Beyond Palliative Care: Collaborating With a Hospice Program

Dear Dr. Jeff:

We have recently been approached by a local hospice to sign an agreement allowing them to provide services to our residents. They say we are one of the few local facilities without hospice services. We believe that we already provide excellent services to residents at the end of life, as confirmed by our excellent pain scores and general family satisfaction. Most of our dying residents have advanced dementia and would not appear likely to benefit from hospice care. There appear to be issues about duplication of services. What do you think?

Dr. Jeff responds:

Hospice care is extensively available in nursing homes, but by no means universally so. Nationwide, the total number of individuals using hospice services has risen, reaching 1.6 to 1.7 million in 2014, according to estimates from the National Hospice and Palliative Care Organization. Approximately 14.5% of these patients received their care in a nursing home, with an additional 8.7% receiving care in other residential facilities, primarily assisted living. This represented a slight decline in the percentage for nursing homes and a slight increase for residential facilities, perhaps reflecting an increased acceptance by assisted living facilities of their patients dying in the facility, as opposed to pressuring for nursing home placement for patients who are declining and near death.

One study using Minimum Data Set (MDS) information found that the proportion of nursing home residents receiving hospice services at the time of death increased from 14.0% in 1999 to 33.1% in 2006 (Am Geriatr Soc 2010; 58:1481–88). If the growth in nursing homes has paralleled the national increase in hospice usage, that number will certainly be higher in 2017. Nursing home residents receiving hospice services were predominantly female, white, older than 85, and had a non-cancer primary diagnosis — in short, they were typical nursing home residents at the end of life.

Nursing home palliative care services and hospice services are complementary, not alternative programs. Palliative care — directed at the relief of symptoms, rather than curing disease or prolonging life — should be available to all residents. Hospice care is essentially an insurance program, offering covered benefits only to those who would be expected to die within 6 months if their disease takes its usual course. Both hospices and nursing home facilities develop care plans to address issues in the dying process. These care plans must be mutually determined and congruent, including who will be responsible for each aspect of the plan. However, the nursing home remains responsible for the care of the resident, and the nursing home physician remains the attending physician. The hospice cannot prescribe for the resident or write care orders.

The Centers for Medicare & Medicaid Services has issued comprehensive regulations concerning nursing home relationships with hospice programs (Medicare and Medicaid programs; requirements for long term care facilities; hospice services. 78[124] Fed Regist. [June 27, 2013] 38594–38606 [codified at 42 CFR §483]). Among the requirements is that facilities that don’t provide hospice services assist residents who desire such services in finding another facility that does.

There is one important distinction between hospice and palliative care. To qualify for hospice services, patients must agree to forgo curative or life-prolonging treatments for their terminal diagnosis. By contrast, palliative care may be provided in tandem with curative treatment, such as chemotherapy. Residents who have been on palliative care may transition to hospice care as their condition declines; patients in hospice care who stabilize may be determined to no longer meet the hospice criteria and could transition back onto non-hospice palliative care. These scenarios are relatively common.

When to Refer?

A factor in physicians’ reluctance to make hospice referrals for dementia patients is that predicting the life expectancy for these residents is extremely difficult. Even the Advanced Dementia Prognostic Tool (ADEPT), currently one of the best-validated scales available, is only moderately specific and lacks sensitivity in identifying residents who have fewer than 6 months to live.

Low body mass index with poor intake and weight loss are major elements of the ADEPT scale. Despite nutritional supplements, careful hand-feeding, and the best efforts of certified nursing assistants, many late-stage dementia residents experience decreased oral intake and gradual weight loss, and the poor prognosis of elderly patients with weight loss is well known. However, most hospice programs will provide 15 to 20 hours of aide services for program participants weekly. These aides, working one-to-one and with abundant time to devote to a single resident, are often able to increase oral intake sufficiently to maintain weight and stabilize functional decline. No nursing facility can afford to routinely devote this volume of individualized time to a single resident, but the hospice can. If weight loss ceases or weight is regained, the resident may be determined to have a better prognosis, and hospice services will be discontinued (a “live discharge”). Afterward, when the usual care is resumed, the weight loss may recur — leading to a new referral to the hospice.

A sane person would certainly question the wisdom of a health care system that requires these elaborate machinations to provide needed services for the frail and helpless, but there is no reason for the conscientious practitioner to deny patients the services to which they are entitled, and from which they would benefit.

Residents who do not have issues with oral intake and weight loss also may benefit significantly from hospice services. The hospice aide or volunteer can wheel a terminally ill resident outdoors to enjoy fresh air and sunshine, bring a pet to visit, share music or other activities, or simply provide companionship. Spiritual counselors (chaplains) can help patients and families address their religious and spiritual issues. Cognitively intact residents may be offered extended time for life review or reminiscence.

Often, the suffering around the death of an end-stage dementia patient is primarily experienced by the spouse or children left behind. Even excellent nursing home-based palliative care services cannot offer the comprehensive bereavement services for the family that are a required benefit for every hospice. Although the residents you describe may “not appear likely to benefit from hospice care,” their families might.

