Hospice in the Nursing Home: Opportunities for Partnership
(Collaborative Strategies for Improvement)
February 4th, 2008

Presenter: Yvonne J. Corbeil
Director for Network Development for Palliative Care
Dartmouth-Hitchcock Medical Center
603-650-5402      Yvonne.J.Corbeil@Hitchcock.org
Mrs Phoenix, 76 year old woman with Alzheimer’s who said her whole life:

“... and I’d never want to be in a nursing home”
Where People Die *

- Hospital 48% (707)
- Nursing Home 20% (280)
- Home 17% (262)

* All deaths in 3 NH/VT counties surrounding DHMC
Some facts …

1. Americans are increasingly spending the last years of their lives in nursing homes.
2. The Medicare Hospice Benefit defines a right of Americans to receive enhanced care at the end of life if they choose to and meet eligibility criteria.
3. Nursing homes are a defined site for delivery (and receipt) of hospice care at the end of life under the law.
4. Hospice provides important services that enhance the quality of care and quality of life at the end of life.
5. Hospice is associated longer survival for patients with several cancers and CHF.
Hospice vs. non-hospice in Nursing Homes

Research documents:

- Fewer hospitalizations in last 6 mths
- Received superior pain assessment
- A greater likelihood of having pain treated
- Fewer invasive treatments
- Less likely to have feeding tubes
- Less likely of being restrained
Hospice vs. nonhospice in Nursing Homes

- General increased satisfaction
  - Resident
  - Families
  - Staff

The best interest of the resident and his/her family, NH admin and Hospice are strategically aligned
Factors Influencing Hospice Involvement in Nursing Homes

Policy level
- Reimbursement / Regulatory

Organizational level
- Myths/ lack of knowledge
- Staffing and turnover

Individual resident level
- Lack of information to make the choice
Hospice Utilization in Nursing Homes

• NHs increasingly the site of death

• Percentage of hospice enrollees in nursing homes has increased over the last decade

• However, hospice remains underutilized in this setting both in terms of
  • non-referral of appropriate patients
  • late referral → very short lengths of stay
Hospice Utilization in Nursing Homes

Individual and Organizational Providers

- Need policies, procedures & systematic data collection for assessment of terminal status / hospice referral

- Need hospice informational materials
Medicare Hospice Benefit in Nursing Homes – recent study

- About 80 percent of nursing homes now have arrangements to provide hospice care

- Barriers to ACCESS
  - Failing to identify residents who need hospice
  - Financial incentives for nursing homes to keep providing skilled care

Gozalo P, Miller S. Hospice enrollment and evaluation of its causal effect on hospitalization of dying nursing home patients. *Health Services Research* (online), 2006
The study was funded by a grant from the Agency of Healthcare Research and Quality, U.S. Department of Health and Human Services.
Referral Challenges in the Nursing Home

• Referrals frequently based on belief that hospice is appropriate only when “something bad happens”

• NH nurses frequently use their own assessments of the patient’s comfort and the family’s need for support as determining factor

• Belief among some NH staff that hospice does not add substantially to the end-of-life care of dying residents

• Limited input from physicians *
Triggers Facilitating Hospice Referral

- Resident had begun to decline and/or death is expected
- Pain problem facilitated hospice referral
- NH staff played an important role in raising the hospice option
- NH staff have good understanding of the full range of hospice services
- Agreement that good care results from the presence of both NH and hospice providers
Common Challenges

- Increasing regulatory scrutiny
  - Including documentation expectations
  - Quality Assurance and Performance Improvement requirements

- Reimbursement issues
Collaborative Solutions

~- BEST PRACTICES ~

Use of and referral to hospice

Provide consistent availability of palliative care expertise and support

Higher quality of care at the end of life
Essentials to Successful Collaboration

Constant Relationship Building and Open Communication

- Mutual respect (permeating the relationship)
- Commitment to collegiality
- Understanding of each other’s business
- Customer Service orientation and responsiveness
- Policies and procedures clarify roles
Physician Involvement

Improving the Use of Hospice Services in Nursing Homes

A Randomized Controlled Trial

Context

Hospice care may improve the quality of end-of-life care for nursing home residents, but hospice is underutilized by this population, at least in part because physicians are not aware of their patients’ preferences.

