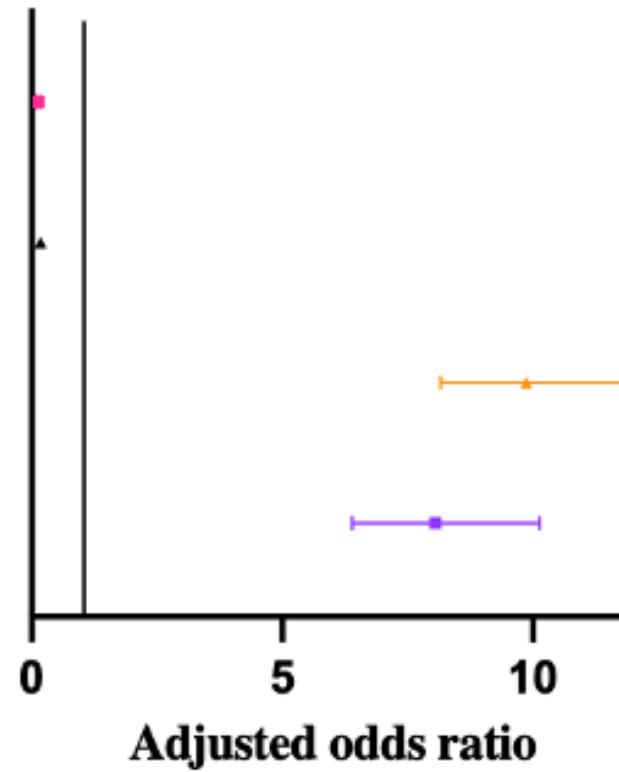
(Piscitello, GM, JPSM, 2026)

Documented GOCC with Specialty Palliative Consults are Associated with Decreased Odds of In-hospital Death

All propensity-score matched patients

ICU Cohort

In-hospital death



- ▶ GOCC anytime during hospital admission
- GOCC ≤ 48 hours from hospital admission
- ▶ GOCC anytime during hospital admission with specialty palliative consult
- GOCC ≤ 48 hours from hospital admission with specialty palliative consult

(Piscitello, GM, Unpublished, 2025)

Conclusion: Documented GOCC are Associated with Cost-Saving Outcomes

- When conducted within 48 hours of hospital admission
- When specialty palliative consultants are involved in patient care

(Piscitello, GM, JPSM, 2026)

