NURSING HOME/HOSPICE PARTNERSHIPS

A Model for Collaborative Success—Through Collaborative Solutions

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**Pilot Sites:**

- Home & Hospice Care of Rhode Island
- Saint Elizabeth Manor, East Bay

**Project Sites:**

- Yolo Hospice
- Alderson Convalescent Hospital
- TideWell Hospice and Palliative Care
- Pines of Sarasota
- Hospice of Southwest Michigan
- The Laurels of Galesburg
- Hospice of the Twin Cities, Inc.
- Ambassador Good Samaritan Center
- Four Seasons Hospice & Palliative Care
- Brian Center Health & Rehabilitation
- Hunterdon Hospice
- Hunterdon Care Center
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>
<thead>
<tr>
<th>Table 1. Key Collaborative Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Systematic processes facilitate communication between NH and hospice staff, and between all levels of staff.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>3) NHs share their care expectations with their hospice partners (within regulatory guidelines and as practical) and provide feedback to hospices.</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Resources/Inputs</th>
<th>Activities—Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHs and hospices share similar philosophies of care; and</td>
<td>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;”</td>
</tr>
<tr>
<td>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.</td>
<td>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;</td>
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<tr>
<td></td>
<td>Mechanisms are in place to facilitate regular assessment of the partnership;</td>
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<td></td>
<td>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;</td>
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<td></td>
<td>Dedicated hospice teams provide care focusing exclusively on NH residents (as feasible per hospice size); and</td>
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<tr>
<td></td>
<td>Hospice presence is high in NHs.</td>
</tr>
<tr>
<td>Activities—Processes</td>
<td>Hospices respond promptly to NH requests;</td>
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<tr>
<td></td>
<td>Hospice visits are purposefully structured—hospice staff check in with like discipline upon arrival and departure, and ask for input;</td>
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<tr>
<td></td>
<td>Dialogue on care planning and provision is frequent;</td>
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<tr>
<td></td>
<td>NH Medicaid per diem payment is prompt (even when state Medicaid payment is slow) and 100% of per diem is paid by hospices; and</td>
</tr>
<tr>
<td></td>
<td>Hospices provide support to NHs during Medicare/Medicaid surveys as well as with bureaucracy such as Medicaid applications/follow-up for hospice residents.</td>
</tr>
</tbody>
</table>

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.
Palliative care is “both a philosophy of care and an organized, highly structured system for delivering care;” it is “operationalized through effective management of pain and other distressing symptoms, while incorporating psychosocial and spiritual care according to patient/family needs, values, beliefs and culture(s)” (National Consensus Project, 2004). Hospice care is a form of palliative care. Palliative care programs/teams in hospitals have been shown to be associated with reductions in pain and other physical symptoms, (Bailey et al., 2005; Jack et al., 2003 & Modonesi et al., 2005) and reductions in acute care hospitalizations and costs (Back, et al. 2005; Costantini et al., 2003 & Elsayem et al., 2003). A recently completed comprehensive palliative care project across primary care, acute care and long-term care settings found participants reported improved pain and symptom management, and a high proportion of decedents (48%) used hospice prior to death (London et al., 2005).

Nursing homes (NHs) choose differing strategies for meeting end-of-life (EoL) palliative care needs. Many U.S. NHs (75% in 2000) have chosen to partner to some extent with hospice programs to help them address the EoL palliative care needs of their residents/families (Miller & Mor, 2004). These NHs as well as NHs not partnering with hospices may or may not have established or have available to them nonhospice palliative care expertise/programs, but the extent to which such expertise/programs are available in NHs is unknown.

In addition to the below synthesis, the reader is encouraged to access the bibliographies, manuscripts and slide presentations on hospice/palliative care in NHs available on the project’s website, http://www.nhpco.org/nursinghomes. Once the website is accessed, click on “Bibliographies” or “Resources & Guidelines” for these additional resources.

Hospice Care and Its Use in NHs

Hospice care provision in the United States (U.S.) began in the early 1970’s in response to the need to ameliorate the unremitting physical and psychological pain and suffering which may occur in the process of dying. In 1982 the U.S. Congress passed legislation allowing payment for hospice care provided to terminally persons (i.e., those with certified prognoses of 6 months or less to live [if the disease runs its normal course]) who are qualified to receive government Medicare health care benefits (generally, persons 65 years of age and older or younger persons with permanent disability) (Tax Equity and Fiscal Responsibility Act of 1992 (TEFRA-82), (P.L. 97-248). In 1985, the US Congress passed legislation to extend the Medicare benefit to persons living in NHs (Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA-85), (P.L. 99-272) and the Omnibus Budget Reconciliation Act (OBRA) of 1989 resulted in greater availability of the hospice benefit in NHs since it clarified payment mechanisms for dually eligible (i.e., Medicare and Medicaid eligible) residents who receive hospice care (Miller et al., 1998).

