



Hospice and Long Term Care

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Covenant Hospice & Palliative Care



Objectives

1. Identify the unique relationship within the healthcare system that enables co-ordination of care between LTC facilities and hospice agencies.
 - ◆ 2. Define the responsibilities of the LTC facility and hospice agency in providing care for the resident who chooses the Medicare hospice benefit.
 - ◆ 3. Understand some of the limitations and potential conflicts specific to Nursing Homes and how that impacts the application of hospice care within the facilities.
 - ◆ 4. Explore various options to expand the hospice benefit to meet the growing needs of the eligible populations within the LTC continuum



Considerations

- ◆ Effective hospice work in LTC requires a more than cursory understanding of the bases for LTC operations and oversight.
- ◆ Due to similarities and analogous programs in funding, regulatory origins and oversight, and in patient populations, etc., confusion and misunderstanding abounds amongst workers in both hospice and LTC.

FACTORS for Consideration

- ◆ The current LTC regulatory path emerged from a study in the mid-1980s by the National Academy of Sciences Institute of Medicine (IOM) Committee on Nursing Home Regulation.
- ◆ In response to the IOM's recommendations, Congress enacted the nursing home reform provisions contained within the Omnibus Reconciliation Act of 1987 (OBRA 87).
- ◆ Under OBRA 87 (codified at 42 CFR [Code of Federal Regulations] part 483) the federal government requires each nursing facility that receives Medicare or Medicaid funds to meet minimum standards for care.
- ◆ In 1990, the OBRA '90 law refined the original law somewhat.
- ◆ States are authorized to conduct on-site surveys in nursing homes to ensure provider compliance with those standards.
- ◆ To promote national consistency, CMS has published surveyor guidelines to assist surveyors and facilities in interpreting F-TAGs (requirements) and to help surveyors conduct surveys.
- ◆ The State Operations Manual (SOM) contains the procedures for conducting the surveys (for both NF and Hospices).



SOM*

The SOM includes specific instructions about gathering and interpreting information collected before and during the survey, drafting and presenting the statement of deficiencies to facilities, drawing conclusions about the scope and severity of the facility's alleged non-compliance, determining penalties for noncompliance, and other issues such as various levels of appeal. All state survey agencies must use the procedures and tasks in the SOM to conduct the survey. Each state may have additional survey regulations and requirements, which may complement but not contradict the SOM.

*State Operations Manual



Further FACTORS for Consideration

- ◆ Some 130,000 pages of federal regulations govern nursing facilities in the United States, more than the accumulated regulations for the nuclear power industry.

- ◆ In order to wind our way through part of this talk, we will reference Dementia care as a guide.

A blue-tinted photograph of the Golden Gate Bridge at night, with the bridge's towers and suspension cables visible against a dark sky and water.

\$\$\$ Considerations

- ◆ LTC costs about \$45K – 75K/year
- ◆ Therapy - PT/OT
- ◆ Pharmacological Rx
- ◆ Assisted living costs avg. ~\$33K/year, w/o extras (eg. paid caregivers, services)

- ◆ 2/3 of Americans without Advanced Care Planning, including LTC plans

\$\$\$ Considerations

- ◆ Private care in home setting ~\$196 billion/yr (both paid/unpaid)
- ◆ Lost production cost ~\$33 billion
- ◆ Huge expense: recurrent hospitalizations for acute illness complicating dementia
 - ◆ >42% NH Pts. hospitalized 1 or more times in last month of life
 - ◆ Increasing numbers of pts being admitted into hospitals/LTC due to poor reimbursement for home care



Mortality Considerations

- ◆ Nearly 2 million older adults die from non-traumatic causes each year, many from chronic progressive illnesses, often unaware of palliative care services designed to support them in their course of illness.
- ◆ ~ 47% of older adults die in hospitals,
 - ◆ the remainder die in LTC (NF & ALF) and private homes.
 - ◆ Every year a half million Americans die in NHs
 - ◆ 8% Admit to SNF from hospitals die within 30 days
- ◆ ~31% adults with chronic disease, who die, die in their homes

Mortality Considerations

◆ Heart disease	28.0%
◆ Neoplasm	22.5%
◆ Cerebrovascular	6.5%
◆ COPD	5.0%
◆ Alzheimer's	2.8%

