HOSPICE - CBRF INTERFACE

Care Coordination Guidelines for Hospice Patients who are Residents of Community-based Residential Facilities

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
DIVISION OF QUALITY ASSURANCE

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SECTION I INTRODUCTION AND BACKGROUND

Persons who are eligible to access their hospice entitlement have the right to receive those services in their primary place of residence. For some persons, their place of residence may be a Community-based Residential Facility (CBRF). This document provides guidelines for hospice and CBRF providers when jointly serving hospice patients who choose to reside in a CBRF.

This guideline is not a regulatory requirement, but it is consistent with federal and state regulations, if properly implemented. It is intended as a tool for quality improvement that providers can integrate into their policies, procedures, and clinical practice. The document is not a "blueprint" for providers. The guidelines offer a framework to structure joint relationships to promote regulatory compliance and the mission of both hospice and CBRF providers in service to a common patient/resident and their family at the end of life.

The Division of Quality Assurance (DQA) would like to thank the Hospice Organization and Palliative Experts (HOPE) of Wisconsin for their input and assistance in the development of this guideline.

SECTION II REGULATORY REFERENCES

Protocols and guidelines outlined in this document were developed with consideration for existing state and federal regulations.

Wisconsin State Statutes

Chapter 50, Wisconsin State Statute

Wisconsin Administrative Code

- Chapter DHS 131, Hospices
- Chapter DHS 83, Community-based Residential Facility

DQA Memos

DQA Memo 09-042, "Palliative Care"

Federal

- 42 Code of Federal Regulation (CFR) Part 418, Hospice
- Social Security Act Section 1861(dd)
- Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix M, Hospice Survey Procedures and Interpretive Guidelines

SECTION III CONTRACT CONSIDERATIONS

A. INTRODUCTION

The following list of key considerations during hospice/CBRF contract negotiations is meant to assist providers in effectively coordinating provider services to the hospice patient receiving routine home care who resides in a CBRF. While by no means all-inclusive, these factors reflect many provisions found in the hospice and CBRF regulations and were compiled from comments and guidance distributed by authoritative state (Division of Quality Assurance) and federal (Centers for Medicare and Medicaid Services) sources.

The information that follows is specifically pertinent to the routine home care (when the patient is not receiving inpatient, continuing, or inpatient respite care) contract. It is not intended to comprehensively address considerations for continuous care (predominately nursing care for brief periods of crisis to maintain the patient in their home setting) which hospices and CBRFs may elect to include as part of the same contract or as separate contracts. Providers are encouraged to review the following contract considerations, but since the listing is not exhaustive, are cautioned to also review their respective regulations, insurance and liability concerns, financial position, and attorney's advice prior to entering into any formal contract.

B. CONSIDERATIONS FOR THE HOSPICE "ROUTINE HOME CARE" CONTRACT

1. Contract Requirements

Federal Conditions of Participation (§ 418.112) and State of Wisconsin rules and regulations (DHS 131.30) for hospice have specific requirements related to the written agreement. The agreement specifies the provision of hospice services in the CBRF and must be signed by authorized representatives of the hospice and the CBRF before the provision of hospice services. Whether a hospice is allowed access into a CBRF is the decision of the administrator/owner. While an exclusive or semi-exclusive arrangement can promote efficiency and safety, providers should avoid illegal inducements in negotiating.

The negotiated, written agreement must include at least the following:

a. The manner in which the CBRF and the hospice are to communicate with each other and document such communications to ensure that the needs of patients/residents are addressed and met 24 hours a day. § 418.112(c)(1)

b. A provision that the CBRF immediately notifies the hospice if:

   1) A significant change in a patient's/resident's physical, mental, social, or emotional status occurs;

   2) Clinical complications appear that suggest a need to alter the plan of care;

   3) A need to transfer a patient/resident from the CBRF, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or in patient care necessary related to the terminal illness and related conditions; or