Nursing homes can offer hospice care to dying residents by developing working relationships (including formal contracts) with Medicare approved hospice providers. Nursing home residents who elect the Medicare hospice benefit agree to waive their right to receive standard Medicare benefits related to their terminal illness, including all curative treatment, unless they chose to “disenroll” from hospice, something that can be done without jeopardizing reenrollment. With hospice enrollment, NH residents and their families receive physical, psychosocial and spiritual support and care from a hospice interdisciplinary team as well as drug coverage for medications related to their terminal illness; the NH continues to provide the care covered through Medicaid or private pay “room and board.” Residents who receive Medicare Part-A skilled nursing facility (SNF) care for their terminal condition at present cannot simultaneously access Medicare hospice. In 2000, an estimated 16% of U.S. NH residents who died accessed Medicare hospice care (Miller & Gozalo, 2005).
Most research supports the notion that NH decedents who enroll in hospice, versus decedents who do not, are less frequently hospitalized and have a higher quality of care and life at the EoL. Population-based research in NH’s (in Kansas, Maine, Mississippi, New York and South Dakota) has shown hospice residents, compared to nonhospice residents, experience fewer hospitalizations near the end-of-life, have fewer invasive treatments (i.e., enteral tubes, intravenous fluids, and intramuscular medications), and receive analgesic management for daily pain that is more in agreement with guidelines for management of chronic pain in long-term care settings (Miller, Gozalo, & Mor, 2001; Miller, Gozalo, & Mor, 2001; Miller et al., 2002). Nonhospice residents in NHs also appear to benefit from hospice presence in NHs. Research has found nonhospice residents residing in NHs with a greater hospice presence (i.e., a greater proportion of residents enrolled in hospice), versus in homes with no or a limited hospice presence, to be less frequently hospitalized at the end-of-life and to more frequently have a pain assessment performed (Miller, Gozalo, & Mor, 2001; Miller, Mor & Teno 2003). Additionally, recent population-based NH research (in Kansas, Maine, New York, Ohio and South Dakota) has shown residents who enroll in hospice have a lower likelihood of being hospitalized even when sophisticated statistical techniques are used to control for the differences between NHs who are more or less likely to collaborate with hospice and between NH decedents who are more or less likely to elect Medicare hospice (Gozalo & Miller, 2007).

Family members of persons who died in NHs have noted improvements in care after hospice admission, such as fewer hospitalizations and lower levels of pain and other symptoms (Baer & Hanson, 2000), as well as enhanced quality of life (Wetle et al., 2005). However, some family members report referrals to hospice are too late and also describe misunderstandings between NH and hospice staff regarding hospice’s role and scope of care (Wetle et al., 2005). Nursing home administrators and directors of nursing, although reporting hospice to be positive and valuable for residents, also indicate a need for improving NH/hospice relationships (Parker-Oliver & Bickel (2002).

Contrary to the studies showing benefits with hospice enrollment, a study in two NHs using data from participant observation, event analysis and chart review found no differences in the prescribing of opioids or the use of “as needed” prescribing (p.r.n.) between hospice and nonhospice residents with pain (Kayser-Jones, Alison, Miaskowski, et al., 2006). This study concluded that the context in which the care was provided in the two NHs studied (i.e., limited physician availability, NH staff and pharmacologic knowledge) adversely influenced care for hospice and nonhospice residents. So, in these NHs, the hospice(s) providing care was(were) unable to offset the contextual limitations. Another study including NHs and assisted living facilities found no significant differences by hospice enrollment status when only residents having a known expectation of death were compared. While it may be that the inclusion of assisted living facilities and/or the control for known expectation of death may yield differing research findings, it may also be that “spill over” of hospice knowledge/expertise and/or processes may have resulted in better NH staff assessment of residents’ terminal status and/or in better care processes (Miller, Gozalo, & Mor, 2001; Miller, Mor & Teno 2003; Wu et al., 2003). Especially with the increased use of hospice by NHs (Miller & Mor, 2004), understanding the hospice effect becomes very difficult when comparing processes and outcomes for hospice and nonhospice residents in the same NH. Research is needed that attempts to disentangle the impact of hospice presence in NHs on hospice and nonhospice resident/family outcomes. Also, research is needed to understand the benefits of hospice care in assisted living facilities (where there is a whole different set of interorganizational challenges).

**Nonhospice Palliative Care in Nursing Homes**

While the extent to which nonhospice palliative care programs exist in NHs is unknown, some NH palliative care interventions have been studied. Based on these studies, it has been concluded that NH staff education alone will not improve EoL care in NHs (Ersek & Wilson, 2001).
Nursing Home/Hospice Partnerships: A Model for Collaborative Success—Through Collaborative Solutions

Needed are multifaceted efforts that consider the context in which care is provided and incorporate the physician in the quality improvement or intervention effort. Educational interventions enhanced by consultation or quality improvement efforts have been successful in improving care processes but not necessarily the targeted care outcomes (Tuch et al., 2003 & Weissman et al., 2001). A study combining palliative care education with a quality improvement program, and focusing on pain reduction, observed a reduction in NH pain prevalence (Baier et al., 2004). In another (intervention) study, hospice staff recruited and trained NH palliative care leadership teams, NH staff received performance feedback, and a NH staff member “championed” the effort. This study observed significant increases in (nursing) pain assessments, in the proportion of residents for whom in-depth EoL discussions occurred, and in the ordering of non-pharmacologic pain treatments. However, the intervention did not significantly improve the prescribing of pain medication for residents with documented pain (Hanson et al., 2005). The authors concluded that interventions incorporating targeting to physicians and other prescribers may be necessary to change prescribing patterns since higher-quality pain assessment data alone did not appear to change prescribing patterns. In fact, Keay and colleagues did find an educational intervention directed at twelve NH attending physicians in four NHs to be associated with significant improvement in physician prescribing practices (Keay et al., 2003).

Palliative care consultation is provided in some NHs. One such program in Rhode Island provides NH consultation through a nurse practitioner (Rochon et al., 2006). Over a five-year period, this care model has been widely accepted, as evident by the growth in the number of consultations; they averaged 151 in year one but sustained an average around 280 in the four subsequent years. In this program, consultation recommendations were followed in 93% of the cases. For those residents with moderate to severe pain on initial assessment, 75% noticed improvement once recommendations were implemented; this proportion was 56% for residents with mild pain. For residents who reported that pain impacted sleep, 60% reported improved sleep. Similar programs appear promising in improving symptom management for Medicare SNF residents dying in NHs (who cannot simultaneously access hospice care when SNF care is for their terminal condition) as well as for residents unable or unwilling to elect hospice.

