



Objectives

- Recognize how integration of hospice/palliative care concepts into LTC enhances resident care
- Consult hospice appropriately to add benefit to the end of life care of LTC residents
- Employ methods to foster successful collaboration between LTC and hospice/palliative care teams
- Identify and manage potential conflicts between regulations guiding LTC and hospice care




By 2020, 40% of persons who die of non-traumatic causes are predicted to reside in nursing homes at time of death.




Hospice / Palliative Care in Nursing Homes

- Models of Palliative Care Delivery in NH
 - Traditional hospice
 - Non-hospice palliative care consultations
 - Palliative care programs developed and instituted by NHs




Hospice in Nursing Homes

- 1986: Medicare hospice benefit extended to NHs; expanded in 1989
- 2000: 75% of NHs have a hospice contract
- Hospice use in NHs is increasing
 - 1995-97: 5% of NH deaths with hospice (13-17% of hospice enrollees)
 - 2000-06: 16-22% of NH deaths with hospice (22% of hospice enrollees)
- Wide variation in use by NHs



Hospice-Nursing Home Model

- A collaborative and complementary effort
 - NOT intended to be competitive
- NH provides:
 - Room and board, personal care, nursing care, support to maintain function and quality of life
- Hospice provides:
 - Symptom management, emotional and spiritual support to residents and families, counseling related to common EOL issues, bereavement support for families and caregivers, payment for certain medications, supplies, tests, & treatments



Benefits of Hospice Care in the Nursing Home

- Better pain and symptom control
 - Residents more likely to have pain assessed
 - Residents more likely to receive opioid analgesic for pain
 - Hospice AND non-hospice residents had more pain assessments completed
- Use of restraints, TF, IVs, therapies, and hospitalizations decreased (44% vs 24%)
- Lower rate of hospitalization in last month of life for hospice and non-hospice residents

Benefits of Hospice Care in the Nursing Home


- Family perceptions
 - Increased quality of care with initiation of hospice services (to patient AND to family)
 - Better pain management
 - More emotional and spiritual support
 - Hospice services valued as additive
 - Did not perceive NH and hospice care as duplicative

Benefits of Hospice Care in the Nursing Home

- IDT colleagues trained in end of life care
- Additional educational resources for NH staff
 - Lectures and/or in-services
 - Print / electronic references
- Consultations for symptom management
- Collaboration for policy and system enhancements


Hospice Eligibility

- Eligible for Medicare Plan A services
- Attending physician and medical director BOTH certify that patient's life expectancy is less than 6 months if disease runs normal course
- Patient's treatment goals (or family's) are focused on symptom relief rather than "cure" of the underlying disease




Hospice Eligibility

- Guidelines exist for:
 - Cancer
 - Dementia
 - HIV/AIDS
 - Neurologic Diseases
 - Pulmonary Diseases
 - Renal Failure
 - Stroke
 - Heart Disease
 - Failure to Thrive/Debility NOS




Hospice Eligibility

- The issue is PROGNOSIS
 - Some conditions have a prognosis of 6 months or less
 - There are not guidelines for all diagnoses
 - A patient may not meet all guidelines for a condition
 - Significant co-morbidities / constellation of conditions matter
 - Medically current information may not be reflected in the guidelines




Hospice Eligibility

- Even if the patient lives longer than 6 months, eligibility continues if:
 - Prognosis continues to be 6 months or less
 - Guidelines continue to be met
 - Patient demonstrates ongoing decline




Common Prognostic Factors

- Rapid progression of disease
- Significant functional decline
 - FAST, PPS, BADLs, NYHA
- Nutritional compromise
 - Weight loss of 10% or more in last 6 months (extrapolation may be indicated)
 - Albumin less than 2.5 mg/dL




Common Prognostic Factors

- Frequent ER/physician visits
- Hospitalizations for dehydration
- Patient / family seeking care focused on comfort rather than "cure"




