More than 25% of Americans now die in a nursing home, with this percentage growing as our country rapidly ages. By 2030, the nursing home will likely be where 40% or more of Americans will die. Thus, it is imperative that nursing homes prepare for their compelling mission as "palliative care providers." Nursing homes must embrace their role in providing palliative care for their residents with life-limiting and terminal illness so as to provide those appropriate and limited interventions based on the goals of care. Similarly, nursing homes also must be prepared to provide hospice or full comfort care for those residents who are dying.

Although still wholly underused, palliative care programs and hospice services are fortunately being used more frequently in the nursing home setting. As a result, the interdisciplinary care of palliative care and hospice teams is benefiting more nursing home staff, family members, and residents at a time when they are facing the increased and urgent needs associated with end-of-life care and the dying process. However, there is considerable evidence that residents of nursing homes still are not receiving optimal palliative or end-of-life care.

The article "Hospice in the nursing home: Perspectives of frontline nursing home staff," by Dr Unroe et al in this issue of JAMDA, provides a good introduction to some of the benefits and challenges of providing end-of-life care to nursing home residents. It examines the long-standing and still very pertinent question of how to best provide comfort and quality of care to nursing home residents, many of whom would benefit from a greater focus on end-of-life care. This article nicely highlights the difference between how social work staff and nursing staff view the value of hospice as an adjunct to the care already being provided by the nursing home. Although most staff responded favorably regarding hospice care in the nursing homes, approximately one-third of the nursing staff rated coordination of care lower with hospice involvement. In addition, many qualitative comments provided examples of when hospice was felt to be unnecessary and unresponsive to patient needs. However, social work was much more universally positive concerning the care provided by hospices, representing an important opportunity for improvement in an interprofessional approach to palliative and end-of-life care in the nursing home. The study also provided support for the common belief that hospice provides a greater benefit and is more accepted by the nursing home resident and his or her family than the nursing home staff themselves. This mixed method study provides a valuable contribution to our growing understanding of how we might better provide end-of-life care to nursing home residents, including providing support for the position that an interprofessional approach is essential to providing optimal end-of-life care to nursing home residents.

Many health care providers, patients, and patient's families have long been aware that a goal of comfort is much more satisfying and reasonable for nursing home residents than are aggressive life-prolonging goals. A defined and well-resourced palliative and end-of-life care program can make it much easier for nursing home staff, physicians, and other providers to give comprehensive comfort and end-of-life care to their frail and terminally ill nursing home residents. In this respect, an interprofessional approach is essential in communicating with and educating nursing home residents and their families when a comprehensive comfort and end-of-life care program is developed. The attending physician must then take responsibility for clearly defining goals of care and translating that into an explicit advance directive.

A palliative and end-of-life care program in the nursing home could take the form of either a specific internal program developed and maintained by the nursing home or by contracting with one or more community-based palliative and/or hospice providers. The Medicare hospice benefit is currently the only form of consistent funding for such a focused end-of-life care program in nursing homes. Unfortunately, this type of funding is unavailable as a direct financial resource for nursing homes as they seek to provide broader palliative and quality end-of-life care to their residents. Thus, the arrangement of contracting with one or more community-based hospices is overwhelmingly the most common approach to addressing the end-of-life care needs of nursing home residents, often missing the opportunity to provide palliative care to residents before they are terminal. As the Unroe et al article demonstrates, this arrangement can lead to less than optimal coordination of end-of-life care and the underutilization of an interprofessional care approach.

However, there is good evidence that nursing home residents who receive hospice services are more likely to have good pain assessment and management, have lower rates of inappropriate medication usage, and are less likely to have physical restraints. The use of hospice also has improved the quality of end-of-life care in nursing homes in the following ways: (1) improved communication among patients, physicians, families, and nursing home staff; (2) support for...
advanced care planning; (3) improved goal setting; (4) proper documentation by the nursing home; (5) appropriate earlier referrals for end-of-life care; and (6) education of nursing home staff, residents, and their families.\textsuperscript{6,17}

Like most dying patients, nursing home residents prefer to remain in their usual setting. In the absence of an internal palliative and end-of-life care program, the nursing home is left to contract with community-based hospices to support the natural dying process in the nursing home. However, nursing residents and their families would greatly benefit from a much broader approach to better advance care planning and more timely conversation of their care goals to comfort care. In addition to the already cited advantages of involving hospice in the care of the terminally ill nursing home resident, there would be many other benefits to providing the focused and earlier intervention of a palliative care program in the nursing home.\textsuperscript{5} In particular, a simplified and focused interprofessional goal of pain relief and symptom control would be a great benefit to the residents, as well as limiting hospitalizations and life-prolonging therapies. There could be specially trained palliative care professionals and volunteers to provide the many comfort care services beyond those usually offered in the nursing homes. Specifically, prolonged visits for compassionate listening, spiritual support, and companionship would all be possible. Managing the increasing hygienic needs would be another important benefit. In addition, the family and nursing home staff could be provided improved end-of-life education and bereavement support.

Although the presence of hospices in nursing homes has been shown to demonstrate many advantages, the number of residents who benefitted and the time that they are impacted has been limited. Although the evidence for internally developed palliative and end-of-life care programs is yet to be developed, it is very reasonable to believe that the same measurable outcomes can be improved at least as much as when hospices have been involved in providing end-of-life care in nursing homes. In an effort to provide the best integrated palliative and end-of-life care to the most residents and families, nursing homes must provide this much-more global and intensive care themselves. The value of a better integrated and internally driven approach to this care should not be underestimated.

