

End-of-Life Issues: The Role of Hospice in The Nursing Home

Susan C. Miller, Ph.D.
Center for Gerontology &
Health Care Research
BROWN MEDICAL SCHOOL



Overview of Presentation

- The rationale for the Medicare hospice benefit in NHs
 - Need
 - Added Value
- The problem of short hospice stays
- The barriers and facilitators of hospice referral in RI NHs
- The regulations governing the NH / hospice collaboration
 - How is payment made?

Changing Site of Death for Non-traumatic Deaths

- Dying now frequency occurs in institutional settings
 - 1949 -- 49.% of U.S. deaths in institutions (39.5% in hospitals)
 - Sites of (non-traumatic) Death in 2001*:
 - 23.4% in nursing homes
 - 49.5% in hospitals (and their emergency rooms)
 - 23.2% in homes in the community (including residential care / assisted living)
 - 3.9% in other locations
- In RI, 95% of persons dying with AD/dementia die in the NH

*(<http://www.chcr.brown.edu/dying/factsondying.htm>, 2004).

What is the added value of
hospice care in nursing homes?

Research on Benefits of Hospice Care

- Few Studies Documenting Superior Outcomes, but
 - Greater satisfaction
 - Less invasive treatment
 - Fewer Hospitalizations
 - Better Care Practices
- Fewer Unmet Needs (Teno et al., 2004, JAMA)
 - Home with hospice significantly fewer unmet needs than home with home care or hospital or NH death

Acute Care Hospitalization (percent hospitalized) --Received Hospice Entire 30 or 90 Days—MDS Data in 5 States—1992-96

Time Prior
to Death

Hospice
Percent

Non-Hospice
Percent

30 days

2 %

39 %

90 days

3 %

50 %

Comparisons -- Pain Prevalence and Treatment – MDS Data in 5 States in 1992-96

	<u>Hospice</u>	<u>Non-Hospice</u>
Daily pain with analgesic administered twice a day	57%	39%

Hospice in Nursing Homes: An Empirical Examination of its Scope and Quality Outcomes

(Funded by RRF; Investigators: Susan C. Miller, Vincent Mor and Joan Teno)

- **Convenience sample of hospices and nursing homes in 6 geographic areas across the United States.**
 - **11 hospice programs and 28 nursing homes participated.**
 - **209 hospice decedents and 172 non-hospice decedents dying in time period--8/1/97 -- 7/30/98--Total n = 381**
- **Resident nursing home and hospice records for the 30 days prior to death, interviews with staff, interviews with next-of-kin**

Hospitalization at End of Life¹

	Hospice	Non-Hospice
Died in Hospital	2%	17%
Hospitalized in Last 30 Days of Life ²	12%	37%

¹Includes acute care hospitalization and inpatient hospice.

²Excludes hospice patients hospitalized only prior to hospice admission

Pharmacological Management of Assessed Pain

(Miller SC, Mor V, Teno J. 2003. *Journal of Pain & Symptom Management*)

	Hospice		No Hospice (N=118)
	≤ 7 Days (N=32)	> 7 Days (N=115)	
Any opioid--last 48 hours	75%	90%	69%
Any opioid given twice a day -- last 48 hrs. of life	50%	79%	60%

Perceived Influence on NH Hospice Beneficiaries & Families by Nursing Home Administrators/Staff (interviews of staff at 19 NHs in 6 states)

- Theme -- Hospice allows more one on one care.

“Extra set of hands / hearts”

“Hospice “very important for family and resident--lot of extra support and guidance given.”

“Extra TLC”

“Even though nursing facility staff give 110% the extra help is needed.”

