

The Barriers and Facilitators to Hospice Care in Nursing Homes: Are There Feasible and Affordable Policy Fixes?



*Improving Care Delivery at
The End of Life: A Focus on Public Policy*
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What Is the Medicare Hospice Benefit In Nursing Homes?

Hospice In Nursing Homes

Eligibility for Medicare hospice care in nursing homes --

- Private pay nursing home residents
- Medicare / Medicaid eligible residents
- **NOT Medicare skilled nursing home residents**
- Physician-certified terminal prognosis of 6 months or less (if disease runs its normal course) –made in *good faith*

Hospice Care in Nursing Homes

Reimbursement--

--Hospice receives Medicare hospice payment.

--Hospice receives 95% of Medicaid per diem and pays nursing home 95 to 100% of per diem.

Hospice Care In Nursing Homes

- Requirements for Medicare Hospice Care in Nursing Homes
 - Contract between hospice and nursing home
 - Medicare certified hospice provider
 - Coordinated care planning and evidence of this
 - According to regulations, hospice assumes care coordination

The Proportion of U.S. Nursing Homes that Contract with Hospice

Nursing Homes with Any Residents on Hospice-- Kansas, Maine, Mississippi, New York and South Dakota

- 1993 23.3%
- 1996 56.6%
- 1997 51.3%

2000 76%--ALL STATES

Florida 96%; Wyoming 36%

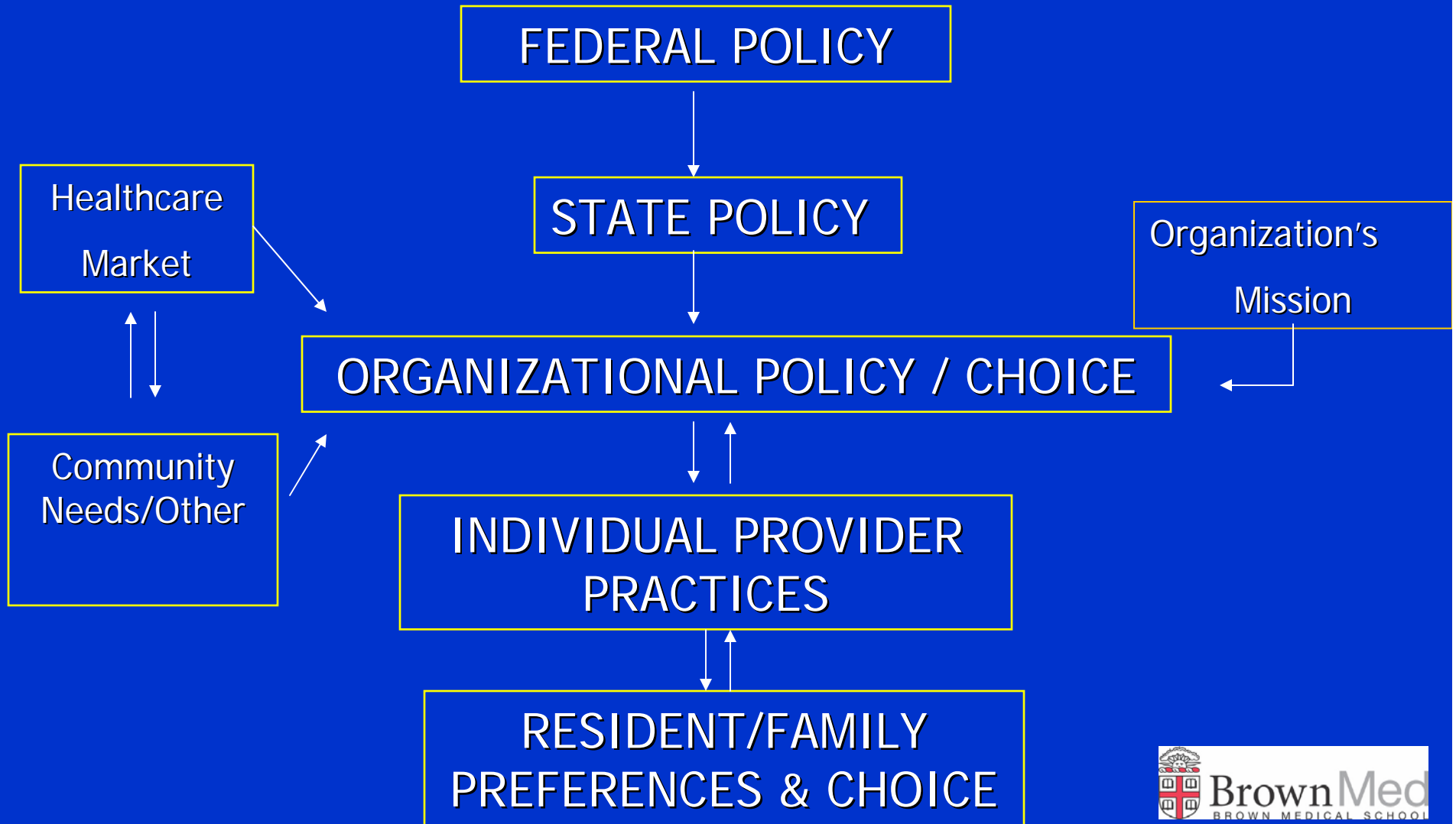


Proportion of Dying NH Residents Who Access Hospice

- **23% in U.S.--Preliminary Analysis—2000**
 - Residents had NH care (i.e., MDS) in 2000 & died in 2000 and had hospice in last 6 months of life. (Some may have died in community so estimate presently is a little high.)
 - **Highest--38.5% in Arizona; 34% Florida; 32% Colorado**
 - **Lowest—5% in Maine & Vermont; 7% Wyoming**



The Hospice “Choice”



Policy-Level Barriers to (Timely) Hospice Access

- Federal Level
 - Requirement of “pass through” of 95% of NH per diem
 - Restricted access to Medicare hospice to SNF residents
 - NH physician payment policies and oversight
- State Level
 - Manual submission, Medicaid NH per diem
 - Hospice residents removal from Medicaid case mix

Is Lack of Simultaneous Access to Hospice and SNF Short-Sighted?

Big differences in Medicare spending when SNF residents access hospice:

- **Mean daily Medicare expenditures in last month of life—had SNF in last 30 days of life and:**

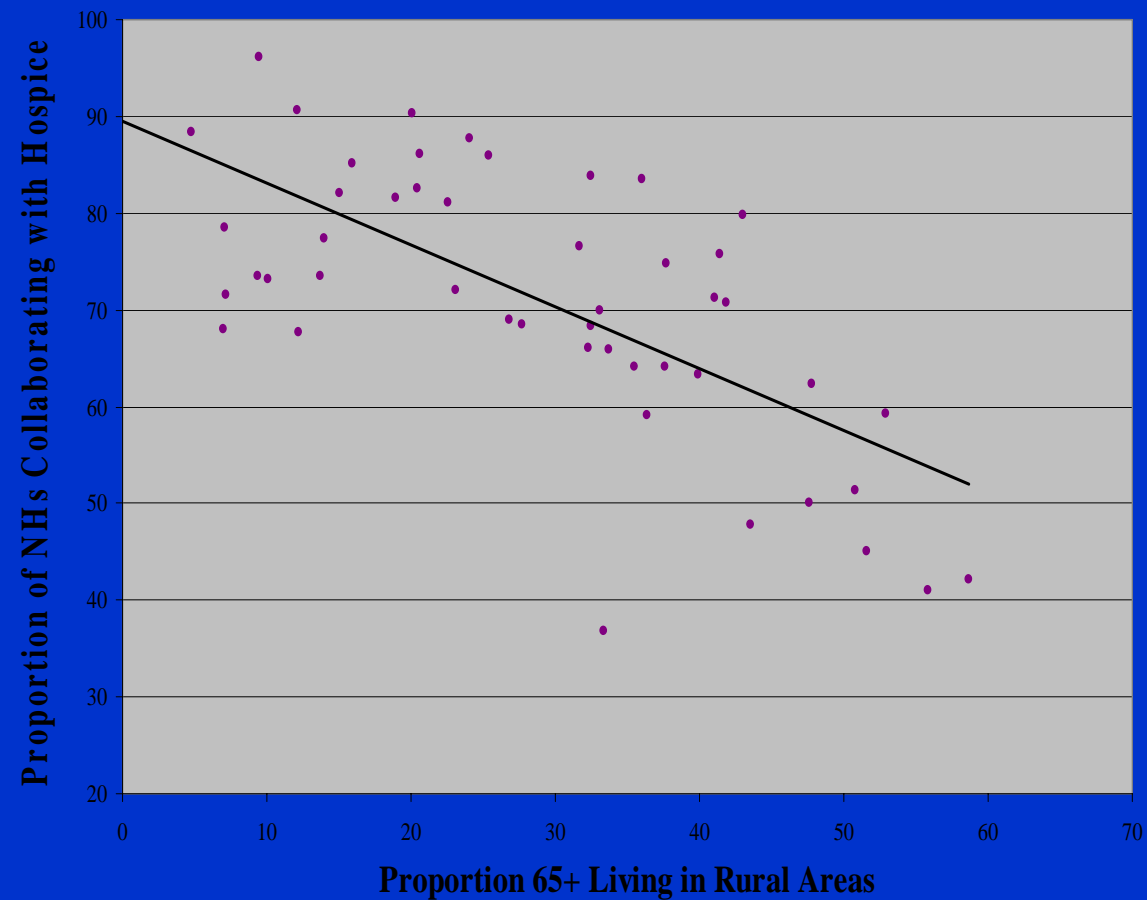
DID NOT ACCESS HOSPICE	\$428 (SD \$340)
(N=1,872)	