The NH/Hospice Partnership

A monograph describing the challenges and benefits of the NH/hospice partnership can be accessed by going to this project’s website, http://www.nhpco.org/nursinghomes and clicking on “Resources & Guidelines,” and then on the listed monograph. This monograph discusses the challenges faced in interorganizational and interdisciplinary relationships, generally and specific to the NH/hospice collaboration. It also presents findings from NH and hospice interviews conducted in conjunction with an earlier Retirement Research Foundation-funded study. The RWJ project’s interview findings described below corroborate these earlier findings, but also extend these findings by providing more detailed information on how NH/hospice partnerships succeed and are nurtured.

Understanding Successful NH/Hospice Partnerships

Validating Factors Important to Successful Partnerships

To assist in choosing sites and in developing the site visit procedures and interview tools, we began by attempting to understand whether NH and hospice providers concurred on the collaborative practices perceived to be important factors for achieving partnership success. To do this, we conducted a survey of providers. The survey asked for input on twelve domains advisory committee members thought contributed to successful NH/hospice partnerships. Respondents were asked the degree to which they agreed the twelve factors listed were important to a successful collaboration as well as about the types of policies or procedures their NHs/hospices have used to successfully address each factor. Additionally, those responding were asked to identify continuing barriers to achieving greater success. The survey was sent to
Nursing Home/Hospice Partnerships: A Model for Collaborative Success—Through Collaborative Solutions

a convenience sample of NH and hospice providers by advisory committee members representing the national NH organizations (ACHA and AAHSA) and the NHPCO.

Nine-three providers responded to the survey (23 NHs and 71 hospices). From responses, eight domains were found to be consistently cited as important to successful collaboration. Table 3 shows these domains as well as commonly cited practices and barriers to collaboration. Survey findings informed the design of a screening tool for choosing study sites as well as the interview tools. For the site selection screening tool, identification of the barriers helped in choosing successful sites—those with systems in place addressing identified barriers and/or sites with no or little evidence these barriers still existed in their partnership(s).

Table 3. Domains Important to Successful Nursing Home/Hospice Collaborations

<table>
<thead>
<tr>
<th>Administering the collaboration</th>
<th>Practices: Fostering of good relations</th>
<th>Continuing Barrier: Maintaining functioning vs. dying; Medicare Part A skilled NH care versus Medicare hospice; curative vs. palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-disciplinary practice</td>
<td>Practices: Cultivating personal relationships</td>
<td>Continuing Barrier: Competition and turf issues, staff judgment issues, other</td>
</tr>
<tr>
<td>Communication (including conflict resolution)</td>
<td>Practices: Open &amp; frequent communication; use of hospice liaisons to improve communication with NHs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Practices: Education for hospice and NH staff, and for families</th>
<th>Barriers: NH time constraints, NH turnover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care planning</td>
<td>Practices: Joint care plan meetings, integrated care plan</td>
<td>Barriers: Lack of invitation to meetings, poor attendance</td>
</tr>
<tr>
<td>Care provision</td>
<td>Practices: Consistency of hospice team in NH</td>
<td>Barriers: Multiple hospice providers may be in one NH, lack of consistent communication regarding resident changes/needs</td>
</tr>
</tbody>
</table>

Hospice support to resident/family

<table>
<thead>
<tr>
<th>Hospice support to NH staff</th>
<th>Practices: Memorial services, other</th>
</tr>
</thead>
</table>

| Hospice support to NH staff | Practices: One-on-one support, education, other |

Choosing Study Sites and Making Site Visits

State NH and hospice associations nominated potential study sites, and partnering NHs and hospices submitted self-nominations. Then, based on sites’ responses to the screening criteria as well as on their size and geographic location, we chose six NH/hospice sites for case studies. Study sites included smaller and larger NHs and hospices and were located in each of the four major U.S. geographic regions (see Table 4 below).

Site visit procedures and interview tools were developed. Organizational and market information provided us with an understanding of providers’ environments, and information on a state’s policies and practices in place (collected in conjunction with another study [Grabowski et al., 2004]) gave us information on the potential regulatory and/or Medicaid payment barriers to NH/hospice collaboration within each state (Miller & Mor, 2004). In Appendix A are tables showing selected study site characteristics.

To understand the site infrastructures and practices, we planned to interview six groups of staff: administrators/chief executive officers (CEOs), 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). Interview questions covered the domains shown in Table 3. Six different interview tools were designed since information of
Nursing Home/Hospice Partnerships: A Model for Collaborative Success—Through Collaborative Solutions

interest differed across groups. Initial interview questions were broad (in order to obtain unanticipated information), but follow-up questions asked for specific information if not offered during the initial response. For example, a staff question regarding communication read: Overall, how would you describe the frequency and quality of communication between you and the staff at <collaborating NH/hospice>? Then, probes asked: How often and when does communication usually occur? Would you describe communication as open? What is typically the topic of the communication? What has helped foster communication between nursing and hospice staff? Have there been barriers to this communication? If so, please explain. We piloted the visit procedures and interview tools at a Rhode Island NH and hospice, and as necessary, changes in visit protocol and interview tools were made. The project director or coordinator, and a project consultant, visited each study site between June and September 2005, spending one day with each provider.

Table 4. Nursing Home & Hospice Study Sites and Their Size† (in 2004)