Although there is good evidence that supplemental hospice services in addition to usual nursing home services in the terminally ill nursing home residents will improve medical outcomes, as well as family and resident satisfaction, it remains to be seen whether internally developed palliative care programs in nursing homes can offer the same end-of-life care benefits. Before nursing homes can provide quality palliative and end-of-life care, they must overcome many significant financial, regulatory, cultural, and operational barriers.

First, one of the most significant barriers is the emphasis of federal policy and reimbursement on rehabilitation and restoration of function as the primary goals of nursing home care. Yet, at the end of life, all indicators of successful restoration are going to fail. Additionally, nursing homes are one of the most heavily regulated industries in many countries, including the United States. Many survey domains, such as weight loss, anorexia, functional decline, and increased usage of opioids and antipsychotic medications, are common in palliative care. Therefore, goal setting and documentation becomes imperative to avoid this “clash of philosophies.”\textsuperscript{40}

If governmental regulatory priorities can be refocused on providing quality palliative and end-of-life care in the nursing home, a second primary barrier to self-directed programming by nursing homes will be having adequate available resources. Both internal and external financial limitations will have to be addressed for nursing homes to develop high-quality, self-directed end-of-life care for their residents. Although internal prioritization of resources will aid nursing homes in developing their own palliative programs, the impact will be limited unless adequate external funding is made available to nursing homes. A new palliative care benefit providing direct reimbursement to nursing homes for care of their terminally ill residents would be the single most important step in alleviating their financial limitation on providing quality end-of-life care. Payment for this service by Medicare, Medicaid, and third-party payers would be a tremendous benefit to nursing home residents and their families.

Operational barriers are a third primary set of barriers to high-quality palliative and end-of-life care in nursing homes. For example, many nursing homes do not have established procedures for ensuring that their residents receive the appropriate palliative and end-of-life care. In addition, most nursing home residents have multiple comorbidities, including progressive dementia in more than half. This makes life expectancy estimates much more difficult, along with the transition to a comfort care approach. Thus, nursing home residents are more likely to be referred later to palliative care and hospice than would be the most beneficial. High staff turnover, limited staff training, and insufficient staffing in nursing homes are also significant barriers to quality palliative and end-of-life care.\textsuperscript{5,17,18}

Given these many operational barriers in nursing homes, there must be a concerted internal effort to overcome them. An important current limitation of nursing home staff is on the type of knowledge, skills, and attitudes required to provide quality end-of-life palliative care, especially given the lack of adequate reimbursement for this more intensive level of care. First, there is ample evidence that the knowledge base, experience, and attitudes of nursing home management (nursing home administrators, directors of nursing, nursing home medical directors) with and toward hospice care in the nursing home have been poor.\textsuperscript{19–21} This may very well be a function of having to rely on an outside entity to provide a service that requires a great deal of coordination and collaboration for the care to be excellent, which is difficult when there are 2 teams providing the care.

In contrast, the measurement of knowledge and skills of direct care staff concerning end-of-life palliative care for nursing home residents has been notably absent from the literature. However, nursing home staff have been shown to have a relatively positive attitude toward many aspects of end-of-life palliative care for nursing home residents.\textsuperscript{22} Generally, all staff believed it was their responsibility to assist residents and their families with the dying process and the family with bereavement after the resident’s death. Staff also generally identified the dying process to be difficult at times for residents and their families. However, there are some notable differences in some of their personal beliefs, values, and attitudes.\textsuperscript{19} These differences were most evident across job categories, with the attitudes of registered nurses, attending physicians, rehabilitation staff, and clinical managers significantly more positive than those of unlicensed nursing staff and volunteers. Specifically, the attitudes of the unlicensed nursing staff and volunteers toward death, end-of-life care, and their own personal feelings about the process were significantly more negative. It is, of course, concerning that the staff with the most direct care responsibilities held the least-positive beliefs, values, and attitudes toward death and end-of-life care. These findings provide a strong basis for nursing homes to undertake a concerted effort to improve the knowledge, skills, and attitudes of their staff at all levels.

Another significant limitation to quality end-of-life care in the nursing home is the lack of specific interprofessional education and practice in this setting. The same financial and staff issues generally limiting nursing homes in providing quality end-of-life care are especially important to address so as to specifically implement the type of team-based care necessary for palliative care. Fortunately, nursing home staff do have a relatively overall positive attitude toward interprofessional practice.\textsuperscript{22} Although interprofessional work
seems to be an integrated value in the teamwork of nursing home staff, communication concerning end-of-life care is at times a challenge among staff members, as it has certainly been for communication between the staffs of nursing homes and hospices caring for the same patient. Like the need to improve staff knowledge, skills, and attitudes toward death and end-of-life care, these findings indicate a need for nursing homes to undertake a concerted effort to improve interprofessional education and practice opportunities for their staff.

In summary, the most important barriers to nursing homes providing high-quality palliative and end-of-life care to their residents include the emphasis on restoration and rehabilitation by the nursing home survey process and funding sources, lack of communication between the nursing home and hospice providers, and late referrals to hospice due to the difficulty in predicting life expectancy. Communication, goal setting, documentation, and education can overcome these barriers to quality palliative and end-of-life care by hospices in nursing homes. Internally developed palliative care programs in nursing homes offer hope for wider implementation of quality end-of-life care for nursing home residents, but adequate resources must be made available to nursing homes by our system of payment. If given adequate resources, nursing homes will then need to develop the requisite leadership, programming, staff training, and staffing to provide high-quality palliative and end-of-life care. In addition, it will be essential for nursing homes to implement and sustain the needed interprofessional education and practice within their facilities to provide the high-quality palliative and end-of-life care so needed by their residents.

References