Serious Illness Care:
The State of Hospice Services

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Objectives

- Understand the hospice care model including Diversity, Equity, and Inclusion (DEI) considerations
- Recognize hospice as an at-risk, value-based care model
- Appreciate hospice as a key partner in nursing home end-of-life care
- Identify patients that can benefit from hospice services

Chronic Illness Progressive Illness

Goals of Care Serious Illness Hospice Discussion

Surprise Question Advance Care Planning Transitions in Care

Acute on Chronic Illness Pain Complex Management

Coordination of Care Symptom Management

Case Discussion

PF Skilled and HF

- 88 y/o with 1 recent ED visit and 1 hospitalization for HF
  - Transitioned Skilled
- PMH: rheumatoid arthritis, macular degeneration, spinal stenosis, anxiety/depression, mild dementia
- SOB minimal exertion
- Weight loss 44 pounds, 188 to 144
- Dependent IADL, ADL independent
- Served in Army
- Alert and oriented person and place, forgetful, periods of severe restlessness
- Goal: get stronger to go home

MF LTC and Dementia

- 68 y/o residing LTC progressive mixed dementia
- PMH: hypothyroid, arthritis, s/p CVA, s/p fall with hip fracture several months ago, new onset seizures, severe anxiety
- Recent eating difficulty with dysphagia (solids) and episodes of coughing
- UTI a couple of weeks ago
- Weight loss 5 pounds, 135 to 130 pounds, poor appetite; no skin breakdown
- Newly bedbound/needs 1-2 assist WC
- Dependent 4-5/6 ADLs; minimally verbal
- Goal: comfort care, not go back to the hospital

Domains to Consider

Clinical Judgment	Would you be surprised if this patient passed within 6 months?
Nutrition	> 10% of normal body weight in 6 months > 5% of normal body weight in 1 month Declining Body Mass Index (BMI) < 22 kg/m2 Dysphagia
Physical Function	PPS, ADLs (3/6), falls, bedbound
Cognition	Awareness of self and environment, communication, consciousness
Healthcare Utilization	ED, hospital, clinic
Symptoms	Delirium, fatigue, shortness of breath, pain, and agitation
Disease-specific Decline	Cardiac, pulmonary, dementia, cancer, ESRD, sepsis

Functional Status Predicts Hospice Eligibility

The lower the PPS, the higher the mortality

Hospice eligible for advanced non-curable metastatic cancer

Hospice eligible for advanced illness
(e.g., lung, heart , dementia, sepsis/post-sepsis, etc.)

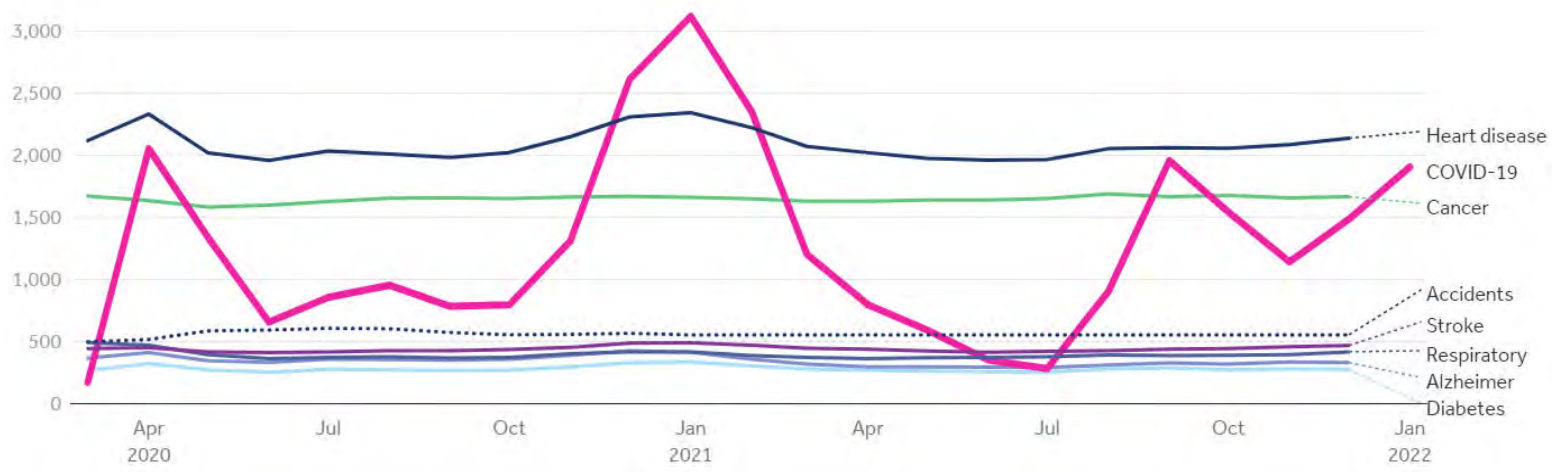
%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Consciousness
100	Full	Normal Activity	Full	Normal	Full
No Evidence of Disease					
90	Full	Normal Activity	Full	Normal	Full
Some Evidence of Disease					
80	Full	Normal Activity With Effort	Full	Normal or Reduced	Full
Some Evidence of Disease					
70	Reduced	Unable to Do Normal Job/Work	Full	Normal or Reduced	Full
Some Evidence of Disease					
60	Reduced	Unable to Do Hobby/Housework	Occasional Assistance Necessary	Normal or Reduced	Full or Confusion
Significant Disease					
50	Mainly Sit/Lie	Unable to Do Any Work	Considerable Assistance Required	Normal or Reduced	Full or Confusion
Extensive Disease					
40	Mainly in Bed	As Above	Mainly Assistance	Normal or Reduced	Full or Confusion
30	Totally Bed Bound	As Above	Total Care	Reduced	Full or Drowsy or Confusion
20	As Above	As Above	Total Care	Minimal Sips	Full or Drowsy or Confusion
10	As Above	As Above	Total Care	Mouth Care Only	Drowsy or Coma
0	–	–	–	–	–

Background

- Hospice remains underutilized by about 1 million US deaths per year, with 84% being related to non-cancer conditions
  - 46% general population die with hospice
  - 40% NH die with hospice
- Over 25% of US deaths occur in US nursing homes
  - 20% cancer, 25% COPD, 50% dementia
- Patients on average have 3 transitions in last 90 days of life
- 30% of decedents use the skilled benefit in the last 6 months of life with about 1.5% being referred to hospice at time of discharge

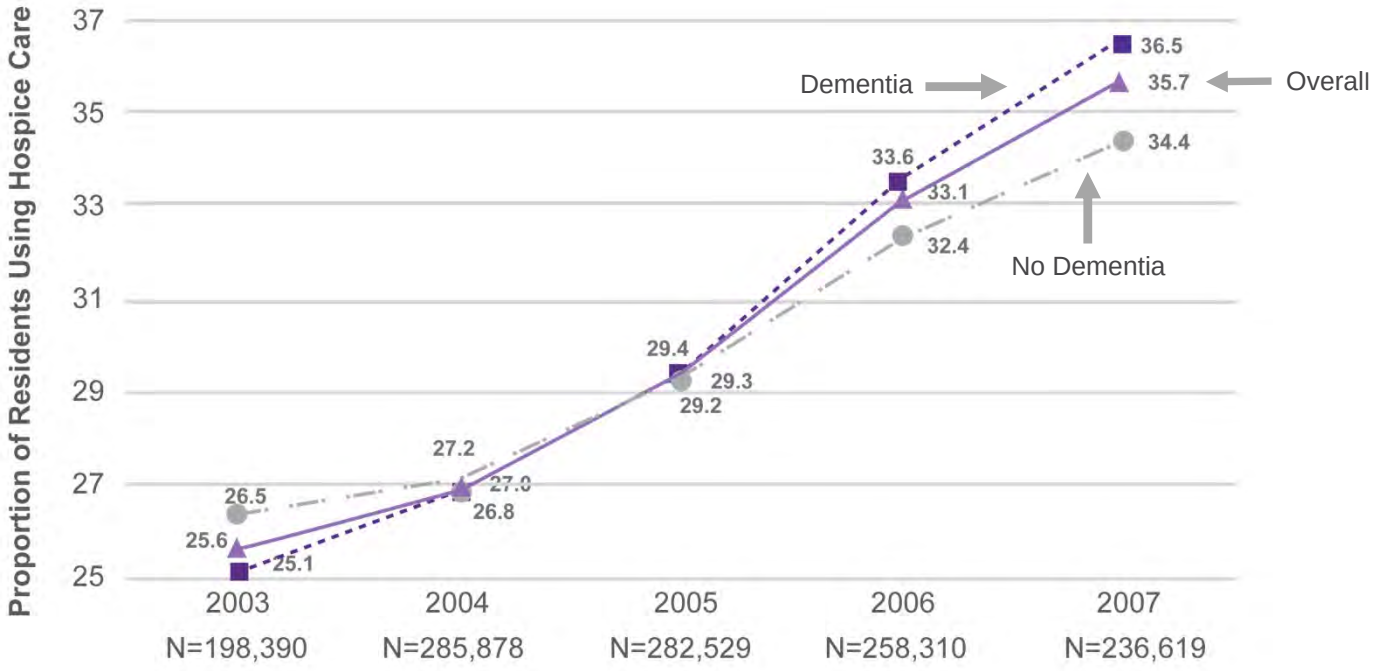
Teno, et al. “Change in end-of-life care for Medicare beneficiaries: site of death, place of care, and health care transitions in 2000, 2005, and 2009.” *JAMA* 309.5 (2013): 470-477.
Wang, et al. “End-of-life care transition patterns of Medicare beneficiaries.” *Journal of the American Geriatrics Society* 65.7 (2017): 1406-1413.
Cagle, et al. “Hospice utilization in the United States: A prospective cohort study comparing cancer and noncancer deaths.” *Journal of the American Geriatrics Society* 68.4 (2020): 783-793.