   4) A patient/resident dies. § 418.112(c)(2)

c. A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. § 418.112(c)(3)

d. A stipulation that services are to be provided only with the authorization of the hospice and as directed by the hospice plan of care for the patient. DHS 131.30(2)(b)2

e. Identification of the services to be provided by each provider. DHS 131.30(2)(b)1

f. The manner in which the contracted services are coordinated and supervised by the hospice. DHS 131.30(2)(b)3

g. A delineation of the hospice's responsibilities for all services delivered to the patient/resident or the patient's/resident's family, or both, through the contract, which include, but are not limited to the following:

   1) Providing medical direction and management of the patient/resident;

   2) Nursing;

   3) Counseling (including spiritual, dietary, and bereavement);

   4) Social work;

   5) Provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and

   6) All other hospice services that are necessary for the care of the patient's/resident's terminal illness and related conditions. § 418.112(c)(6)

h. Services to be provided by the CBRF may include:

   - Personal care services
   - Assistance with activities of daily living (ADLs)
   - Assistance with administration of medication under the direction of the hospice (IV, IM meds are the responsibility of the hospice). (CBRF staff may be limited to the type of medication administered based on training, competency, and supervision.)
   - Community/leisure time activities
   - Room cleanliness
   - Supervision/assistance with durable medical equipment (DME) use and prescribed therapies
   - Family/legal representative contacts unrelated to medical/terminal conditions
   - Health monitoring of general conditions (i.e., accuchecks/temps/blood pressure) and report to hospice
   - Nutritional meals/snacks

i. The delineation of the roles of the hospice and service provider in the admission process, assessment, interdisciplinary group meetings, and ongoing provision of palliative and supportive care. DHS 131.30(2)(b)4

j. A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient/resident property by anyone unrelated to the hospice to the CBRF administrator within 24 hours of the hospice becoming aware of the alleged violation. § 418.112(c)(8)

Although not required by DHS 83 (CBRF) for a CBRF to inform hospice, exchange of this information should be encouraged.

k. A method of evaluation of the effectiveness of those contracted services through the quality assurance program based on state and federal rules and regulations. DHS 131.30(2)(b)5

l. The qualifications of the personnel providing the services. DHS 131.30(2)(b)

m. A delineation of the responsibilities of the hospice and the CBRF to provide bereavement services to CBRF staff. § 418.112(c)(9)

2. Reimbursement Issues

Providers must have a clear understanding of the financial ramifications of the partnership. Specify which entity is responsible for billing the cost of specific services and determining to whom billing is directed. (See chart below.)

HOSPICE QUALIFIED	CBRF
Medicare Hospice services for the palliation of the terminal illness may include: physician services, nursing care, hospice aide care, medical equipment, medical supplies, drugs/biologicals, PT, OT, speech therapy, social work services, dietary counseling, volunteer, and grief and loss counseling for the patient, family, and CBRF staff. **Medicaid** Qualified patient/resident has a right to elect hospice Medicaid benefit, which pays for hospice services including routine home care and continuous home care in the CBRF. Hospice services are the same as the Medicare services listed above. **Private Insurance** Most private insurances cover hospice homecare services.	**Direct Billing** ▪ CBRF directly bills patient and/or family for CBRF services. ▪ FamilyCare, Medicaid Home and Community-based services ▪ Private insurance

SECTION IV CLINICAL PROTOCOL DEVELOPMENT

Effective coordination of care that assures patient/resident needs and regulatory requirements are met necessitates careful planning by both the CBRF and the hospice. The development of policies and protocols that define care coordination issues is essential to ensure consistent quality.

A. Priority Areas

Priority areas have been identified for consideration in the development of clinical protocols.

- Admission Process
- Medical Orders
- Supplies, Equipment, Medications, and Contracted Services
- Medical Record Management
- Hospice Core Services
- Death Event
- Quality Assessment / Performance Improvement (QAPI)
- Emergency Care / Change in Condition
- Employment Issues

1. Admission Process

Protocols should be developed that clarify the process of admitting a current CBRF resident to hospice, a current hospice patient to the CBRF, and for the simultaneous admission of a person who is new to both the hospice and the CBRF. Both providers verify appropriate licensing under DHS 131 and DHS 83.

