Collaborative Care: Improving the Hospice-Nursing Home Relationship

California HealthCare Foundation

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Introduction

As the nation's population ages, care received by patients at the end of life is becoming more extensive, and choice among options more important. Much media attention has been paid to the importance of end-of-life care choices, but there has been little focus on nursing homes as a site where people receive end-of-life care. Nursing homes have become a significant provider of care delivery at the end of life, particularly for frail Medicare beneficiaries. For these patients, hospice care can significantly improve their quality of life. Consequently, a relationship between a hospice and a nursing home that facilitates access to hospice care delivery is a crucial element of high quality end-of-life care.

Although California hospices are widely known as pioneers in the development of hospice care in the United States, California has been slower in moving hospice care into nursing homes compared to the country as a whole. In 2006, for example, approximately 17 percent of all hospice admissions and 18 percent of all hospice deaths in California occurred in nursing homes, compared to 22 and 23 percent, respectively, in the United States.[1] Although the reasons for this disparity have not been thoroughly analyzed, the greater number of for-profit and larger nonprofit hospice providers in other states may influence patterns of nursing home use by hospices there. Additionally, some other states may have more flexible reimbursement or regulatory policies that encourage hospices to collaborate closely with nursing homes. In Rhode Island, for example, state law requires that on admission to a nursing home, each patient not only receive the Patient's Bill of Rights but also have the right to hospice care specifically noted and explained.[2]

The potential benefits of hospices bringing their services into nursing homes are significant. Nursing homes receive the hospices' expertise in pain and symptom management, access to enhanced patient benefits such as pharmaceuticals and bereavement support, and access to training resources. Hospices gain access to alternative bed arrangements for inpatient care, round-the-clock support and supervision, and dietary services. Perhaps most importantly, hospices and nursing homes working well together create a synergy that is better able to meet the end-of-life care needs of nursing home residents than either could provide on its own.

How beneficial the relationship is in any particular facility, however, depends heavily on how well the hospice and the nursing home are able to cooperate. Despite the significant benefits that might accrue to all parties involved, creating a strong relationship between a hospice and a nursing home is not always easy.

To better understand how hospices and nursing homes work together, the California HealthCare Foundation commissioned The Corridor Group, Inc. (TCG) to conduct research on these relationships in California: benefits and risks for each entity; types of collaboration; perceived quality of care by each provider type; and opportunities for improvement in care delivery, resource allocation, and cooperation.

In undertaking the project, TCG conducted telephone or online surveys with 138 industry stakeholders and representatives of hospices and nursing homes throughout California. (Although the goal was to obtain a cross-section of information and opinions from each of these sectors, it should be noted that far more survey responses were obtained from hospices than from nursing homes or other industry stakeholders.) This issue brief explores the survey findings, and recommends a call to action in response to certain challenges observed in the relationship between hospices and nursing homes, with the goal of improving end-of-life care delivery and access in California nursing homes.

Background

Since 1983, Medicare has provided coverage of hospice services at four levels of care.[3] Most care under the Medicare Hospice Benefit is provided in the patient's place of residence. Typically, this is in the patient's private home, but in recent years hospice care delivery has increased in nursing homes as patients' nursing home stays have lengthened, with the nursing home becoming their primary residence. The two levels of care provided in the primary residence are referred to as routine home care and continuous care.

Hospice providers are also required by Medicare to provide short-term inpatient care, when appropriate, in Medicare- or Medicaid-certified facilities. These facilities are typically acute care hospitals and skilled nursing facilities (nursing homes). This short-term inpatient care may be provided at either of two levels: inpatient care for symptom and pain management (referred to as general inpatient care), and inpatient care for the purpose of providing caregiver respite (known as inpatient respite care).

There are separate delivery and reimbursement guidelines for each of these four levels of care. There are additional reimbursement implications to hospices and nursing homes when care is delivered to patients in a nursing home. (See Appendix: California Hospice Payment and Benefit Structures.)

Whenever hospice care is provided in a nursing home — whether to a long term resident or to a patient the hospice moves to a nursing home for short term care — the hospice and nursing home must enter into a contractual agreement that reflects standards established by 42 C.F.R. 418 (§§418.108, 418.110, 418.112). These standards set out the roles and responsibilities of the hospice and the nursing home with regard to staffing, physical environment, safety management, eligibility, and professional management.

With the increased use of nursing homes by hospice patients, significant interest has been generated concerning the quality of end-of-life care in nursing homes, the level of pain and symptom management provided there, the types of relationships that exist between hospices and nursing homes, and models of collaboration to enhance these relationships—subjects that this issue brief addresses.