US Deaths by Cause



https://www.healthsystemtracker.org/brief/covid-19-leading-cause-of-death-ranking/

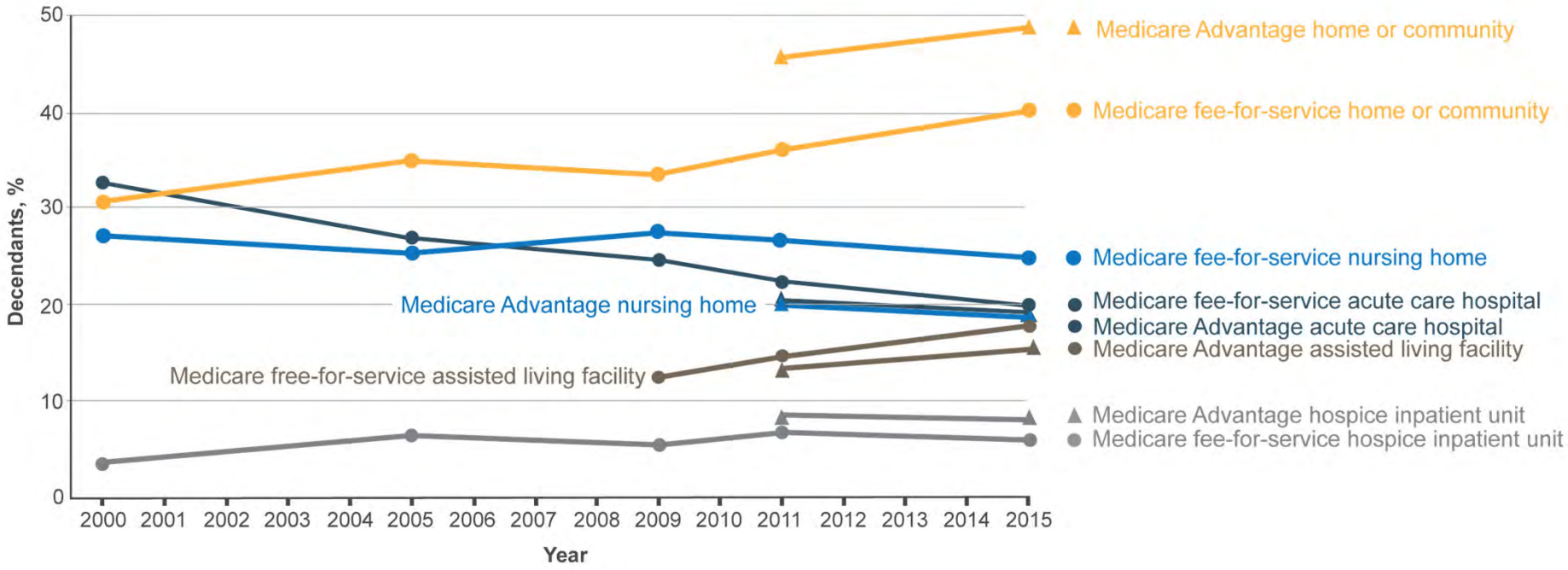
Nursing Home Deaths by Dementia Status in LTC



- 35.7% used hospice care in the last 100 days of life
- 16.3% died in a hospital
  - 19.7% versus 14.2% non-dementia compared to dementia

Li, et al.. “End of life quality of care among long-term nursing home decedent residents with and without dementia.” *Journal of the American Geriatrics Society* 61.7 (2013): 1066.

Location of Death in the US 2000 to 2015



Teno, et al. "Site of death, place of care, and health care transitions among US Medicare beneficiaries, 2000-2015." *JAMA* 320.3 (2018): 264-271.

What Constitutes a Good Death

Patient	Proportion
Preferences for dying process	94%
Pain-free status	81%
Emotional well-being	64%
Dignity	67%
Life completion	61%
Treatment preferences	56%
Religiosity/spiritualty	61%
Presence of family	61%
Quality of life	22%
Relationship with HCP	39%
Other: costs, pets, touch	28%

Family Members in a NH
Basic resident care
Recognize and treat symptoms
Continuity of care
Respecting end of life wishes
Offering environmental, emotional, psychosocial, and spiritual support
Keep family informed
Promote family understanding
Establish partnership with family and guide through shared decision-making

Meier, et al. “Defining a good death (successful dying): literature review and a call for research and public dialogue.” *The American Journal of Geriatric Psychiatry* 24.4 (2016): 261-271.
Gonella, et al. “Good end-of-life care in nursing home according to the family carers’ perspective: A systematic review of qualitative findings.” *Palliative Medicine* 33.6 (2019): 589-606.

Hospice Overview

- Federal law in 1982 defines the benefit per the Conditions of Participation
- Fully at-risk for population to cover all end-of-life related costs through fixed daily rate based upon level of care
  - No adjustment for acuity and complexity
- Elements of value-based care
  - Not volume driven as don't get paid for doing more
  - Team-based home care focus including volunteers
  - Medical model plus; 24/7/365 availability
  - Bundle of services
  - Community focus and helps link those services
- Underutilized
  - Proportional use and short LOS

Hospice Eligibility and Service Requirements

- Prognosis of 6 months or less
  - Physician's certification the patient is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course
- Election process with focus on quality of life
  - Patient/family agree to a care plan with goals palliative in nature, primarily focused on management of physical, psychosocial, emotional, and spiritual symptoms

Interdisciplinary Team of Hospice Professionals

Home Medical Equipment

Medication

Bereavement Support

Routine Home Care
98.2%

Inpatient Care
1.3%

Continuous Care
0.2%

Respite Care
0.3%

Hospice Enrollment

The Value of a Partnership with VITAS

All hospices must provide core services, but substantial variation exists in how these services are delivered.

