In 1989, the rules for hospice care were clarified to allow the delivery of home hospice care to residents of long-term care facilities (LTCFs). In this issue, Flock and Terrien contribute an interesting perspective to the ongoing debate within hospice and long-term care on the value-added benefits of hospice care for those in LTCFs. In the present retrospective study of next of kin, they conclude that there is no difference in satisfaction between those whose loved ones in long-term care (LTC) received hospice and those who did not. This finding is at odds with 2 previous reports. This year, the 2006 Medicare Recovery Audit Contractors pilot program was extended to the entire Medicare program. One target of this program is to audit nonhospice providers including skilled nursing facilities (SNFs), home health, and hospice billing. This adds a certain urgency to our discussion of the added value of hospice in LTC. The purpose of this editorial is to outline those debates and lay a context for the direction of continuing research.

There have been many debates on the benefits of extending home hospice to residents of LTCFs. The National Hospice and Palliative Care Organization reports that in 2008, 22% of all hospice care was delivered in nursing homes (NHs). There has been a plethora of research in the past 10 years documenting the inadequacies of end-of-life care in NHs. Likewise, there has been research evaluating the effect of hospice care, when it is provided, on the quality of end-of-life care for those in LTCFs. In the present retrospective study of next of kin, they conclude that there is no difference in satisfaction between those whose loved ones in LTC received hospice and those who did not. This finding is at odds with 2 previous reports.

Advocates for earlier and increased hospice cite the reduced anxiety and improved emotional support as a significant benefit for families with loved ones in NHs. Hospice advocates consistently identify improved symptom and pain management for residents receiving hospice care compared with those who did not. Having hospice workers in a NH offers NH staff an opportunity to observe them. This is cited as an indirect benefit for other NH residents because hospice practices have been shown to “spill over” to nonhospice residents. The benefit appears to occur not only as a correlate of the individual NH, but also as a more diffuse effect of the penetration of hospice into a local medical community.

Nursing homes provide nursing care, socialization, and rehabilitation. Hospice organizations are required to provide 3 services not always available in NHs: regular pastoral care, social services by a credentialed social worker, and bereavement services for the families. The hospice also provides consultation from the hospice physician, a physician presumably with specialized training in palliative medicine. Hospice enrollment includes a financial incentive for patients and families because under Part A, the hospice assumes the cost of all medications and durable medical equipment required to palliate symptoms from the terminal disease. Finally, hospice employees are required to provide inservice training at least annually for NH staff in any facility in which they provide services. This requirement addresses the expectation that best practices for end-of-life care will diffuse throughout the culture of posthospital care.

CON: HOSPICE REFERRAL OF NURSING HOME RESIDENTS IS REDUNDANT AND OPENS THE DOOR FOR POTENTIALLY FRAUDULENT MEDICARE CLAIMS

Despite these benefits, Medicare regulators are aware of the potential for abuse in this setting. Some critics have alleged that hospices do not provide the same level of service to LTC residents as they do to those residing in their own homes;
specifically that hospices may deliver fewer nursing visits to NH residents than to their home care patients. However, it has not been shown that LTC residents, because they are in a 24-hour care environment, need as many skilled visits as a patient at home with untrained family caregivers. More at issue is the concern that hospices are enrolling residents for whom the benefits of hospice might be questionable. Specifically, the regulators are scrutinizing how hospice is used for care of patients with advanced dementia for whom neurological and nutritional symptoms predominate and for whom the trajectory of dying is unpredictable and often prolonged. Miller et al examined this question and determined that patients with dementia in hospice lived longer and incurred increased costs of health care compared with those who did not. This finding is interesting to compare with a recent study of patients with cancer, the archetypal hospice population. A randomized controlled trial allocated half of 151 newly diagnosed patients with stage IV non–small cell lung cancer to usual care with adjuvant palliative care or usual oncology care alone. The experimental group had modestly improved quality of life at 12 weeks, lower health care costs, and 70% relative increased survival.

Bringing "outside" care providers into the NH has been associated with poor communication and even conflicts between nurses working for the hospice and the long-term care staff. Specifically the long-term care nurses feel that they care for the resident every day and have known them in many cases for years before the hospice was consulted. Hospice workers then come into the final weeks or months of their patients’ lives. The floor nurses feel that their caring and expertise are not acknowledged or valued by the "outsiders," and they may impute a degree of arrogance to the visitors who “come in here and write notes and leave without talking to anyone.” The poor communication between the 2 caregiving teams results at least in part from each operating under different sets of regulations. Just as other categorized providers have been accused of cherry picking, hospice companies have been accused of seeking out the low-cost, low-intensity patients, such as patients with dementia in LTCF, and refusing patients with conditions requiring heavy care, such as bariatric patients, and patients with treatment preferences for expensive, high-technology palliative interventions. Discharging a patient from hospice who elects surgical repair of a pathological hip fracture and then readmitting the patient after hospital discharge is an example. By narrowly defining the terminal condition, for example, cancer, and carving out nonterminal conditions for "straight surgery" interventions. Discharging a patient from hospice who elects surgical repair of a pathological hip fracture and then readmitting the patient after hospital discharge is an example. By narrowly defining the terminal condition, for example, cancer, and carving out nonterminal conditions for “straight Medicare,” eg, dialysis, an odd sort of chimerical patient has emerged, one who is receiving end-of-life care for one comorbidity and life-prolonging therapy for another. Compared with hospice, pure palliation is relatively undervalued.