- ◆ 1/3 people admitted to a nursing home expected to die within one year
- ◆ Currently < 15% of nursing home residents receive hospice care.
- ◆ 36% of adults dying in their homes receive no nursing services.
- ◆ In the Program of All-inclusive Care for the Elderly (PACE), 32% of enrollees die within a one-year period, but these enrollees do not have the ability to simultaneously enroll in hospice (and remain in PACE)

The background of the slide is a photograph of the Golden Gate Bridge in San Francisco, taken at dusk or dawn. The bridge's towers and suspension cables are silhouetted against a dark, blue sky. The water of the bay is visible in the foreground, reflecting the ambient light. The overall mood is serene and somewhat somber, fitting the topic of dementia.

Dementia

- ◆ 5th leading cause of death for ages >65
- ◆ For all ages, 7th leading cause of death
- ◆ In US, 4 million suffer from Alzheimer's
- ◆ The number of people age 65 and over with Alzheimer's disease is estimated to be 7.7 million in 2030, a > 50% increase over the number of people currently affected.

Demography of Dementia

- ◆ 68%-female
- ◆ 85%-white
- ◆ National average of persons >age 60 will
- ◆ double by 2050
- ◆ Patients 85+ suffer dementia > 54%
- ◆ Increased incidence of dementia w/ HTN, dyslipidemia, DM and Afro-American
- ◆ If incidence remains unchanged, 14 million people by 2050

End of Life Care in LTC - Dementia

- ◆ 2/3 of dementia-related deaths are in NHs
- ◆ 71% of residents with advanced dementia die within 6 months, yet 6% referred to hospice.
- ◆ Non-palliative care common and often harmful
- ◆ 1/3 of all patients in LTC suffer w/ Dementia
- ◆ Of hospice census, only 9.8% with dx of dementia

!!!



QuickTime™ and a
H.264 decoder are
required to see this picture.

2006



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H.264 decoder are
required to see this picture.

2007



Alzheimer's Ass'n Campaign for Quality Residential Care

- ◆ Practice Recommendations

- ◆ Nutrition and Hydration, Pain Management, Social Engagement
- ◆ Wandering, Falls, Physical Restraints
- ◆ End of Life Care

- ◆ Consumer Empowerment and Education

- ◆ CareFinder (www.alz.org/carefinder)
- ◆ CareFinder Workbook
- ◆ State and Federal Advocacy
- ◆ Staff Training (Supervisors and Direct Care Staff)



Dementia Care in LTC- Objectives for Hospices

- ◆ Identify those patients with dementia who are appropriate for hospice services - ?!
- ◆ Explore EOL issues related to dementia care in LTC
- ◆ Match assessment, care plan, interventions and documentation closely
- ◆ Improve your care of people with dementia by fine-tuning communication skills, observation skills and relying on the experts: family and care-giving staff



NEWS FROM THE ASSOCIATION

Palliative Care Tops List of Initiatives Annual Symposium

SEPTEMBER 2007

AMDA - Here are the top priorities.

Medical Director F-Tag 501

Hospice and palliative care

Pay for performance/value-based purchasing

Assisted living

Professional liability (medical director and attending physician)

Medication errors

Pain management

Electronic medical records/health information

Reimbursement

Scope of practice (i.e., physician versus non-physician practice issues)

Advance planning/directives

Home health

Prescription drug benefit

State survey enforcement

Emergency preparedness/disaster management

State survey process

Subacute care

Strategic Planning, May '07



Further FACTORS for Consideration

The Hospice CoPs,

- ◆ The Proposed CoPs for Subparts C and D were issued for comment on May 27, 2005 and are expected to be accepted as a final rule in ?-Spring 2008.

The Nursing Facility CoPs.

- ◆ The Proposed CoPs for LTC, were published for input, 2004.

