FREE WEBINAR
Sept. 20, 2017
12 - 1 pm

Understanding the Opportunities and Challenges of Hospice Delivery in Diverse Sites

By: Lores Vlaminck, MA, BSN, RN, CHPN

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OBJECTIVES

Describe the Medicare Hospice Benefit as the foundational basis
Identify the regulations, required services and reimbursement structure
Recognize and appreciate the opportunities and challenges inherent in the unique venues of care
A BIT OF HISTORY

HOSPICE PHILOSOPHY

"You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die.”

Cicely Saunders-1967
INTRODUCTION TO THE MEDICARE HOSPICE BENEFIT (MHB)

1965-Florence Wald invited Dame Cicely Saunders to Yale
1974-Wald, two pediatricians, chaplain founded Connecticut Hospice.
1979-HCFA initiates 26 demonstration hospice programs
1986- US Congress made the Medicare Hospice Benefit permanent-Medicare “A” hospital insurance

States were given the option to include hospice in their Medicaid programs

MEDICARE HOSPICE BENEFIT (MHB)

Extended to nursing home residents in 1989
Over 80% of hospice patients are > 65 yrs., so most hospice care is paid for by MHB
MHB pays per diem rate to cover all expenses related to terminal illness; other insurers now pay similar benefit
HOSPICE NUMBERS, 2014

Over 6,100 hospice programs in the US
Median length of stay in hospice was 17.4 days
35% die within ≤ 7 days of enrollment
14.5% of patients died while receiving hospice care were in nursing homes
Approximately 46.2% of all deaths in the US were under the care of a hospice program

NHPCO, 2015

10 LEADING CAUSES OF DEATH FOR ADULTS 65+

<table>
<thead>
<tr>
<th></th>
<th>Disease</th>
<th>%</th>
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<tbody>
<tr>
<td>1</td>
<td>Diseases of the heart</td>
<td>21.5%</td>
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<tr>
<td>2</td>
<td>Malignant neoplasms</td>
<td>21.5%</td>
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<tr>
<td>3</td>
<td>Chronic lower respiratory diseases</td>
<td>6.5%</td>
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<tr>
<td>4</td>
<td>Cerebrovascular disease</td>
<td>5.9%</td>
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<tr>
<td>5</td>
<td>Alzheimer's disease</td>
<td>4.8%</td>
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<tr>
<td>6</td>
<td>Diabetes mellitus</td>
<td>2.8%</td>
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<tr>
<td>7</td>
<td>Accidents</td>
<td>2.5%</td>
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<tr>
<td>8</td>
<td>Influenza and pneumonia</td>
<td>2.3%</td>
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<tr>
<td>9</td>
<td>Nephritis, nephritic syndromes and nephrosis</td>
<td>2.1%</td>
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<tr>
<td>10</td>
<td>Septicemia</td>
<td>1.5%</td>
</tr>
<tr>
<td>11</td>
<td>Other</td>
<td>24.5%</td>
</tr>
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THE THREE HOSPICE COMPONENTS

WHAT IS HOSPICE?

A form of comprehensive care that provides comfort and support to facing a life limiting illness and their families.

A team of specialists with experience in time-tested expertise devoted to compassionate professional end-of-life care.

Hospice goal is for patients to find dignity meaning and peace during their last months, weeks, and days that is meaningful to them.
WHO IS ELIGIBLE?

Any age and diagnosis
Receptive to the hospice philosophy of care
   (signature from patient acknowledging the choice of comfort care, not curative care)
Terminal prognosis
   (six months or less should the disease run its normal course)
Both the attending physician and the medical director certify the patient as ‘terminally ill”

WHAT WILL HOSPICE DO?

Provide access to a RN on-call 24/7
Development of a patient/family care plan by a hospice IDG (Interdisciplinary Group) pursuant to the patient’s goals-collaborate every 14 days or more
Assess and manage/treat all physical symptoms related to the illness
Address emotional, spiritual, social aspects of coping
Assist in navigating through end-of-life decision making
Bereavement support for family 12-13 months post death
WHO WILL PROVIDE HOSPICE?
CORE TEAM MEMBERS

Hospice Medical Director
Registered Nurse
Social Worker
Chaplain/counselor

ADDITIONAL TEAM MEMBERS

Hospice aide/homemaker
Volunteers
Physical, Occupational, Speech-Language Therapist
Registered Dietician
Pharmacist
ADDITIONAL INTEGRATIVE THERAPISTS*