<table>
<thead>
<tr>
<th>Region</th>
<th>Study Sites</th>
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<tbody>
<tr>
<td>California (Western Region)</td>
<td>Yolo Hospice (average daily census of 13 NH residents)</td>
</tr>
<tr>
<td></td>
<td>Alderson Convalescent Hospital (average daily census of 130 residents)</td>
</tr>
<tr>
<td>Florida (Southern Region)</td>
<td>Tidewell Hospice and Palliative Care (average daily census of 84 NH residents)</td>
</tr>
<tr>
<td></td>
<td>Pines of Sarasota (average daily census of 194 residents)</td>
</tr>
<tr>
<td>Michigan (Midwest region)</td>
<td>Hospice Care of Southwest Michigan (average daily census of 21 NH residents)</td>
</tr>
<tr>
<td></td>
<td>The Laurels of Galesburg (average daily census of 89 residents)</td>
</tr>
<tr>
<td>Minnesota (Midwest region)</td>
<td>Hospice of Twin Cities, Inc. (average daily census of 106 NH residents)</td>
</tr>
<tr>
<td></td>
<td>Ambassador Good Samaritan Center (average daily census of 81 residents)</td>
</tr>
<tr>
<td>New Jersey (Eastern Region)</td>
<td>Hunterdon Hospice (average daily census of 4 NH residents)</td>
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<tr>
<td></td>
<td>Hunterdon Care Center (average daily census of 158)</td>
</tr>
<tr>
<td>North Carolina (Southern Region)</td>
<td>Four Seasons Hospice and Palliative Care (average daily census of 93 NH residents)</td>
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<tr>
<td></td>
<td>Brian Center Health and Rehabilitation (average daily census of 131 residents)</td>
</tr>
</tbody>
</table>

† For hospices, the average daily census reflects only those hospice patients in nursing homes (NHs)

The Model of Successful Partnerships

Table 5 portrays a model illustrating how the study sites achieved collaborative success—the resources/inputs invested, the infrastructures established, and the collaborative processes put in place to achieve desired outcomes. Not every aspect of the model was present at all sites, but the “Resources/Inputs” and “Activities” common to three or more sites are shown. Many of the “Planned Outcomes” (particularly short-term outcomes) reflect input heard during interviews, but they also represent potential outcomes for NHs and hospices to monitor in order to gain an understanding of how the collaboration is functioning and how it is impacting resident/family care and support, and NH staff. Measurement of these outcomes was not a part of this study. The model presented is a “blueprint” to be used by other NH/hospice providers to design and build successful partnerships, and to evaluate whether the program established is meeting planned goals/outcomes (W.K. Kellogg Foundation, 2004).

The model shares collaborative solutions potentially capable of leading to successful partnerships and high-quality outcomes, even when the context in which NH care is provided is not as favorable as observed at the study NHs. While this report shares the successes of the study sites and how this success was achieved, it also presents the major continuing challenges still faced by at least some of the study sites.
<table>
<thead>
<tr>
<th>INVESTMENTS</th>
<th>ACTIVITIES—INFRASTRUCTURE &amp; PROCESSES</th>
<th>PLANNED AND/OR ACTUAL OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources/Input</td>
<td>Activities—Infrastructure</td>
<td>Administrative Management of Collaboration</td>
</tr>
<tr>
<td>NH and hospice have a shared philosophy of care.</td>
<td>Mechanisms for administrator dialogues.</td>
<td>• Regular meetings or dialogue between CEOs</td>
</tr>
<tr>
<td>Partnership is mission driven.</td>
<td>Partnership and staff relationships (at all levels) result from planned systems and activities—not dependent on individual, time, and not left “to chance”</td>
<td>• Hospice responsive to NH requests and/or concerns</td>
</tr>
<tr>
<td>NH recognizes care and services needed to address needs of dying residents and acknowledges death in the NH</td>
<td>NH proactive about their expectations</td>
<td>Communication / Conflict Resolution / Inter-disciplinary/ Inter-organizational Practice</td>
</tr>
<tr>
<td>Administrators committed to collaboration</td>
<td>Mechanism for regular assessment of relationship.</td>
<td>• Hospice staff given profiles of NHs—contacts, preferences, other</td>
</tr>
<tr>
<td>Hospice CEO is knowledgeable about NH care &amp; environment</td>
<td>Dedicated hospice NH team (at most sites)</td>
<td>• Purposeful structure of hospice visits—check in with own discipline upon arrival, ask for input and communicate visit information.</td>
</tr>
<tr>
<td>Hospice administrator is a skilled leader and has a vision for the collaboration that is easily conveyed, such as a “win-win” (endeavor), “it’s about the relationship,” “customer service”</td>
<td>Individual(s) serves as liaison(s)</td>
<td>• Positive acknowledgements in both directions—shared celebrations</td>
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<td></td>
<td>Consistent hospice staffing in NH</td>
<td>Hospice visible, including off hours</td>
</tr>
<tr>
<td></td>
<td>Low NH and hospice staff turnover</td>
<td>System in place to address conflict and staff have ability/license to resolve conflicts, although liaisons/others are involved as necessary</td>
</tr>
<tr>
<td></td>
<td>High hospice presence in NH</td>
<td>Care Referral, Planning &amp; Provision</td>
</tr>
<tr>
<td></td>
<td>Alternatives to hospice (routine home care) available</td>
<td>• NH has formal and/or informal mechanism(s) to identify potential referrals</td>
</tr>
<tr>
<td></td>
<td>− Hospice inpatient suites</td>
<td>• Family informed of NH/hospice care &amp; service expectations</td>
</tr>
<tr>
<td></td>
<td>− Palliative care programs</td>
<td>• Hospice response to referrals &amp; to on and off-hour calls is timely.</td>
</tr>
<tr>
<td></td>
<td>− Palliative care Consults</td>
<td>• Hospice attends NH care plan meetings and attempts to involve NH staff in hospice care planning meetings.</td>
</tr>
<tr>
<td></td>
<td>Hospice cultivates &amp; monitors relationship with NH managed care provider.</td>
<td>• Continental NH/hospice staff dialogue on care planning &amp; processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support for Resident/Family &amp; for NH Staff &amp; NH</td>
</tr>
<tr>
<td></td>
<td>Staff verbalizes NH and hospice has common missions, visions.</td>
<td>• Hospice employees verbalize and actualize goal to provide support to NH staff &amp; residents/families—“How can we help?”</td>
</tr>
<tr>
<td></td>
<td>NH staff, supervisors and administrators find partnership results in added value to residents, families and staff.</td>
<td>• Systems in place to provide emotional &amp; bereavement support to NH staff</td>
</tr>
<tr>
<td></td>
<td>Partnership does not result in negative financial consequences for NH, hospice or patient/family.</td>
<td>• Short turn-around time for NH per diem payment &amp; 100% of Medicaid per diem paid by hospice</td>
</tr>
<tr>
<td></td>
<td>Less prevalence of pain</td>
<td>• Support to NH with Medicare/Medicaid survey and applications/follow-up for hospice residents</td>
</tr>
<tr>
<td></td>
<td>Improved scores on other NH quality indicators</td>
<td>• NH provides “extras” when resident near end of life—private rooms, comfort carts for residents/families, etc.</td>
</tr>
<tr>
<td></td>
<td>Lower NH staff turnover</td>
<td>• NH has rituals to acknowledge death—bed unfilled for specified time, other</td>
</tr>
<tr>
<td></td>
<td>Fewer hospital deaths</td>
<td></td>
</tr>
</tbody>
</table>
In addition to their use of hospice, the study NHs also had practices in place to meet the special needs of dying residents and their families. These practices ranged from special accommodations or services for dying residents and their families (such as private rooms or “comfort carts”) to the presence of pain management teams or other teams that focused on improving the quality of care and life for residents and their families. Whether partnering with hospice influenced the introduction of such teams, or whether these NHs chose hospice to further advance an already high-quality of care and support, cannot be known in this type of study, but both explanations seemed plausible, alone or together. An administrator of an “Eden Alternative” NH, for example, said the NH is an Eden NH because it is a high-quality NH, not vice-versa. This same NH viewed hospice as “complementary” to its NH care. On the other hand, we heard evidence of diffusion of hospice processes and knowledge to the NH and its staff. For example, one hospice introduced a pain assessment tool at the NH and one NH medical director discussed how he was surprised when, “. . . the nursing home staff here, at the facility, were role modeling some wound care things that they had learned from the hospice people.” Staff at the same NH said, “. . . hospice has trained us well.”