Admission: Referral of CBRF Resident to Hospice

- Referral of resident to Hospice made by the CBRF or others
- Consult / information provided by Hospice
- Resident meets hospice admission criteria and elects to receive hospice care. The hospice inter-disciplinary group (hospice team) conducts assessments and collaborates with the physician for any change in orders.
- Hospice/CBRF begin initiation of a coordinated plan of care / individualized service plan.

Admission: Referral of Hospice Patient/resident to CBRF

- Hospice makes referral to CBRF. The hospice may initiate contact with the CBRF and facilitate communication between the patient/family and the CBRF representative.
- CBRF performs pre-admission assessment.
- CBRF agrees to admit patient to CBRF and determines admit date.
- Hospice and CBRF coordinate securing required admission paperwork (i.e., history and physical, tuberculoses screening, physician orders, etc.)
- Hospice transfers patient to CBRF. Hospice involvement continues on day of transfer.
- Hospice/CBRF begin initiation of a coordinated plan of care / individualized service plan.

Admission: Simultaneous Referral to Hospice and CBRF

- Provider makes referral to hospice and CBRF. (Let each provider know that referrals are being made to the other provider.)
- Hospice and CBRF coordinate the admission process and required paperwork.
- Provider transfers patient/resident to CBRF. After admission to the CBRF, hospice continues to care for the patient.
- Hospice/CBRF begin initiation of a coordinated plan of care plan/individualized service plan.

2. Medical Orders

- Hospice is responsible for securing medical orders and assuring that they are consistent with the hospice philosophy.
- All orders must be patient/resident specific. Orders are obtained by the hospice and provided to the CBRF. These orders are initiated by the hospice according to patient/resident need.
- All verbal, phone, and written orders must be pre-authorized by hospice before initiated.
- Laboratory tests or other diagnostic procedures related to the terminal illness must be approved by hospice and specified on the plan of care/individualized service plan.
- CBRF may carry out orders from a hospice nurse as prescribed and as delegated by the CBRF RN, if applicable.
- Contract should include timeline as to how the CBRF will obtain a copy of signed orders.

3. Supplies, Equipment, Medications, and Contracted Services

Supplies and medications related to the management of the terminal illness are the responsibility of the hospice. The CBRF remains responsible for room and board services that it would provide for non-hospice patients. Hospice should coordinate obtaining and monitoring the following according to the terms of their contract:

- Disposable medical supplies related to the terminal illness, as specified in the plan of care.
- Durable medical equipment (DME), which can include hospital bed, wheelchair, walker, bath bench, commode, or oxygen related to the terminal illness.
- Prescription and/or non-prescription medications related to the terminal illness (medications supplied by hospice) must meet CBRF pharmacy labeling and packaging requirements in DHS 83 and company policies and procedures.
- The hospice is responsible for assessing the need for and obtaining medications related to the terminal illness in a timely manner.
- The CBRF is responsible for securing storage of adequate medications and for accounting of medications.
- For hospice residents in pain, providers must coordinate their care including:
    - Choice of palliative interventions

- Responsibility for assessing pain
- Responsibility for monitoring symptoms of pain and adverse reactions
- Modifying interventions as needed

- Provision of contracted services, i.e., physical therapy, occupational therapy, speech therapy, dietary, related to the terminal illness should be specified on the plan of care and clarified in the contract.

4. Medical Record Management

- Providers mutually agree upon a system to store and share documents in the medical record. If the medical records are maintained in notebooks, combining documents in the same notebook separated by a hospice tab may facilitate the communication of information.

- Documents provided by the hospice, such as election forms, advance directives, certification of terminal illness, and any subsequent re-certifications of terminal illness should remain in the CBRF medical record and not be thinned.

- The patient's/resident's record in the CBRF will confidentially identify the person as a hospice patient.

- The records of a patient/resident residing in the CBRF must include clinical information that is relevant to the care of the patient/resident (orders, data assessment, etc.), whether obtained by the hospice or the CBRF.