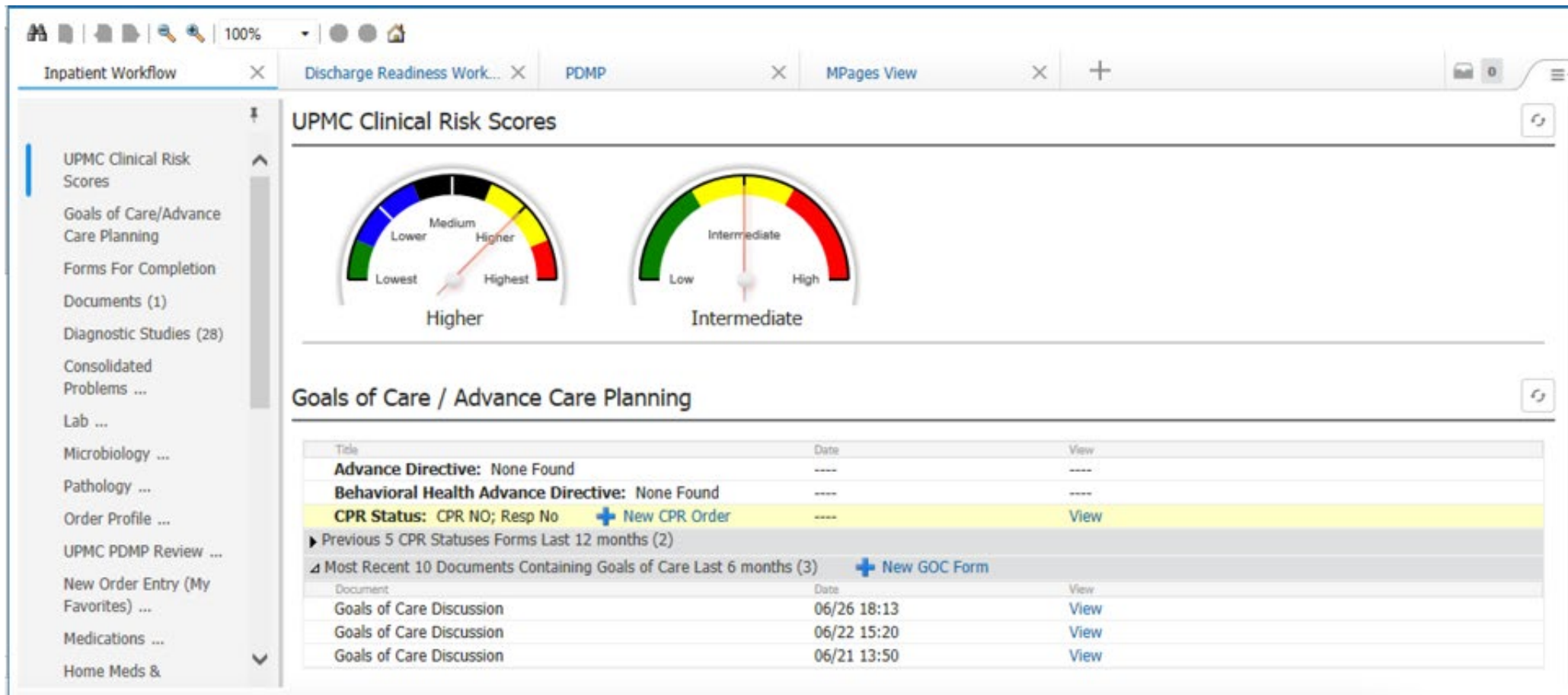
Disparities in Allocation of GOCC

Allocation of GOCC

- Access to goals of care conversations are often limited by workforce shortages and clinician time constraints

(You JJ et. al., *JAMA Intern Med*, 2015)
(Piscitello GM., *JPSM*, 2023)