Hospice Core Services

Core Team | All Levels of Care | 24/7 Availability
Medications | Equipment

Elevated Care

- Telecare
- Telehealth
- Intensive Comfort Care®
- Visits after hours and weekends
- Physician centric care model

Distinctive Programs

- Advanced lung
- Heart failure
- Sepsis/Post-Sepsis
- Oncology
- Dementia behavioral protocols
- ED diversion
- Academic partnerships and publications
- Robust educational platform offering CEUs, CMEs, multilingual patient and family education
- Clinical pastoral education
- Local ethics committee

Complex Modalities

- IV hydration/TPN Lyte
- IV/PO antibiotics
- Inotrope therapy
- Sub-Q diuretics
- Therapy Services: PT, OT, Speech
- Paracentesis
- Thoracentesis
- Blood transfusions
- Oncology taskforce for anti-tumor treatments (hormonal, XRT)
- PleurX drains
- Nutritional counseling
- ICDs/LVADs

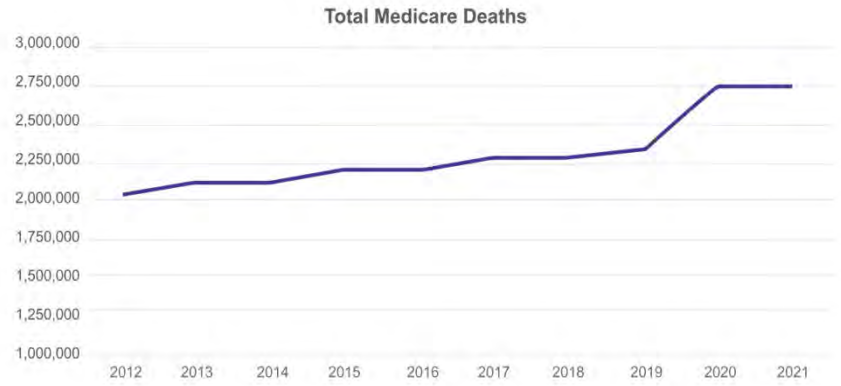
VITAS-Owned HME

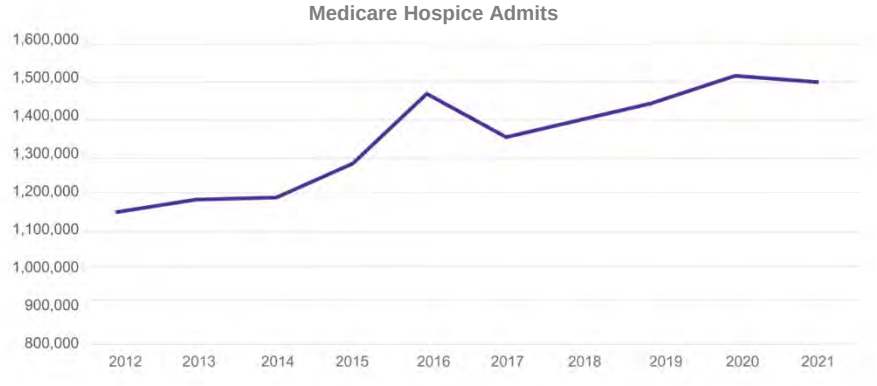
- Oxygen, including high-flow
- Non-invasive ventilation, BiPAP, CPAP, home ventilator, and Trilogy
- Hospital bed
- Specialized mattresses
- ADL assist devices
- Incontinence supplies
- Wound care supplies
- Hospice-specific access (24/7/365) and speed to home medical equipment (HME)

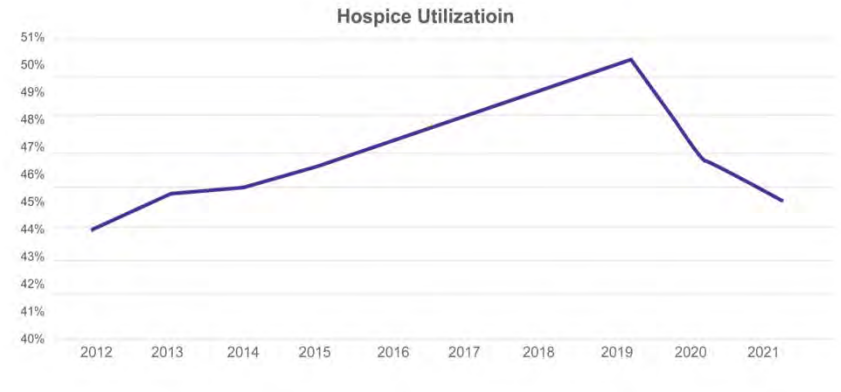
Specialty Therapies

- Respiratory therapy
- Music
- Massage
- Pet
- PT/OT/Speech
- Wound care
- Dietary
- Child-life specialist
- Bereavement/ support groups
- Veterans specialist

Medicare Deaths, Hospice Admits, and Utilization



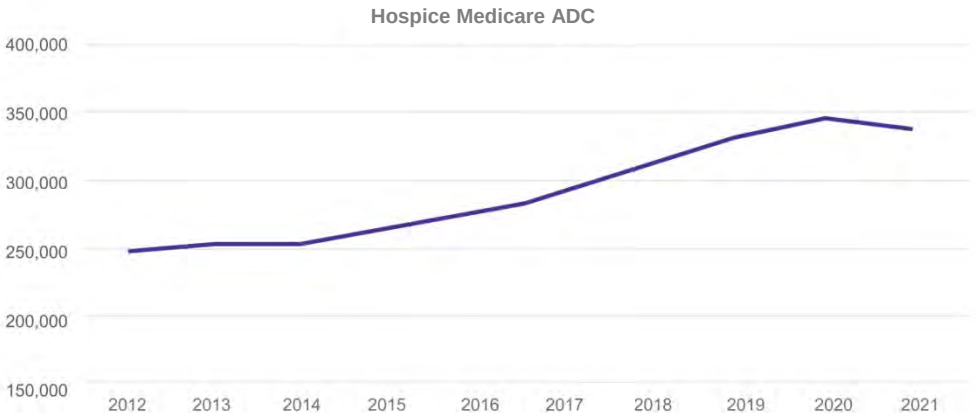




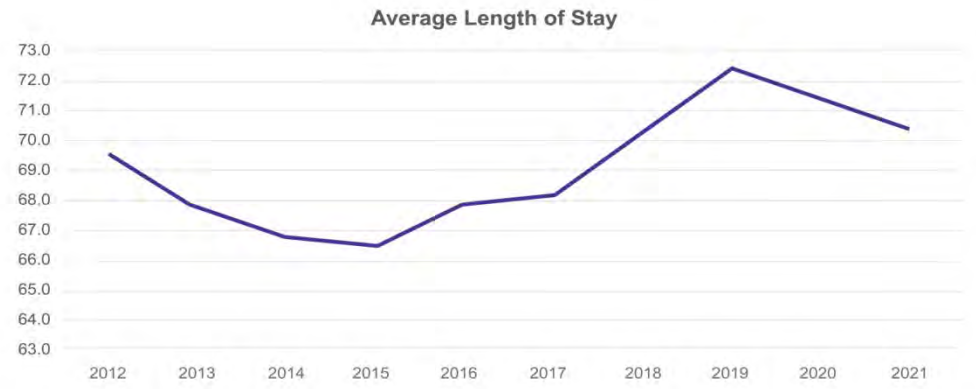
- Deaths in 2021 decreased by 5,000 (<1% YoY)
- Medicare hospice admits decreased 1.1% YoY
- Hospice use increased annually between 2012 and 2019, but declined in both 2020 and 2021
- 2021 utilization below 2013's rate of 45.2%, despite the 2nd most beneficiaries ever dying on hospice
- Hospice use decreased from 46.4% in 2020 to 44.9% in 2021

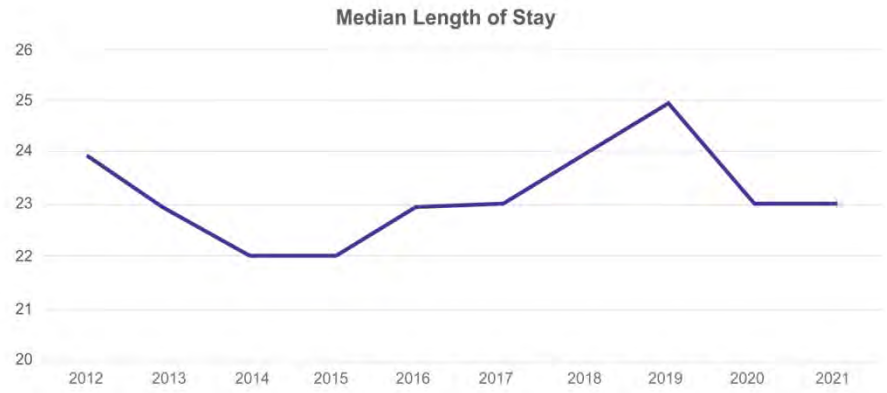
Data Source: Hospice Analytics

Hospice Medicare ADC, Median, and Mean LOS



- Medicare Hospice ADC decreased 2.5% from 2020 to 2021
- MLOS remained the same from 2020 to 2021, and ALOS decreased slightly





Data Source: Hospice Analytics

Nursing Home, End of Life, and DEI

Advance Care Planning

- AD completion lower for persons of color compared with White residents, with racial differences increased for Black and cognitive impairment severity
  - Dementia, black residents had the lowest odds of having an AD aOR 0.26 (0.25-0.27) compared with White residents
- AD are completed on average 21 days from admission for Whites compared with 229 days for persons of color
- White residents were consistently more likely to have both a DNR aOR 3.79 (2.80, 5.14) and DNH aOR 2.51 (1.55, 4.06) compared persons of color

Hospitalization

- Persons of color are significantly more likely to be hospitalized in the last 90 days before death, $p<0.001$
- Black residents experienced more EOL hospitalizations compared with White residents
  - Persons of color had an aRR 1.24 (1.22, 1.26) of a hospitalization in the last 90 days of life
- NH residents in facilities with higher proportions of Black residents had a higher risk of in-hospital death compared with NHs with lower proportions of Black residents

Estrada, et al. "Racial/ethnic disparities in nursing home end-of-life care: A systematic review." *Journal of the American Medical Directors Associatio*n 22.2 (2021): 279-290.

