


# Improving End of Life Care for Nursing Home Residents

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A decorative graphic consisting of several sets of concentric circles, resembling ripples in water, is positioned in the bottom right corner of the slide. The circles are light blue and vary in size and opacity, creating a subtle background element.

# Overview

- Policy goal is to provide high quality, efficient palliative and EOL care for NH residents, of which reducing avoidable hospitalizations and improving transitions are important parts
- Also includes:
  - Improving clinical management of pain, shortness of breath, and chronic conditions
  - Aligning care with resident and family preferences
  - Improving communication across providers
- Challenges are symptomatic of a dysfunctional system for individuals with supportive service needs at the end of life
  - Service needs fragmented across payer types
  - Incentives often misaligned with residents' best interests
  - Little coordination across key actors

# End of Life Care in Nursing Homes

- Nearly 2 million people die each year in the U.S.
  - Almost half die in hospitals
  - Remainder die at home and in nursing homes and assisted living facilities
- As individuals grow older, increasing numbers die in nursing homes and other LTC settings
  - Almost half of all deaths among those 85+ occur in a nursing home
  - Two-thirds of dementia deaths occur in nursing homes

# End of Life Care in Nursing Homes

- EOL care provided in combination with long-term supportive services in the NH
- Palliative care can be integrated at any point into NH service delivery
  - Provided by the NH provider or by a separate end-of-life care provider (e.g., a hospice)
- Election of hospice can occur alongside receipt of NH care
  - Provided via a Medicare-certified hospice agency
  - Hospice and SNF care cannot be used in combination for the same condition

# Hospice Use

- Medicare hospice initially focused on individuals with cancer diagnoses receiving services at home
  - Shift over time to include other types of patients and settings – around 25% of hospice users in NHs
- Hospice use and spending have grown substantially in recent years, especially among non-cancer diagnoses
  - Increased number of recipients
  - Increased costs per user (primarily via increased length of use)
- Hospice spending now \$11B – projected to double over the next decade

# Positive Impact of Hospice on NH EOL Care

- Studies identify variety of benefits of hospice
  - Decreased hospitalization in last 30 days of life
  - Improved pain assessment and management
  - Lower use of physical restraints and feeding tubes
  - Positive spillovers for other residents in NH
- Still, important limitations and challenges remain, some of which have to do with the nature of the hospice benefit itself (e.g., Huskamp *et al*, 2010; Meier *et al*, 2010)
  - Although increasing, 7 in 10 NH decedents do not use hospice
  - Even among enrollees, benefit overlays the fragmented financing and delivery system described above

# What Can We Do?

## ➤ Benefit reform

- Do we need a new or reformed EOL benefit for NH residents? Are palliative and EOL care components of high quality NH care?

## ➤ Payment reform

- How can we re-balance financial incentives to elevate palliative care while mitigating incentives for hospitalizations, tube feeding, and IV therapies?

## ➤ Delivery system reform

- Should the locus of responsibility for EOL care be NHs or hospice agencies? How can we ensure all entities involved have the resources and expertise to succeed?

## ➤ Regulatory reform

- How can EOL care quality measures be integrated into an assessment culture that has prioritized restoration and maintenance of functioning?

# Concluding Thoughts

- Bottom line: Tools like INTERACT and other QIO-supported efforts can lead to meaningful change *especially* if accompanied by more coherent policies
- Key question: What policy changes can further incentivize and support the infrastructure needed to achieve sustainable, positive change?
  - Payment reform seems essential but only if providers have adequate resources and expertise
- Important caveat: “...providing financial incentives for reducing hospitalization without the necessary infrastructure could worsen care quality if NHs are rewarded for managing sicker residents in the NH with inadequate capabilities to do so safely.”

Ouslander et al, 2010