David Casarett, MD, MA; Jason Karlawish, MD; Knashawn Morales, ScD; Roxane Crowley, BA; Terre Mirsch, RN, BSN, CHPN; David A. Asch, MD, MBA  JAMA. 2005;294:211-217
Physician Involvement

Objective

To determine whether it is possible to increase hospice utilization and improve the quality of end-of-life care by identifying residents whose goals and preferences are consistent with hospice care.

Design, Setting, and Participants

Randomized controlled trial (December 2003-December 2004) of nursing home residents and their surrogate decision makers (N=205) in 3 US nursing homes.
Physician Involvement

Intervention

- A structured interview identified residents whose goals for care, treatment preferences, and palliative care needs made them appropriate and eligible for hospice care.

These residents’ physicians were notified and asked to authorize a hospice informational visit.

Main Outcome Measures

- Hospice enrollment within 30 days of the intervention.
- Families’ ratings of the quality of care for residents who died during the 6-month follow-up period.
Results

- Of the 205 residents in the study sample, 107 were randomly assigned to receive the intervention, and 98 received usual care.

- Intervention residents were more likely than usual care residents to enroll in hospice within 30 days and to enroll in hospice during the follow-up period.

- Intervention residents had fewer acute care admissions and spent fewer days in an acute care setting.

- Families of intervention residents rated the resident’s care more highly than did families of usual care residents.
Physician Involvement

Conclusion

A simple communication intervention can:

- Increase rates of hospice referrals
- Increase families’ ratings of end-of-life care
- Decrease rate of hospital admissions and utilization of acute care
Resource - Tool - www.nhhpco.org

NEW HAMPSHIRE HOSPICE AND PALLIATIVE CARE ORGANIZATION
125 AIRPORT RD, CONCORD, NH 03301  603-225-0900  info@nhhpco.org

... improving access to quality care for New Hampshire residents with life-threatening conditions

What’s New  NH Providers  Notices  NH Pain Initiative  Membership  Info  Contact

Best Practices

- Opioid Use Guidelines
  These Opioid Use Guidelines have been prepared by the NHHPCO Palliative Care Clinicians Special Interest Group as part of their ‘Best Practices Project.’
  Opioid Use Guidelines HERE

- Unipolicy Guidelines
  Introducing NHHPCO Unipolicy Draft Worksheets.  SEE Downloads below
  These worksheets are tools designed for determining hospice eligibility within the Unipolicy guidelines that took effect on December 1, 2007.
  These documents replace the Hospice Quick Guide and will be reviewed by Medicare’s Region 1 Hospice Advisory Committee in the coming months. They are guidelines and must be used appropriately in the clinical context. Please send us your suggested revisions as you work with these documents.

DOWNLOADS:

Determining Terminal Status - Complete Document - PDF format (60 KB)

Individual Worksheet Downloads in Word format:
Determining Terminal Status - ALS
Determining Terminal Status - Cancer
Determining Terminal Status - Stroke and Coma
Unipolicy Guidelines
Introducing NHHPCO Unipolicy Draft Worksheets. SEE Downloads below

These worksheets are tools designed for determining hospice eligibility within the Unipolicy guidelines that took effect on December 1, 2007.

These documents replace the Hospice Quick Guide and will be reviewed by Medicare's Region I Hospice Advisory Committee in the coming months. They are guidelines and must be used appropriately in the clinical context. Please send us your suggested revisions as you work with these documents.