5. Hospice Services

Hospice services are defined by the Code of Federal Regulation (CFR). All covered hospice services must be available through the hospice provider through the plan of care as necessary to meet the needs of the patient/resident for the terminal illness and related conditions. These services are to be routinely provided directly by hospice employees and cannot be delegated to the CBRF staff. Hospice core services include nursing services, medical social services, physician services, medical director, and counseling services. Hospice non-core services include therapies, aides, homemaker services, and volunteers.

a. Nursing Services

Nursing care is a core service of hospice for assessment, planning, intervention, and evaluation.

The hospice may involve CBRF staff to assist with the administration of prescribed interventions as specified in the plan of care based on the staff's qualifications and CBRF regulations. This involvement would be to the extent that the hospice would routinely utilize the patient/resident's family/caregiver in implementing the plan of care.

b. Medical Social Services

Social services constitute a core service of hospice for assessment, planning, intervention, and evaluation related to the terminal illness.

Other social service interventions may be provided collaboratively by hospice and CBRF social workers based on the plan of care.

c. Counseling Services (Bereavement / Dietary / Spiritual / Other)

Counseling is a core service of hospice for assessment, planning, intervention, and evaluation related to the terminal illness (type of counseling is defined by individual hospice).

Bereavement services are a required service for licensure per DHS 131.25(6)(a), Wisconsin Administrative Code. Bereavement counseling is extended to other residents of the CBRF as identified in the bereavement plan of care.

Additional counseling interventions may be provided collaboratively by the hospice and CBRF staff based on the plan of care.

d. Physician Services

Physician Services are a core service of hospice for assessment, planning, intervention, and evaluation related to the terminal illness.

At the time of admission to hospice, a decision is made as to the role of all physicians providing care. The patient/resident has the right to choose her/his attending physician, if any.

Consulting physicians may be involved. Coverage for attending physicians is provided by consulting physicians. The hospice is responsible for arranging consulting physician services.

e. Therapy Services

Therapy services (physical therapy, occupational therapy, and speech-language pathology) should be made available based on patient/resident need and as specified in the plan of care. Provision of contracted services, such as physical therapy, occupational therapy, speech therapy, etc. related to the terminal illness, should be specified on the plan of care and clarified in the contract.

f. Hospice Aide Services

Aides may provide personal care services, such as bathing, grooming, dressing, or other personal care, and will be identified by the hospice RN and noted in the patient's plan of care. Hospice aides must have successfully completed hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness and trained in how to interact with CBRF staff.

g. Hospice Volunteer Services

Volunteers may be used to provide patient care services. The services will be identified by the hospice RN and noted in the patient's plan of care. Volunteers are considered hospice employees and will receive a background review, training, and orientation in hospice and assisted living prior to any patient care.

6. Death Event

Death is an anticipated event for the hospice patient/resident. Protocols should be established to define mutual responsibilities at the time of death:

- At the time of death, the CBRF must notify the hospice. The hospice RN is legally authorized to pronounce death and is responsible for coordinating the death pronouncement and subsequent interventions, including coordination with the family and funeral home or coroner, if indicated.
- Review state, county, and CBRF guidelines regarding coroner/medical examiner involvement, and follow the protocol.
- The hospice nurse coordinates notification of physician for release of body.
- Medication disposal should be discussed and disposed of via terms of the contract.
- Specify hospice and CBRF role in supporting the patient's/resident's family/caregivers and CBRF staff.

7. Quality Assessment Performance Improvement

The CBRF and hospice must work together and use a collaborative approach for problem solving; outcome monitoring is encouraged for inter-related issues.

8. Emergency Care / Change in Condition

Emergency care is defined as unexpected and may or may not be related to the terminal illness.

Care should be consistent with the patient's/resident's stated wishes in the advance directive and with the physician's orders, including cardiopulmonary resuscitation.

CBRF staff provides immediate care in conjunction with CBRF policy and/or based on plan of care.

CBRF staff must notify hospice immediately of patient/resident change of condition for further assessment and revision of plan of care as specified in the contract.