Many of the NH administrators interviewed viewed hospice as a value added service. As one NH administrator said, “Hospice brings in a different dimension, different perspective.” Nursing home staff consistently cited the most valued hospice contributions to be the additional one-on-one support available to the resident, and the family support provided (especially in regard to conflict resolution). The added value of hospice’s pain management expertise was also often cited as was the informal education that occurred between hospice and NH nurses. These cited benefits of hospice were strikingly similar to those heard in the previous NH/hospice study discussed earlier in this report (Miller & Egan, 2006).

**Resources/Inputs**

Study NHs and hospices had similar missions and shared philosophies of care. Whether this was true at the onset of the partnerships is unknown. Both hospice and NH CEOs verbalized community-focused missions and NH staff voiced an awareness that part of their mission was to support the needs of dying residents and their families.

Hospice CEO’s were instrumental to the partnership’s success. These administrators were well-versed in NH regulations and environments, and a couple had worked in NHs. They, together with their staff, designed a program of hospice care delivery specific to NHs’ needs. Several hospice administrators spoke of care in the NH as being a separate “product line,” with the NH and resident/family as the customer, and with systems designed to provide care in a manner compatible with the NH environment and its case-mix.

At two study sites, NH staff shared how the hospice partnership had improved when there was a change in hospice leadership. One NH provider said, “Hospice felt like red tape before, now (provide) support and assistance.” At another site a staff member described the NH/hospice relationship as having been “adversarial” but said that hospice now, “doesn’t take over.” Hospice administrators cited their involvement in local or state NH groups/associations as a method for cultivating their relationships with NH administrators. For example, one administrator was a member on a state NH trade association and was pursuing a leadership opportunity with this association.

It was remarkable how staff at hospice sites articulated a similar vision for their hospice’s role in the NH. This vision was provided by the administrators and reinforced in a number of ways. Examples of phrases used to describe the vision included (it’s a) “win-win” (endeavor), “it’s about the relationship,” and “customer service.” Additionally, NH and hospice staff voiced their common goal, to provide a quality EoL experience to residents/families.
In summary, some collaborative solutions for NH and hospice administrator to be aware of are:

- Be the “champion” of the partnership—provide a vision;
- Touch base on a regular basis and let staff know you support the partnership;
- Develop a “Product Line” approach to providing hospice care in NHs; and
- Understand each others’ systems, regulations, and financing.

Activities—Establishing the Infrastructure

Planning. To plan for a partnership NHs and hospices focused on facilitating good interorganizational and interdisciplinary relationships. The study sites introduced systems to ensure the partnership functioned as desired. At most sites, hospice administrators had activities planned so they regularly “touched base” with their NH counterparts. At all staff levels, systems and processes facilitated good relationships, and communication between NH and hospice staff. Hospices took the lead in establishing these systems. These planned systems empowered hospice staff by providing them with the tools, knowledge and skills needed to overcome the varying challenges inherent with the provision of interorganizational care. (Of note, specifics on the processes used by study sites are presented below in “Activities—Processes . . .”)

Nursing home administrators shared their expectations with hospices and had processes in place to gather information to understand the extent to which hospices were meeting their expectations, and those of residents/families. For example, staff at one NH asked the hospice to provide them with information on the range and frequency of services provided to NH residents as well as with data on how hospice benefits their residents. They also requested hospice representation at their QI meetings. In another NH, the administrator said she made it clear upfront that she didn’t want hospice to be just “day care,” and that she wanted education provided to all shifts. From site visit interviews, NH requests for hospice accountability appeared vital to successful partnerships. Of course, NH expectations must conform to NH and hospice regulations and should be practical (hospice aides can only visit a limited number of residents in the early morning), but by sharing expectations with hospices and monitoring the care and services provided, the NH is actively involved in molding the partnership and care provided to its residents and their families. Additionally, this requested accountability better equips the NH to understand those hospices that are and are not meeting their needs, and their residents’/families’ needs.

