

## HOSPICE IN MINNESOTA: A RURAL PROFILE

### Background

Numerous national polls have found that when asked, most people would prefer to die in their own homes.<sup>1</sup> Contrary to these wishes, 75 percent of deaths in Greater Minnesota (outside the seven-county metro area) occur in institutional settings. The best way to assure that a person's wish to die at home with high quality of care is through the use of hospice services.

Hospice is a specialized form of care for people with terminal and life-threatening conditions. The focus of hospice care is on treatment and support to provide comfort rather than to cure the disease. Most hospice patients are able to live their final days at home. Hospice programs provide the medical expertise, support and teaching to enable families to care for their loved ones at home. For those who cannot be cared for at home, hospice care can also be provided in a nursing home, residential setting or hospital.

The provision of hospice services in rural Minnesota presents some unique challenges. The 2002 report from the Minnesota Commission on End of Life Care identified rural communities as an underserved population:<sup>2</sup>

*“Helping dying patients to stay at home and providing high-quality end of life care is challenging in rural areas. Hospice programs that could help patients to remain in their homes do not cover all of Minnesota, and many rural hospice programs struggle financially because of the small numbers of eligible patients.”*

*Minnesota Commission on End of Life Care*

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### End of Life Demographics

According to the 2000 census, Minnesota has a total population of 4,919,479. Of those, 2,277,425 or 46% live in Greater Minnesota (outside the seven county metro area.) In 2001 37,505 people died with 20,822 or 55 percent of the deaths occurring in Greater Minnesota. Leading cause of death in both rural and metro areas was heart disease followed by cancer.

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<sup>1</sup> *Means to a Better End*, Last Acts, 2002. H[www.lastacts.org](http://www.lastacts.org)H (6/13/03)

<sup>2</sup> Minnesota Commission on End of Life Care, 2002. H[www.hospicemn.org](http://www.hospicemn.org)H (6/13/03)

Place of Death:

## 2001 Deaths in Minnesota

	Minnesota	%	Greater Minnesota	%	7 County Metro	%
Hospital	14,005	37%	7,826	37.50%	6,179	37%
Nursing Home	13,784	37%	7,773	37%	6,011	36%
Residence	7,876	21%	3,813	18%	4,063	24%
Other	1,840	5%	1,410	7%	430	1%
Total	37,505		20,822		16,663	

In Greater Minnesota 39 percent of all nursing home discharges were due to death compared to 24% in the Metro area.

Most people who die in the state are over the age of 65. The aging population, particularly in the rural areas is a powerful indicator of the need for hospice services.

- 80% of people who die are over the age of 65
- 41% of Minnesota's population over the age of 65 live in rural areas<sup>3</sup>
- The less populated the county, the less likely death will occur at home<sup>4</sup>

### Hospice

Most hospice services are provided to individuals in their homes. The type and frequency of hospice services are tailored to meet the needs of the person who is dying and his or her family. Hospice provides<sup>5</sup>:

- Expertise in comfort care including medications and therapies to relieve pain and symptoms
- Twenty-four hour support in the form of on-call services
- Coordination of help and services needed in the home, including volunteer services
- Necessary medical equipment such as hospital beds and oxygen

Under Minnesota law all hospice programs must be licensed by the Minnesota Department of Health. Most hospice programs in Minnesota are also federally certified in order to provide services under the Medicare Hospice Benefit.

<sup>3</sup> *Implications of rural Minnesota's Changing Demographics*, Minnesota Planning Critical Issues, July 2000, [Hwww.mnplan.state.mn.us/pdf/2000/rural\\_01.pdf](http://www.mnplan.state.mn.us/pdf/2000/rural_01.pdf)H (6/13/03)

<sup>4</sup> Minnesota Commission on End of Life Care

<sup>5</sup> [www.hospicemn.org](http://www.hospicemn.org)

The majority of licensed hospice programs in Minnesota are outside the Twin Cities metropolitan area:

- 83% of all licensed hospices are located outside the seven county metro area
- 38% (4,321) of the 11,359 patients served in 2002 were in rural areas
- 2002 average rural hospice program census was 12 patients<sup>6</sup>

Hospice Programs	Rural	Urban	Total
Licensed	64	13	77
Medicare Certified*	54	10	64

\* Must also be licensed by the state

### Reimbursement

Hospice services are covered under Medicare, Medicaid, Minnesota Care and most private insurance providers.

