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”

- Federal Policy
- State Policy
- Organizational Policy / Choice
- Individual Provider Practices
- Resident/Family Preferences & Choice

Organization’s Mission
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

![Graph showing 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."

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**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
- Editorial

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