Original article :

Main Referral Sources Based on Hospice Organizational Structure Variances in the United States

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Abstract

Background and Aim:
Referral contracts are an avenue for understanding the organizational structure of different hospice organizations. The aim of the study is to determine whether an organization's type and ownership impact patient referral patterns.

Methods:
A cross-sectional retrospective study was conducted among a nationally weighted representative sample of 620 hospice agencies in the United States. The survey responses were collected using a stratified, multistage probability design.

Results:
The data supported that hospice referral sources are impacted by organizational variations in ownership status. The data showed that 101(23.5%) of for-profit hospitals reported a hospital as their main referral source. Approximately 167(68.5%) of respondents reported hospitals which were the main referral sources, were part of a chain. For-profit hospice agencies were 7.82 times and 4.21 times more likely to have nursing homes and physicians' offices as the main

الملخص

الخلفية و الهدف:
تعتبر عقود الإحالة وسيلة لفهم الهيكل التنظيمي لمختلف مؤسسات التلطيفيه و الهدف من الدراسة هو تحديد ما إذا كان نوع المؤسسة و ملكيتها يؤثران على أنماط إحالة المرضى.

طريقة البحث:
أجريت دراسة استعادية مستعرضة لعينة ممثلة و مرجحة وطنيا من ٦٢٠ مؤسسة تلطيفية في الولايات المتحدة. وتم جمع ردود المسح باستخدام تصميم احتمالي متعدد المراحل

النتائج:
دعمت نتائج هذه الدراسة أن مصادر إحالة المرضى إلى مؤسسات الرعاية التلطيفيه تتأثر بالتغيرات التنظيمية وحالة الملكية. وأظهرت النتائج أن ١٠١ (٢٣,٥٪) من المستشفيات الربحية هى من مصادر الإحالة الرئيسيه للمرضى. كما أفاد حوالي ١٦٧ (٦٨,٥٪) من المستجيبين أن مصدر إحالتهم الرئيسية كان جزء من سلسلة مستشفيات . و كانت دور الرعاية التمريضيه و العيادات الطبية التى تمتلكها مؤسسات الرعاية التلطيفيه الربحية اكثر عرضة كمصدر إحالة رئيسي للمرضى ٧,٥ و ٤,٢١ مره على التوالى. كما بينت النتائج ان ٤٢٪ (نسبة الأرجحية المعدلة = ٠,٥٨ ؛ فاصل الثقة ٩٥٪ = ٠,٣٦-٠,٩) من مؤسسات الرعاية التلطيفيه غير الهادفة للربح أقل احتمالية أن يكون لديها مشرفون بدرجة ماجستير من أولئك الذين لديهم درجة البكالوريوس. واثبت الانحدار اللوجستي متعدد التغيرات إن مؤسسات الرعاية التلطيفيه غير الهادفة للربح من المرجح ٤,٤٢

patient referral source. Not-for-profit hospices were 42% (adjusted odds ratio = 0.58; 95% confidence interval = 0.36–0.9) less likely to have administrators with a master's administrator than those with a bachelor's degree. Not-for-profit hospices were 4.42 times and 1.72 more likely to be part of a change and have no formal contracts with outside sources.

Conclusion:

Hospice care is a comprehensive interdisciplinary approach to end-of-life care for patients. The referral sources are impacted based on their ownership statuses. Proper knowledge of hospice and hospice services delivery is essential to provide effective referrals. The data presents that internal and external factors play critical roles in the overall referral sources of hospice organizations.

Keywords:

Hospice care, referral sources, organization ownership, affiliation status

مرة جزءًا من التغيير ، و١,٧٢ ليس لديها عقود رسمية مع مصادر خارجية.