DOWNLOADS:

Determining Terminal Status - Complete Document - PDF format (60 KB)

Individual Worksheet Downloads in Word format:
Determining Terminal Status - ALS
Determining Terminal Status - Cancer
Determining Terminal Status - Stroke and Coma
Determining Terminal Status - Decline
Determining Terminal Status - Dementia
Determining Terminal Status - Heart Disease
Determining Terminal Status - HIV
Determining Terminal Status - Liver Disease
Determining Terminal Status - Pulmonary Disease
Determining Terminal Status - Renal Failure

Minutes of NHHPCO Unipolicy Meeting held June 19, 2007
Long Term Care Facility ~ Hospice Collaboration at End of Life

Hospice in the Long-Term Care facility is designed to optimize end-of-life services in the facility. Hospice services enhance care provided to the resident and the resident’s family. Additionally, Hospice is a resource for facility staff in pain & symptom management, addressing complex psychosocial issues, and complying with regulatory and facility standards & requirements.

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>HOSPICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>REGISTERED NURSE</td>
<td></td>
</tr>
<tr>
<td>Recognize the need for hospice services, and integrate hospice care into 24-hour care of resident.</td>
<td>“Value added” consultation and care management support to enhance EOL experience for resident and facility staff.</td>
</tr>
<tr>
<td>⇒ MDS oversight &amp; reporting</td>
<td>⇒ Available 24/7 for pain/symptom consults &amp; visits.</td>
</tr>
<tr>
<td>⇒ Explore referral to hospice w/MD &amp; patient/family.</td>
<td>⇒ Documentation to support regulatory requirements.</td>
</tr>
<tr>
<td>⇒ Call hospice with changes in condition.</td>
<td>⇒ Integrate facility &amp; hospice plan of care.</td>
</tr>
<tr>
<td>⇒ Follow-up with hospice recommendations to MD.</td>
<td>⇒ Recommendations to facility MD for pain/symptom mgt.</td>
</tr>
<tr>
<td>NURSING ASSISTANT</td>
<td></td>
</tr>
<tr>
<td>Provides physical care, ensures safety, and gives loving support within timeframe allowed and according to restrictive guidelines.</td>
<td>Enhance physical care and resident support through longer, personalized visits and 1:1 contact.</td>
</tr>
<tr>
<td>⇒ Routine AM/PM care and feeding.</td>
<td>⇒ Enhanced personal care.</td>
</tr>
<tr>
<td>⇒ Notify RN with changes in condition.</td>
<td>⇒ Notify facility and hospice RN with changes in condition.</td>
</tr>
<tr>
<td>SOCIAL WORK</td>
<td></td>
</tr>
<tr>
<td>Complete paperwork required by state and federal regulations; psychosocial patient/family.</td>
<td>Seek opportunities to support families and staff in addition to 1:1 life closure intervention with.</td>
</tr>
</tbody>
</table>
Resource

Center for Gerontology And Health Care Research
Brown Medical School

NURSING HOME/HOSPICE PARTNERSHIPS
A Model for Collaborative Success
Through Collaborative Solutions

A Report Funded by the Robert Wood Johnson Foundation

Susan C. Miller, PhD, MBA
Associate Professor (Research) February 2007
NURSING HOME/HOSPICE PARTNERSHIPS
A Model for Collaborative Success
Through Collaborative Solutions

A Report Funded by the Robert Wood Johnson Foundation

Susan C. Miller, PhD, MBA
Associate Professor (Research)  February 2007
Domains Identified as important in the NH/Hospice Partnership

• Administration of the collaboration
• Communication (including conflict resolution)
• Inter-disciplinary practice
• Education
• Care planning
• Care provision
• Support for resident/family (prior to, during and after death)
• Support for NH staff (prior to, during and after death)
Notable Collaborative Solutions

Resources/Inputs

- NHs and hospices share similar philosophies of care
- 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
Notable Collaborative Solutions

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
Notable Collaborative Solutions

Infrastructure

• 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
Key Strategies for Success

Administrators

• Develop systematic processes to facilitate communication between NH and hospice staff, and between all levels of staff.

• Be well-versed in regulatory and care environments of your partner and present a consistent vision for hospice NH care.