The CMS Nursing Home Quality Initiatives (Nov '02)

- ◆ Quality Measures
- ◆ MDS 2.0 then MDS 3.0
 - ◆ The medical regimen must be consistent with the staff's assessment of the resident performed according to a uniform instrument, the Minimum Data Set (MDS), etc.
- ◆ Nursing Home Compare

MDS 3.0

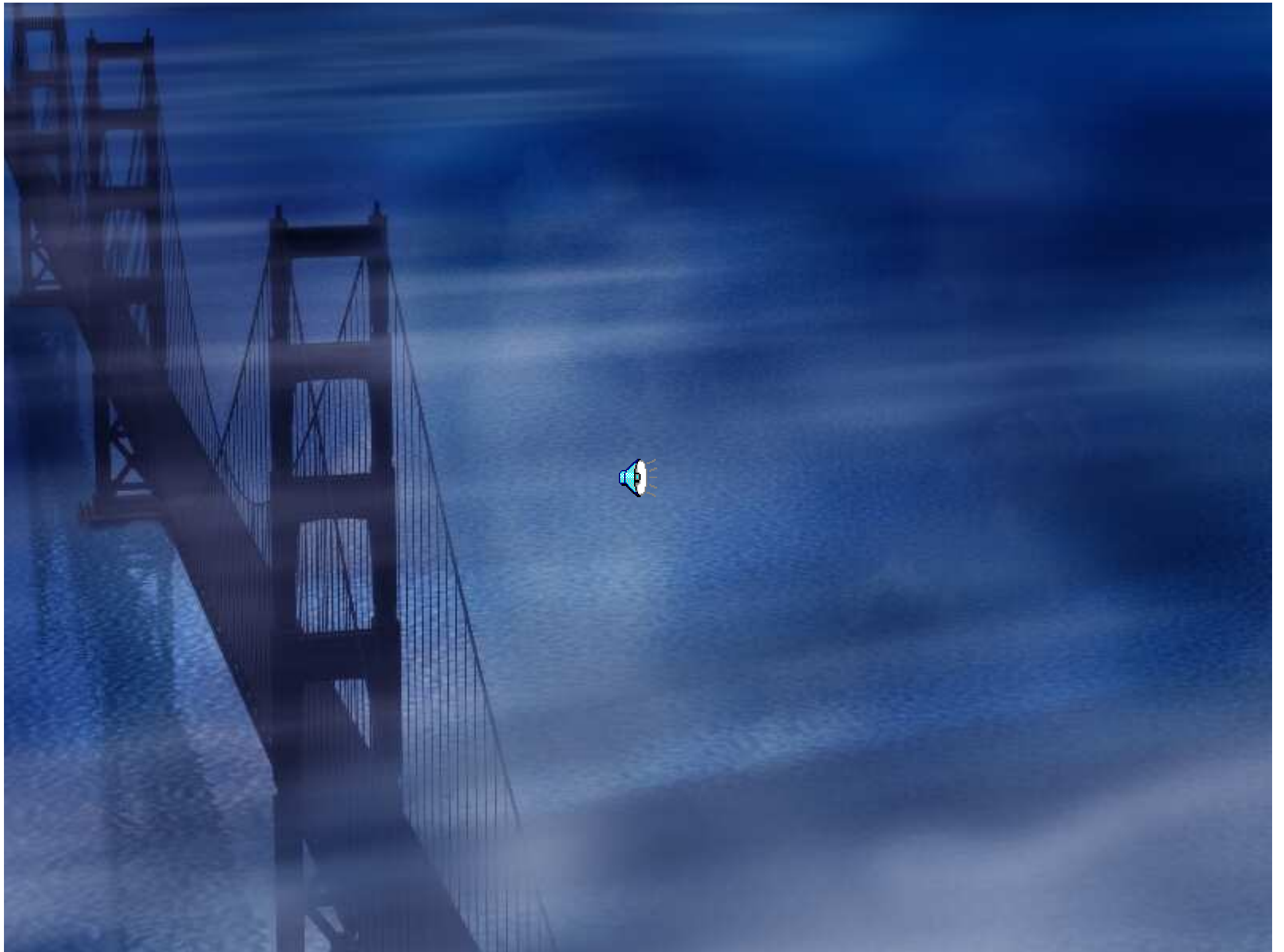
Focuses on clinical assessment of nursing home residents to screen for common, often unrecognized or unevaluated, conditions and syndromes..and to increase the accuracy of assessments.

The reasons for the MDS 3.0 revision are broad:

- ◆ To make the MDS more clinically relevant, while still achieving the federal payment mandates and quality initiatives;
- ◆ To improve ease of use and efficiency;
- ◆ To integrate selected standard scales; and
- ◆ To elicit resident voice by introducing interview questions.

