For Profit vs. Not-for-Profit Hospice: It is the Quality that Counts

As the National Medical Director of the largest for-profit hospice organization in the United States, I have often been confronted with questions and concerns as to how any hospice can stay true to its mission of providing compassionate care to the dying while paying attention to “the bottom line.” As I attempt to respond to these concerns, I always make sure to include the comments of Sister Irene Kraus, a former Chair of the American Hospital Association, who, when presenting to the administrators of the hospitals in her not-for-profit organization, told the group “No margin, no mission.” Because Sister Irene realized that whether an organization is for-profit or not-for-profit, if it does not operate according to sound business practice and pay attention to “the bottom line,” it will not remain a viable business for a long enough period of time to fulfill its declared organizational mission.

What about hospice? Is it reasonable for hospices to operate as for-profit entities, or does the seriousness of the hospice mission—the care of patients near the end of life and their families—preclude the notion that hospices can properly provide this care while having to address the perceived conflict of generating a positive bottom line? Or conversely, are not-for-profit hospices—despite perceptions that without concerns over the “bottom-line” they are able to provide more services to patients than their for-profit counterparts—actually subject to the same business and financial pressures to which for-profit hospices are beholden. In other words, does “No margin, no mission” apply to not-for-profit hospice?

Many believe that these are important questions to ask, because of the growth of the hospice industry over the last 10 years, and the fact that the increase in for-profit hospice programs has accounted for a disproportionately high percentage of that growth. Based on the GAO Report on the Medicare Hospice Benefit released in 2000, there has been a significant increase in the percentage of hospice programs that are for-profit, up from 13% in 1992 to 27% in 1999. Furthermore, while the percentage increase in the total number of hospice programs was 82% (1208 in 1992 to 2196 in 1999), the percentage increase in for-profit hospices during the same period was 293% (151 in 1992 to 593 in 1999), with for-profit hospices accounting for 45% of the industry’s growth during the 7-year period. The year 2001 also saw the first for-profit hospice organization successfully complete an IPO (initial public offering) and become a publicly held and traded corporation.

In this issue of the Journal, Lorenz et al. attempt to answer the questions posed above in the article, “Cash and Compassion: Profit Status and the Delivery of Hospice Services.” By comparing a number of demographic and service delivery variables between for-profit and not-for-profit hospices operating in the state of California, the authors try to determine whether there are significant differences between the two types of organizations. Based on their interpretation of the data, the authors conclude that “for-profit status was independently associated with providing care to certain types of patients including those from long term care facilities, patients with diagnoses other than cancer, and patients for whom government is the primary source of reimbursement.” They also report that “for-profits provided more total nursing visits but less skilled visits, and that a higher percentage of for-profit patients had stays exceeding 90 days” while they found no difference between the willingness of for-profit or not-for-profit hospices to provide patients access to “high-cost” therapies, such as chemotherapy or radiation therapy.

Superficially, the authors’ conclusions seem to answer the questions in the expected fashion. For-profit hospices, being more focused on the “bottom line,” are “selecting” patients who, because of the nature of their terminal illnesses (non-cancer) and where they reside (nursing homes), are more likely to have a length of stay exceeding 90 days, and require a lower percentage of skilled nursing services, and hence, cost less to care for. Conversely, not-for-profit hospices are
more often caring for patients dying of cancer who live at home, require a higher percentage of skilled nursing services, and are less likely to remain on hospice for more than 3 months. A closer look at the data presented in this study, however, raises serious doubts about these conclusions.

First, the conclusion that these patients are “selected” or intentionally sought out by the for-profit hospices because they are less costly to care for is purely speculative. As the authors themselves point out, “(F)or profit hospices serve populations that have historically made limited use of hospice.” These populations, which include patients suffering from noncancer diagnoses such as chronic obstructive pulmonary disease (COPD) and advanced dementia, and patients who reside in nursing homes, are the very patients that, according to the authors, are being “selected” by the for-profit hospices. One could just as easily conclude that it is the desire and the ability of the for-profit hospices to reach out to underserved populations of terminally ill patients, and not financial concerns, that account for the differences in patient demographics that were found in this study.

Conversely, an argument could be made that it is the not-for-profit hospices that are actually doing the “selecting,” avoiding admission of a high percentage of noncancer patients for whom hospice eligibility has been under increased regulatory scrutiny during the past several years.

Conclusions based on the incremental length of stay also require reexamination. Whereas the data do show that for-profit hospices have a higher percentage of patients with stays of more than 90 days, the authors fail to point out that this difference is lost at 180 days. Is this a function of patient “selection” as the authors suggest, or, at a time when hospice programs all over the United States are trying to find ways to help patients access hospice services earlier in the course of terminal disease, do these data demonstrate that for-profit hospices are more successful than not-for-profit programs in assisting patients in obtaining earlier access?

Finally, do patients being cared for by not-for-profit hospices truly require more skilled nursing services than those cared for by for-profit hospices, as reported by the authors? Examination of Table 1 of the article shows, in fact, that there was no significant difference in the actual number of skilled nursing visits per patient day provided by for-profit hospices (0.33) versus not-for-profit hospices (0.35). With this additional information, one is forced to conclude that the skilled needs of patients, irrespective of the type of hospice, were the same and that the for-profit hospices were providing a higher number of non-skilled nursing services per patient day (0.41) as compared to the not-for-profit programs (0.25).

Having completed this reanalysis of the data, what conclusions can we now draw? It is clear that with more than one way to interpret the data, the questions surrounding the differences between for-profit and not-for-profit hospice remain unanswered. Perhaps, that is as it should be.

When choosing hospice programs for their patients and families, physicians need to consider many factors. Among the most important, as determined a number of years ago by an independent marketing firm, were:

1. Effective pain and symptom management, including the availability of written guidelines and protocols.
2. Ability to provide patient care in a variety of settings: home, nursing home, inpatient bed.
3. Continued involvement of the attending physician, with the hospice providing adequate communication and other support services.
4. Family counseling provided by skilled professionals, as well as bereavement support for the family after the death of the patient.
5. Interdisciplinary care provided by professionals trained in end-of-life care.

Additional factors that may assist physicians in choosing the right hospice program for patients and families include the experience and expertise of the hospice’s medical directors and physicians and whether or not they are board certified in Hospice and Palliative Medicine, the strength of the hospice’s internal performance improvement and education programs, the hospice’s presence in the community in providing end-of-life care education, the ability of the hospice to provide continuous home care to patients who require it, and whether the hospice is Medicare certified and certified by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or another recognized accrediting body. As we look at these factors, what is abundantly clear is that they all have something in common; they are all indicators of the quality of patient care that the hospice program provides.

For it is the quality of care that a hospice pro-
vides, and not whether it is for-profit or not-for profit, that determines whether the patient and family receive the appropriate end-of-life care. And for the patients, their families, their physicians, and their hospice providers, whether for-profit, or not-for-profit, quality of care should be the ultimate “bottom line.”

REFERENCES


Address reprint requests to:
Barry M. Kinzbrunner, M.D.
VITAS Healthcare
100 South Biscayne Boulevard
Suite 150
Miami FL 33131-2011

E-mail: Barry.Kinzbrunner@vitas.com