Over 80 percent of all hospice care is provided under the Hospice Medicare Benefit. Reimbursement is based on a per diem payment that includes the cost of the professional staff, durable medical equipment (such as hospital beds and oxygen) and all medications and therapies related to the treatment of the terminal illness. Under the Medicare Benefit, hospice programs are reimbursed for four different levels of care:

- Routine Home Care. Care provided while the individual is at home. Per diem payments must cover the cost of visiting hospice staff, medications and medical equipment
- Inpatient. Per diem payment covers the cost of a stay in a hospital or acute care facility during a medical crisis
- Respite. Per diem payment covers the cost of short term stay in a hospital, nursing home or other facility to provide respite for the family
- Continuous Care. Per diem payment covers the cost of additional hours of care in the home when the individual is in a medical crisis that would otherwise require hospitalization

Medicare Hospice reimbursement is less for rural areas<sup>7</sup>:

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<sup>6</sup> ibid

<sup>7</sup> ibid

## Daily Medicare Reimbursement Rates

Type of Reimbursement	Rural	Urban
Routine Home Care	\$112.92	\$126.94
Inpatient	\$502.71	\$560.79
Respite	\$117.09	\$128.51
Continuous Care	\$659.06	\$740.85

### Challenges

Not all areas of rural Minnesota have hospice programs available. For those that do, provision of hospice care presents a number of unique challenges:

- Lack of informal caregivers. Hospice care is based on the premise that individuals who want to remain in their homes have either family or informal caregivers. In many areas, the children and younger caregivers have moved to metro areas.
- Financial hardships. Under the Hospice Medicare Benefit, programs must provide an array of services under a per diem mechanism. A low volume of patients creates financial hardships in spreading the risk of high-cost patients. For example, a hospice program will receive only \$112.92 a day for all services even if it is paying several thousand dollars to provide palliative radiation or expensive pain medications<sup>8</sup>.
- Lack of qualified professional staff. Rural areas face an increasing health workforce shortage including nurses. Hospice licensure requires specially trained interdisciplinary professional staff and 24 hour seven day a week coverage. Small hospice programs often have difficulty finding qualified personnel to share the 24/7 burden.
- Increased expenses due to greater travel, more expensive telecommunications systems and inability to cost share through purchasing cooperatives. Reimbursement from Medicare does not take into considerations some of the higher costs of providing services in a rural community<sup>9</sup>.

*“In our region, many of the children have moved away. When someone is old and frail, they have no one to take care of them.”*

*Rural Public Health Nurse*

<sup>8</sup> *Use of Hospice Benefit by Rural Medicare Beneficiaries*, Rural Health Research Center, University of Minnesota, Minneapolis, MN September, 2002.

<sup>9</sup> *ibid*

## Recommendations

The Minnesota Commission on End of Life Care issued four recommendations regarding improving care and strengthening hospice in rural Minnesota.<sup>10</sup>

- Create education and development opportunities to strengthen the rural hospice infrastructure. Strategies include hospice management workshop to help hospice leaders expand access, understand finances, and explore benefits of building coalitions.
- Fund the development of hospice programs in unserved areas. Strategies include public and private grants and local fund-raising initiatives.
- Educate the public on end of life services through locally based initiatives. Strategies include training staff from Area Agencies on Aging and county workers on hospice benefits and other resources.
- Educate physicians, nurses, and other health care personnel in hospice and palliative medicine. Strategies include development of local and regional education opportunities.

### Five Guiding Principles for End of Life Care

1. Preference for treatment and care will be discussed and respected.
2. Every reasonable effort will be made to relieve pain and other undesirable physical symptoms.
3. Emotional, spiritual, and personal suffering will be identified, addressed, and discussed.
4. Appropriate and realistic information will be provided regarding prognosis and the expected course of the events preceding death.
5. Grieving will be acknowledged.

*Minnesota Commission on End of Life Care*

<sup>10</sup> Minnesota Commission on End of Life Care.

## Resources

Hospice Minnesota. Provider organization. Lists hospice programs and other resources. Contains full report of the Minnesota Commission on End of Life Care. [www.hospicemn.org](http://www.hospicemn.org)

Last Acts. A website listing a variety of end of life resources including the report *A Means to a Better End*, a state by state report on end of life care. [www.lastacts.org](http://www.lastacts.org)

Minnesota Department of Health. Website lists all licensed hospice programs in Minnesota. <http://www.health.state.mn.us/divs/fpc/directory/fpcdir.html>

National Hospice and Palliative Care Organization. Lists hospice programs throughout the country and other resources. [www.nhpc.org](http://www.nhpc.org)

