

Nursing Home/Hospice Partnerships: A Model for Collaborative Success—Through Collaborative Solutions

February 2007



A Robert Wood Johnson Funded Project

*Conducted By: The Center for Gerontology and Health Care Research
School of Public Health, Brown Medical School*

Susan C. Miller, PhD, Project Director

EXECUTIVE SUMMARY

For many years hospice programs have been working in close collaboration with nursing homes (NHs) to offer holistic, interdisciplinary end-of-life (EoL) care to NH residents and their families. However, the road to successful NH/hospice partnering is not always smooth (Hirschman et al., 2005; Miller & Egan, 2006; Parker-Oliver & Bickel, 2002; Wetle et al., 2004). The establishment of interprofessional and interorganizational collaborations is challenging in itself, but NHs and hospices in addition must often navigate (at least perceived) conflicting regulatory requirements. Even so, it appears attempts at achieving success in this partnership are beneficial (Baer & Hanson, 2000; Hirschman et al., 2005; Miller, Gozalo, Mor, 2001; Miller, Mor, Wu et al. 2001; Parker-Oliver & Bickel, 2002; Wetle et al., 2004). Therefore, the goal of this RWJ-funded project was to identify “Best Practices for NH EoL Care”—practices contributing to successful NH/hospice partnerships. These practices are identified in this report as “collaborative solutions.”

Using a nomination and review process, we chose six NH/hospice collaborators across the four major U.S. geographic regions for case studies. During site visits, project staff and consultants interviewed administrators, NH/hospice liaisons, medical directors, directors and assistant directors of nursing, chief financial officers and/or billing staff, and other NH/hospice staff (e.g., nurses, aides, social workers, other). Interviews focused on domains identified as important to the NH/hospice partnership: 1) administration of the collaboration, 2) communication (including conflict resolution), 3) inter-disciplinary practice, 4) education, 5) care planning, 6) care provision, 7) support for resident/family (prior to, during and after death), and 8) support for NH staff (prior to, during and after death).

Organizational culture drove successful partnerships. For the hospice, a customer service culture with the NH as the customer drove practices and, for the NH, a mission-driven patient-centered culture motivated the NH to use hospice and to demand “hospice’s best.” Systems in place ensured the partnership worked, and independent of individual personalities. Thus, while the NH and hospice organizational cultures described were observed at the study sites, they may not be requisite to the implementation of systems associated with success—systems that may ultimately influence organizational culture.

This report presents a brief synthesis of the background literature on hospice/palliative EoL care in NHs and of the project’s methodology before discussing in depth the “Collaborative Solutions” identified through this project. In relation to the collaborative solutions, a logic model is presented, “A Model for Collaborative Success—Through Collaborative Solutions.” A logic model can be thought of as a picture of how an organization accomplishes its work (W.K. Kellogg Foundation, 2004). The model links the resources invested to the processes/activities that occur, and then to the benefits or changes resulting (or planned). The model presented in this report is a blueprint to

be used by other NH/hospice providers to build successful partnerships. While not all aspects of the model are appropriate for every organization, organizations can adopt those that are.

Three collaborative solutions vital to achieving partnership success, and potentially capable of facilitating positive change in existing partnerships are listed below.

Table 1. Key Collaborative Solutions

- 1) Systematic processes facilitate communication between NH and hospice staff, and between all levels of staff.
- 2) Hospice chief executive officers (CEOs) are well-versed in NH regulatory and care environments, are skilled leaders, and convey a consistent vision for hospice NH care.
- 3) NHs share their care expectations with their hospice partners (within regulatory guidelines and as practical) and provide feedback to hospices.

Many other important collaborative solutions emerged in the course of this project. Some of the especially notable solutions are listed below by relevant categories.

Table 2. Notable Collaborative Solutions

Resources/Inputs

- NHs and hospices share similar philosophies of care; and
- NHs openly acknowledge the occurrence of death in NHs and have practices in place to provide special care and/or services to dying residents/families.

Activities—Infrastructure

- Partnership and staff relationships (at all levels) result from planned systems and activities—they are not dependent on individual, time, and not left “to chance;”
- Hospices cultivate collaborative relationships with NHs’ managed care providers to promote the providers’ recognition and use of the value added care/support provided by hospices;
- Mechanisms are in place to facilitate regular assessment of the partnership;
- Education addresses relationship building and conflict resolution, the unique aspects of care provided by NH and hospice staff, and NH and hospice regulatory and care environments;
- Dedicated hospice teams provide care focusing exclusively on NH residents (as feasible per hospice size); and
- Hospice presence is high in NHs.

Activities—Processes

- Regular meetings and/or dialogue occur between NH and hospice CEOs;
- Hospices respond promptly to NH requests;
- Hospice visits are purposefully structured—hospice staff check in with like discipline upon arrival and departure, and ask for input;
- Dialogue on care planning and provision is frequent;
- NH Medicaid per diem payment is prompt (even when state Medicaid payment is slow) and 100% of per diem is paid by hospices; and
- Hospices provide support to NHs during Medicare/Medicaid surveys as well as with bureaucracy such as Medicaid applications/follow-up for hospice residents.

In summary, the successful NH/hospice partnerships studied did not occur by chance—they resulted from well-planned efforts by knowledgeable leaders and motivated staff. The partnerships were dynamic. Regular dialogues between leaders, and routine assessment of interorganizational relationships and of the care and services provided, led to expert symptom management and to the provision of higher levels of support to dying residents and their families.

REFERENCES

Baier, R.R., Gifford, D.R., Patry, G et al. Ameliorating pain in nursing homes: a collaborative quality-improvement project. *J AM Geriatr Soc.* 2004;52:1988-1995.

Gozalo P, Miller SC. Hospice Enrollment and Evaluation of its Causal Effect on Hospitalization of Dying Nursing Home Patients. To Appear, HSR 2007. Online at:
<http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1475-6773.2006.00623.x>

Hirschman KB, Kapo JM, Straton JB, Stanley L, Strumpf NE, Casarett DJ. (2005) Hospice in long-term care. *Annals of Long-Term Care.* 13, 25-29.

Miller, S.C. & Egan K. (2006) How can clinicians with diverse backgrounds and training collaborate with one another to care for patients at the end of life? THE NURSING HOME/HOSPICE PARTNERSHIPS. Available at:
http://www.chcr.brown.edu/nhhsp/RWJ_MONGRAPH_REVISED5_7_10_06.PDF

Miller, S.C., Gozalo, P., & Mor, V. (2001). Hospice enrollment and hospitalization of dying nursing home patients. *Am J Med,* 111, 38-44.

Miller, S.C., Mor, V., Wu, N. (et al.) (2001). Does receipt of hospice care in nursing homes improve the management of pain at the end-of-Life? *JAGS,* 50, 507-515.

Parker-Oliver D, Bickel D. (2002) Nursing home experience with hospice. *J Am Med Dir Assoc.,*3, 46-50.

W.K. Kellogg Foundation. (2004) Logic Model Development Guide. W.K. Kellogg Foundation, Battle Creed, MI, available at: <http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf>

Wetle T, Teno J, Shield R, Welch LC, and Miller SC. (2004) End of life in nursing homes: Experiences and policy recommendations. Report #2004-14. 2004. Washington, D.C., AARP Public Policy Institute.