More Hospice Benefits

There are additional, significant benefits to collaborations between nursing homes and hospice programs. For those facilities with less advanced palliative care programs, the hospice can offer training in end-of-life care to the nursing home staff. Additionally, the hospice must pay for medications related to the care of terminal prognoses — often including comparatively expensive medications that a nursing facility might otherwise struggle to obtain from standard Medicare D drug plans. The hospice can offer expertise in the nursing management of certain terminal conditions, such as the odors produced by a gangrenous limb or palliative wound care, or the management of excess secretions with actively dying residents. Hospice medical directors are available as consultants to facility attending physicians, and they can offer expertise in the management of complex pain problems as well.

A hospice collaboration may provide clarity regarding the goals of care and the inevitability of functional decline and death. Facility staff and, unfortunately, many state surveyors have difficulty understanding palliative care goals, even when clearly defined in progress notes or in the Physician Orders for Life-Sustaining Treatment paradigm forms (POLST, MOLST, POST, COLST, or other state variants). Surveyors — and ultimately attorneys — may question the inevitability of negative outcomes such as skin breakdown or contractures in residents who are obviously dying. The decision to not subject a resident to hospitализation or even testing for the etiology of a symptom, or to use a medication condemned by the Beers criteria, may require defending when it is subjected to (literally) post-mortem review. For those who are sophisticated in palliative care or made anxious by the reality of impending death, hospice status will clarify the goal: maximizing resident comfort at the expense of other concerns.

Because the decision to enroll in hospice usually ends the cycle of recurrent hospitalizations, repeated tests, consultations, and polypharmacy that frequently increase both the discomfort and the expense of the dying process, insurers typically encourage the use of hospice. The triad of better care, increased patient and family satisfaction, and decreased cost appears to create an obvious win-win-win for the facility, the family, and the insurance payers. However, one of the cost savings offered by hospice plans may actually be at the expense of the skilled nursing facility and the resident.

Medicare, and consequently most other insurers, will not allow a resident to use the skilled care benefit and the hospice benefit at the same time. The extended care benefit is theoretically designed for the patient recovering after an acute illness who is being restored to health; the hospice benefit is for the patient who is experiencing inevitable decline from a terminal condition. The underlying simplistic logic is that a patient may be getting better or getting worse, but not both simultaneously. Because the hospice benefit does not cover the room and board costs of a nursing home, which are provided for post-acute services under the extended care benefit, use of hospice services may come at considerable expense to the family.

Because Medicare reimbursement is usually higher than other payment sources, the loss of Medicare Part A days represents a lost financial opportunity for the nursing home and a frequent source of nursing home resistance to

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hospice care. Common days for hospice enrollment are the 21st and 101st after admission, which is consistent with the reality that financial and clinical needs both play significant roles in hospice use.

There is money to be made in hospice care, and the greatest margin is in the care of nursing home residents. Consequently, hospice care, once almost exclusively the province of nonprofits, has increasingly been turned over to for-profit entities. Nationally, the number of hospices has multiplied, with the growth exclusively among the profit-making entities while the total number and enrollment in nonprofits has declined. Nursing home residents tend to have longer lengths of stay, fewer emergency needs, and less expensive medication requirements than typical hospice participants: for a “business” where costs are largely front-loaded (the enrollment and assessment process) and back-loaded (bereavement), this makes them particularly attractive. Weekly nursing visits can be clustered, as can aide hours. Hospices receive the same daily rate for nursing home residents that they would if they were in the community because this is considered “home hospice.”

With all this in mind, I am not surprised that the hospice is soliciting your business. All hospices are required to offer the same basic benefit package, but not all will be equally sensitive to the needs of your special population or skilled in meeting those needs. Depending on your facility location, you may be able to contract with more than one hospice, but be advised that some are much better at working with nursing homes than others. You should interview potential hospice partners and speak to references from the other nursing homes where they provide services. As the medical director, you are in a position to find the best possible hospice to help you care for your residents.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.

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**FDA Bans Powdered Gloves**

Kari Oakes

The Food and Drug Administration has banned powdered gloves for use in health care settings, citing “numerous risks to patients and health care workers.” The ban extends to gloves currently in commercial distribution and in the hands of the ultimate user, meaning powdered gloves will have to be pulled from examination rooms and operating theaters.

“A thorough review of all currently available information supports the FDA’s conclusion that powdered surgeon’s gloves, powdered patient examination gloves, and absorbable powder for lubricating a surgeon’s glove should be banned,” according to a FDA final rule, which was published in the Federal Register on Dec. 19, 2016.

Specific risks of powdered gloves cited by the FDA in support of the ban include health care worker and patient sensitization to latex, the risk of peritoneal adhesions if the powder comes in contact with exposed tissue during surgery, and other adverse events related to the inflammatory response that glove powder can provoke. Severe airway inflammation, asthma, conjunctivitis, and dyspnea have all been associated with powdered glove use.

Since viable nonpowdered alternatives exist, the FDA believes that the ban would not have significant economic impact and that shortages should not affect care delivery. Many nonpowdered gloves now “have the same level of protection, dexterity, and performance” as powdered gloves, according to the FDA.

The FDA received many comments asking for a ban of natural rubber latex (NRL) gloves. The FDA noted that NRL gloves already must carry a statement alerting users to the risks of allergic reaction, and also noted that eliminating powder from NRL gloves reduces the risk of latex sensitization.

In its analysis of the costs and benefits of the ban, the FDA estimated that the annual net cost savings would be between $26.8 million and $31.8 million.

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