• Share expectations openly and clearly with partners
Key Strategies for Success

Administrators

- Provide a VISION for the partnership and take on the role of visible CHAMPION
- Report to the staff on the success (or challenges) of the partnership
- Understand each others’ systems, regulations, and financing… and seek out opportunities to discuss mutual concerns
- Articulate the mutual relationship in brochures and marketing literature
Strategies for Success

Administrators

- Regular meetings and/or dialogue occur between NH and hospice CEOs
- Hospices respond promptly to NH requests
- Assign Hospice/NH dedicated staff to maximize relationships and maximize consistency
- Nursing Home Liaison positions/role
Strategies for Success

VISIBILITY

• Cultivate high hospice “presence” in NH
• Provide a schedule of hospice staff visits to the Nursing Home
• 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
• Provide contact information in a prominent spot on the hospice resident’s record
• Provide for responsive after hours coverage 24/7
Strategies for Success

- Provide opportunities for ‘feedback forums’ for NH staff to Hospice staff and vice versa
- Share a double-letterhead newsletter with end-of-life topics
- Invite each other’s staff to social and public events
- Send ‘referral thank you’ notes to residents’ physician
- Hospices provide support to NHs during Medicare/Medicaid surveys as well as with bureaucracy such as Medicaid applications/follow-up for hospice residents
Inter-disciplinary practice & Communication

Conflict management & problem solving

- Involve & give feedback to all who were involved
- Communicate common goal – quality EOL experience
- Encourage problem solving with each other
- Follow-up on outcome of collaborative problem solving
Education

- Formal NH inservice sessions with a lot of informal education (by hospice team)—ALL NH shifts
- NH institutes mechanism to assure attendance
- Provide NH staff with ongoing resources for quality EOL care (articles, tools, etc.)
- Provide hospice staff with detailed information on systems/forms/procedures for each NH
- Provide hospice staff with NH profiles including preferred contact persons, NH preferences, other
- Educate hospice staff on NH regulations, documentation (MDS, Profiles, etc.), financing
Care Planning / Provision

Joint care plan meetings, integrated care plan

Challenges

- Not being invited to meetings and/or poor attendance
- Consistency of team
- Lack of communication regarding resident changes/needs
Care Planning / Provision of Care

- Hospice attends NH care plan mtgs and attempts to involve NH staff in hospice care planning mtgs
- Continual NH/hospice staff dialogue on care plan & provision of care
- NH has formal and/or informal mechanisms to identify potential referrals
- Family informed of NH/hospice care & service expectations
- Hospice response timely to referrals & to on and off-hour calls
Specific Approaches to Facilitate Coordination

- Development of a coordinated care plan
- Nursing Home care plans are easily accessible
- Hospice care plan meetings are occasionally held at the Nursing Home
- Hospice Medical Director does rounds in the Nursing Home with Nursing Home staff in attendance
- Assignment sheet is used by the Nursing Home
- Assignment sheet records Resident information and care plan issues as well as whether resident is on hospice or receiving palliative care
Specific Approaches to Facilitate Coordination

- Coordination is more verbal, than written
- Nursing Home has (face down) communication log sheet on back of resident’s door
- Hospice sends faxes to Pharmacy to order medications and indicate who is paying
- Family informed of NH/hospice care & service expectations.
Support to resident/family & NH staff

• Hospice employees verbalize and actualize goal to provide support to NH staff & residents/families- “How can we help?”

• Systems in place to provide emotional & bereavement support to NH staff

• Support to NH with survey and with bureaucracy such as Medicaid applications/eligibility
Resource

Center for Gerontology And Health Care Research
Brown Medical School

NURSING HOME/HOSPICE PARTNERSHIPS
A Model for Collaborative Success
February 2007

And much more at:

www.nhpco.org/nursinghomes
Yvonne J. Corbeil
Director for Network Development for Palliative Care
Dartmouth-Hitchcock Medical Center
603-650-5402      Yvonne.J.Corbeil@Hitchcock.org