ACCESSED HOSPICE	\$253 (SD \$138)
(N=184)	

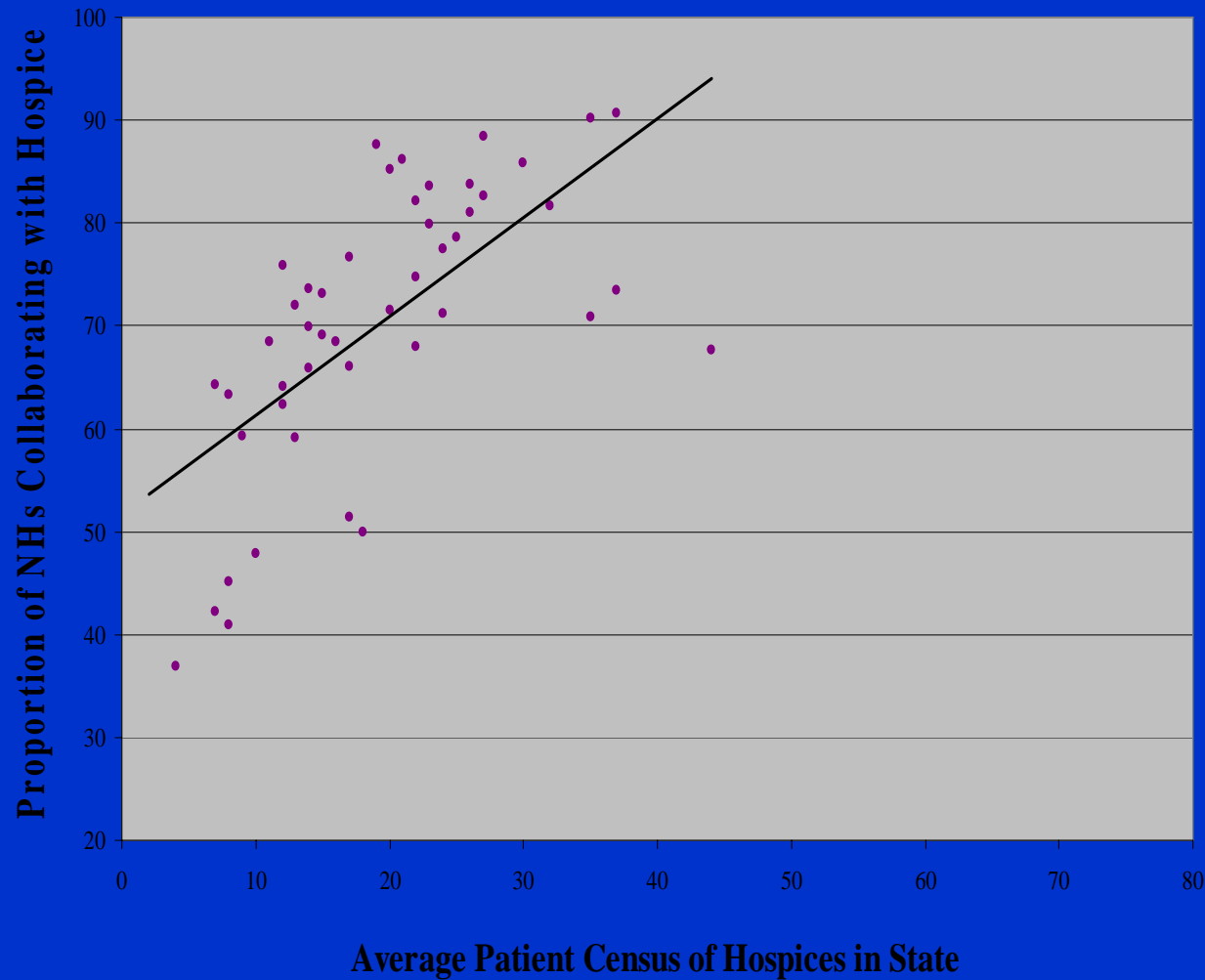
Organizational-Level Barriers to (Timely) Hospice Access