الخلاصة:

الرعاية التلطيفيه هي نهج شامل ومتعدد التخصصات لرعاية نهاية الحياة للمرضى. إلا أن مصادر الإحالة تتأثر بناءً على حالة ملكيتها. المعرفة الصحيحة عن الرعاية التلطيفيه وخدماتها أمر بالغ الأهمية لتوفير الإحالات بشكل فعال. تلعب

Introduction

For the past two decades, hospice use has been viewed as a measure for quality end-of-life care, with a dramatic increase in decedents using hospice from 23% in 2000 to 48.2% in 2017.[1] Furthermore, for-profit hospices has increasingly entered the U.S. market during the last decade.[1, 2] This privatization has affected access to and quality of hospice care.[3] Today, there are two main types of hospice ownership, for-profit and not-for-profit. For-profits tend to maximize their profits to meet the interests of stakeholders, while not-for-profits must satisfy the mandates and provisions set forth by the communities and charities that support them. In many cases, this includes accepting unfavorable risks to maintain their nonprofit tax status.[4] Furthermore, hospice care was created as a federal benefit reimbursable by Medicare more than three decades ago and provides comprehensive end-of-life care based on clinician support and services that, if deemed reasonable, may be elected by patients in any venue of care.[5]

Thus, physicians and hospital referral co-

ordinators should be aware of the impact that improper framing of their hospice services discussions might have on a patient[6] Hospitals are a major referral source for hospice organizations.[7] Studies have indicated that hospice services, along with palliative care consulting services, have increased patient and family satisfaction, improved quality of life, reduced lengths of stay in intensive care units, and decreased costs of hospitalization.[8-11] Within hospitals, increasing the knowledge of hospice services has proven to affect the amount and quality of referrals to hospice organizations.[12]

The timely referral of a patient to hospice can minimize the patient and caregiver's distress and can ensure that quality of care and quality of life are optimized.[13] Physicians are demanding reform to the process of referring patients to hospice. For physician offices and hospitals referring patients to hospices, having pre-established referral contracts are critical for the optimization of resources.[14] Despite the benefits of hospice care, there is a significant level of variation in who is enrolled in hospice, which is not based on patient or caregiver preferences. Studies have shown that health-care system characteristics, such as health maintenance, organization membership,[15] and region,[16, 17] contribute to hospice enrollment. However, to our knowledge, limited studies have explored the impact of ownership status on referral patterns. Therefore, the purpose of the study is to determine whether ownership status impacts patient referral patterns.

Methods

Design and Data Source

This study used a secondary cross-sectional retrospective design to analyze the U.S. National Home and Hospice Care Survey (NHHCS),[18] representing more than 15,000 agencies and 160,700 home health aides. The data is publicly available through the Centers for Disease Control and Prevention. Survey responses were collected by the Centers for Disease Control and Prevention using a stratified, multistage probability design. A detailed methods report on the NHHCS is on the NHHCS website at http://www.cdc.gov/nchs/nhhcs.htm.[18] The data was collected through in-person interviews with agency directors and through designated staff members. There was an omission of patients or their families and friends. Data pertaining to agency administrative records included the year the agency was established, the types of services the agency provided, and referral sources. There are three main types of agencies: home health, hospice only, and home health and hos-

pice. There were 1,036 agencies and data on 9,416 current home health patients and hospice discharges from these respected agencies. Inclusion criteria for the study was that the agencies provided hospice care only; 359 agencies were hospice care facilities. Because NHHCS is a sample survey and is designed to produce national estimates for agencies, patient discharges, and home health aides, data analyses must include sampling weights to inflate the sample numbers to national estimates. To help encompass a weighted average that resembled the onset of the general population, "strata stratum" and "weight sizagywt" were used.[18] Post implementing survey weight design; the final representative sample consisted of 620 hospice care facilities. The research was reviewed and categorized as "exempt" by the Institutional Review Board of the University of South Carolina because the study analyzed secondary data.

Measures

The outcome variable within this study is the number of referrals, based on a percentage of all hospice patients as a whole. This is significant because it will indicate the percentage of different referrals for a given type of hospice and any differences between referral sources. Although the outcome variable is not indicated on a per hospice basis, it does explore how differences within the hospice corporate structures are related.

Ultimately, this study explored variables that were based exclusively on hospice agencies. There are a number of exploratory independent variables that were explored through this study. These include type of hospice agency, type of ownership, agency director, formal contacts, and chain.