Key Findings

The relationship between a hospice and a nursing home works best where:

- There is good and open communication between them;
- The nursing home leadership and staff alike understand the value of hospice;
- The leadership of both the hospice and the nursing home are committed to making the relationship work;
- Both the hospice and nursing home make a significant effort to work collaboratively, especially in care planning; and
- The hospice consistently sends the same personnel to a particular nursing home.

The relationship between a hospice and a nursing home often flounders, however, where the nursing home staff does not understand the overall value of hospice or what its role is, including what specific services it provides and how and why it uses certain drugs. The relationship also may not work well if the hospice staff does not understand how to function in a nursing home, in particular showing a lack of responsiveness, a lack of staffing consistency, or poor communication with the nursing home staff. Not surprisingly, hospice does not do well in a nursing home if neither side shows a commitment to building a relationship. All of these problems are compounded when there is high turnover of nursing home clinical staff.

Significant Benefits

The survey respondents indicated many benefits to both hospices and nursing homes when a good relationship develops. The stronger the relationship is, the greater the benefits to hospice, nursing home, residents, and families.

Benefits to the Nursing Home and Its Residents

The most common benefits accruing to the nursing home from a good relationship with a hospice include:

Nursing homes get expertise in pain and symptom management. Many patients require intensive pain management during the end stages of life. Hospice staff are trained in the nuances of pain management and often are better able than nursing home staff to titrate medications (under the direction of the patient's physician or the hospice medical director) for maximum patient comfort.

Residents can receive great value from the hospice interdisciplinary team. Most nursing home residents are eligible for the Medicare or Medi-Cal (Medicaid) hospice benefit. Residents who elect this hospice coverage are eligible for extra nursing, hospice aide, social work, and pharmaceutical benefits, in addition to services already provided by the nursing home.

Residents, families, and nursing home staff can receive grief support. After a resident on hospice dies, hospice continues to serve the family through its bereavement program for up to a year after the death. Hospice also can provide grief support, as well as bereavement education and training, to the nursing home staff.

Nursing homes get the added services of certified hospice aides (nursing assistants). Hospice aides complement services already provided by the nursing home and may offer a level of personal care assistance not often available throughout the nursing home.

Non-hospice residents receive secondary benefits. Research has found that non-hospice residents residing in those nursing homes that have a greater proportion of residents enrolled in hospice are less frequently hospitalized at the end of life and more frequently have pain assessment performed.[4,5] Also, hospice bereavement counselors may be available to provide additional grief counseling to residents not in the hospice program. Some hospices have community bereavement programs that are offered as a community service and may be arranged through the nursing home.

Hospice staff are expert resources for the nursing home. Hospice staff are experts in end-of-life care and are available to answer questions and provide guidance, particularly in those relationships where the leadership of both hospice and nursing home understands the overall benefits of hospice care and encourages collaboration.

Benefits to the Hospice and Its Patients

The benefits to the hospice provider of a good relationship with a nursing home include:

Hospices are able to meet the end-of-life care needs of more patients. Hospices hope to serve as many patients as possible who are at the end stage of life. Since this includes many nursing home residents, hospices that work regularly with nursing homes have the opportunity to serve more patients.

Hospice patients in nursing homes receive access to additional facility-based services. Hospice patients often need care when regular hospice visiting staff is not working. The nursing home setting offers round-the-clock care and supervision to patients, as well as dietary services. This can reduce the need for the hospice staff to visit outside routine business hours.

Hospices may obtain alternative bed arrangements for their patients. While most people would prefer to be at home at the end of life, for many this is not possible due to family circumstances, financial resources, or cultural mores. Additionally, hospice patients may need inpatient care for acute or respite stays. Nursing homes offer a good venue for short term stays of hospice patients who are not nursing home residents.

Hospices may realize a more efficient environment and better flow of patients. Hospices may serve multiple residents in the same nursing home, allowing for one team of hospice staff to concentrate on one facility. This is not only cost-effective but also provides an opportunity for stronger nursing home relationships, since the same hospice staff visit frequently and the two staffs thus become more familiar with each other.

Significant Challenges

The survey identified six significant challenges to a good relationship between a hospice and a nursing home.

Lack of Understanding

Frequently, a lack of understanding exists on the part of each staff regarding what is expected from the other: what role each has; what services hospice can and should provide; how hospice should operate in a nursing home setting; and how narcotics and other medications are to be used.