Hospice Services

- RN: pain and symptom support
- Personal care and homemaker services
- Social Worker: emotional and family support
- Chaplain: spiritual (+/- religious) support
- Bereavement Counselor
- Volunteers: companionship, family respite, specific services
- Hospice medical director
- Pharmacy consultant
- Other therapists as indicated/available: dietitian, PT, OT, massage, music, aroma, pet



Other Services


- Related to the hospice diagnosis:
 - Durable medical equipment
 - Medical supplies
 - Medications for palliation and management
- Laboratory and diagnostic tests
- Chemotherapy or radiation
 - Within a palliative plan of care
- Ambulance transport and many other regularly covered Medicare services



Hospice Conditions of Participation 2008


Focus on patient-centered, outcome-oriented, and transparent process that promotes quality patient care

- Includes:
 - Patient rights
 - Comprehensive assessment
 - Care planning with patient, caregivers, and hospice interdisciplinary group (IDG)




NH and Hospice Interface

- Nursing home and hospice team must collaborate to develop plan of care and to achieve goals
- Best way for this to occur is for hospice team members to attend NH care planning meetings
- Collaboration must be documented



Challenges to Palliative Care

- Ambivalence in American culture about death and dying
- Aging US population becoming more racially and ethnically diverse
- Staff from diverse backgrounds may have different perspectives




Challenges to Palliative Care

- Newer and more advanced technological services continually become available
- Both physicians and patients may be reluctant to move from cure directed to comfort directed care. This may be perceived as "giving up"




Challenges to Palliative Care in the Long Term Care Setting

- Poor communication
- Lack of coordination of care
- Inadequate pain and symptom control
- Organizational Barriers
- Financial Barriers
- Regulatory Barriers




Poor Communication

- Between interdisciplinary team members
- Between interdisciplinary teams
- Between patient, family, and medical professionals




Lack of Coordination of Care

- Prevented and/or resolved by advance care planning, coordination of care, good hand offs between levels of care within and between facilities if transfer necessary




Pain and Symptom Control

- High prevalence of pain in nursing home population
 - OA and other musculoskeletal problems common
- Physicians, advance practice nurses, and staff nurses need to know
 - Non-pharmacologic treatments for pain
 - How pain medications should be prescribed and administered
 - Risks of OTC analgesics
 - Myths surrounding opioid analgesics




Organizational Challenges

- Few bridges support continuity between long term care setting and hospital setting
- Good care within each setting often undone through poor handoffs
- Patient safety jeopardized
 - medication errors
 - no transfer summary (or illegible)
 - multiple prescribers




Organizational Challenges

- Inadequate staffing levels
 - labor shortages
 - difficulties in worker retention
 - supervision
 - training opportunities
- Absence of continuous education
- Inconsistency




Organizational Challenges

- Training in pain and symptom management
- Training in conducting effective goals of care discussions with residents and families
- All nursing home staff
- Enhanced by the presence of physician or nurse practitioner




Financial Challenges

- Increasing acuity in nursing home/SNF
- Burden of paying for nursing home care
- Medicare's SNF reimbursement emphasizes rehabilitation and restoration rather than palliation




Financial Challenges

- Hospice benefit does not include room and board at a NH
- If a patient receiving benefits through Medicare A elects hospice, then the patient and their family become responsible for room and board
- If a patient receiving Medicaid benefits elects hospice, then the NH may receive less reimbursement for room and board




More Financial Challenges

- Some long term care facilities offer "comfort care only" and "palliative care" for patients who might otherwise benefit from hospice or a formal palliative care consultation.
- Patients and families may or may not receive extra services that could be helpful
 - Social worker, chaplain, & bereavement support
 - Skilled nursing, home health aide
 - Medications and durable medical equipment




and More Financial Challenges

- Medicare reimbursement lower for personal care services, symptom management and emotional and spiritual care than for intensive rehabilitation or procedural nursing skills
- Medicare reimbursement rules assume that rehabilitative care and medical technology are more costly to provide. RUG categories do not acknowledge many hours of nursing and social work needed for skilled pain and symptom management, personal care, and emotional support during dying.