Music
Massage
Certified Animal Therapists
Therapeutic touch
Aromatherapy
Art therapy
Other

* Not required—not reimbursed by Medicare/MA

LEVELS OF CARE

In Home Hospice
Continuous Care
In-patient facility
    General inpatient facility
    Respite Care
IN-HOME HOSPICE

Intermittent visits are made by the appropriate clinicians and volunteers based on the care plan and patient needs
Support and education is provided to the patient/family

CONTINUOUS HOME CARE

Care provided 1:1 during crisis by nursing staff
  RN’s/LPN’s must provide >50% in a 24-hour period starting at 12am
  Hospice aides may provide <50% of care
  Services are invoiced in 15 minute increments
GENERAL IN-PATIENT (GIP)

Provided in partnership with a contracted Medicare certified facility for crisis management not able to be managed in any other setting
Examples;
- Pain management and symptom intervention
- Bowel obstruction
- Fractures
- Bleeding
- Other

IN PATIENT RESPITE

Provision of up to five days of respite to provide relief for the patient’s caregiver
- Not applicable for a patient who lives alone
- Not applicable for a patient who lives in a SNF
- Not applicable to relieve paid staff
WHAT ELSE IS COVERED AND PROVIDED?

MEDICATIONS AND TREATMENTS

Medications and treatments related to the primary terminal diagnosis, palliative symptom management, and related diagnoses

Contracted pharmacy available 24/7

Treatment may include palliative radiation, chemotherapy
DURABLE MEDICAL EQUIPMENT

DME equipment related to the primary terminal diagnosis, related diagnoses and palliative care
Contracted Medicare certified supplier

BEREAVEMENT SUPPORT

Minimum of 12=13 months following death
Available to ‘family’
Available to identified SNF staff and residents in need of grief support
WHO PAYS FOR HOSPICE?

Medicare Part “A” hospital insurance
MN Medical Assistance-Title 19
Health Plans
Veteran’s Administration
Private Pay
Charitable Funds
Long-term care insurance

CMS NATIONAL HOSPICE RATES-2017

RHC Day 1-60 ~$190.00
RHC Day 61+ ~$149.00
SIA ~$40.16
Continuous Care ~$963.00 (cap) ~$40/hr
Inpatient Respite ~$170.00
General Inpatient ~$734.00
WHERE CAN HOSPICE CARE AND SERVICES BE DELIVERED?

WHEREEVER THE PATIENT CALLS “HOME”

- Private residence
- Skilled nursing facility
- Assisted living facility
- Acute care facility-hospital
- Foster care
- Homeless shelter
- Supervised living facility
- Jail/Prison
- Other
CHALLENGES AND OPPORTUNITIES IN PROVIDING HOSPICE IN A VARIETY OF SETTINGS

CHALLENGES IN PROVIDING HOSPICE CARE IN A PRIVATE HOME/APARTMENT

- Lack of willing and able caregivers
- Less than optimal environment for staff and volunteers
- Self-neglect
- Declining health-unable to meet own needs
- Safety
- Adherence to medications/care
- Needs exceed hospice ability to meet
- Short length of stay
OPPORTUNITIES FOR HOSPICE CARE IN A PRIVATE HOME/APARTMENT

Most desired location for most patients
Willing and able caregivers
Privacy
Continuity of care between caregivers
Length of time in hospice
Uncomplicated disease process
Open communication between patient/family/providers

CHALLENGES IN PROVIDING HOSPICE CARE IN AN ASSISTED LIVING FACILITY

Staff may have little experience with death and dying
Staffing ratios of AL licensed and unlicensed staff
Coordination of care between AL and hospice staff
Availability of AL staff
Pain and symptom management
Medication administration
Lack of understanding of each other’s rules
OPPORTUNITIES FOR HOSPICE CARE IN AN ASSISTED LIVING FACILITY

Greater success when the dying process has been brief
AL staff are highly committed to end of life care for their residents
Consistent staffing patterns for hospice and AL
Long standing relationship with resident may encourage the ‘above and beyond’
Understanding of each others’ rules

A WORD ABOUT NURSING HOMES
DEATHS IN NURSING HOMES (NHS)