The Proportion of Nursing Homes that Contract with Hospice

2000 76%--ALL STATES

Florida 96%; Wyoming 36%

RHODE ISLAND = 68%



2003 – 78% IN RI --PER STATE SURVEY

Proportion of Dying NH Residents

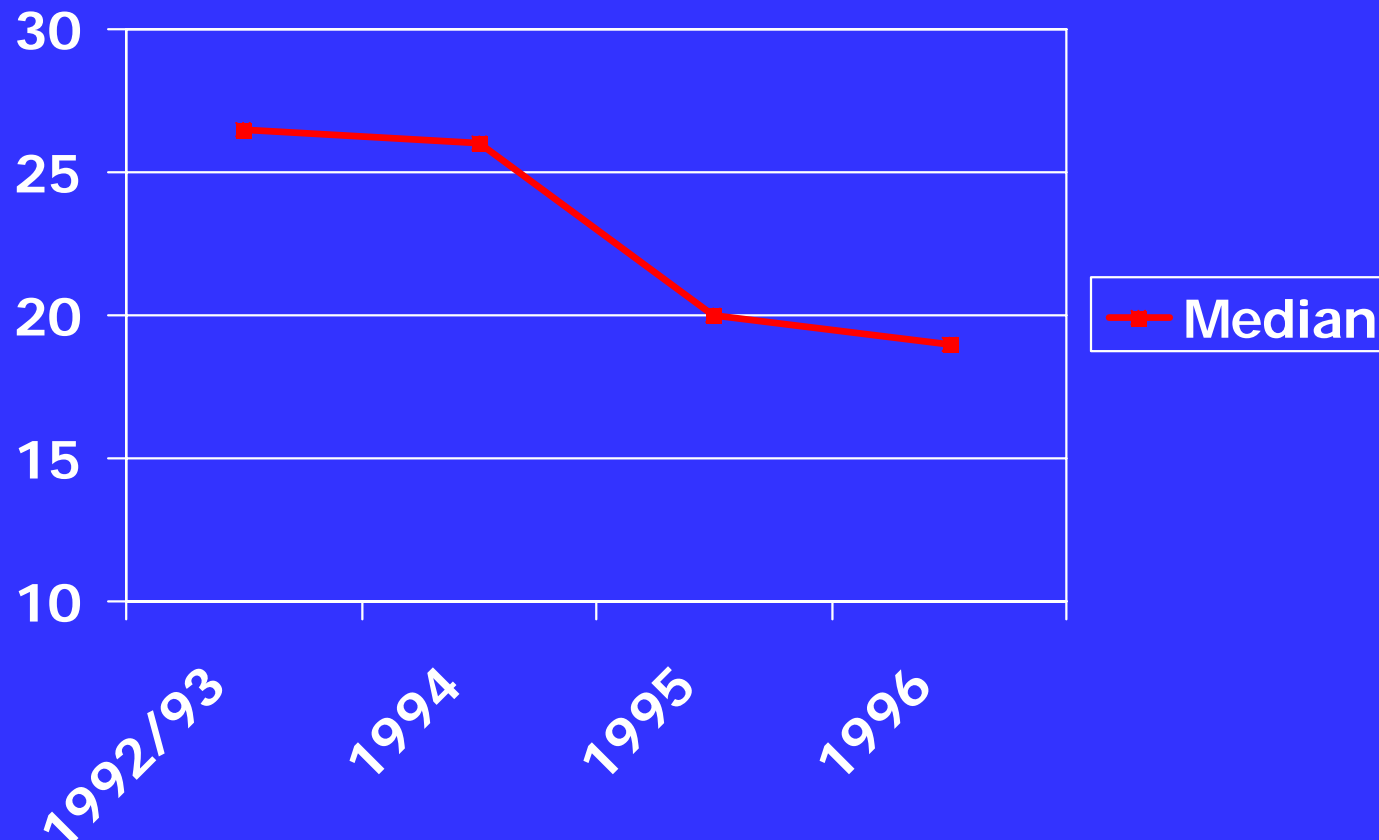
Who Access Hospice (Miller, 2004, manuscript in preparation; Derived from “Residential History File” using MDS and Medicare enrollment file & claims)

- **18% in U.S.—July -- December, 2000**
 - **24% in NHs who have any hospice**
 - **Highest—39% in Arizona & Colorado; 31% Florida; 36% Texas**
 - **Lowest—10% in Maine & Idaho; 9% Vermont**
 - **RHODE ISLAND = 14%**

Median Hospice Length of Stay Over Time— Hospice Decedents Admitted after Nursing Home

Admission (in KS, NY, MD, MS, SD) (Miller SC,
Mor V, Gozalo P, 2000)