Regulatory Challenges

- OBRA '87 – a set of national minimum standards of care may lead to disparate goals of care for patients who are dying
- Perceptions of NH staff of what services hospice does or should provide
- Lack of understanding of NH regulations and requirements by hospice staff




Regulatory Challenges

- Perceived conflicts in plan of care
- Nursing home plan of care driven by the Minimum Data Set (MDS)
- Hospice plan of care is total care of the resident dealing with a life threatening illness




Regulatory Challenges

- Does MDS make hospice and palliative care services less feasible?
- MDS can be used to support and guide quality end of life care as long as long term care facility correctly identifies palliative care as the primary treatment goal
- Medicare structural financial incentives
 - After three day hospital stay for acute care, resident may be eligible for higher "SNF" reimbursement rate




Minimum Data Set (MDS)

- "Promote the highest practicable level of functioning"
 - Emphasize rehabilitation and restorative care with the goal of improving or maintaining function
- Quality of life and quality of care
- Develop care plans
 - Background information
 - Daily function
 - Medical condition




Minimum Data Set (MDS)

- Useful information to facility staff and medical providers
- Functional assessment tool
- Standardized
- Required
 - Admission
 - Change in condition
 - Quarterly




Hospice and the MDS

- MDS not often used by hospice
- Form often not current
- If current
 - MDS can be a great resource for documenting functional decline
 - Routine weights should continue to be documented



Hospice Plan of Care

- Doesn't meet federal and state expectations of improving or maintaining function
 - NH regulated by CMS
 - Hospice regulated by Department of Health
- Unless carefully documented, the care of patients who are enrolled in hospice can be perceived as poor
 - Conditions of Participation state hospice responsible for coordinating the plan of care



Hospice Responsibility to Contracted NH

- Common courtesy
- Integration of the hospice & NH plans of care
- Services provided according to the plan of care
- On-site collaboration with each visit
- Awareness, compliance, and documentation per LTC regulations
 - Prevent the appearance of non-compliance
- Collaboration regarding family conflicts and complaints



NH Responsibility to Contracted Hospice

- Integration of the hospice & NH plans of care
 - Recognize hospice's regulatory responsibility for coordination of care
- Notification regarding changes in resident's condition
 - Including notification *at time of death*
- Significant changes in medications or treatments
- Collaboration regarding transfer to hospital




OIG: Medicare Hospice in NH

- Objective: to determine the extent to which hospice claims for beneficiaries in nursing facilities in 2006 met Medicare coverage requirements
- Findings: 82% of hospice claims for beneficiaries in nursing facilities did not meet at least one Medicare coverage requirement
 - Medicare paid ~\$1.8 billion for these claims




OIG: Medicare Hospice in NH

- 33% did not meet election requirements
- 63% did not meet plan of care requirements
- 31% of time, hospices provided fewer services than outlined in POC
- 4% did not meet certification of terminal illness requirements




OIG: Medicare Hospice in NH

- Recommendations
 - Educate hospices about coverage requirements
 - Provide tools and guidance to hospices
 - Strengthen monitoring practices
- Response from CMS
 - Concurred with recommendations




OIG Fiscal Work Plan for 2010

- Physician billing for Medicare hospice beneficiaries
- Duplicate drug claims for hospice beneficiaries




Common Questions

- If a patient's chart is reviewed and deemed to not meet eligibility criteria...
 - Who is liable for the cost of care already provided by the hospice?
 - Who is responsible for making the appeal?
- Can a patient receive hospice care and skilled care at the same time?



Common Questions

- What is covered by hospice and what is not covered? Who decides?
- Who can discharge a patient from hospice care?
- Who determines duration of hospice services?




Medicaid/Medicare

- A Medicare beneficiary who resides in an SNF or NF may elect the hospice benefit if the residential care is paid for by the beneficiary or the beneficiary is eligible for Medicaid and the facility is being reimbursed for the beneficiary's care by Medicaid, and the hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual.
- A beneficiary could be in a SNF under the SNF benefit for a condition unrelated to the terminal condition and simultaneously be receiving hospice for the terminal condition.




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