CBRF staff immediately notifies the hospice if:

- A significant change in a patient's/resident's physical, mental, social, or emotional status occurs;
- Clinical complications appear that suggest a need to alter the plan of care;
- A need to transfer a patient/resident from the CBRF arises and the hospice makes arrangements for, and remains responsible for, any necessary continuous or inpatient care related to the terminal illness and related conditions; or
- A patient/resident dies.

Hospice is responsible for making the decision as to the level of care required and subsequent arrangements for the patient/resident to receive the care, medications, or equipment, if needed, related to the terminal illness.

9. Employment Issues

- A key consideration for both the hospice and CBRF is the extent to which services will be directly provided by hospice with its own staff, since hospice receives the payment.

- A hospice may use contracted employees for core service only during
  - Periods of peak patient/resident load
  - Extraordinary circumstances
- For a hospice, “employee” is defined in 42 CFR 418.3 and DHS 131.13(7) and (25). (These definitions also apply to volunteers.)
- CBRF employees may be employed by or volunteer for a hospice during non-CBRF employment hours. The hospice will ensure:
  - Accurate time records and wage and hour compliance
  - The hospice employee or volunteer will provide care and services only to hospice patients.
  - Clear delineation of responsibilities to avoid allegations of dual reimbursement or inducement of referrals
- The hospice and the CBRF will ensure that all state and federal employment regulations are met. Individual employer records will be kept by each entity and shared with the other entity as specified in the contract.
- Specify orientation and on-going training requirements, as per contract.
- Criminal background checks will be completed per contract.

B. Patient/Resident Assessment

The agreement between the CBRF and the hospice stipulates responsibilities related to patient/resident assessments. Both providers are required to complete assessments periodically and sharing these evaluations will be important for addressing the patient/resident needs.

Hospice

- **An interdisciplinary team consults with the patient’s/resident’s attending physician** and completes an initial comprehensive assessment when the hospice determines that a patient/resident is appropriate for admission to hospice, even if the patient/resident is already a CBRF resident.
- This comprehensive assessment identifies the physical, psychosocial, emotional, and spiritual needs related to the terminal illness and insures that they are addressed in order to promote the hospice patient’s well-being, comfort, and dignity throughout the dying process.
- Hospice should involve the CBRF staff in providing information about the patient/resident as part of the comprehensive assessment.
- Hospice utilizes the comprehensive assessment and any updates in planning the patient’s/resident’s care.

CBRF

- The CBRF holds a face-to-face interview with the patient/resident or representative, and other service providers as necessary, and completes a resident assessment in the same manner as they would a non-hospice resident assessment.

- The CBRF may involve hospice staff in providing information relating to the patient's terminal illness for inclusion in their resident assessment.

C. Plan of Care

The CBRF and hospice must develop a coordinated plan of care for each patient/resident that guides both providers. The coordinated plan of care must identify which provider (hospice or CBRF) is responsible for performing a specific service. The coordinated plan of care may be divided into two portions, one of which is maintained by the CBRF and the other by the hospice. Based on the shared communication between providers, both providers' portion of the plan of care should reflect the identification of:

- A common problem list
- Palliative interventions
- Palliative outcomes
- Responsible discipline
- Responsible provider
- Patient/resident goals

When a patient/resident is admitted, both providers are responsible for establishing and updating their portion of the plan of care based on their requlations.

- When a patient/resident is admitted and on an ongoing basis, both providers are responsible for establishing/updating their portion of the plan of care based on their regulations. The hospice interdisciplinary group (IDG) establishes and maintains the plan of care for hospice service for the terminal illness and related conditions in consultation with CBRF staff, the attending physician (if any), and the patient/resident or representative. The hospice and CBRF establish a mechanism for the exchange of information to ensure that a coordinated plan of care is utilized in the provision of care.

The provision of care by each provider for the patient/resident and their family is based on the coordinated plan of care. The care, treatment, and services by either provider related to the terminal illness and related conditions must be provided based on the hospice portion of the coordinated plan of care.