UPMC Goals of Care Initiative



UPMC Goals of Care Initiative Pre and Post-Implementation

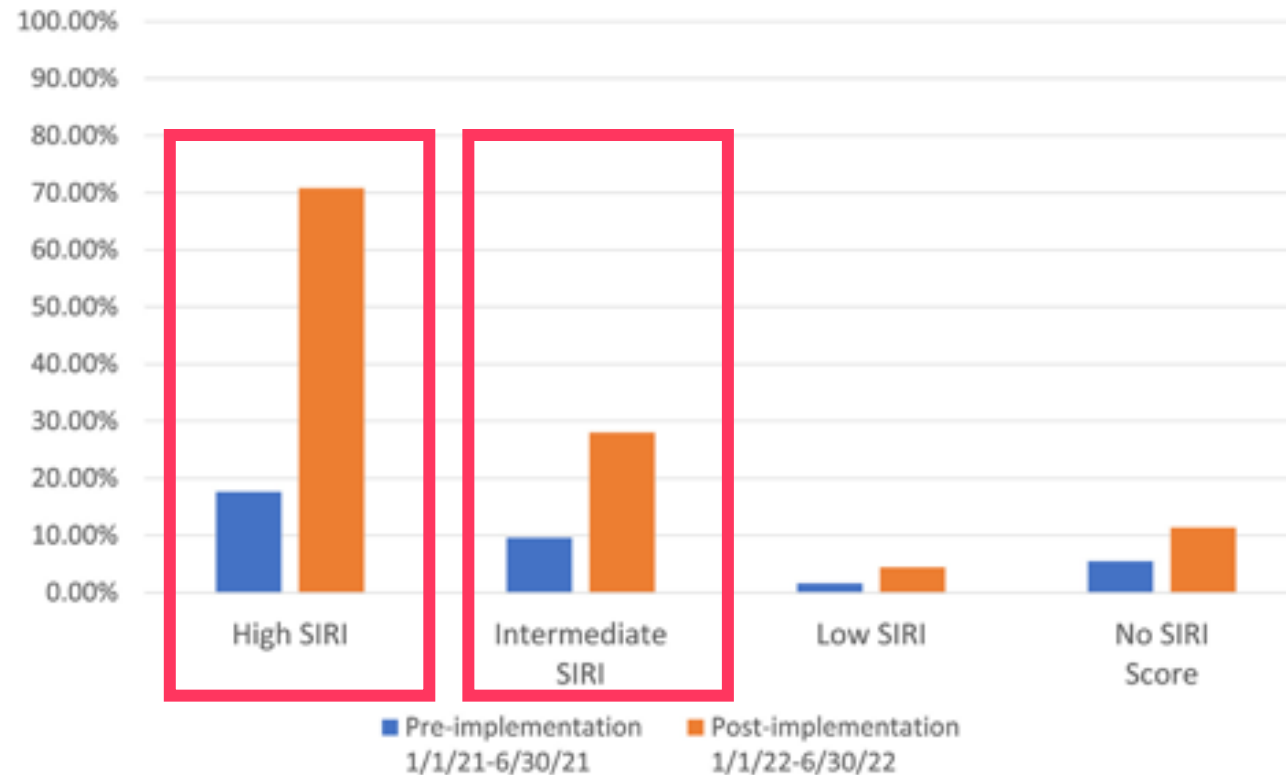


Fig. 2. Rates of goals of care documentation for hospitalized patients before and after a quality improvement initiative, by serious illness risk indicator (SIRI) mortality risk score. The denominator is the total hospitalized patients at each serious illness risk indicator (SIRI) mortality risk level. High SIRI: >60% risk of dying within 90 days; Intermediate SIRI: >30% risk of dying within 90 days; Low SIRI: ≤30% risk of dying within 90 days; No SIRI: patient's record contains insufficient data to assign a risk score.

(Schell et. al., JPSM, 2024)

UPMC Goals of Care Initiative UPMC Presbyterian

Elevated SIRI (Includes High and Intermediate SIRI Scores)	n=3643	≥30% 90-day mortality risk
Low SIRI	n=20404	<30% 90-day mortality risk
No SIRI	n=10067	Insufficient UPMC ambulatory data to calculate a SIRI score

(Piscitello GM, JGIM, 2024)

Equity in Using Artificial Intelligence to Trigger Goals of Care Conversations

- **No SIRS** patients
 - disparities in GOC documentation existed by race, age, and insurance
- **Elevated SIRS** patients targeted by the goals of care initiative
 - no disparities in goals of care documentation prevalence by race, age, or insurance status

Equity in Using Artificial Intelligence to Trigger Goals of Care Conversations

- In the propensity-score matched cohort, patients with elevated SIRS scores had higher odds of goals of care documentation than patients with similar severity of illness with no SIRS score (**aOR 2.1, $p < 0.0001$**)

Equity in Using Artificial Intelligence to Trigger Goals of Care Conversations

- Using AI to target GOC documentation may improve sociodemographic equity in GOC documentation in patients with Elevated SIRS Scores
- It may also have the unintended consequence of disadvantaging severely ill patients lacking AI-generated scores from receiving targeted GOC documentation, including patients who are more likely to be nonwhite and have Medicaid insurance

Disparities in Documentation of GOCC

Quotation Use in Documented GOCC Notes

"She describes pt as "sassy" and pleasant. I agree that she answered my questions in a "sassy " manner.

Why Are Quotations Used?

- Quotations may be used to promote accuracy in documentation
- They also may be used to cast skepticism on patient speech

Examples of Quotations

- Family in agreement to avoid furthering pt's "suffering."
- If pt's heart stopped in current state . . . wife would like to "give him a jump start" if that occurs.
- His goal is to take her home and get her strong and work for "a cure" and live as long as possible.

(Piscitello GM, Chest, 2025)

Examples of Quotations

- When asked what her sense of where things are at currently she shared she wasn't sure and "feels like they are hiding from me."
- Her sons know her wishes and they need to follow them "or I'll haunt them."
- They told him he is "dying," and he "isn't ready to accept that."
- pt admits she getting tired of aggressive treatments (even her lasix) and affirms that if she gets sicker "just put me in the ground I guess."

(Piscitello GM, Chest, 2025)

Quotation Use in Documented GOCC Notes

- In our assessment of 1003 GOCC notes across 14 hospitals, quotations were identified within 32% of all documented GOC notes

(Piscitello GM, Chest, 2025)

Differences in Quotation Use within Documented GOCC Notes

- Black patients were more likely to have at least 1 quotation documented within a GOC note when compared with White patients
 - 41% vs 30%; adjusted OR, 1.73 [95% CI, 1.11-2.71]
- Palliative clinicians were more likely to use quotations in GOC notes when compared with nonpalliative clinicians
 - 38% vs 21%; adjusted OR, 2.62 [95% CI, 1.66-4.13]

Quotation Themes

- The most frequent content quoted within GOC notes was
 - (1) patient feelings
 - (2) family preferences
 - (3) patient discussion about death

(Piscitello GM, Chest, 2025)

Quotation Themes by Patient Sociodemographic Characteristics

- Family preferences were more likely to be quoted in GOC notes for Black patients when compared with those for White patients
 - 11% vs 5%; unadjusted OR, 2.5, [95% CI 1.3-4.8]