It is important to note that this information is solely descriptive. Home health organizations offering home health and hospice were omitted from the dataset. This did lower the number of observations that were available from 1,036 to 359, as previously noted, but it was believed that having a dataset that was completely homogeneous in respect to organization type was crucial to the sustainability of any findings. The variable of organizations offering home health and hospice was omitted, even though these organizations had a hospice part, because of the possible effect that having two different types of organizations might have on the overall findings of that subgroup. Ownership status was another focus area for this study.

Within this area, information was explored with respect to agency administration, contracts with outside agencies, and agency chain status. With respect to agency, there

were two main responses retained during analysis: for-profit and other. It is important to note that "other" included not-for-profit and government agency ownership. In exploring the basis of these variables, it is important to note that, in some cases, the organizations might be seen as a "hybrid." This refers to organizations that were for-profit but also had a variable organization division that assisted some patients. In these cases, even though there might be a nonprofit section, the overall organization was coded as for-profit. The recipients that answered "inapplicable/not ascertained," "refuse to answer," or "don't know" were omitted from the framework of the study.

When asked, "what is the agency's main patient referral source for hospice care," the responses were combined to help provide a better understanding of current trends. The respondents that answered "hospital" or "nursing home" were kept intact, while respondents that indicated "physician's office," "patients/family/friends," or "all others" were combined into a single group.

Consolidation with respect to the highest amount of education that an agency director or administrator received helped to streamline this variable. Respondents that indicated 'diploma degree in nursing', 'associate's degree in nursing', 'associate's degree in health-care administration', 'associate's degree' (other health-related), or 'associate's degree' (not health-related) were reassigned to a category that was renamed "associate's degree." Respondents that indicated 'bachelor's degree in nursing', 'bachelor's in health-care administration', 'bachelor's degree'

(other health-related), or 'bachelor's degree' (not health-related) were reassigned to a category that was named 'bachelor's degree.' Respondents that indicated 'master's degree in nursing', 'master's in health-care administration', 'master's degree' (other health related), 'master's degree' (not health related), or doctorate-level degree were reassigned to a category that was named "graduate degree." Respondents that indicated "other" were omitted.

Formal contracts play a major role within the organizational structure of hospice organizations. This was extremely evident when respondents were asked if their organizations had formal contracts with outside agencies or organizations to provide services to residents, assisted living, life care or a continuing care retirement community, hospital, skilled nursing facility, hospice, or managed organization. Respondents that answered "inapplicable/not ascertained," "RF," or "don't know" to any of these questions were omitted from the study.

A number of hospice organizations are

members of a chain; therefore, exploring the variables of being in a chain was important in this study. There were two main responses to this question. Respondents indicated either that they were part of a chain or that they were not part of a chain. Respondents that answered "inapplicable/not ascertained," "refuse to answer," or "don't know" were omitted from the study.

Statistical Analysis

STATA 14.2 was used to account for the complex, weighted, and clustered structure of the sample design. Statistical significance was determined by an alpha level of 0.05 and verified through a 95% (CI). We conducted univariate and bivariate chi-square analyses and reported, frequencies, percentages, and P-values. A logistic regression model was used to explore whether a hospice organization's type and ownership impact patient referral patterns. We also reported the P-values from the Wald statistics.

Ethical Considerations

In accordance with the policy of the University of South Carolina, the University's Institutional Review Board categorized the research as exempt because the study analyzed secondary data that is publicly accessible.

Results

The data for this study isolated respondents that were solely a hospice agency. This was done to help explore the findings in a hospice-only environment. Although this did decrease the number of available participants, it also helped to provide powerful insight into the hospice-only arena. The number of respondents dropped to a weighted 620 from a previous participant pool of 1,036. Table 1 shows the sample's descriptive statistics. About 63.1% (426) of referral sources are from hospitals, a little over a third (36.5%, n = 247) of administrators had diplomas, and another third (38.2%, n = 363) had master's degrees. The results of our cross-tabulation chi-square show a significant relationship between main referral source, highest degree of the administrator, part of a chain and having any formal contract with outside sources, and hospital ownership status.