MDS 3.0

- ◆ End-stage disease, <6 mo
 - Section J.= Health Conditions
- ◆ Hospice Care
 - Section P.= Special Treatments and Procedures
- ◆ Care Plan Problems:
 - ◆ Combined Mood State & Behavior
 - ◆ Nutrition/Tube Feeding/Dehydration
- ◆ Added Problems:
 - Dental Care & Oral Hygiene
 - ◆ Pressure Ulcer- Prevention -Quality of Life
 - ◆ Restorative Care Discharge Planning -Pain
 - ◆ Infection Control & Prevention



The background of the slide is a photograph of the Golden Gate Bridge at night, illuminated with blue lights. The bridge's towers and suspension cables are visible against a dark sky. The water below is also lit with blue light, creating a reflection of the bridge.

CoPs

- ◆ Hospice Conditions of Participation apply also to patients residing in a Nursing Facility.
- ◆ The Nursing Facility Conditions of Participation apply to residents who elect to receive Hospice care. Hospice patients in a facility are not exempt from those regulations or completion of the Minimum Data Set.
- ◆ Survey of either Nursing Facility/Hospice can trigger a survey of the other provider.



Proposed CoPs - Hospice

- ◆ Hospice must assume full professional management responsibility
- ◆ Hospice routinely provides all core services
- ◆ Medical director and physician designee provides overall coordination of the medical care of the hospice resident
- ◆ Providers must have a written agreement
- ◆ Plan of care developed by both providers
- ◆ Coordination of services
- ◆ Orientation and training of staff
- ◆ Others



Proposed CoPs - Hospice

- ◆ “In entering into the relationship, each provider retains responsibility for the quality and appropriateness of the care it provides. Both providers must comply with applicable conditions/requirements for participation in Medicare/Medicaid.”
- ◆ “Implementation of the plan of care changes resulting from physician orders received by the nursing facility must have prior hospice approval.”



Proposed CoPs - LTC

- ◆ Hospice CoPs cannot dictate to NF's for compliance
- ◆ Ultimate care by LTC personnel and policies
- ◆ CMS asked to consider a change in NF regulations to facilitate compliance.
- ◆ Delay implementation of this section until the Nursing Facility rule is in place
- ◆ Nursing Facility rule written, but on hold until the Hospice CoPs are finalized



Proposed CoPs

- ◆ Education - Required of Hospice for LTC Staff
 - ◆ For All LTC Staff
 - ◆ Must be continual Process
 - ◆ Application to both interdisciplinary groups/teams
 - ◆ Before patients admitted, education is expected to have been completed



Hospice Challenges With NF's

- ◆ Explicit consideration of Palliative Care/Hospice appears absent from LTC planning efforts
- ◆ Six-month Prognosis estimation
- ◆ Unrestricted growth of Hospices
- ◆ Infrequent Hospice Surveys
- ◆ "No one should die alone"
- ◆ High Turnover of personnel
- ◆ Whimsical NF Relationships
- ◆ Competitive Practices
 - ◆ "trolling"
 - ◆ "extra hands"
 - ◆ "Anytime" Crisis care
 - ◆ And ...
- ◆ Medication Management
- ◆ Dual Certification



Hospice Challenges With NF's

- ◆ Chronic Staff Shortages
- ◆ Inadequate LTC Reimbursement
- ◆ Exclusive Contracts
- ◆ NF "Demands"
- ◆ Competition - too little or too much
- ◆ Communication
- ◆ Obstructionism
- ◆ Ignorance
- ◆ Education
- ◆ Bias



Barriers to Hospice With NF's

- ◆ Many--same as Challenges
- ◆ Accurate analysis of clinical course towards death
- ◆ Unwillingness of NF to collaborate w Hospices
- ◆ Resistance from key LTC Personnel
- ◆ Ignorance of key personnel
- ◆ CONs (no longer our states)
- ◆ PACE
- ◆ Inadequate State & Federal Policies
 - ◆ Interstate variations - high
- ◆ Medicaid reimbursement practices
 - ◆ Case-mix adjustments
- ◆ Nursing Home Compare
- ◆ Restricted Access for SNF pts on skilled MC-A
- ◆ Inadequate Advanced Care Planning
- ◆ Medicare-A "Abuses"

Barriers to Hospice With NF's

“Skilled” NF Benefit \$

<u>Primary Group</u>	<u>Federal Urban Rate for 2006</u>
Rehabilitation	\$549.45
Extensive Services	\$261.89
Special Care	\$225.34 to \$325.67
Clinically Complex	\$179.99 to \$241.84

“COMPETITION”

Cherry Meier, RN, MSN, LNHA

A photograph of the Golden Gate Bridge in San Francisco, taken from a low angle looking across the water towards the towers. The sky is a deep blue, and the bridge's structure is silhouetted against it. The water in the foreground is dark and reflects the bridge's lights.