- Hospice may involve CBRF nursing personnel in the administration of prescribed therapies, as they would use the patient/resident's family/caregiver in implementing the plan of care. Hospice remains responsible for arranging, providing, and ensuring availability for patient/resident use of medications or other interventions for symptom control, medical supplies, or DME related to the terminal illness. The hospice's care includes the provision of the respective functions that have been agreed upon and included in the hospice portion of the coordinated plan of care as the responsibility for hospice to perform.

The providers must have a procedure that clearly outlines the chain of communication between the hospice and the CBRF in the event a crisis or emergency develops, a change of condition occurs, and/or changes to the hospice portion of the plan of care are indicated.

D. Expected Outcomes

Certain changes in patient/resident condition are expected outcomes with a high probability of occurring as part of the progression of the terminal illness and/or dying process. Some examples include the following. Both providers may want to discuss possible interventions should the need arise.

- **Dehydration and Fluid Maintenance.** Changes in hydration status and fluid balance may occur as part of the progression of the terminal illness and/or dying process.

- **Psychosocial Changes.** Changes in lifestyle and interactions may occur as part of the progression of the terminal illness and/or dying process.

- **Activities of Daily Living (ADL).** The hospice patient/resident residing in the CBRF may become increasingly dependent on assistance with his or her activities of daily living as part of the progression of the terminal illness and/or dying process.

- **Mood States.** The person experiencing a terminal illness, from diagnosis to death, is anticipated to have emotional fluctuations.

- **Activities.** A decrease in or non-involvement in activities is an expected outcome of the progression of the terminal illness and/or dying process.

- **Nutritional Status.** Declining nutritional status with progressive weight loss may be expected in a terminal illness.

- **Sensory Functions.** A decrease in sensory function may occur as part of the terminal illness and dying process.

E. Special Circumstances

Changes in patient/resident condition that present the potential need for feeding tubes or physical restraints warrant special consideration. These interventions may have potential expected outcomes when utilized for patients/residents with progression of the terminal illness and/or dying process; and they are of such a nature as to merit different elements of review.

- **Physical Restraints.** Physical restraints, of the least restrictive type appropriate to the patient/resident, may be used in CBRFs, but **only** under the order of a physician and with department approval. CBRFs must submit a request for the use of physical restraints to the Bureau of Assisted Living's regional office. The request should include a copy of the doctor's order and the hospice's recommendation and assessments addressing the need for restraint. If used, the restraints must enable the patient/resident to maintain his or her highest level of function.

  Restraint use must be consistent with federal Medicare guidelines (hospice), state administrative rules --- DHS 131 (hospice), DHS 83 (CBRF), and with Department of Health Services guidance. Additional information can be obtained from:

  http://www.fda.gov/downloads/MedicalDevices/Safety/AlertsandNotices/PublicHealthNotifications/ucm063107.pdf

- **Feeding Tubes.** A normal part of the dying process is the body's decreased need and the patient/resident's decreased desire for nutrition and hydration. The hospice is responsible for discussing the use of feeding tubes with the patient/resident/family as the terminal illness progresses and will initiate enteral/parenteral feeding at patient/resident/family request, as consistent with the philosophy of the individual hospice. CBRF staff is involved to the extent that the hospice would routinely utilize the patient/resident's family/caregiver in the provision of enteral/perenteral feedings.

SECTION V GUIDELINES FOR INSERVICE / EDUCATION PLANNING

Clear communication of the basic components of the contract, the policies and protocols that guide care coordination, and understanding the key regulations that govern both providers is essential for a successful CBRF/hospice partnership. Achieving quality outcomes for patient/residents and their families should be the focus of all staff efforts.

Assuring effective participation by all levels of staff requires careful planning of the initial orientation following the establishment of a contract. Ongoing educational efforts aimed at improving the efficiency and understanding of experienced and new staff is also essential.