(Piscitello GM, Chest, 2025)

Disparities in Decisions to Withhold or Withdraw Life-sustaining Treatment



Addressing Sociodemographic Disparities in Decisions to Withhold or Withdraw Life-sustaining Treatment

Theme 1. Have not witnessed sociodemographic disparities in clinician decisions to withhold or withdraw LST



“I don't necessarily notice any disparities when it comes to socioeconomic status, I guess in my practice. I feel like we treat everyone the same no matter what that status is. I just don't feel like I have a lot of experience in seeing like the disparities.” Nurse



It has not been my experience that we've withheld treatments on different populations. I feel like we even offer - at times - more care than we should to...all the populations.” Nurse

Addressing Sociodemographic Disparities in Decisions to Withhold or Withdraw Life-sustaining Treatment

Theme 2. Concern for sociodemographic disparities in clinician decisions to withhold or withdraw LST



"I've had very similar patients who've had bad infective endocarditis dying from their infective endocarditis who need valve replacement in order to save their life, and I feel like I've seen scenarios where we've gotten a white patient and a black patient who look very similar, like who are systemically both very sick, and for whatever reason, we are offering the white patient lifesaving surgery and we really don't even offer the black patient surgery." Physician



"I feel when there is a language barrier, I feel that inherently makes things more challenging, especially if there are no family that are easily found, or the family may only speak a certain language, and maybe we just haven't actually been able to communicate with them." Nurse

Addressing Sociodemographic Disparities in Decisions to Withhold or Withdraw Life-sustaining Treatment

Theme 3. Barriers to addressing sociodemographic disparities in clinician decisions to withhold or withdraw LST