Staffing. At all sites, designated persons served as liaisons to the NH or hospice. The liaison role was more formalized at the hospices, and for larger hospices this was a full-time position; for others, it was assumed by staff that also had other roles. The hospice liaison regularly communicated with the designated NH liaison (not always formally designated), who was often a nurse supervisor or the director of nursing. Hospice liaisons frequently had substantial NH backgrounds; they had good understanding of NH care and environments and were the designated problem solvers when conflicts or issues arose.

The four larger study hospices had teams dedicated to provide care in NHs. In these hospices, teams were consistently assigned to the same NHs, enabling the formation of solid relationships between NH and hospices staff. Almost all nurses on these hospice NH teams had NH backgrounds. Based on interview information, summarized below are some important attributes to consider when selecting hospice nurses to serve on dedicated NH teams.
Two smaller study hospices did not have dedicated NH teams and this worked well for these hospices, in part because hospice and NH turnover was low (see Appendix, Tables A1 & A2), leading to long-standing relationships. At one of these hospices, administration decided against a dedicated NH team because the hospice nurses did not necessarily have NH backgrounds and they preferred to care for a more diverse patient population.

Nonhospice Palliative Care and On-site Inpatient Hospice Care. All study hospices offered either some form of nonhospice palliative care to NH residents (palliative care or pain management consults, other) and/or the option of on-site inpatient hospice care. The availability of palliative care allows NH residents access to specialized palliative care expertise without waiving their Medicare Part A benefits and/or when their prognoses are not 6 months or less. It also extends access to expert palliative care to residents receiving Medicare SNF care, for whom electing hospice means either the resident/family has to assume payment for Medicare’s portion of the NH per diem or, for dually eligible residents, the NH has to forfeit the higher Medicare NH per diem and instead receive the much lower Medicaid per diem for NH care (since residents cannot simultaneously receive Medicare hospice and SNF care if SNF care is for the terminal condition).

Study NHs also had inpatient hospice beds (or suites) where NH residents received more intensive short-term hospice services when they were actively dying or needed intensive symptom management. These beds allow residents to die in place in the NH even when more intensive care, than available through Medicare routine home care, is needed. Nursing homes noted this inpatient care was most often used for persons admitted to the NH in the last week or days of life (frequently Medicare SNF patients). This inpatient hospice care circumvents the financial disincentives associated with hospice election for SNF residents since hospices pay the NHs (from the hospice general inpatient per diem) a negotiated per diem that is comparable to the Medicare NH per diem. However, per Medicare regulations, general inpatient hospice care is to be of short duration and cannot overall exceed 20% of a hospice’s total Medicare days of care.

Pursuing Relationships with NHs’ Managed Care Providers. Last in this section, is an example of one hospice’s approach for cultivating relationships with a NH managed care provider. Managed care companies providing care to NH residents receive a capitated (monthly) dollar amount to care for each NH resident. These companies have a financial incentive to avoid costly acute care and employ nurse practitioners who regularly assess and provide care to NH residents enrolled in their plans; they may not feel hospice care brings additional benefits to their members and/or to the managed care organization.

Two study hospice CEOs discussed how they cultivated relationships with NH managed care providers. At one study site, at the hospice CEO’s urging, representatives from the two provider organizations met to explore how they could work together. Additionally, the hospice medical director played a valuable role in building this relationship by establishing communication with the managed care medical director. The hospice CEO stated the end result was the recognition by the managed care provider of the complementary care and expertise hospice could provide to its members. The hospice/managed care relationship at the time of site visit was described as “excellent.” While managed care hospice referrals were more often
In summary, collaborative solutions for establishing a partnership infrastructure include:

- Develop systems to address the need for regular dialogue among administrators;
- Designate a person at the NH and the hospice to serve in a liaison role and to receive regular information on the quality of the partnership;
- Design systems so NH provides regular input to hospice on its expectations and the extent to which hospice is meeting these expectations (within regulatory guidelines and as practical);
- Establish dedicated NH teams (as hospice size and preferences allow) and provide consistent staffing to the NH (i.e., same hospice staff, as feasible);
- Hire hospice nurses with prior NH experience and with the attributes needed by nurses serving on dedicated NH teams;
- Offer alternatives to Medicare hospice care to better meet the needs of all NH residents;
- Cultivate relationships with NH managed care providers; and
- Through all of the above, have a high hospice presence at collaborating NHs.

Activities—Processes and Tools to Achieve Desired Outcomes

Administrative Management of Collaboration and Conflict Resolution. Hospice CEOs undertook various activities to regularly “connect” with their counterparts. At one site, the NH and hospice CEOs routinely e-mailed each other. At another site, the hospice CEO planned lunch once a month with one of nine NH administrators (from the NHs partnering with the hospice).

Nursing homes looked for responsiveness from hospice administrators, and from what we heard during interviews, hospice leaders communicated their willingness to address concerns or issues by saying things such as, “Have me paged anytime.” Problem solving was often collaborative and there was follow-up. Also, hospice staff and educators identified and conveyed concerns or problems to hospice liaisons/leaders so action could be taken early. Liaisons and supervisors acknowledged the need to occasionally remove a hospice staff member who doesn’t “match” with a particular NH.

Communication and Interorganizational Practice. A variety of practices and tools assist hospice staff in their communication efforts. Hospices use “preference sheets” to share with staff a NH’s likes and dislikes as well as other information specific to a NH. These sheets, for example, inform staff of things such as directions to the NHs, who to call when an issue arises, how hospice documentation is incorporated into the NH record, where residents records are found, etc.

The structure of hospice visits endorsed by study sites appeared key to the existence of the reported good communication between hospice and NH staff. Hospices instructed staff (at most sites and as preferred by study NHs) to “check in” with their discipline counterparts upon NH arrival (nurse to nurse; aide to aide, other). At the “check in,” hospice staff ask for input on the resident/family and also ask NH staff, “How can we help?” After a visit, staff also “touch base” to report visit findings/other. This visit structure seemed to be most consistently followed by the hospice nurses. Nurses described, however, how they were aware when a NH nurse didn’t appear to have time to be interrupted, and when this was the case, hospice nurses might just talk with the NH nurses prior to departing the NH.
Nursing home and hospice staff nurtured interorganizational relationships and facilitated communication between staff and residents and families in many other ways, some of which are summarized below.