Table 1: General Characteristics of Home Health and Hospice Agencies (NHHCS)

	Total	For-Profit	Others (Not-For-Profit, Government)
	n (%)	n (%)	n (%)
Main Referral Source*			
Hospital	426 (63.1%)	101 (23.7%)	325 (76.3%)
Nursing Home	85 (12.6%)	61 (71.8%)	24 (28.2%)
Physician's Office	164 (24.3%)	96 (58.5%)	68 (41.5%)
Highest Degree of Administrator*			
Diploma	347 (36.5%)	129 (37.2%)	218 (62.8%)
Bachelors	241 (25.3%)	114 (47.3%)	127 (52.7%)
Masters	363 (38.2%)	69 (19.0%)	294 (81.0%)
Affiliation			
Free Standing	362 (34.9%)	111 (30.7%)	251 (69.3%)
Non-Free Standing	674 (65.1%)	244 (36.2%)	430 (63.8%)
Part of Chain*			
Yes	244 (23.6%)	167 (68.4%)	77 (31.6%)
No	792 (76.4%)	188 (23.7%)	604 (76.3%)
Formal contact with outside source*			
Yes	801 (77.6%)	238 (29.7%)	563 (70.3%)
No	231 (22.4%)	114 (49.4%)	117 (50.6%)

* Indicated finding were significant with a $p<0.05$

For-profit hospice agencies were 7.82 times and 4.21 times more likely to have nursing homes and physicians' offices as the main patient referral source than hospitals (Table 2). Not-profit hospices were 42% (Adjusted Odds ratio (OR) = 0.58; 95% Confidence interval (CI) = 0.36, 0.9) less likely to have administrators with 'master's degrees' than administrators with 'bachelor's degrees'. Not-for-profit hospices were 4.42 times and 1.72 more likely to be part of a chain and have no formal contracts with any outside sources.

Table 2. Multivariable logistic regression to examine the association between hospice ownership and main patient referral source, adjusting for hospice characteristics, n=620

	Hospice Ownership Status	
	Adjusted OR	95% Confidence Limits
Main Patient Referral Source (Reference: Hospital)		
Nursing Home	7.82***	[4.33-14.14]
Physician's Office	4.21***	[2.57-6.89]
Administrator's Highest Degree (Reference: Bachelors)		
Diploma	1.07	[0.64-1.80]
Masters	0.58*	[0.36-0.93]

Affiliation (Reference: Non-Free Standing)		
Free Standing	0.79	[0.43-1.43]
Part of Chain (Reference=No)		
Yes	4.42***	[2.69-7.26]
Having any formal contact with outside source (Reference: Yes)		
No	1.72*	[1.13-2.63]

Exponentiated coefficients; 95% confidence intervals in brackets, 416 observations were removed due to missing data

Discussion

The number of hospice organizations has grown in the United States from a single hospice in 1975 to well over 3,400 organizations in 2016.[19] Current population trajectories suggest that hospice organizations will be utilized even more.[20] Our findings conclude that hospice referral sources are impacted based on their ownership status. We highlight that the optimal hospice structure consistent through all different environments is not present and that internal

(i.e., highest degree of administrator) and external (i.e., within the environment and hospice agency) factors play critical roles in the overall referral sources of hospice organizations.