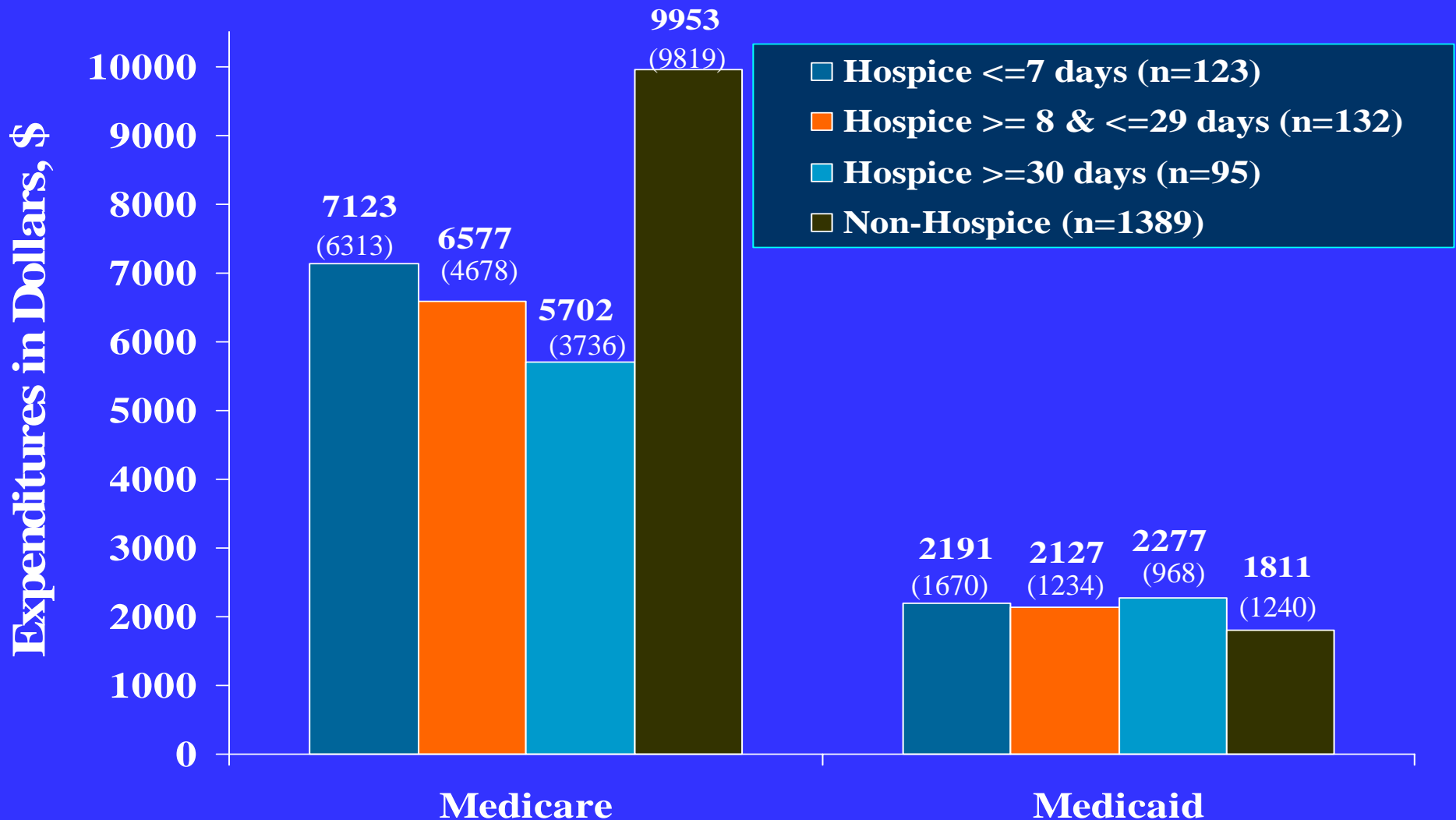
(RI HOSPICE LENGTHS OF STAY SHORTEST IN COUNTRY – 13.6
DAYS IN 2001)