Nursing Home, End of Life, and DEI

Hospice

- Studies show mixed results, but trends emerge
- Over time, hospice use has increased in NH residents for persons of color and White residents
- Persons of color use hospice less than White residents and for a shorter LOS
  - Persons of color in the same facility had less hospice use OR 0.85 (0.78, 0.94) compared to White residents
  - Persons of color were found to be less likely to have long hospice stays of >180 days; OR 0.54 compared to White residents
- Factors associated with greater hospice use in persons of color include hospice contract, high tier NH, DNR status, and DNH order

Pain Management

- Black residents in NHs with a diagnosis of dementia and cancer had significantly higher Discomfort Behavior Scale scores compared with White residents (16 vs 39, respectively; P<0.0009), which is indicative of a higher prevalence of pain

Estrada, et al. "Racial/ethnic disparities in nursing home end-of-life care: A systematic review." *Journal of the American Medical Directors Association* 22.2 (2021): 279-290.

Case Discussion

PF Skilled and HF

- 88 y/o with 1 recent ED visit and 1 hospitalization for HF
  - Transitioned Skilled
- After 14 days he plateaus with no improvement in functional status, can walk 15-20 feet with walker
- One fall, unwitnessed, no injury
- SOB minimal exertion
- Weight loss continues 144 pounds to 136
- Stage II sacrum, worsening
- Dependent IADL, ADL help bathing and dressing
- Increased forgetfulness, paranoia, worsening restlessness, episodes severe shortness of breath
- Goal: get stronger and go home

MF LTC and Dementia

- 68 y/o residing LTC progressive mixed dementia
- Continued eating difficulty with dysphagia solids and episodes coughing
- New onset myoclonus
- Weigh loss continues 125 pounds, poor appetite; no skin breakdown
- Bedbound; no longer getting into wheelchair; sleeping more, about 14 hours a day
- Dependent 5/6 ADLs; minimally verbal
- Goal: comfort care, not going back to the hospital

Day 14 Considerations

Factors indicating poor restorative outcomes and further conversations about care goals with patient and family:

- Progressive dementia
- Significant functional debility, low likelihood of return to independence
- Custodial needs > skilled needs
- Tolerate < 20 minutes of therapy/day
- Motivation and ability to participate
- Multiple comorbidities
- Ongoing decline anticipated and unavoidable
- Requires 24-hour care

Casper Report: 13 Quality Measures

Resident Name	AO31OA/B/F	High Risk/Unstagable Pre Ulcer (L)	Physical Restraints (L)	Falls (L)	Falls with Mechanical Injury (L)	**Antipsychotic Meds (S)**	Antipsychotic Meds (L)	**Antianxiety/hypnotic, prev (L)**	**Antianxiety/hypnotic, % (L)**	Behavioral Symp Affect Others (L)	**Depressive Sx (L)**	UTI (L)	Cath Insert/Left Bladder (L)	Lo-Risk lose B/B Con (L)	**Excess Weight Loss (L)**	**Incr ADL Help (L)**	**Move Independent Worsens (L)**	**Improve in function (S)**	Quality Measure Count
PF						**X**												**X**	**2**
MF								**X**	**X**		**X**				**X**	**X**	**X**		**6**

CMS Nursing Home Quality Measures: Hospice Risk Adjustment

Long-Stay Resident Measures	Hospice Impact	Hospice Risk Adjustment
Number of hospitalizations per 1,000 long-stay resident days	X	X
Number of outpatient emergency department visits per 1,000 long-stay resident days	X	X
Percentage of long-stay residents who got an antipsychotic medication	X	
Percentage of long-stay residents experiencing one or more falls with major injury	X	
Percentage of long-stay high-risk residents with pressure ulcers	X	
Percentage of long-stay residents with a urinary tract infection	X	
Percentage of long-stay residents whose ability to move independently worsened	X	X
Percentage of long-stay residents whose need for help with daily activities has increased	X	X
Percentage of long-stay residents who report moderate to severe pain	X	
Percentage of long-stay low-risk residents who lose control of their bowels or bladder	X	
Percentage of long-stay residents who lose too much weight	X	X
Percentage of long-stay residents who have symptoms of depression	X	
Percentage of long-stay residents who got an anti-anxiety or hypnotic medication	X	X

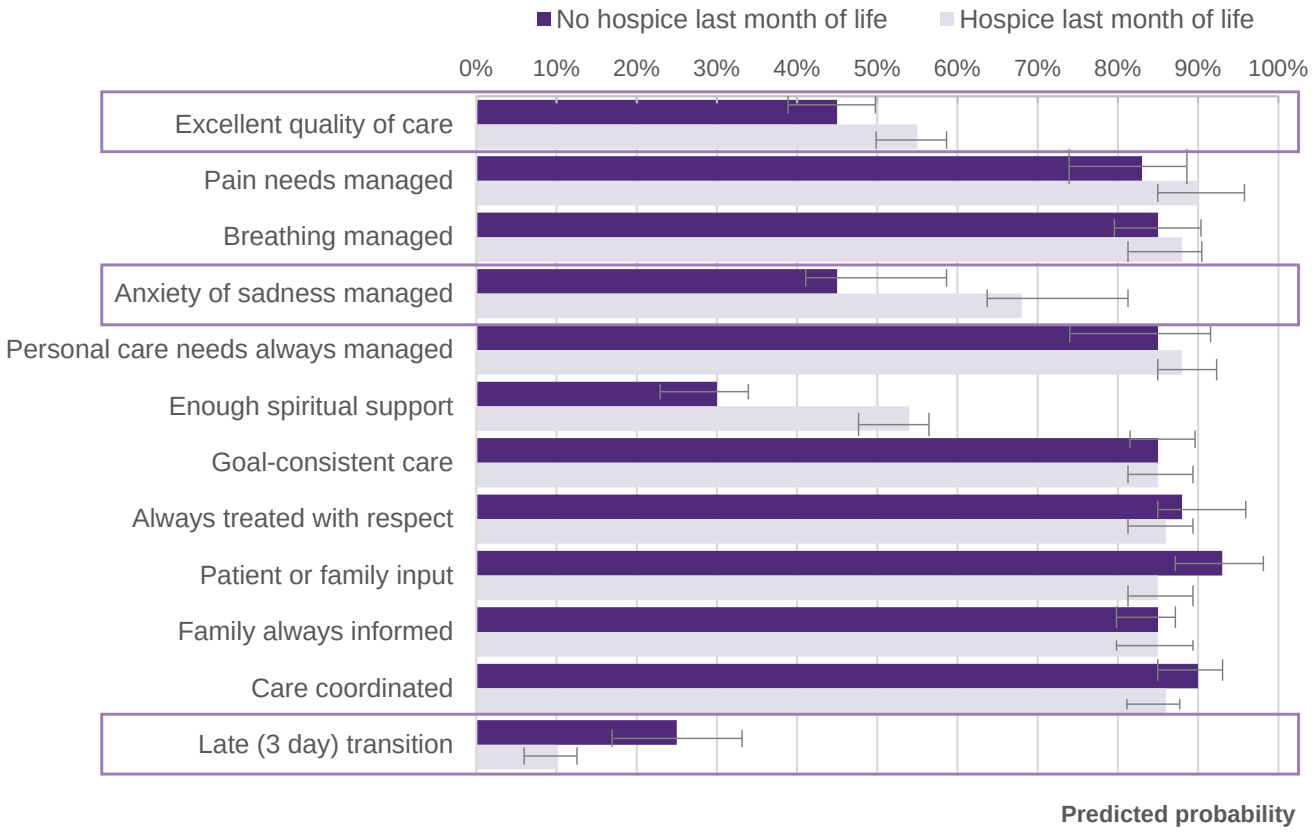
Last Place of Care Experience

Outcome	Hospice	Nursing Home	Home Health	Hospital
Not Enough Help with Pain, %	18.3	31.8	42.6	19.3
Not Enough Help Emotional Support, %	34.6	56.2	70	51.7
Not Always Treated with Respect, %	3.8	31.8	15.5	20.4
Enough Information about Dying, %	29.2	44.3	31.5	50
Quality Care Excellent, %	70.7	41.6	46.5	46.8