This lack of understanding is due partly to the Hospice Medicare Conditions of Participation, which place the responsibility of professional management on the hospice, though the nursing home remains legally responsible for the patient. For example, the hospice must develop a plan of care that guides delivery to the hospice patient of all medical care related to the terminal illness, and the hospice is responsible for all decisions related to such care. But the nursing home, too, must develop a plan of care that guides its delivery of care and services. When nursing home staff members do not fully understand these rules, there may be confusion about who is responsible for the plan of care, as well as about individual care decisions.

Education and training for both staffs about the role of the hospice care plan can help alleviate this confusion.

Hospice as Substitute for Nursing Home Care

A distinct undercurrent was detected from surveyed hospice providers that some hospices (labeled frequently as the “for-profits”) are providing more services to nursing homes then federal law allows. At the same time, some nursing homes may feel they are not receiving a full range of hospice interdisciplinary services, including volunteers and spiritual care counselors. These attitudes can lead to confusion by both hospice and nursing home when entering into contractual agreements or care coordination activities. They may also result in a strain on the relationship when some hospice services are requested but not provided.

Clear delineation of these responsibilities in a written contract is essential to avoid conflict or confusion about the care that is to be delivered by each entity, pursuant to the following categories of responsibility:

- The hospice is responsible for providing medical direction and patient management, nursing, counseling, social work, medical supplies, durable medical equipment, and pharmaceuticals related to the patient’s terminal illness. The hospice may use the nursing home staff to assist with the administration of prescribed therapies.

- The nursing home is responsible for providing 24-hour room and board care, and for meeting the personal care and nursing needs that would have been provided by the primary caregiver at home.

Leadership Cooperation Between Hospice and Nursing Home

Coordination of the plan of care between nursing home and hospice can be difficult in even the best of relationships between the two staffs. In a poor relationship, nursing home staff can present real barriers to some hospice interventions. A clear, coordinated written plan of care developed together by the nursing home and the hospice can obviate some of these problems. But when the leadership of either entity is not invested in the relationship, there may be insufficient incentive for the nursing home care delivery staff to collaborate on the patient's care plan, to suggest improvements in the plan of care, or to contact the hospice staff when the patient's condition changes, requiring care plan modifications.

In stronger relationships, the leadership of both hospice and nursing home create a culture of collaboration that allows for and encourages care plan coordination. In this regard, some hospices even develop special teams that circulate to various nursing homes to assure that patient care delivery is well coordinated with each facility.

Nursing Home Staff Turnover

The staff turnover rate in California nursing homes is 67 percent. To the extent high staff turnover exists in any particular nursing home, building a strong, durable relationship with hospice providers is extremely difficult. (Turnover rates of hospice staff are not available, but anecdotally are perceived to be relatively low.) Since there are no "standard" plan of care requirements, medication regimens, or other elements of clinical care delivery, the hospice must provide frequent education to new staff— a difficult task when both hospice and nursing home staffing resources are limited.

The high nursing home staff turnover also impacts the ability of hospice and nursing facility staffs to develop long term relationships and loyalty to a particular end-of-life care delivery approach, which may produce subjective and idiosyncratic approaches to care that are not always in patients' best interests.

Lack of Surveyor Understanding

Nursing homes are visited each year by a team of surveyors from the state, to ensure compliance with state and federal regulations. A number of hospice providers interviewed for this study reported that some surveyors do not fully understand hospice regulations. Specific surveyor misunderstandings relate to control of the plan of care, medication management, and resident eligibility for hospice. These misunderstandings tend to trigger various negative outcomes: surveyors misinterpreting the scope of work that the regulations permit hospice aides to perform in a nursing home; a greater number of deficiencies issuing from any given survey; and nursing home reluctance to enter into a hospice relationship because of fear of surveyor citations. The newly revised (June 5, 2008) Medicare Hospice Conditions of Participation (CoPs) may improve surveyor understanding and interpretation of hospices in nursing homes; in this regard, however, careful training and attention to the new CoPs will be important.

Lack of Hospice Access to Nursing Homes

Not all nursing homes have a relationship with a hospice. Some nursing homes feel they do not need hospice because they believe their staff can provide good end-of-life care without it. Other nursing homes have had such negative experiences with individual hospices that they do not see the value of hospice as worth the significant effort that would be needed to make the relationship work.

The number of nursing homes without a hospice relationship is a serious challenge because nursing homes provide end-of-life care to so many patients, particularly frail Medicare beneficiaries.