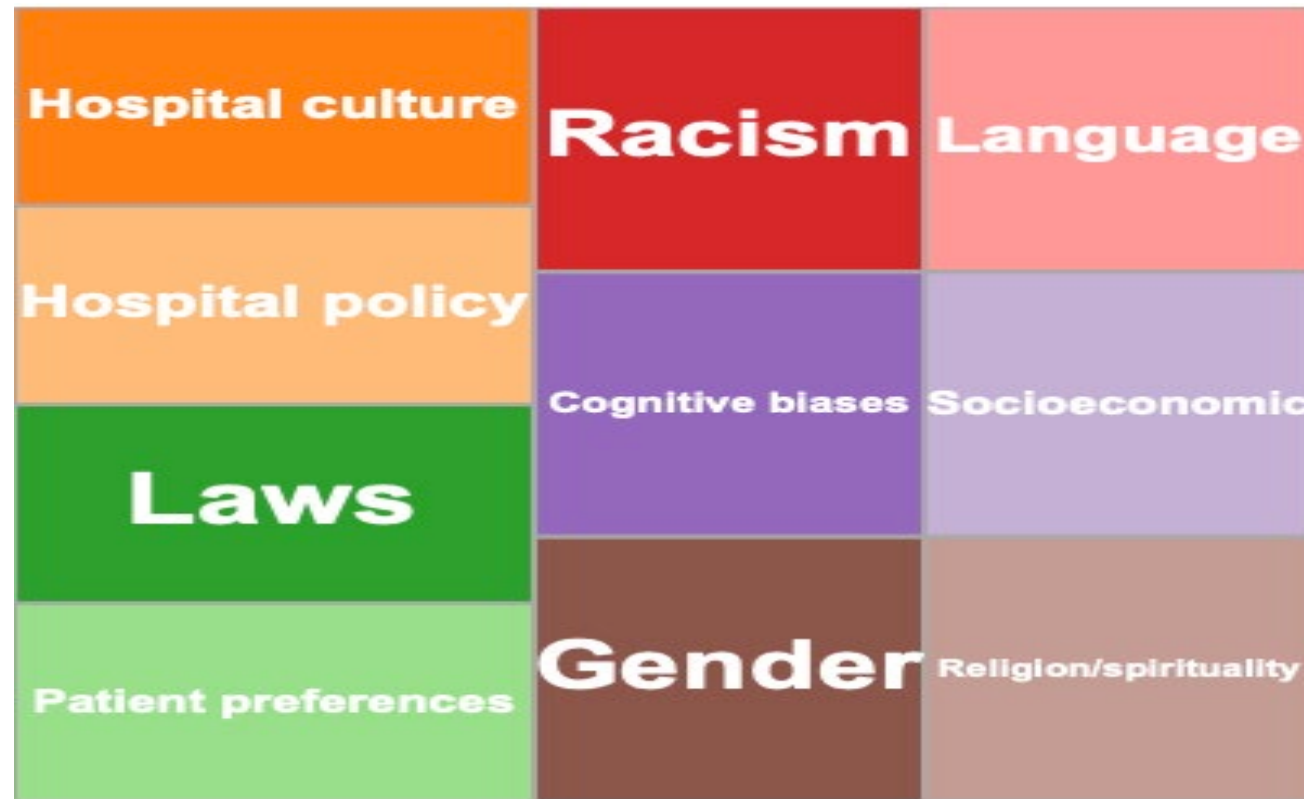


"I'm not aware of any specific approaches the hospital takes to try to reduce those disparities or make people aware of those disparities... I'm not aware that they're routinely evaluated."
Nurse



"So I think where the barrier lies is that I just, I don't think that we're aware, that we're consciously aware that we are creating these barriers... I don't no one's going into being like, I'm gonna communicate differently because their race is X, you know what I mean? Like it's this unconscious thing that happens." Physician

What are the Reasons for Differences in Clinician Decision-making?



Approaching Cases of Physiologic Futility, “Potentially Inappropriate” Treatment

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units

Gabriel T. Bosslet , Thaddeus M. Pope , Gordon D. Rubenfeld , Bernard Lo , Robert D. Truog , Cynda H. Rushton , J. Randall Curtis , Dee W. Ford , Molly Osborne , Cheryl Misak , David H. Au , Elie Azoulay , Baruch Brody , Brenda G. Fahy , Jesse B. Hall , Jozef Kesecioglu , Alexander A. Kon , Kathleen O. Lindell , and Douglas B. White ; on behalf of The American Thoracic Society *ad hoc* Committee on Futile and Potentially Inappropriate Treatment... [Show less](#)



Hospital Policies and State Law Guidance Vary Widely Regarding How Clinicians Should Approach Decisions to Withhold or Withdraw Life-sustaining Treatment

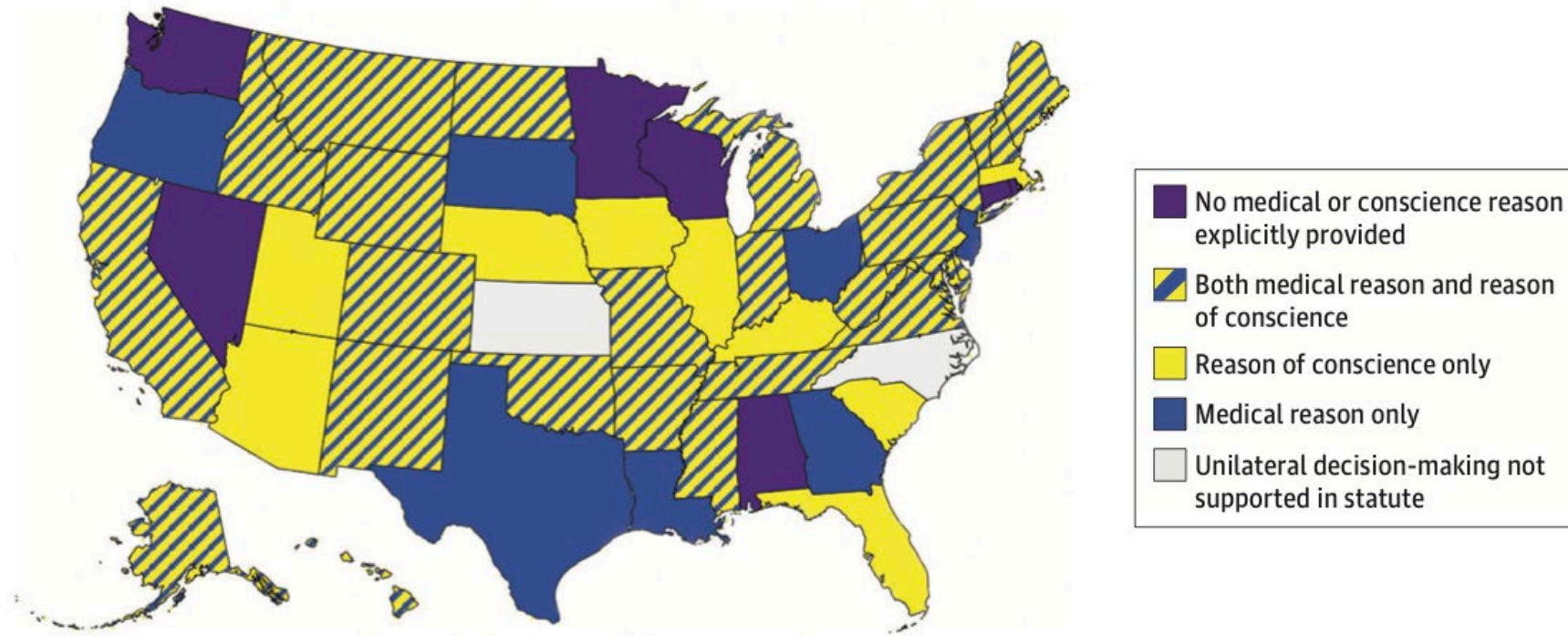
Hospital Policy Variation in Addressing Decisions to Withhold and Withdraw Life-sustaining Treatment