There were three key findings from the multivariable analysis. The first shows that for-profit hospice agencies are more likely to receive referrals from nursing homes and physicians' offices than from hospitals. For-profit hospices typically have greater emphasis on nursing home referrals.[21] Hospices that are part of chains have the potential to achieve greater efficiency and quality through mechanisms, such as increased standardization, knowledge transfer, and enhanced information systems.[21] Based on a U.S. national study, approximately 27% of Medicare-certified hospices do not provide a single day of general inpatient care.[22] Based on information from the NHHCS, 32% of hospice agencies had no contracts with any hospitals, and half of those hospitals did not have a contract with a skilled nursing facility either. This ultimately resulted in a disconnect within the continuum of care, where hospices were unable to provide general inpatient care referrals for those in need of inpatient care.[22] By 2015, nursing homes contracted with 3.8 hospice agencies on average, while only 36% of nursing homes had residents receiving hospice from one (17%) or two (19%) agencies, with 20% of nursing home-hospice users receiving hospice and nursing home care from entities with overlapping financial interests.[16, 22] Meaning that the hospice organization and the nursing facilitates share ownership interests. Notwithstanding common

ownership between hospice agencies and nursing homes becoming more common, the broader health-care sector continues to consolidate and streamline its corporate organizational structure.[23]

We expanded the literature by our second key finding, which showed that not-for-profit hospices were likely to have administrators with higher educational attainment. To our knowledge, no research has examined the impact of administrative educational attainment level in hospice agencies. However, borrowing from the leadership literature, one of the major benefits of higher education in leadership can be traced to the incorporation of the interdisciplinary team approach to care[24] A study showed the major barrier for hospice providers is coordinating with the current caregiver, which is either a nursing home, staff member, or caregiver in a private residence. Poor provider relations can easily derail optimal care for the hospice patient, making barriers important to address when providing optimal hospice care.[25] The focus for leadership training and care coordination should be at the administration level.[26, 27] Nevertheless, transformational leadership within hospice has undergone several changes;[28] however, it continues to focus heavily on nurses rather than medical doctors and health administrators.[29] The components of transformational leadership, behavior, and characteristics are linked to hospice theory and hospice-specific practices.[30] Many believe this focus is rooted in the very beginnings of hospice. There is also a connection between nurse managers' attitudes about the existing organizational culture and the strategy of the top level and their management idea.[31] Within hospitals, increasing the knowledge of hospice services has proven to affect the amount and quality of referrals to hospice organizations.[32, 33] Ultimately, due to the changing health-care landscape and the incorporation of more nurses and other clinical staff in management positions, the overall organizational structure of hospices within the United States will continue to evolve.[29] Health care providers cite the huge burden in correctly estimating prognoses and care provided by hospice services.[34] Proper knowledge of hospice and hospice service delivery is critical to provide effective referrals.[35]

The third key finding highlighted that not-for-profit hospice agencies were more likely to be part of a chain and have limited or no formal established contracts with outside care delivery sources. Having a referral source between current health-care providers and a hospice organization would help mitigate any confusion that a patient and/or family member(s) might have.[36] Confusion over services combined

with emotional issues make the transfer to hospice a very important yet difficult choice with which many patients and/or caregivers are faced. Given that variations of services exist not only between different hospices but also hospices within the same region or large organization,[36] having a referral contract between health-care providers and hospice organizations could help mitigate confusion between service providers and help ease the anxiety associated with switching medical providers for patients, their caregiver(s), and their current health-care providers.[22, 37] Hospice care is generally viewed as a gold standard for life-limiting care.[25] It is believed by many health-care management executives that the need for hospice and home health care services will continue to increase over the next 30 years to accommodate the current "baby boomers" and our nation's continued population growth.[38] Thus, establishing formal contracts with external care providers will ensure smoother handoffs and easier transitions for the patients and providers.[39]

The study presented here has several limitations. The study uses a cross-sectional design, and thus, we are limited to examining associations. As this is the first and the only representative sample of hospice agencies, it provides us with advantages in understanding their key referral patterns and issues, which might persist over time. These findings justify follow-up surveys to understand the hospice industry and position the industry to meet the needs of an aging population. Our study fails to address patients' feelings about losing their health-care providers. The largest barrier that patients indicate when enrolling in hospice is the fear of losing contact with their current health-care providers.[34] Many qualified patients fail to utilize hospice services or enroll too late.[40]

Conclusion

Our study shows that hospice referral sources are impacted based on their ownership statuses. Future research needs to address patterns of referrals over time and to explore the impact of politics and practice changes on hospice referrals.

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