Nurturing NH/hospice staff relationships and facilitating communication between staff and residents/families

- NH staff provide positive feedback to hospice staff, and vice versa;
- Hospices reported staff communicate respect in communications and attitude on a daily basis;
- One hospice brought to NHs something they called “Heart Lines”—a postcard with an inspirational piece the NH could hang on the wall or bulletin board;
- Above hospice also had a double-sided newsletter on EoL related topics, “Hospice Insights,” it mailed monthly to NHs;
- When invited, hospice staff celebrate with NH staff at social activities;
- At one site, NH and hospice staff attend each other’s retirement parties;
- Several of the hospices celebrate events important to NH staff such as NH week by providing certificates for staff, bringing in food to celebrate, other (of note, some hospices do not provide any food/candy or other tokens of appreciation for fear that this may be interpreted as inducing referral);
- Hospices send referral thank you notes to residents’ physicians, and at one hospice, these notes come from the hospice medical director;
- Hospice aides wear scrubs and nurses wear lab jackets at one site to communicate their presence to NH staff and residents/families;
- At many sites, hospice visit schedules are provided to NH staff;
- At one site, a sheet containing contact information for everyone on the hospice team is placed inside a hospice resident’s NH record; and
- At the same hospice, staff use “walkie-talkies” to communicate with each other, “easier and quicker at the time of need.”

Education and Educational Materials

While hospices provided NHs with educational materials and conducted formal inservice education sessions, both NHs and hospices said it is the one-on-one informal education provided by hospice staff to NH staff that was most important in advancing the knowledge of NH staff. Still, NHs valued the formal education provided by hospices. Providers we had surveyed cited NH turnover or attendance as barriers to hospice educational efforts, but at the study sites these barriers were addressed by more frequent education (described as “constant education” at one site) and by providing incentives for NH staff to attend education program. At one NH, for example, staff who had not attended education sessions could not access their paychecks as early as staff who had attended such sessions.

There was variation on how frequently formal education was provided at NHs, but on average two to four sessions were provided each year. Some hospices provided education to all NH shifts, and NHs preferred this. One hospice, unlike the others, focused on providing education to the NHs’ medical directors.

All hospices provided informational materials to NHs. Two hospices provided NHs with a notebook containing palliative care related articles. Several hospice NH liaisons provided to NHs relevant articles as they became available.

Hospice medical directors at two hospices were particularly involved in staff educational efforts. One medical director performed “rounds” at the NH with NH staff in attendance. This hospice also held some of its care plan meetings at the NH. At another hospice, the medical director saw his role as empowering the hospice staff and he did this through helping staff actively work on conflict resolution, and by including some role playing in their teams meetings. This medical
Nursing Home/Hospice Partnerships: A Model for Collaborative Success—Through Collaborative Solutions

director said he felt that to make a NH/hospice collaboration work it is of foremost importance that hospice knows what they're doing; as he said, “If you’re going to take the high road, you’d better know which one it is.”

Beyond that described above, hospice liaisons and/or educators provide much education to hospice staff. One topic of key importance is NH care and the NH environment, including NH regulations, documentation systems and oversight. Also, hospice staff receive formalized education on relationship building and conflict resolution.

Family education first occurred at the hospice initial visit (the intake visit). At this visit, staff at two hospices described how hospice nurses and social workers clarify for family members the scope of hospice’s care and services and what the family can expect from hospice. One hospice considered this “long intake conversation” between family and the hospice nurse and social very important to success.

Care Referral, Planning and Provision

Care Referral. Study NHs actively assessed residents’ palliative/hospice care needs. At the California site, where median lengths of stay were the longest (see Appendix, Table A1), families were frequently the referrers to hospice. The hospice social worker and medical director both speculated that these family referrals result since the community is small and many people in the community are familiar with hospice (i.e., most people know someone who received hospice). Also, at this site, NH staff (per hospice) are sensitive to resident decline. At another study site, the NH has a “stand up” meeting every morning where residents “taking a decline” or with “pain out of control” are identified for potential hospice referral.

Care Planning and Provision. The communication systems and processes described earlier resulted in well-coordinated care planning and provision. We were surprised to observe that documentation systems per se did not drive coordinated care provision, but instead the frequent high-quality communication between hospice and NH disciplines ensured well-coordinated care—a high presence of hospice staff made the difference. Still, forms created specifically to facilitate collaboration, and care planning documentation systems, did assist in the provision of coordinated care.

Only the California study hospice used a totally integrated NH/hospice care plan form, although another site was developing such a care plan form and used a special assessment form for NH residents. The integrated care plan form was developed over a two-year period and reflected input from several area NH directors. Hospice staff reported surveyors liked the form. The hospice designs the form differently for each partnering NH, but the same information is included; a NH’s form design is updated periodically to meet changing NH needs. The NH liaison teaches the use of the care plan to NH staff. (This care plan is copyrighted by the California study site.)

At other study hospices, staff shared how the hospice care is integrated into the NH’s care plan. As one NH staff member stated, “There is a tread of hospice throughout the whole care plan.” In one NH an “assignment sheet” (separate from the NH record) facilitated coordination. This sheet contained resident information and care plan issues as well as whether the resident was receiving hospice or palliative care. According to the NH, the development of the “assignment sheet” resulted when a surveyor questioned how the NH and hospice assured care plans were coordinated.

Nursing homes invite hospice staff to attend care planning meetings and/or hospice nurses inquired as to the date and time of care planning meetings. Per report, hospice nurses attend care plan meetings, although emergencies and scheduling problems do appear to interfere with attendance. As mentioned earlier, one hospice holds some of its care planning meetings at the study NH, and also, the hospice medical director makes rounds at the NH. Staff at one hospice
reported that issues arising at NH care plan meetings become agenda items at the next hospice care plan meeting.