Gina M. Piscitello, MD; Patrick G. Lyons, MD; Valerie Gutmann Koch, JD; William F. Parker, MD, PhD; and Michael Huber

**Only 12% of Assessed Hospitals Had Policies That
Aligned With the ATS/AACN/ACCP/ESICM/SCCM
Consensus Policy Statement**

State Statutes

Figure. Reasons Supporting Unilateral Clinician Decisions to Decline Initiating or Maintaining Life-Sustaining Treatment



(Piscitello GM, JAMA Health Forum, 2025)

State Statutes

Table. Required Actions If Clinicians Use Medical Reason to Decline Initiating or Maintaining Life-Sustaining Treatment

Action	States that require action
Inform patient or surrogate about decision to decline initiating or maintaining life-sustaining treatment	Alaska, Arkansas, California, Delaware, Georgia, Hawaii, Maine, Maryland, Mississippi, New Mexico, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Vermont, Virginia, Wyoming
Obtain a second medical opinion	Alaska, Colorado, Maryland, Montana, New Hampshire, New York, Virginia, Vermont, West Virginia
Pursue a medical, ethics, or interdisciplinary committee review	Colorado, Montana, Texas, ^a Virginia
Offer patient or surrogate the opportunity to attend medical, ethics, or interdisciplinary committee review	Texas, Virginia
Address conflict	Virginia
Cooperate with transfer to another clinician or institution	Alaska, Arkansas, California, Colorado, Georgia, Hawaii, Idaho, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia, Wyoming
Do not impede transfer	Delaware
Continue to provide life-sustaining treatment until patient transferred to another clinician or institution	Alaska, Arkansas, California, Delaware, Georgia, Hawaii, Maine, Maryland, Mississippi, New Mexico, New York, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Vermont, Wyoming
Can withhold or withdraw life-sustaining treatment if transfer cannot be pursued	Arkansas, Tennessee, Texas, ^b Virginia ^c
Do not need to pursue transfer to another institution if life-sustaining treatment is “medically inappropriate”	Indiana
Limited to do-not-resuscitate decisions for patients who both lack decision-making capacity and a surrogate decision-maker	New Hampshire, New York
Track and report the sex, race, age, and insurance of patients without decision-making capacity brought before committees to discuss clinician decisions to decline initiating or maintaining life-sustaining treatment	Texas

^a In Texas, the committee's review can consider the patient's well-being but cannot make

^c In Virginia, life-sustaining treatment can be stopped after 14 days, subject to the right

(Piscitello GM, JAMA HF, 2025)

How to Hospital Policies and State Law Guidance Influence Clinician Approaches to Withhold or Withdraw Life-sustaining Treatment?

- Semi-structured interviews of ICU nurses and physicians across 3 geographically diverse locations in 2024

Approaching Cases of Physiologic Futility

Don't perform CPR

"I would not offer CPR in this case, and then I would continue to discuss in an empathetic and caring manner why we're not going to do CPR, because there is no way for that to extend their life, it would only extend their suffering and death, and I would say about half of my colleagues would do the same and the other half would be likely to just provide a short, very abbreviated course of CPR." Physician

Perform CPR

"And I think if they still were absolutely insistent that we performed CPR, I would probably honor that wish but very quickly bringing them into the room so they could see what was happening. And hopefully they would be willing to have us stop rather quickly." Physician

Approaching Cases of Physiologic Futility, “Potentially Inappropriate” Treatment, and Unrepresented Patients

No participants’ response completely aligned with all requisite actions for approaching the three ethically challenging patient cases outlined in their hospital’s policies, state laws, or medical society guidelines.

((Piscitello GM, Chest, 2025))

Next Steps

Identify interventions to improve clinician decision-making disparities during GOCC (decision-making, verbal communication and documentation)

Thank you!