Teno, et al. "Family perspectives on end-of-life care at the last place of care." *JAMA* 291.1 (2004): 88-93.

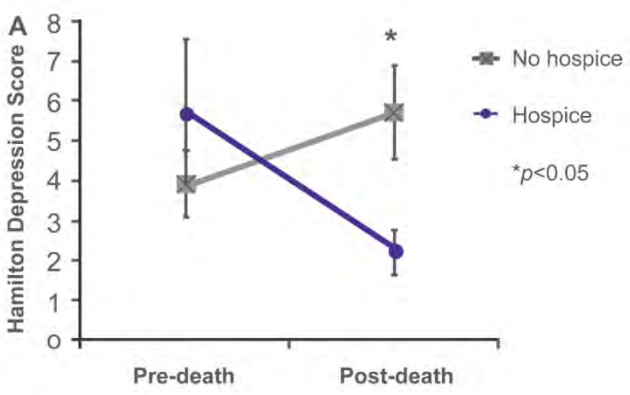
Hospice Impact Dementia Care: Patient

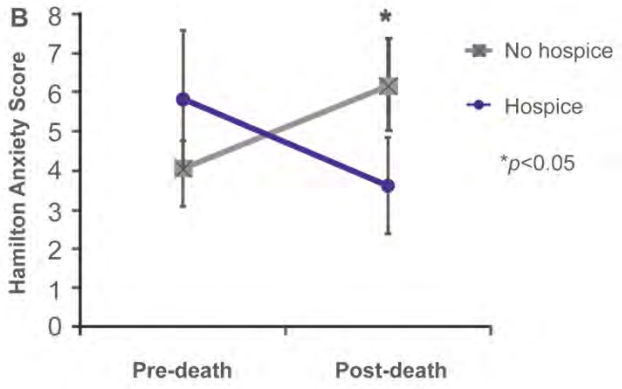
- More likely to die at home (76% vs. 38%)
- Less likely to die in the hospital (7% vs. 45%)
- Improved pain and symptom management
- Fewer end-of-life transitions

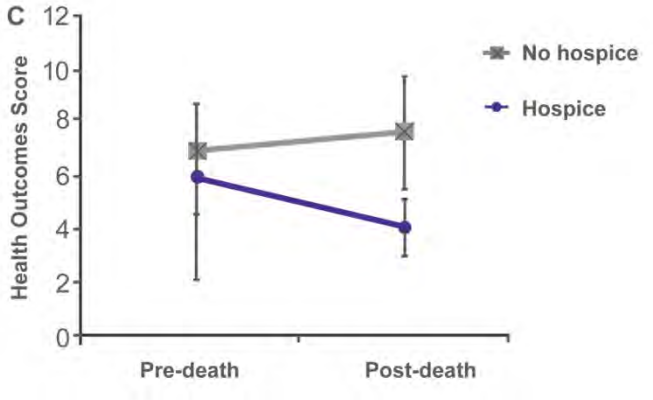


Shega, et al. "Patients dying with dementia: experience at the end of life and impact of hospice care." *Journal of pain and symptom management* 35.5 (2008): 499-507.
Harrison, et al. "Hospice Improves Care Quality For Older Adults With Dementia In Their Last Month Of Life: Study examines hospice care quality for older adults with dementia in their last month of life." *Health Affairs* 41.6 (2022): 821-830.

Hospice Impact Dementia Care: Family







- Increased satisfaction with care
- Decreased burden
- Decreased anxiety and depression
- Improved overall health

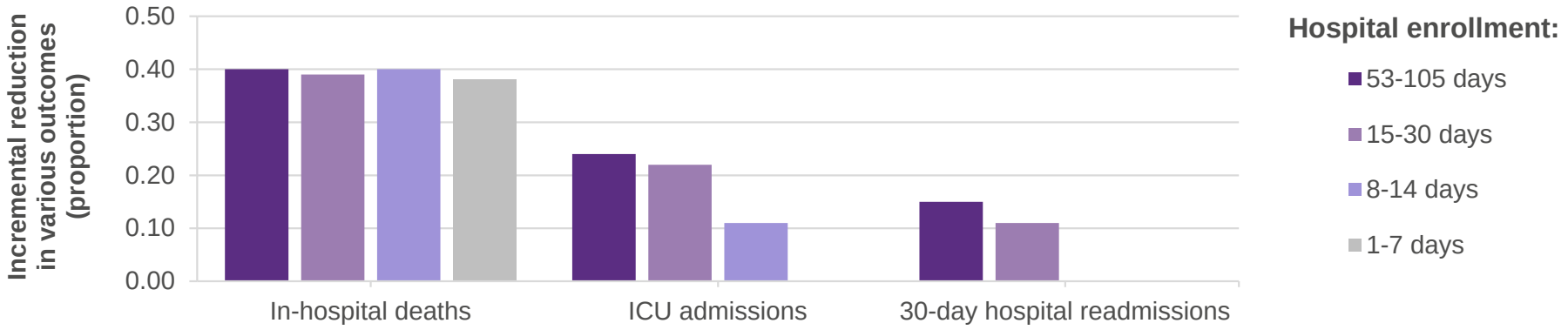
Irwin, et al. "Association between hospice care and psychological outcomes in Alzheimer's spousal caregivers." *Journal of Palliative Medicine* 16.11 (2013): 1450-1454.

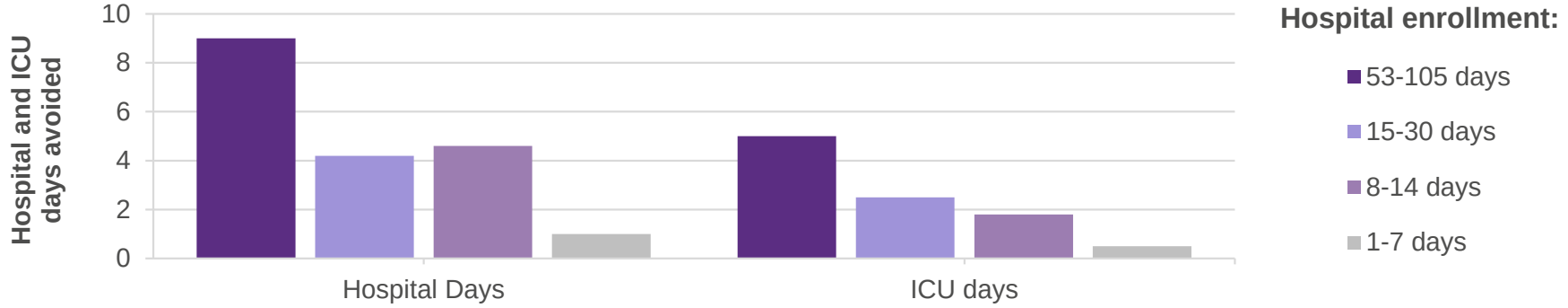
Hospice Decreases End of Life Care Expenses

