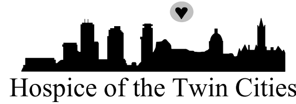

Hospice of the Twin Cities

Hospice Insights

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A Comparison of Home Hospice Patients to Skilled Nursing Facility Hospice Patients

In a recent issue of The American Journal of Hospice and Palliative Care, (Volume 24, Number 6) there is an interesting article comparing the characteristics between home and skilled nursing facility (SNF) hospice patients (pp.479-486). The authors, Beth Han, MD, PhD, MPH, Ronald Tiggle, PhD, and Robin E. Remsburg, PhD, examined 1170 deceased home hospice patients from the 1998 National Home and Hospice Care Survey and 617 deceased nursing home hospice patients from the 1997 and 1999 National Nursing Home Surveys. They found that the nursing home hospice population is significantly different from the home hospice patients.

Before comparing the two populations it should be mentioned that the SNF hospice patients have SNF staff as their primary care givers, and hospice staff work collaboratively with the SNF staff to provide quality end-of-life care for these patients. Home hospice patients are usually cared for by family members or staff hired to supplement the care provided by the family and are taught by the hospice team to care for their loved ones.

It should also be noted that currently 20% of elderly Americans die in nursing homes and within the next 12 years it is estimated that number will become 40%. Also mentioned, 25% of people who died in 2000 were on hospice and this number is increasing at a rapid pace.

When nursing home residents choose hospice care at the end-of-life, there are many challenges the SNF and the hospice program must work through to make this a memorable experience for the patient and their family. Some of the challenges include high staff turnover in the SNF, limited hospice training for SNF staff, cultural and philosophical differences between hospices and SNFs, and Medicare nursing home regulations and reimbursement which encourages SNF care over the Medicare Hospice Benefit. Because many SNFs are not meeting the residents basic needs for pain and symptom control, families are requesting hospice care for their loved ones at the end of life.

The Office of the Inspector General (OIG), found that SNF hospice patients receive 50% fewer nursing and aide services from hospice staff than hospice patients living at home (OIG looked at 200 hospice patients from 31 hospice agencies outside of our region). (A Hospice of the Twin Cities audit found we provide the same or more services to our SNF hospice patients.) One question that came from this finding was, "is there a significant difference between home care patients and SNF patients?

"One of the secrets of a happy life is continuous small treats."
Iris Murdoch

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Basic End-Stage Indicators:

- Overall physical decline
- Life limiting condition
- Clinical progression of the disease as evidenced by
  - *Multiple ER visits*
  - *Inpatient hospitalizations*
  - *Serial physician assessment*
  - *Laboratory studies*
  - *Radiologic or other studies*
- Impaired nutritional status
  - *Decrease in appetite; increase in wt loss*
  - *Serum albumin <2.5mg/dl (not to be used in isolation)*
- Multiple co-morbidities
- Decline in functional status (ADLs)

Specific Guidelines for determining Prognosis

End-stage Renal Disease

Acute Renal Failure (1 and either 2 or 3 must be present. Factors from 4 will lend supporting documentation.)

1. Patient is NOT seeking dialysis or renal transplant;
2. Creatinine clearance <10cc/min (<15cc/min for diabetics); or <15cc/min (<20cc/min for diabetics) with comorbidity of congestive heart failure;
3. Serum creatinine>8.0 mg/dl(>6.0 mg/dl for diabetics);
4. Comorbid conditions (check all that apply): Mechanical ventilation; Malignancy (other organ system), Chronic lung disease; Advanced cardiac disease; Advanced liver disease; Sepsis; Imunosuppression/AIDS; Albumin <3.5 gm/dl; cachexia; Platelet count <25,000; Disseminated intravascular coagulation; Gastrointestinal bleeding.

Chronic Renal Failure (1 & either 2 or 3 must be present as outlined above.) Factors from 5 will lend supporting documentation.

5. Signs and symptoms of renal failure: Uremia; Oliguria (<400 cc/24 hours); Intractable hyperkalemia (>7.0) not responsive to treatment; Uremic pericarditis; Hepatorenal syndrome; Intractable fluid overload, not responsive to treatment.

Continuation: Comparing SNF Hospice Patients to Home Hospice Patients

The answer is a resounding "yes", and some of those differences are listed below:

Demographic Characteristics ~ SNF patients are more likely to be 85 years and older, widowed, and have Medicaid as the primary source of payment. Home hospice patients are more likely to be younger than 75 years, married, and have Medicare as their primary payment source. 50% of SNF hospice patients were ≥ 85 yrs. compared to 17% of home hospice patients. 90% of SNF hospice patients were ≥ 65 yrs. and only 31% had Medicare as their primary payer in their last month of life. 74% of home hospice patients were ≥65 yrs. and 72% had Medicare as their payment source. There were no significant differences in race, gender, or region.
Primary Discharge Diagnosis ~ 34% of SNF patients had cancer as their primary diagnosis compared to 63% of home hospice patients. SNF patients were also more likely to have a dementia or cardiac disease as their primary diagnosis (10%) compared to home hospice patients (2%). Cardiac disease was the primary diagnosis for 23% of SNF hospice patients and for 11% of home hospice patients. They did not differ greatly with the diagnosis of Parkinson's, diabetes, and respiratory diseases.
Activities of Daily Living ~ SNF hospice patients were more likely to need help with bathing, dressing, eating, transferring, and walking. They also had more difficulty controlling their bowels or bladder.
Selected Service Utilization ~ SNF hospice patients received more dietary/nutrition services, medication management, and physician services than home hospice patients in this study.

With these stated differences it is evident each group has their own specific needs. With different diagnoses come different symptoms and treatment options. It is also evident as time goes on and people live longer, we are more likely to be caring for a larger population ≥85 years of age. This means we will be dealing with more cognitive deficiencies and behavioral problems as our society ages. Also, more patients are likely to live in the community, indicating there will be more family caregivers or purchased home care services. Even with these changes we need to continue collaborating and perfecting hospice services for those who reside in the SNF.

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Mission Statement

Hospice of the Twin Cities' mission is to enhance the quality of the lives of our patients and their families by providing respectful care based on maintaining dignity, alleviating physical, psychosocial, and spiritual suffering, advocating for fundamental rights, and affirming the sacred value of life.