Hospice/Palliative Care in LTC: Special Circumstances

- ◆ Contracting for General Inpatient Care
 - ◆ 80/20 Rule
- ◆ Contracting for Respite Care
- ◆ Providing Palliative Care
 - ◆ Consultations
 - ◆ Service

A photograph of the Golden Gate Bridge at night, illuminated against a dark blue sky. The bridge's towers and suspension cables are visible, extending from the left side of the frame towards the center. The water below is dark and reflects some of the bridge's lights.

Hospice Contract for GIP

- ◆ Must be written; “stand-alone”
- ◆ Must fulfill terms of CoPs
- ◆ Must comply with federal anti-kickback statutes
 - ◆ a criminal offense to willfully or knowingly offer, pay, solicit or receive remuneration to reward or induce referrals of items or services payable by a Federal health care program. The statute contains a safe harbor for management contracts and personal services.



Hospice Contract for GIP- CoP Requirements

- ◆ 24 hr Nursing Svc sufficient to meet POC, (includes on-site & hands-on RN)
- ◆ Must be MC/MC Provider
- ◆ Capable of providing comfort, privacy, room for visiting, place for family to sleep, décor, unlimited access (including for children)

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Hospice Contract for GIP- CoP Requirements

- ◆ Written Agreement
- ◆ Clear description of svc's, responsibilities, authorization, roles, documentation, qualifications of personnel, +
- ◆ Hospice provides POC to NF and specific svc's
- ◆ GIP provider has P&P in accord with hospice, and agree to provide care per hospice protocols
- ◆ GIP Provider specifics also include:
 - ◆ Care Coordination, QA/PI, Survey/Complaint Assistance
- ◆ Medical Record provisions, including discharge summaries, shared by facility to hospice

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Palliative Care Specific

- ◆ As Part of Hospice Care
 - ◆ As Independent Consultation
 - ◆ Physician, w/wo Extenders
- ◆ As Specialty Care service
- ◆ As Educational Extension



*Palliative Care Specific -
AMDA Toolkit*

Palliative Care in the Long-Term Care Setting

This information **tool kit** provides helpful and practical guidance to long-term care professionals who are motivated to improve palliative and end-of-life care by providing organizational leadership, promoting education, developing best-practice guidelines, and implementing quality.



"Risky Business"

(<http://oig.hhs.gov/authorities/docs/hospicx.pdf>)

OIG

- ◆ Incentives to Referral Sources
- ◆ Overlap of Svc's in SNF; hospice not providing sufficient care
- ◆ \$ Billing > necessary level of care
 - ◆ Inadequate oversight of svc's
 - ◆ Non-adherence to CoPs

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"Risky Business"

(<http://oig.hhs.gov/fraud/docs/alertsandbulletins/hospice.pdf>)

OIG

Fraud & Abuse Concerns

- ◆ Goods offered free or below mkt value
- ◆ Payments to SNF for overages of "Room & Board" svc's that are really core svc's
- ◆ Payments to SNF in excess of established fed payments
- ◆ Payments to SNF for extra svc's above fair mkt value


"Risky Business"

(<http://oig.hhs.gov/fraud/docs/alertsandbulletins/hospice.pdf>)

OIG

Fraud & Abuse Concerns

- ◆ Inducements for Referrals
 - ◆ Referrals for Referrals
- ◆ Employees "provided" to SNF on hospice Payroll
 - ◆ Hospice caring for pt in SNF for free or <fair mkt value, expecting that pt will be on their hospice in future.



“I often say dying is not a clinical or medical event. It really is a social event, something that happens in community, and I think that is especially true when you think about people who die in long-term care settings. The facility becomes heaven’s waiting room and they’re all in it together.”

**--Myra Christopher, President and CEO
Center for Practical Bioethics**