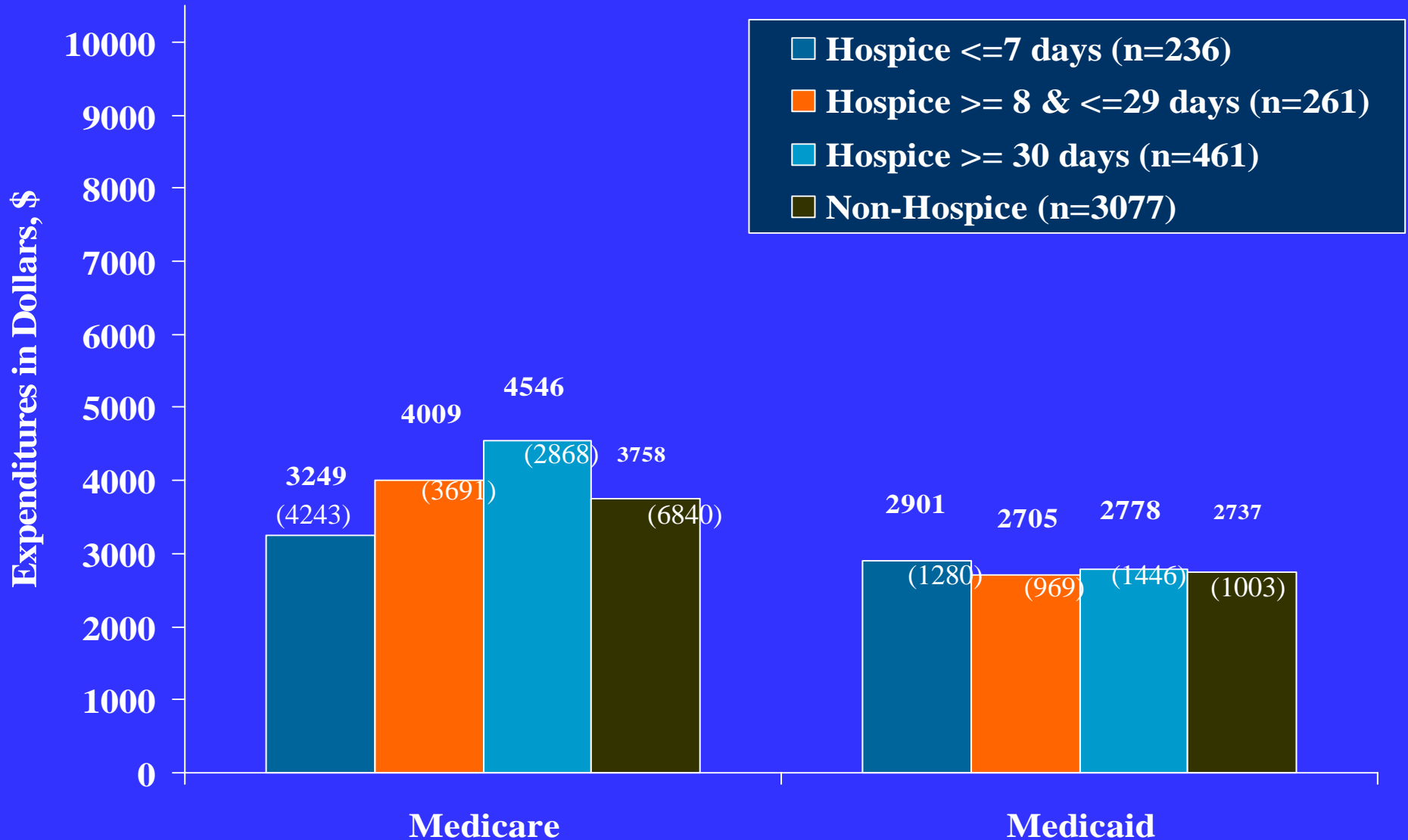
Research on Benefits of Hospice Care (continued)

- Short Hospice Stays (Schockett, Teno, Miller, Stuart, in press)
 - “Too late” hospice referral versus not “too late” (per NOKs), associated with lower satisfaction with hospice, more concerns with coordination of care, other (Schockett, Teno, Miller, in submission).

Expenditures in the Last Month of Life by Hospice Status and Length of Time in Hospice – FL Short-Stay NH Residents -- 1999



Expenditures in the Last Month of Life by Hospice Status and Length of Time in Hospice – FL Long-Stay NH Residents -- 1999



RI Study Methodology — Sample

2 Hospices & 7 Nursing Homes

-- NHs had contracts with the hospices

Frequency of hospice referral determined

(based on referral history obtained from hospice)

Less frequent = 3

More frequent = 4

-- Per DON interview, 1 NH appeared to have in place a more structured assessment of terminal status

Methodology — Decedents & Staff Interviewed

	All	CA	CA/Dem	Dem	Other
<u>Decedents</u>	32	8	6	11	7

Total Staff Interviewed

- NH Nurses 34
- NH Certified Nurse Assistants 30
- Hospice Nurses 17

Impediments to Hospice Referral– Theme Across NHs

- **Belief that hospice is appropriate only when “something bad happens”**
 - NH nurses frequently use their assessments of the patient’s comfort and the family’s need for support as determining factor as to whether hospice care is needed.

Belief that hospice is appropriate only when “something bad happens”--

I: *“Now would you discuss what factors led to [resident] not being cared for by hospice?”*

R: *“I think he was adequately cared for and he never had any pain. His wife and family were very supportive and understanding.”*

--a NH nurse regarding a 94 year old resident with cancer and AD/dementia; no hospice services

Impediments to Hospice Referral Themes in Lower Referring NHs (N=3)

- Residents death was rapid and, therefore, a surprise.
- Belief among some NH staff that hospice does not add substantially to the end-of-life care of dying residents.
 - Although many respondents spoke of the benefits of hospice care for residents, their family members and NH staff, some did not see hospice services as adding substantially to the end-of-life care provided by NH staff.

