MINNESOTA GERONTOLOGICAL SOCIETY

**FREE WEBINAR**
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# Understanding the Opportunities and Challenges of Hospice Delivery in Diverse Sites

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## PRESENTER

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Palliative Care, Assisted Living
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Home Care/Hospice Founder and Director
41 years of nursing experience
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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+

| | |
|---|---|
| 1. Diseases of the heart | % |
| 2. Malignant neoplasms | 21.5% |
| 3. Chronic lower respiratory diseases | 6.5% |
| 4. Cerebrovascular disease | 5.9% |
| 5. Alzheimer's disease | 4.8% |
| 6. Diabetes mellitus | 2.8% |
| 7. Accidents | 2.5% |
| 8. Influenza and pneumonia | 2.3% |
| 9. Nephritis, nephritic syndromes and nephrosis | 2.1% |
| 10. Septicemia | 1.5% |
| 11. Other | 24.5% |

## 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 it's 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?

## WHEREVER 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

## 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


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