Characterstics	Adjusted mean, $		Difference	*P* value
	Hospice Group	Propensity score weighted controls		
Total expenditures				
Last 3 d[a]	2473	5285	-2831	<.001
Last wk[b]	2106	8911	-6806	<.001
Last 2 wks[c]	4083	12 869	-8785	<.001
Last mo[d]	8558	20 305	-11 747	<.001
Last 3 mos[e]	20 908	31 816	-10 908	<.001
Last 6 mos[f]	43 679	43 357	322	.93
Family out of pocket				
Last 3 d[a]	67	139	-71	<.001
Last wk[b]	46	262	-216	<.001
Last 2 wks[c]	159	424	-265	<.001
Last mo[d]	241	912	-670	<.001
Last 3 mos[e]	2412	1763	649	.41
Last 6 mos[f]	4096	2988	1109	.55
Medicare				
Last 3 d[a]	2121	4389	-2267	<.001
Last wk[b]	2029	7337	-5308	<.001
Last 2 wks[c]	3824	10 576	-6752	<.001
Last mo[d]	7835	16 559	-8724	<.001
Last 3 mos[e]	17 523	25 250	-7727	<.001
Last 6 mos[f]	36 208	33 036	3171	.26
Private Insurance				
Last 3 d[a]	90	207	-117	<.001
Last wk[b]	3	347	-345	<.001
Last 2 wks[c]	11	567	-556	<.001
Last mo[d]	52	918	-866	<.001
Last 3 mos[e]	165	1499	-1334	<.001
Last 6 mos[f]	105	2252	-2147	<.001

Aldridge, et al. “Association between hospice enrollment and total health care costs for insurers and families, 2002-2018.” *JAMA Health Forum*. Vol. 3. No. 2. American Medical Association, 2022.

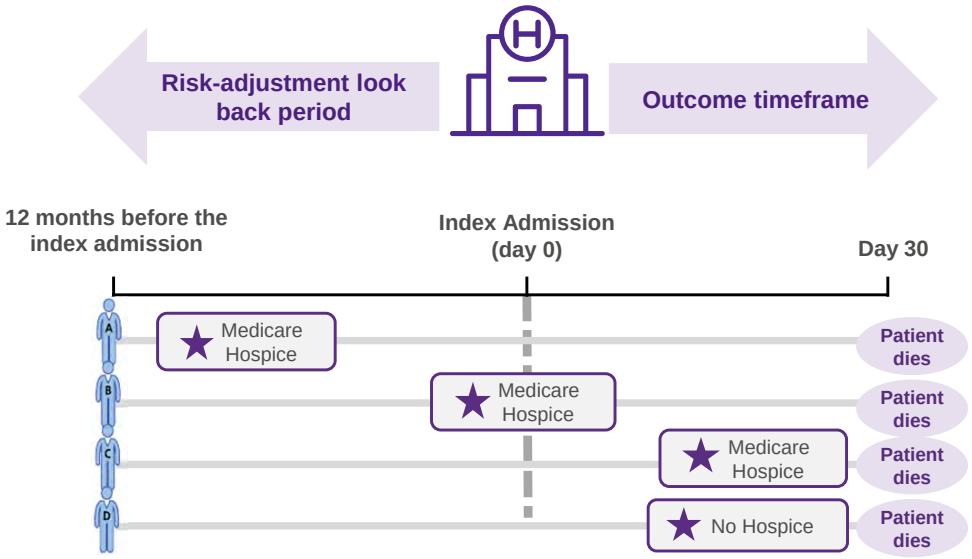
Hospice Decreases Acute-Care Utilization





Kelly, A. et al. . Hospice Enrollment Saves Money and Improves Quality. *Health Affairs 2013.* 32(3):552–561.

Hospice Impact on Quality for a Health System



Hospice Enrollment	Mortality	Hospital Readmission	ICU and Hospital Bed Availability	Medicare per Beneficiary Spend
12 months before	↓	↓	↑	↓
First day of index admission	↓	↓	↑	↓
After the first day of index admission	↑	↓	↔	↓
No hospice	↑	↑	↓	↑

CMS, FAQ for the Risk-Standardized Outcomes & Payment Measures Public Reporting Year 2019 (July 1, 2019 - June 30, 2020). VITAS Proprietary Case Study

California Hospice Licensure and Oversight- March 29,2022

- Rapid increase in hospice agencies without correlation need
  - 2,800 hospice agencies licensed in the state of CA
  - Los Angeles County has experienced a 1,500 percent increase in its number of hospice agencies since 2010.
  - It had more than six-and-a-half times the nationwide average number of hospice agencies relative to its aged population in 2019
  - A single building in Van Nuys had over 150 licensed hospice–a number that exceeds the structure's apparent physical capacity
- Lack of oversight in licensing and patient complaints
- Hospice agencies using stolen identities
- Care provided for non-terminal patients with high live discharge rates

https://www.auditor.ca.gov/reports/2021-123/index.html

Hospice Mergers and Acquisitions

JAMA Health Forum

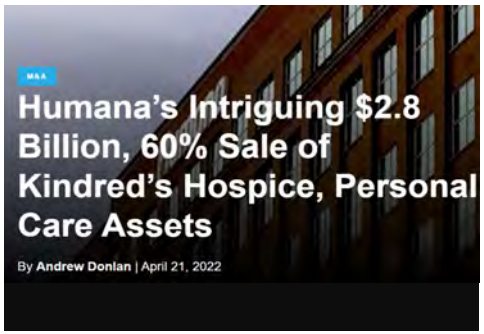
JAMA Forum

Hospice Acquisitions by Profit-Driven Private Equity Firms

Joan M. Teno, MD, MS

- Private equity seeing a huge opportunity to buy hospices- “predator”
  - Kindred Healthcare example
    - 2018 Humana and 2 private equity partners paid $4.1 billion, Humana $800 million for 40% stake with option buy in 3 years
    - In 2021, Humana did so, paying the equity firm 5.7 billion additional
- Articulated warning about private equity and care quality

Privately Owned & Private Equity



For-Profit Insurer & Private Equity

For-Profit Insurer & For-Profit Hospice

For-Profit Hospital and For-Profit Senior Living

Descriptive Summary of Study Findings

For profit hospices were:

- Less likely to providing charity care 80% vs 82%
- Less likely to partner with oncology centers 25% vs 33%
- Likely to care for nursing home patients 30% vs 25%
- More likely to have a higher patient disenrollment rate 10% vs 6%
- More likely to engage in outreach to low-income communities 61% vs 46%
- More likely to engage in minority communities 59% vs 48%

Aldridge, et al. “National hospice survey results: for-profit status, community engagement, and service.” *JAMA Internal Medicine* 174.4 (2014): 500-506.

Enrollee Rates/Hospice Use 5 Largest For- Profit and Not-for-Profit

Largest Five Chains	Agencies	Patients	Hospice Diagnosis and Residence, %			Use Characteristics				
						Length of Use, Days		Stays ≤3 Days	Stays with Live Discharge	No General Inpatient Care or Continuous Home Care in Last 7 Days
	n		Cancer	Dementia	Nursing Home Residence	Mean	Median	%		
For-profit										
VITAS	37	46,494	27	20	25	88.7	16	18	17	26
Gentiva	103	41,693	24	18	35	102.9	20	16	19	61
Heartland	74	19,541	22	22	48	106.7	31	12	23	88
Amedisys	53	14,075	22	17	34	99.1	29	12	24	85
Aseracare	45	9,973	18	22	64	98.6	25	14	19	42
Non-for-profit										
Hospice of the Valley	4	9,086	29	4	14	95.0	20	17	19	42
Providence Health and Services	7	6,424	29	11	18	65.8	22	14	16	92
Chapters Health Hospice	2	6,407	30	16	22	87.3	16	20	22	26
Kaiser Permanente	13	4,530	49	4	8	57.7	27	7	18	97
Convenant Hospice	2	3,734	30	13	30	96.2	17	15	16	50

Stevenson, et al. “Effect of ownership on hospice service use: 2005–2011.” Journal of the American Geriatrics Society 64.5 (2016): 1024-1031.