- NH rural location
- Small hospice providers
- Inter-organizational challenges
- Generally, no policies / procedures in place for assessing terminal status
- Required shift from Medicare to Medicaid NH per diem with hospice election by dual-eligible Medicare SNF resident
- Other

NH Hospice Collaboration by Rural Status of State



NH Hospice Collaboration and Average Daily Patient Census of Hospice Programs



Provider-Level Barriers to (Timely) Hospice Access

- Physicians
 - “Missing in Action” in NHs—usually not initiators of hospice conversation
 - Lack knowledge of hospice referral criteria and of the availability of the benefit in nursing homes
 - Prognoses difficult
 - Communication with resident/family often lacking

Physician Communication with Resident/Family

A Director of Nursing:

“Families say, “ I called the doctor and they, they give me the run around,” and they need their support.”

Provider-Level Barriers to (Timely) Hospice Access

- NH Staff (Nurses, aides)
 - Hospice only when something “bad” happens / for the “very end”
 - Not necessarily aware of full range of care provided.
 - No policies / procedures for assessing terminal status
 - Limited input from physician
 - Belief among some NH staff that hospice does not add substantially to the end-of-life care of dying residents.
 - More predominant in low referring NHs
 - May not understand the full range of hospice services

Resident-Level Barriers to (Timely) Hospice Access

- The required shift from cure to comfort with hospice election
 - Knowledge of prognosis?
 - Knowledge of end-of-life options / hospice?
 - Acceptance Issues
- In some cases, required shift from Medicare SNF to private pay
 - Results in resident/family paying NH per diem
- Logistics of consent (delaying referral)
 - Locating NOK, other

Examples of Reasons for Less Timely Referrals

- Family Issues:

I: *“And what do you think would have needed to happen for the hospice referral to have occurred earlier?”*

R: *“I think more education, you know bringing it up sooner, trying to get the wife to understand where everything stood and how much more quality he could have , you know, if he was just in pain control.”*

--Nurse CNA on 85 year old resident with cancer and AD/dementia; hospice length of stay 10 days

What Changes / Action Are Needed?

Needed Federal-Level Action

- Need benefit for provision of palliative care to dying SNF residents
 - Some form of hospice / palliative end-of-life care simultaneously available
 - Surveyor monitoring of end-of-life care
 - With and without hospice
- Need to end hospice “pass through”
 - “Pass-through” administratively cumbersome / inefficient—a barrier to access
- Physician reimbursement for care of NH residents which motivates a higher level of involvement
 - To acknowledge the current NH case-mix

Needed State-Level Action

- Allow for electronic billing of Medicaid NH per diem by hospices & do not exclude hospice residents from case mix
- Require surveyors to focus on end-of-life care and on the nursing home / hospice collaboration
 - Comfort care / palliative care expertise available
 - Symptoms adequately managed
 - Other
- State Health Department involvement in improving end-of-life care

Individual and Organizational Providers

- Need policies, procedures & systematic data collection for assessment of terminal status / hospice referral
- Need hospice informational materials
 - Types of services available
 - Differing levels of care available and criteria
- “Collaborative Solutions” of successful NH/hospice collaborators – RWJ-funded project with Internet site activation scheduled for January 2005

Consumers and Patients / Families

- Informational materials
- Incorporate Medicare hospice in Patient Bill of Rights
- Educational offerings (with Public Health Department involvement)
- Public service announcements
 - healthcare waiting areas, other
- Editorials

Influencing Public Policy

(A State-Level Example)

- Timing Has To Be Right—Something has raised concern
 - In RI controversial care of a NH resident made newspaper
- Have you done your “homework” / anticipated need
 - We had lots of data.
- Something in it for everyone
 - Everyone “under the microscope,” and thus, incentive to collaborate in improving care
 - Much momentum
- Now, need to focus on follow-through—on keeping momentum going