Issues for Consideration

This project's key findings identify a need to develop, provide, and fund enhanced education to support the hospice-nursing home relationship. The project's survey identified a number of opportunities to improve the relationships between hospices and nursing homes, thus enhancing care delivery at the end of life for residents of nursing homes and for hospice patients who are moved to nursing homes to receive care. There is also an opportunity to improve understanding by federal and state nursing home surveyors regarding hospice. Also, acting on these opportunities may more broadly impact the care that is provided to non-hospice residents of nursing homes.

Individual hospices and nursing homes have a responsibility to collaborate to improve care at the end of life. A strong step in that direction would be for them to participate, and to the extent possible take a leadership role, in the programs of education described below.

But this important task should not be left to individual providers. State and national trade associations can also take a significant role in educating their provider and consumer membership, as well as influencing policy makers to support and fund education of clinical care delivery staff and related consumer awareness campaigns. As the need for hospice services continues to expand and the terminally ill population shifts increasingly to nursing homes, trade associations will be in a unique position to inform on, and provide professional and paraprofessional training in, the benefits of hospice care delivery in nursing homes.

Finally, philanthropic organizations also have a role, to support and fund critical training areas to ensure improvements in quality and care delivery.

Critical Education Opportunities

Training for Nursing Home Leadership and Staff

Education programs should be made available for administrators and directors of nursing homes to help them more fully understand:

- What, when, and how hospice services can be provided;
- What specific laws and regulations (particularly pertaining to inducement, fraud, and abuse) govern hospice care in nursing homes; and
- What the role is of hospice and nursing home staff, under their respective Medicare Conditions of Participation, in caring for a terminally ill nursing home patient.

These programs should go beyond the minimum education efforts from hospices to nursing homes mandated by regulations of the Medicare Hospice Benefit. Nursing homes can collaborate with hospices in this education, and trade associations can help standardize training by developing outlines to guide such programs. The National Hospice and Palliative Care Organization (NHPCO) has already taken a significant lead in such training and could serve as a model for these efforts. NHPCO training resources can be found at www.nhpco.org (public use may require authorization from NHPCO).

Training for Hospice Leadership and Staff

Education programs should be made available for hospice leadership and staff to help them better understand nursing homes and more effectively communicate and collaborate with nursing home staff. This could include efforts to help hospice staff become more familiar with nursing home structures and procedures, facilitate two-way communication, successfully introduce themselves into a new nursing home setting, and address the needs of a nursing home and its staff. Part of such an education program could incorporate reflection

by hospice leadership about the role hospice agencies themselves play in creating strains on the relationship between hospices and nursing homes.

One way to introduce such education would be to make existing certification programs for hospices and nursing homes, currently provided by private organizations and state trade associations, a requirement to obtain state and federal funding. For example, California regulations already specify that certain credentials are required to be an administrator or director of patient care services. These could be strengthened by requiring staff training in certain fundamentals of hospice care in nursing homes.

Training for Consumers

Education programs should be provided to consumers to help them better understand hospice and its value in a nursing home, as well as how to effectively request such care. Educational materials need to be developed, to be provided to potential hospice patients and their families in a nursing home. Trade associations can play a major role in developing and producing such programs and materials.

Coordinated Action Among CMS, Surveyors, Hospices and Nursing Homes

Facilitated Meetings

Meetings between the Centers for Medicare & Medicaid Services (CMS), state surveyors, hospices and nursing homes would help all parties better understand hospice care in nursing homes. Such meetings should address issues including: how and why different medications and treatments are used by hospice; how to reduce the level of required documentation by a nursing home for hospice patients; and how to develop a single collaborative care plan that can meet both hospice and nursing home regulations for care plan documentation.

Expert Attention to Staff Turnover

Factors influencing staff turnover in nursing homes have been addressed in a variety of forums, and the relationship between nursing home staff turnover and quality of care is known. Turnover also has a profound effect on end-of-life care delivery, and on the often poor relationship between hospice and nursing homes. As hospice care delivery in nursing homes continues to increase, nursing home staff turnover will become an even greater barrier to hospice patient care delivery. Implementing practices to reduce turnover should be a high priority for payers, providers, and consumers.

Clarification of Surveyor Guidelines

In collaboration with key state hospice and nursing home leaders, state surveyor guidelines should be updated to clarify: who is an appropriate patient for hospice services in a nursing home; what are the appropriate roles for hospice and the nursing home in caring for the terminally ill (especially the role of facility nursing assistants and hospice aides); and what are the expectations for and by hospice in a nursing home. State trade associations can and should serve as a driver of such efforts to improve the understanding of surveyors about the specific nature of care delivery by hospices in nursing homes.