Facilitators to Hospice Referral – NHs Who Referred More Frequently to Hospice (N=4)

- Resident had begun to decline and/or death was expected;
- Pain facilitated hospice referral; and
- NH staff played an important role in raising the hospice option.

Recognition that resident had begun to decline and/or the death was expected-- Example

R: “For 10 years, I can tell you she went from bad to the worse decline. She would be active, walk around and then evidently declining, she could not walk again. She was in distress, congestion and unhappiness, helpless.”

--NH nurse regarding a 95 year old resident with AD/dementia; hospice length of stay 21-28 days.

Timeliness of Referral

Impediments to Earlier Hospice Referrals—When Gaps Present

- Hospice only appropriate for “very end.”
- Prognosis as an impediment

**What are the regulations
governing the nursing home /
hospice collaboration?**

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

Nursing Home Continues To Provide Room & Board Services

- *. . .the performance of personal care services, assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.*

Eligibility for Medicare hospice care in nursing homes --

- Private pay nursing home residents
- Medicare / Medicaid eligible residents
- NOT Medicare skilled nursing home residents
 - unless skilled care not for terminal diagnosis
 - Example: Fractured hip (not result of bone metastasis)
- Physician-certified terminal prognosis of 6 months or less (if disease runs its normal course)
 - It's based on clinical judgment (per 2000 legislation)

Reimbursement for NH Hospice Residents

- Hospice receives Medicare hospice payment.
- Hospice receives 95% of Medicaid per diem and pays nursing home 95 to 100% of per diem.
- Non-hospice physician continues to bill Medicare Part B for services.

Levels of Hospice Care

- Medicare levels of hospice care:
 - **Routine home care** (~ \$100 a day)
 - **Continuous home care** (in periods of crisis—for at least 8 consecutive hours in one 24 hour period at least half by nurse) (~ \$600 for 24 hours of care)
 - **General inpatient care** (in periods of crisis) (~ \$600 a day)
 - **Respite inpatient care** (~ \$100 a day)
- Routine home care is most used in nursing home (overall, 87% of hospice care provided)

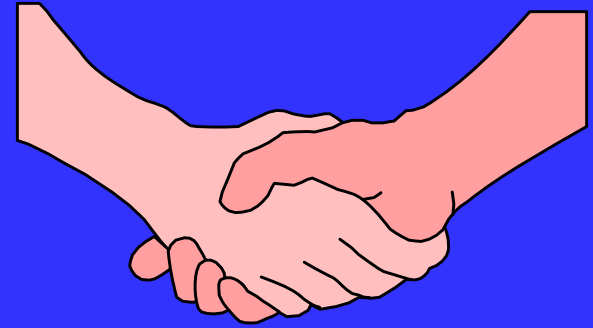
Hospice General Inpatient Hospice

- Short-Term Inpatient Hospice Care
 - *Appropriate for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings.*
 - *Example: . . . may be needed by a patient whose home support system has broken down . . . Or at the end of an acute-care hospital stay Or medication adjustment, observation, or other stabilizing treatment, such a psycho-social monitoring*

Hospice Continuous Home Care

- Continuous Care
 - . . . *may be provided only during a period of crisis*
 - . . . *primarily nursing care to achieve palliation or management of acute medical symptoms*
 - For payment, . . . *Need for an aggregate of 8 hours of primary nursing care is required . . . This means that at least half of the hours of care are provided by RN or LPN.*

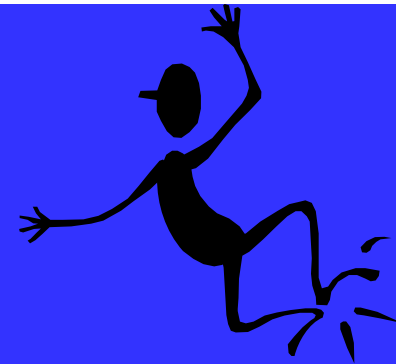
Successful Collaborations...



...are **partnerships** where care planning, coordination and provision are performed in care environments where:

- mutual respect dominates;
- providers routinely share knowledge; and
- policies and procedures clarify the roles of each collaborating party.

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<http://www.chcr.brown.edu/nhhsp/> -- Internet Site on Nursing Home / Hospice collaboration