Slightly more than 20% of US deaths occur as patients transfer from NHs to hospitals
By 2020, up to 40% of deaths may occur in NHs
Proportion of dying NH residents served by hospice is increasing (16% of all NH deaths)

Carpenter & Ersek, 2015; Temkim-Greener et al., 2013

CHALLENGES IN PROVIDING HOSPICE CARE IN NURSING HOMES

Triad of communication
Lack of physician involvement
Coordination of current plan of care
Low staffing levels
Staff turnover
Reimbursement and regulatory policies
CHALLENGES IN PROVIDING HOSPICE CARE IN NURSING HOMES

- Lack of staff knowledge
- Multiple hospice agencies in a SNF
- Conflicting philosophies of care
- Time constraints
- Lack of time for hospice in-service/education

OPPORTUNITIES TO PROVIDE HIGH-QUALITY HOSPICE CARE IN NURSING HOMES

- Daily intensive interaction over time
- Family-like relationships between older adults and staff
- Home-like atmosphere
- History of caring for the dying
- Expertise in dementia care
- Support for SNF staff to provide palliative and hospice care

Carpenter & Ersek, 2015
OPPORTUNITIES TO PROVIDE HIGH-QUALITY HOSPICE CARE IN NURSING HOMES

- Increased comprehensive end-of-life care
- Patient is allowed to remain in familiar surroundings
- Hospice assumes management of pain and symptoms
- Education by hospice for SNF staff
- Bereavement care for the identified residents and staff for 12-13 months

CHALLENGES IN PROVIDING HOSPICE CARE IN FOSTER CARE (FC)

- Wide variability in skills of staff
- Limited RN oversight required
- Medication/treatment delegation to ULP’s
- Variety of settings and expertise
- Triad of communication
- Capped reimbursement for FC despite increased level of care
OPPORTUNITIES TO PROVIDE HIGH-QUALITY HOSPICE CARE IN FOSTER CARE (FC)

- Patient's relationship with FC staff (often long term)
- Usually small residential settings
- Variety of settings
- Support from hospice IDG team supplements the clinical management AFC is not able to provide
- FC provides individualized cares

CHALLENGES IN PROVIDING HOSPICE CARE IN A HOMELESS SHELTER

- Transient population
- Staff is not skilled in end of life care
- Lack of caregivers
- Limited resources
- Access to health care
- Temporary housing
- Medication management
- Restrictions by shelter
  - Floors by gender
  - Visiting hours
  - Limits to length of housing stay
OPPORTUNITIES TO PROVIDE HIGH-QUALITY HOSPICE CARE IN HOMELESS SHELTER

Care management
  Develop Plan “B” or Plan “C”
Advocacy for access to health care and housing
Pain and symptom management while seeking permanent relocation
Support for shelter staff
Care conference facilitation

CHALLENGES IN PROVIDING HOSPICE CARE IN JAIL/PRISON

Conflict between priorities of caring for the patient and ensuring security
Environment is a deterrent to quality end of life care
Staff are not trained for personal care and assistance
Comfort measures may be prohibited or too restrictive
Expression of grief is discouraged
Clinical care is inconsistent with standards for hospice and palliative care
OPPORTUNITIES TO PROVIDE HIGH-
QUALITY HOSPICE CARE JAIL/PRISON

Increased family visitation made possible by modified visiting rules
IDG team support for staff and patient
Skilled symptom management
Modification of physical environment
Facilitation of communication with IDG team and family

CHALLENGES ACROSS ALL SETTINGS

Increase in drug diversion
Increase in co-morbidities of hospice patients
Lack of ‘family’ support
Unwilling or unable caregivers
Uninsured
Underinsured
Staffing shortages
OPPORTUNITIES ACROSS ALL SETTINGS

Advocacy for a patient facing the end of life in ascertaining “what matters most.”
Pain and symptom management
Assessment and interventions for suffering;
   Spiritual, emotional, psychological and financial
Extension of human compassion

SUMMARY

Describe the Medicare Hospice Benefit as the foundational basis
Identify the regulations, required services and reimbursement structure
Recognize and appreciate the opportunities and challenges inherent in the unique venues of care
Lores Vlaminck, MA, BSN, RN, CHPN

Lores Consulting, LLC
3063 Darcy Drive NE
Rochester, MN 55906
Office 507-288-6050
Cell 507-358-4301
FAX 507-288-6050
Email: Lores@charter.net