Appendix: California Hospice Payment and Benefit Structures

Overview

For a hospice patient in a nursing home, the hospice is responsible for providing all core hospice services (nursing, physician care, social work, and counseling), plus medications, supplies, and durable medical equipment. The nursing home provides room and board, and care unrelated to the terminal illness.

Approximately 86 percent of all hospice patients in California nursing homes are under the Medicare Hospice Benefit, with 6 percent more receiving hospice care under Medi-Cal.[1] Medicare pays the hospice directly, based on which of four levels of care the patient is receiving. Three levels of care are paid on a per diem basis; the fourth, continuous care, is paid at an hourly rate. If the patient is dually eligible for both Medicare and Medi-Cal, then the state also pays the hospice provider directly for the patient's room and board, and the hospice in turn pays the nursing home based on their contractual arrangement.

From its Medicare payment, the hospice pays the nursing home for the drugs, supplies, and durable medical equipment provided by the nursing home and related to the terminal illness. The hospice and the nursing home negotiate the rates the hospice will pay the nursing home for the services, drugs, and supplies provided. From the remaining funds, the hospice covers its expenses related to patient care.

Medicare and Medi-Cal Hospice Benefits

Medicare and Medi-Cal follow the same reimbursement guidelines, with Medicare rates serving as the basis.

There are four levels of care under the Medicare Hospice Benefit. For each level, the hospice is paid a per diem for each resident day (or an hourly amount for continuous care). Actual amounts vary depending on the patient's geographic location within the state.

Routine Home Care

Routine Home Care enables hospices to visit patients in their home, whether a private residence, a nursing home, or an assisted living facility. At this care level, the hospice's interdisciplinary team provides intermittent service. In 2006, an estimated 97 percent of all patient care days were routine home care.[1] The per diem base payment rate for routine home care in 2008 is $135.11.[6]

Room and board can be paid by the resident with private pay, private insurance, or Medi-Cal (Medicaid). If the patient is dually eligible for both Medicare and Medi-Cal, the hospice bills the state for 95 percent of the normal Medi-Cal skilled nursing facility room and board rate. The hospice then pays the nursing home for room and board, the actual amount negotiated between the hospice and the nursing home. Following written guidance and oversight by the DHHS Office of Inspector General, the hospice is not to pay the nursing home at more than the normal room and board rate. Because hospice is in a highly competitive market, most hospices pay the entire room and board payment they receive directly to the nursing home.

A small number of nursing home residents on hospice have Medi-Cal coverage but not Medicare. In those cases, the hospice provider receives payment from Medi-Cal at rates set for each level of care, and also receives 95 percent of the nursing home's Medi-Cal room and board rate, out of which it pays the nursing home.

General Inpatient Care

General Inpatient Care (GIP) is provided to a hospice patient who meets hospice acute care criteria, whether in a hospital or nursing home. At this more intensive level of hospice involvement, the patient is visited frequently by hospice staff. GIP involves short-term pain control or acute symptom management when care cannot be provided in another setting. In 2006, an estimated 2 percent of all patient days were GIP.[1] The base payment rate for GIP in 2008 is $601.02.[6]

Inpatient Respite Care

Inpatient Respite Care is provided when the family needs short term relief to prevent caregiver burnout. It is offered at infrequent intervals of no more than five consecutive days. Because nursing home regulations require significant paperwork for such a short stay, many nursing homes are reluctant to admit hospice patients for respite care. The base payment rate for inpatient respite care in 2008 is $139.76.

Continuous Home Care

Continuous Home Care is provided during brief periods of patient crisis. It is comprised predominantly of nursing care for at least eight hours during a 24-hour period. Because of its intensity, many smaller hospices do not have the capacity to provide this level of care. For those hospices that are able to provide it, continuous care can be a significant competitive advantage. The base payment rate for continuous home care in 2008 is $788.55 (billed hourly).

About the Research Partner

The Corridor Group, Inc. (TCG) of San Francisco, CA and Overland Park, KS, provides consulting, executive search, and educational resources to the home care industry. TCG staff and associates involved in this report were Jeannee Parker Martin, R.N., M.P.H. (president and co-owner of The Corridor Group, Inc.); David English, D.B.A; and Cheryl Musial, R.N., B.S.N. More information on TCG is available at www.corridorgroup.com.

About the Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information on CHCF, visit us online at www.chcf.org.

Endnotes

1. National Hospice and Palliative Care Organization. December 2007. *NHPCO 2006 National Summary of Hospice Care, SUPPLEMENT: State Comparison Report.*
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