

The future of hospice

Unshackle from per diem reimbursement and the six-month limit on prognosis

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A 47-year-old man is referred for hospice services with advanced amyotrophic lateral sclerosis. He has two teenaged children; his wife works part time. His physical deterioration over the past three years is well documented. Once lifted into his motorized wheelchair, he has some mobility around the house. His respiratory mechanics fall within the “guidelines for referral.” His secretions are managed by suctioning, and his periodic/nocturnal dyspnea responds well to noninvasive continuous positive airway pressure. The cost of this last therapy alone is \$1,120 per month.

Providing care for such a patient is one tiny fraction of the challenge faced by hospice programs today as they seek to redefine their place in America’s healthcare systems. Many of these dilemmas are generic and can be counted off like rosary beads. They include inadequate or constrained access to health care in general, deficiencies in healthcare professionals’ training and commitment to end-of-life issues, and long-standing, ingrained barriers to pain management and symptom management. All these dilemmas stand forth against a background of reimbursement streams and incentives that often conflict both pragmatically and philosophically with hospice efforts.

But some predicaments specific to hospices are of their own creation. In 1982, hospices made a devil’s bargain with the federal government. In exchange for what was then a life-saving stream of revenue, they accepted two conditions of participation: they would only accept patients with a prognosis of 6 months or less and they would operate on a per diem payment schedule. The net effect has been to define hospice care in the public and professional mind as being more for the brink of death than for the end of life, with average lengths of stay around 36 days and median lengths of stay about 15 days. Within the rigid construct of this regulatory box, most hospices have found the fiscal constraints of reimbursement so confining that they are reluctant to admit patients whose

conditions might not follow the predictable trajectories of malignant disease, or to support expensive and labor-intensive therapies such as continuous positive airway pressure. Reluctance arises especially when the hospice is treating patient populations with special needs, such as children, people with AIDS, the poor, and those who live alone.

Hospice is generally acknowledged to be the exemplary model of palliative care. It follows, then, that it is in the best long-term interest of hospice to unshackle itself from the default position of having to make the terrible choice between curative and palliative care. Studies should provide evidence that efficacy and efficiency in care can be gained by dissembling or waiving the requirement that every hospice patient must have a 6-month prognosis. In addition, studies should consider the effects of eliminating fixed per diem reimbursements and evaluate alternatives, such as variable payment based on acuity and length of stay or provision of services under the cap regulations that already exist. Such models are intuitively appealing, as they adjust for the exponential increases in drug and other fixed costs to hospices far more coherently than the surreal “cost-of-living” methodologies presently used.

These studies will need to be funded by the usual sources—government, educational institutions, and foundations—but they will also need to be championed by the leadership of all hospice constituencies. If studies demonstrate the benefits of new approaches to hospice care, their results will broaden the reach of hospice services to the greatest number of patients, families, and populations, yet hospice organizations will still fulfill their fiscal responsibilities. Such studies will encourage hospice to continue innovative care delivery, which has been the root of its success, and to integrate the precepts of palliative care further upstream in the healthcare system.

They will, in short, allow hospice to unhoist itself from its own petard.