It is the hospice's responsibility to assess the need for hospice employee training and coordinate their staff training with representatives of the CBRF. It is also the hospice's responsibility to determine how frequently training needs to be offered in order to ensure that the CBRF staff furnishing care to hospice patient/residents are oriented to the philosophy of hospice care. CBRF staff turnover rates should be a consideration in determining training frequency.

Suggested content for these educational efforts are separated into "Initial Orientation" and "Ongoing Education."

A. Initial Orientation

Introducing the hospice concept to CBRF staff may be most effectively accomplished by using an interdisciplinary approach. Representation from each of the core disciplines is ideal to establish trusting relationships and encourage professional interaction. Recommendations for inclusion in the initial orientation process are listed below.

Note: *It may be useful to group the topic areas according to individual roles of CBRF staff (i.e., meeting with business office and clerical staff separately from direct patient/resident care staff to allow for questions and discussion specific to the expertise of the group).*

- Discussion of hospice concept and philosophy, including patient/resident's entitlement
- Informed consent and corresponding expectations/accountabilities
- Services available; delineation of benefits
- Introduction of core team members/roles
- Introduction and discussion on the use of hospice volunteers
- Terminology; definition of terms as specified in the contract
- How/when to notify hospice

- On call availability
- Discussion of mutual roles and responsibilities as outlined in the contract
- Communication and collaboration relating to care planning, ongoing patient/resident needs, family support, and record maintenance
- Symptom management practices common for hospice patient/residents
- Securing and processing of physician orders (including utilization of standing orders, if applicable)
- Reimbursement scenarios
- Bereavement services available
- Location of resource materials, such as a hospice manual with accompanying quick references
- DME, disposable supplies, oxygen, and ancillary services to be supplied by the hospice
- Provision of pharmacy services

Clarifying the role of the hospice team in the CBRF needs to be balanced by a corresponding effort to educate hospice staff on the regulations and protocols of the CBRF. Information to be included in this effort might include the following:

- Tour of the facility, with introductions of key personnel, location of records, security system operation, and any information specific to the physical layout and daily routine
- Reporting procedures when entering or leaving the CBRF
- Discussion of patient/resident rights
- Physical environment, including fire/emergency procedures, exits, etc.
- Key terminology; definition of terms, including terms specified in the contract
- Comprehensive assessment process and requirements
- Care planning process, including conferences, family involvement, etc
- Record keeping practices, including documentation and access to electronic records
- Infection control issues, especially including biohazard waste disposal, location of personal protective equipment and blood spill clean-up kit, etc.
- Chemical/physical restraints
- Medication management, including requlations governing use of psychotropic, “unnecessary medications,” self-medication, etc.
- Patient/resident level of care reimbursement scenarios
- Pertinent facility policies (i.e., CPR, hydration, RN coverage, any policies that explore ethical issues)

B. Ongoing Education

Many hospices provide updates for their contracted CBRFs to review practical issues related to mutual roles and responsibilities. This provides an opportunity for dialogue, problem solving, feedback, and recognition of the cooperative relationships and the impact this collaboration has on quality care for patient/residents. Likewise, CBRFs may want to provide similar opportunities for

hospice staff to share current trends and industry standards. Suggested topics for these periodic hospice updates include:

- Pain control and other symptom management protocols commonly used for hospice patient/residents
- Loss, grief, and bereavement care
- Quality assurance and performance improvement study results and recommendations
- Practical issues related to communication with physicians, management of orders, etc.
- Care plan coordination processes
- Volunteer involvement and utilization
- Review and discussion of mutual roles and responsibilities, as appropriate

Some hospices hold regular conferences in the CBRF on a prearranged schedule to communicate patient/resident related issues. Others conduct occasional IDG meetings in the CBRF and encourage CBRF staff participation.

These suggestions, as well as the guidelines for initial orientation, are not intended to be all-inclusive. Creative approaches that foster improved understanding and communication between the CBRF and hospice providers are encouraged. The use of various “mediums” is helpful to have available in the CBRF for staff who are unable to attend scheduled in-services. These might include audio/video tapes, self-learning modules, quick reference materials, and a manual containing pertinent hospice protocols/policies.