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References


Availability of hospice and palliative care is increasing, despite lack of a clear national strategy for developing and evaluating their penetration into and impact on the target population. This study sought to determine whether targeted philanthropic investment helps increase access to hospice care. Receipt of philanthropic funding appeared to be associated with improved access to palliative care and hospice services in NC.


Hospice use in the United States is growing, but little is known about barriers that terminally ill patients may face when trying to access hospice care. This article reports the results of the first national survey of the enrollment policies of 591 US hospices. The survey revealed that 78 percent of hospices had at least one enrollment policy that may restrict access to care for patients with potentially high-cost medical care needs, such as chemotherapy or total parenteral nutrition. Smaller hospices, for-profit hospices, and hospices in certain regions of the country consistently reported more limited enrollment policies. Patients with serious illnesses may desire complex palliative treatments, but few hospices will enroll patients with these complex needs. Only one-third of hospices will enroll patients who are receiving chemotherapy; only one-half will enroll patients receiving total parenteral nutrition, and only two-thirds will enroll patients who wish to continue to receive palliative radiation. Given that these are highly used services for patients who are seriously ill, our findings suggest that hospice providers’ own enrollment decisions


Currently, only approximately one-third of Medicare beneficiaries enroll with hospice prior to death. Many in the field of palliative care view the structure of the MHB as a major barrier to the use of hospice and an increasing number of experts recommend expanding MHB eligibility criteria to improve access to hospice care. The extent to which this percentage reflects underuse of hospice is unknown as it likely reflects a combination of barriers to hospice care and patient preferences to not receive hospice care prior to death. Potential barriers to hospice care include lack of knowledge regarding hospice care, lack of hospice availability, and ineligibility for hospice care under the MHB. In conclusion, although there is fairly universal support for improving access to hospice care, there exists considerable uncertainty regarding if and how to change the Medicare Hospice Benefit to achieve this important goal. MHB eligibility is only one of potentially many barriers to receiving timely hospice care including lack of knowledge of hospice and hospice availability.

Steps taken to increase access to hospice care and to design the new system should be driven, first and foremost, by an explicit discussion of the ethical values that the end of life caregiving system should embody. To determine whether people are able to obtain services, information on the availability of services must be compared to the size and geographical distribution of the population at risk and the characteristics of that population that determine whether hospice care services are desired. These include age, sex, race, and ethnicity, family structure, health care beliefs and information, education, income, and health status. Society’s obligation to provide end of life care plainly encompasses an obligation to provide equitable access to health care at the end of life. Numerous factors influence access to hospice care. Such factors include public policy, health insurance coverage, financing, the attitudes and practices of health care providers, and the attitudes and preferences of health care consumers. Steps taken to increase access to hospice care and to design the new system should be driven, first and foremost, by an explicit discussion of the ethical values that the end of life caregiving system should embody.


Three contributing factors account for the increase in hospice use: patients’ preferences for dying at home, bereaved family members’ high satisfaction with hospice care, and Medicare payment system associated with the Balanced Budget Act of 1997. Barriers to Hospice Enrollment: First is the requirement patients have a prognosis of less than or equal to 6 months to live. Inaccurate prognostication and optimistic prognostic judgments make it difficult to determine which patients are eligible. The second barrier is the requirement patients must choose between life-sustaining treatment and hospice services. The third barrier is the lack of conversations between physicians and patients about advanced care planning, do-not-resuscitate orders, or discussion of hospice option. Per the Code of Ethics for Nurses (ANA, 2001), nurses have an obligation to be knowledgeable of the clinical issues their patients face in their projected last year of life, and help them weigh the benefits and burdens of continued treatment.


Hospice decreases the fear of dying alone, reduces the agony of death, and helps in maintaining dignity at the end of life. Physicians are encouraged to offer hospice to terminally ill patients early on in their end-of-life care to maximize these benefits. However, there is limited data on the changes and characteristics of hospice utilization. We performed a study to determine the changes in the hospice utilization over the last decade in our hospital. In conclusion, our study findings suggest physicians, especially oncologists, are referring more patients for hospice, but
the timing of the referral has not changed. Patients without a DNR status and those who were hospitalized at least once during their enrollment have an increased duration of hospice stay compared to patients with a DNR order and those that are not hospitalized. Thus, efforts to improve hospice utilization should focus on physicians other than oncologists, and efforts should be made to ensure adequate treatment of reversible illnesses in all patients, regardless of code status. In conclusion, this study findings suggest physicians, especially oncologists, are referring more patients for hospice, but the timing of the referral has not changed. Patients without a DNR status and those who were hospitalized at least once.


Disparities in access to health care extend to end-of-life care. Lack of access to hospice mirrors lack of access to health maintenance and primary care. Patients who are served by hospice nationally are disproportionately white and likely to reside in economically stable communities. In many urban low-income communities, less than 5% of decedents receive hospice care in the last 6 months of life. This review focuses on barriers to palliative care and hospice in urban, predominantly low-income communities, including cultural and reimbursement factors and the paucity of hospice providers, outreach projects, and in-patient hospice beds in urban communities.


The consistently lower use of Medicare hospice services before death and smaller sizes of rural hospices suggest that the combination of Medicare hospice payment policies and hospice volumes are problematic for rural hospices. Adjusting Medicare payment policies might be a critical step to assure availability of hospice services for terminally ill beneficiaries regardless of where they live. Rates of hospice use by the Medicare population were significantly associated with geographic location, with lower rates of hospice associated with more-rural environments. The results of this analysis suggest that geographic location and population density are important factors influencing access to hospice services for Medicare beneficiaries. The study also shows that a significant proportion of hospices in rural areas have low patient volumes, leaving them vulnerable to financial instability. This analysis shows a strong and consistent rural-urban gradient in hospice use before death. The contrast between in-hospice and in-hospital death rates across rural and urban areas suggests that the observed pattern is not due to substituting hospital services for hospice services.

Access to hospice care continues to be an enigma. Hospice has been available for nearly three decades in the United States, but the services continue to be underutilized. In an effort to better understand access barriers, a series of focus groups were held with recently bereaved caregivers (mean = 9.9 months since the death of the patient). During the process of the focus group discussions, participants relived their experience with hospice. Although the purpose of this research was to ascertain access recommendations, participants integrated their access comments into the overall richness of their hospice experience. One determining factor for access and timely admission to hospice is the difficulty that confronts physicians in making a prognosis that conforms to Medicare regulations.