Case Discussion

PF Skilled and HF

- 88 y/o with 1 recent ED visit and 1 hospitalization for HF
  - Transitioned Skilled
- After 100 days start talking about placement, difficulty ambulating, unable stand on own
- Three additional falls, unwitnessed, one required 6 stitches
- SOB minimal exertion and at rest
- Weight loss continues 136 pounds to 116
- Stage IV sacrum, foul odor
- Dependent IADL, ADL help all ADL
- Increased forgetfulness, paranoia, worsening restlessness, episodes severe shortness of breath
- Goal: to be in a safe place; DNR/DNH

MF LTC and Dementia

- 68 y/o residing LTC progressive mixed dementia
- Continued eating difficulty with dysphagia solids and episodes coughing
- Myoclonus continues
- Weigh loss continues 120 pounds, poor appetite; no skin breakdown
- Bedbound; no longer getting into wheelchair; sleeping more about 18 hours a day; fell out of bed once with mechanical injury
- Dependent 6/6 ADL's; minimally verbal
- One UTI E coli
- Goal: comfort care, not go back to the hospital

Casper Report: 13 Quality Measures

Resident Name	AO31OA/B/F	High Risk/Unstagable Pre Ulcer (L)	Physical Restraints (L)	**Falls (L)**	**Falls with Mechanical Injury (L)**	**Antipsychotic Meds (S)**	Antipsychotic Meds (L)	**Antianxiety/hypnotic, prev (L)**	**Antianxiety/hypnotic, % (L)**	Behavioral Symp Affect Others (L)	**Depressive Sx (L)**	**UTI (L)**	Cath Insert/Left Bladder (L)	Lo-Risk lose B/B Con (L)	**Excess Weight Loss (L)**	**Incr ADL Help (L)**	**Move Independent Worsens (L)**	**Improve in function (S)**	Quality Measure Count	**Total**
PF				**X**	**X**	**X**		**X**	**X**		**X**				**X**	**X**	**X**	**X**		**10**
MF				**X**	**X**			**X**	**X**		**X**	**X**			**X**	**X**	**X**			**9**

Improving Hospice Access for Short-Stay Residents

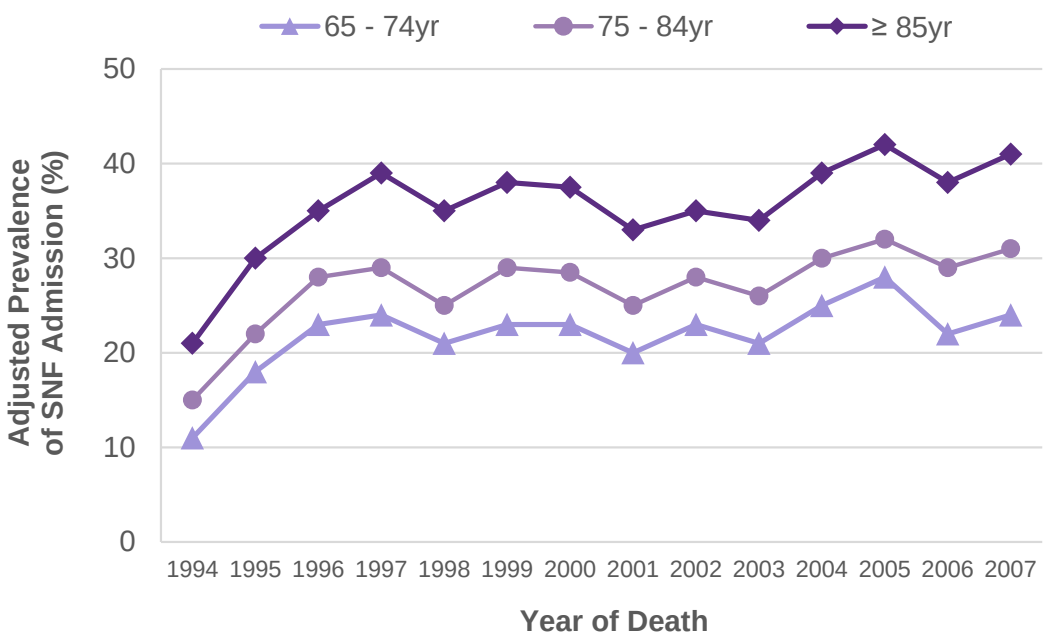


Figure 2. Adjusted prevalence of skilled nursing facility (SNF) admission in the last 6 months of life by age group. Prevalence of SNF admission in the last 6 months of life was calculated with adjustment for groups of age at death and year of death. Reported values incorporate survey weights to account for the complex survey design.

Table 2. Top 10 Medicare Provider Analysis Review File Diagnosis Related Group (DRG) Admission Diagnoses to a Skilled Nursing Facility in the Last 6 Months of Life

DRG Code	Definition	%
127	Heart failure and shock	8.3
462	Rehabilitation	5.4
236	Fractures of hip and pelvis	4.8
89	Simple pneumonia and pleurisy age > 17 years old with complications, comorbidities	4.8
88	Chronic obstructive pulmonary disease	4.4
12	Degenerative nervous system disorders	3.6
14	Intracranial hemorrhage or cerebral infarction (beginning October 1, 2004)	3.3
467	Other factors influencing health status	2.2
90	Simple pneumonia and pleurisy age > 17 years old without complications, comorbidities	2.1
82	Respiratory neoplasms	1.9

Supportive Approaches

	Hospice	Home Health	Palliative Care
Eligibility Requirements	Prognosis required: ≤ 6 months if the illness runs its usual course	Prognosis not required	Varies by program, usually life-defining illness
	Skilled need not required	Skilled need required	Skilled need not required
Plan of Care	Quality of life and defined goals	Restorative care	Quality of life and defined goals
Length of Care	Unlimited	Limited, with requirements	Variable
Homebound	Not required	Required, with exceptions	Not required
Targeted Disease-Specific Program	✓	Variable	Variable
Medications Included	✓	X	X
Equipment Included	✓	X	X
After-Hours Staff Availability	✓	X	X
RT/PT/OT/Speech	✓	✓	X
Nurse Visit Frequency	Unlimited	Limited, based on diagnosis	Variable
Palliative Care Physician Support	✓	X	Variable
Levels of Care	4	1	1
Bereavement Support	✓	X	X

NH Pressures and Benefit Hospice Partnership

Pressure	Opportunity Hospice Partnership
Staffing	**Direct Care Support:** nurse, aide, social worker, chaplain, volunteer, physician and safe discharges for short-stay to hospice in community, veteran support **Nursing Home Staff Retention Initiatives:** Memorial services, bereavement support for staff members, team building, recognition of national healthcare holidays (CNA Week, Nurses Week, Social worker Month, Nursing Home Week)
Census	Continuous care, respite, GIP, co-marketing/education to feeder hospitals with VITAS Rep
Quality	Survey support, attendance at Care Plan Reviews, work with MDS to identify measures that may trigger hospice eligibility on Casper report, hospice risk adjusted quality measures, Behavioral Management Protocol
Staff training	CEU's (hospice, pain, disease specific (dementia behaviors), communication, etc, Hospice and Nursing Home Partnership MDS and Quality Measures)
Infection control	Strict adherence COVID protocols care coordination

Case Discussion

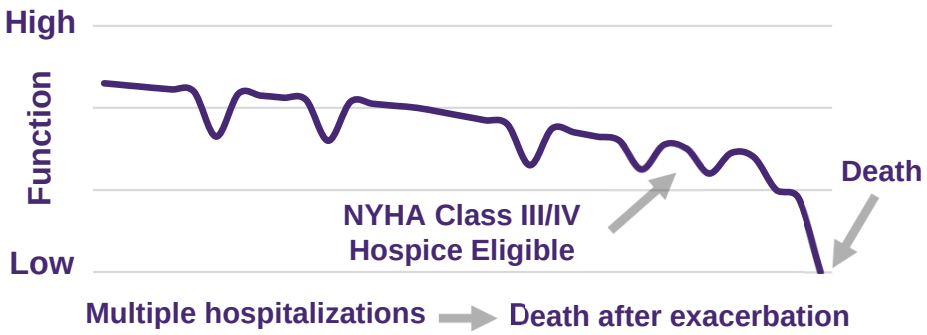
PF Skilled and HF

- 88 y/o with 1 recent ED visit and 1 hospitalization for HF
  - Transitioned Skilled
  - Falls, functional dependency, weight loss
  - Pressure ulcer, stage IV, non-healing
  - SOB minimal exertion and rest
- Physician called to indicate transferred to long-term care
- Did not mention hospice
- We initiated the referral and was admitted that day