THE EVIDENCE FAVORS SELECTIVE REFERRAL TO HOSPICE, AND REGULATORY REFORM TO PROMOTE ORGANIZATIONAL CULTURE CHANGE IN LONG-TERM CARE

We believe there is a role for home hospice providers in LTC and that residents in these facilities should not be denied their right to access their hospice benefits whether through Medicare, Medicaid, or private insurance. Hospice organizations can prove their value by defining new roles and developing new skill sets that augment the care that a good LTCF can give. We have several suggestions based on our experience and the available literature. With the multidisciplinary team, a hospice is skilled in "just-in-time" interventions. Specifically, hospice teams are experts at transitions. There is a role for hospice organizations to serve as the navigators for transitions of care from hospital to NH, from NH to home, and home to NH for respite. Hospice nurses can assist and advise NH staff in stabilizing very symptomatic patients sent from hospitals. They should be urged to consult nurse-to-nurse and provide expert consultation for pain and nonpain symptom management. Hospice chaplains and social workers should engage the LTC nurses and certified nursing assistants to help them work with families through issues of grief and attachment. The requirement for hospices to provide 12 months of grief counseling to families ought to include the caregivers at the NH when they lose a long-stay resident. Part of the hospice task is to inclusively support the caregivers, this means family and the paid staff. For this relationship to be successful, there must be a clearly defined chain of command, communication nodes and procedures that are standardized in the industry, and communication between regulators to reconcile conflicting regulations. Nursing homes have to be selective about contracts with hospices. They should do their own quality improvement/quality assurance performance evaluation of hospices they allow on the premises, and set up their own procedures and expectations as they negotiate hospice contracts. Finally, researchers need to continue to focus on these issues, building an evidence base for best practice for hospice care in this setting and for NH care at the end of life.

Broadly presented, researchers have used administrative databases, such as the minimum data set, to identify opportunities to provide better end-of-life care focusing on the easily coded indicators, such as pain. Cancer pain treatment in NHs was shown to vary by the age of the patient. Considerable state-to-state variation in these indicators raises questions for interpreting these data because it is not clear whether the state survey environment rewards documenting pain or punishes facilities that do. So the link between the indicator and the outcome is weak. Medicare beneficiary files are a way to obtain broadly representative samples and to establish their points of contact with medical care. These studies have shown us the view from 42,000 feet. There are more hospices providing more services to more LTC residents. No one is quite sure from these data what the actual benefit has been.

A second way to examine the role of hospice in NHs is to compare outcomes for end-of-life care across different sites of care and look for differences in agreed upon quality measures. Pain control has been shown to be improved by hospice enrollment no matter the site. Other outcome measures have included anxiety and depression, place of death, survival, family caregiver stress, long-term family caregiver “satisfaction,” hospital admissions, and costs of care. Additional measures of quality of transitions with and without...
hospice are a subject for further investigation.33 This study by Flock and Terrien2 is a very good example of how research on end-of-life in LTC has been done to date. Obtaining data from a neighborhood containing many NHs and many hospices is the strategy chosen by the present study. The negative finding is consistent with that of Teno et al.3 Flock and Terrien’s2 neighborhood is served by a circumscribed group of physicians, some with hospice affiliations. There was no difference in reported levels of satisfaction among relatives of decedents because perhaps there was no difference in the care their family members received, the penetration of hospice philosophy, and technique was so complete. However, there was a difference in the kinds of patients referred to hospice in this study. Patients referred to hospice were more acute; they had a shorter course of illness and a shorter course in LTC than nonhospice decedents. We think that this describes a mature hospice ecosystem. Those patients for whom hospice might have been only marginally beneficial were not referred because the provider network contained sufficient hospice skill to care for them well. The more acute, more symptomatic patients whose families may have been less prepared for the end of life and less comfortable in LTCFs received the hospice increment.

NEW DIRECTIONS FOR RESEARCH

We believe that this identifies a new and important direction for studies of palliative care and hospice in general and for LTC specifically. The statistical science for small area studies has advanced considerably in recent years, mainly to examine root causes of health disparities. For example, racial variations in hospice use were associated with characteristics of the health care neighborhood in one study that applied the small area technique.19 There is a great opportunity here to expand studies of how LTC providers adopt new skills, practices, and perspectives and how these may be linked to better and less variable care at the end of life.

REFERENCES