We heard consistently that hospice staff were available “24/7,” and NH staff and directors of nurses cited this availability as crucial to providing high-quality, well-coordinated care. In fact, both hospice and NH staff talked about “other hospices” that are not as available as the study hospices. Study hospices also provided a full range of hospice services to study nursing homes, including volunteer support, and visit frequency appeared to be acceptable (per NH report). Per staff at one NH, hospice staff, “Spend lots of time with residents and addressing psychosocial . . .,” and “Chaplains are visible.” Staff at another NH said hospice staff doesn’t, “Leave at 4 o’clock,” but “stay as long as they need to help the NH staff get that person settled.”

California hospice staff raised “English as a second language” as being a big issue (although not at the study NH), since some NH staff do not necessarily have “a great grasp of” English. Therefore, to avoid confusion, staff write orders very carefully, trying to write simply and to avoid putting two things in one order. For verbal orders, hospice staff may ask to have orders repeated to ensure NH nurses understand the order.

Support for Residents/Families & for NH Staff and NH

Hospices often provided support to residents/families beyond the Medicare hospice benefit and also provided support to NH staff and to NHs. This support was diverse and numerous. Some of the processes reflecting the support provided are summarized below.

<table>
<thead>
<tr>
<th>Hospice support to residents/families, to NH staff and to NH includes:</th>
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</thead>
<tbody>
<tr>
<td><strong>To Residents/Families—</strong></td>
</tr>
<tr>
<td>• At one hospice, four music therapists were employed and much music therapy provided to NH hospice residents; and</td>
</tr>
<tr>
<td>• Volunteer spends time with residents doing things such as taking residents for walks, doing nails, other.</td>
</tr>
<tr>
<td><strong>To Nursing Home Staff—</strong></td>
</tr>
<tr>
<td>• Hospice provides one-on-one support to NH staff to help them deal with loss;</td>
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<tr>
<td>• Hospice described as “good advocate for NH staff” in terms of family relations—it takes some of the burden off NH staff;</td>
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<tr>
<td>• Hospice volunteers seen as “softening up patients” who otherwise wouldn’t want to do certain things (e.g., bathe, other); and</td>
</tr>
<tr>
<td>• NH staff invited to hospice memorial services.</td>
</tr>
<tr>
<td><strong>To Nursing Home—</strong></td>
</tr>
<tr>
<td>• Hospice provides a short billing cycle (even when state payment delay is present);</td>
</tr>
<tr>
<td>• Hospice pays NH 100% of per diem (even though they receive 95%);</td>
</tr>
<tr>
<td>• Hospice helps NHs with “survey issues” and hospice staff will help at the time of survey when surveyors question something in relation to a hospice resident;</td>
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<tr>
<td>• One hospice offers information on “cultural considerations,” so NH can be sensitive to the community; and</td>
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<tr>
<td>• One hospice has a “speakers bureau” that NHs can access.</td>
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</table>

Observed and Desired Outcomes

Hospices monitored care provided in NHs frequently through post-death family surveys. Several hospices used the NHPCO family after death survey tool and were able to “bench mark” their scores against the NHPCO summarized data.

One hospice described how they target high-referring physicians and give these physicians information on their patients’ lengths of stay, but also ask about the physician’s experience with hospice and ask, “How can we do better?” This hospice also sends satisfaction surveys to NH
medical directors and the hospice medical director follows-up when negative comments are received. At another hospice that had a similar procedure, the NH medical director shared how he receives survey findings from the hospice. When findings refer to timely referral, this medical director said, “He thinks about it a little.”

As stated earlier, this project did not focus on measuring resident/family outcomes, and many of the outcomes listed in the “Results” section of the logic model (Table 5) are outcomes we suggest be monitored to understand how the NH/hospice partnership is influencing the NH and its residents/families. However, throughout our interviews NH staff shared their observations on how hospice influenced care. For example, at one NH, the staff stated pain management is much better since hospice came in. At another site, NH staff felt they had become, “More astute regarding pain management” (because of palliative care presence). Interviews reflected the presence of good relationships. For example, at one NH, a nurse stated that hospice staff are considered to be, “our staff” (and comments such as this were commonly heard).

**Continuing Challenges**

Two continuing challenges are noteworthy—the restricted access to hospice care for dying residents receiving Medicare skilled nursing home care and the notification of hospice when a resident’s condition changes. First, although study hospices have palliative care alternatives and/or use on-site hospice inpatient care as alternatives to Medicare (routine home care) hospice, staff report concern that dying residents receiving Medicare skilled care do not have realized access to comprehensive Medicare hospice care (without a resident/family or NH financial cost). Per report, because of the financial costs associated with hospice election for these residents, most families do not opt for hospice (and NHs often do not suggest hospice) for residents known to be near death.

Second, even with all the communication mechanisms in place, hospices still report instances where notification of change in a resident’s condition does not occur, and when perhaps an emergency room visit or hospitalization results. This usually occurs when the regular NH nurse is not available, when agency nurses are working or when NHs rotate staff. So, mechanisms to further improve this challenge are still needed.

**Summary**

During all interviews we asked, “What three factors are most important to successful NH/hospice collaboration.” Responders consistently cited “good communication” as essential to successful collaborations/partnerships. We summarize commonly cited attributes below.

**Commonly cited attributes essential to high-quality collaboration/partnership are:**

- Communication, communication, communication;
- Mutual respect (permeates the relationship);
- Commitment to collegiality;
- Understanding of each other’s business;
- Responsiveness to NH and hospice, and to resident/family needs;
- Flexible staff;
- Continuity of care; and
- Successful resident/family outcomes.
REFERENCES


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


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Public Policy Institute.