MF LTC and Dementia

- 68 y/o residing LTC progressive mixed dementia
  - Dysphagia solids and episodes coughing
  - Weight loss
  - Bedbound, 6/6 ADL dependent, fall
  - UTI
- Physician not supportive of hospice and physician for a competitor hospice-she is not eligible
- Couple weeks later change LOC and to the hospital
  - UTI with sepsis in ICU hypotension
  - Renal failure, no dialysis decision
  - No escalation of care
- Transferred back to the NH on hospice for comfort care

Heart Failure Eligibility Guidelines



NYHA Symptoms:

- Shortness of breath
- Fatigue
- Chest pain
- Palpitations

Prognosis and HF:

- After diagnosis, 50% dead at 5 years
- NYHA class IV, 50% dead at 1 year

- Symptoms minimal exertion or rest (NYHA Class III/IV) despite standard of care
- Inability to tolerate standard of care medical therapies
- Recent history of cardiac arrest or recurrent syncope
- Inotropic support required and no LVAD/ transplant candidate

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- Oxygen requirement secondary to poor cardiac function
- Cachexia
  - Weight loss of 7.5% in 6 months associated with 29% mortality
- ED visits and hospitalizations from HF exacerbations

Dementia Hospice Eligibility Guidelines

Alzheimer's Disease
Lose ability to speak or communicate meaningfully (FAST 7A)

Non-Alzheimer's Disease or Mixed Dementia
Dependent in 3/6 ADLS:
Dress • Incontinence of bowl and bladder
Transferring • Ambulation • Eating • Bathing

Plus either

A comorbidity resulting in structural/functional impairment:

- Heart Disease (e.g., Heart Failure, Advanced Cardiac Disease, etc.)
- Advanced Lung Disease (COPD)

Or

A clinical complication indicative of disease progression:

- Febrile episode
- **Infection requiring antibiotics (aspiration pneumonia, UTI, sepsis)**
- Pressure ulcers
- Dehydration requiring hospitalization
- **Weight loss 10%**
- **Eating difficulty including dysphagia**
- Delirium
- Feeding tube decision

Onsite Support from VITAS Reps: Care Coordination

Patient: PF	Timely Referral	
Level of Care 	Admit	Nursing Home (Home Care)
	Current	Continuous Home Care
	Discharge	Continuous Home Care

Healthcare Information							
Primary Dx	Chronic systolic (congestive) heart failure						
Comorbidities	Altered mental status, unspecified, Anemia, unspecified, Benign prostatic hyperplasia without lower urinary tract symptoms, Edema, unspecified, Essential (primary) hypertension, Fracture of neck, unspecified, subsequent encounter, History of falling, Muscle weakness (generalized), Rheumatoid arthritis, unspecified, Unspecified atrial fibrillation, Unspecified severe protein-calorie malnutrition						
Active Rx Count	8						
HME	Oxygen, suction, gerichair						
Visits by Discipline	Physician	Nurse	HHA	Chaplain	SW	Other	
	1	18	6	1	4	0	
Level of Care (Days)	Telecare Calls	Routine	Routine-Nursing Home	ICC	Gen Inpatient	Respite	Custodial
	10	2	5	7	0	0	0

Onsite Support from VITAS Reps: Care Coordination

Patient: MF	Timely Referral	
Level of Care 	Admit	Continuous Home Care
	Current	Continuous Home Care
	Discharge	Continuous Home Care

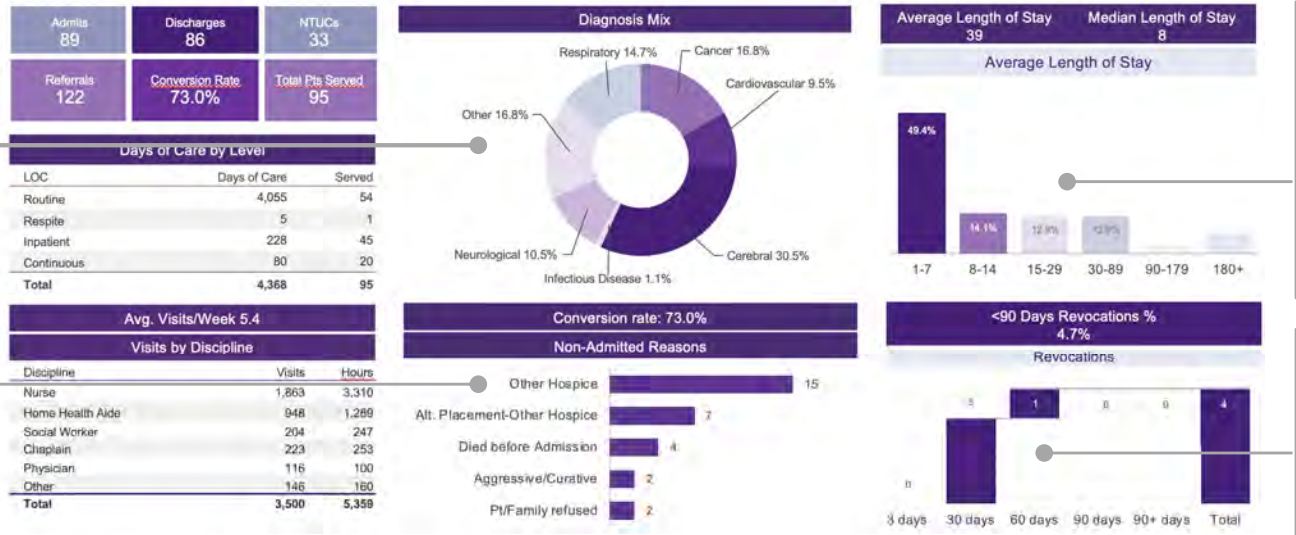
Healthcare Information							
Primary Dx	Cerebral Atherosclerosis						
Comorbidities	Sepsis, urinary tract infection, end stage renal disease, essential primary hypertension, generalized anxiety disorder, heart failure, unspecified, hyperlipidemia, unspecified, hypothyroidism, unspecified, unspecified convulsions						
Active Rx Count	8						
HME	3-in-1, nebulizer, compressor, oxygen concentrator, w/back-up, oxygen portable w/reg; cart, suction						
Visits by Discipline	Physician	Nurse	HHA	Chaplain	SW	Other	
	2	7	7	1	1	1	
Level of Care (Days)	Telecare Calls	Routine	Routine-Nursing Home	ICC	Gen Inpatient	Respite	Custodial
	4	1	5	6	0	0	0

Drive Community Strategy and Execution

Partnership of Care information on mutual patients to help clinicians better understand opportunities to expand hospice care for their patients and how their current patients are being served.

Diagnosis Mix
A review of a clinician's data may reveal under-utilization of hospice for a particular diagnosis type

Not Admitted
reasons can provide insight into a clinician's referral habits



Physician and Facility-Specific Partnership of Care provides data related to mutual patients

ALOS/MLOS
ALOS and MLOS can help identify opportunities for patients to be referred to hospice earlier in their disease trajectory to improve better patient/family outcomes

Revocations
Understand patient trends and areas to spearhead internal improvements

Participate in at-risk meetings with community PGPs and ALF/LTC leadership

Summary

- Hospice is underutilized in the NH compared to other sites of care
- The benefit offers value for all stakeholders
  - Quality: satisfaction, age in place, staff support, patient symptom burden support
  - Value: Cost savings
- Eligibility, understanding hospice benefit, and communication are key pillars to increase hospice access
- Care coordination is a key component of a NH-Hospice partnership

Paradox of Care

What Americans Want	What Americans Get
71% choose quality of life over interventions, receive the opposite (Wehri, 2011)	30% of documented care aligns with preferences (Wehri, 2011) Over-medicalized care in last year of life accounts for 25% of Medicare spending (Calfo, 2004)
80–90% prefer to be at home at end of life	Only 1/3 of deaths occur at home (CDC, 2014) 30% are in the ICU the month preceding death (Teno, 2013) 33% experience 4+ burdensome transitions in last 6 months life 50% of older adults in emergency department last month of life
Not to be a burden on their family	25% seniors are bankrupted by medical expenses (Kelley, 2013) 46% of caregivers perform nursing tasks, such as wound care and tube feeding (Reinhard, 2012) In the last year of a patient's life, family care averages nearly 66 hours per week (Rhee, 2009)